Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

May 25, 2012

Craigan Gray, M.D., M.B.A., J.D.
Director
Division of Medical Assistance
North Carolina Department of Health and Human Services
2501 Mail Service Center
Raleigh, North Carolina 27699-2501

Attention: Teresa Smith

RE: North Carolina Title XIX State Plan Amendment, Transmittal # NC 11-050

Dear Dr. Gray:

We reviewed the proposed amendment to the North Carolina Medicaid State Plan Amendment (SPA) NC 11-050 that was received in the Regional Office on October 31, 2011. The amendment allows North Carolina to implement the Health Homes provision through Section 2703 of the Affordable Care Act. Through this SPA, North Carolina will receive additional Federal support for the enhanced integration and coordination of primary, acute, and long term services and supports for persons across the lifespan who have chronic illness. In accordance with the statutory provisions at Section 1945(c)(1) of the Social Security Act, payments may be made to health home providers under NC 11-050 during the first 8 fiscal year quarters that the SPA is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

In addition, this approval is based on the State's agreement to implement and comply with CMS' health home core set of quality measures.

Based on the information provided, we are now ready to approve the Medicaid State Plan Amendment NC 11-050. This SPA was approved on May 24, 2012. The effective date of this amendment is October 1, 2011. We are enclosing the approved form HCFA-179 and plan pages.

If you have any questions or need any further assistance, please contact Elaine Elmore at (404) 562-7408 or Yvette Moore at (404) 562-7327.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **11- 050**

2. STATE: **NC**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **October 1, 2011**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 2703 of the Affordable Care Act (Pub. L. 111-148 and Pub. L. 111-152

7. FEDERAL BUDGET IMPACT:
a. **FFY 2012 $18,864,732**
b. **FFY 2013 $18,864,732**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Entered in the Medicaid Model Data Lab Web-Based Tool: Prints out Pages 1-31

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
N/A

10. SUBJECT OF AMENDMENT:
Health Homes

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: SECRETARY

12. SIGNATURE OF STATE AGENCY OFFICIAL: Lanier M. Cansler

13. TYPED NAME: Lanier M. Cansler

14. TITLE: Secretary

15. DATE SUBMITTED: 10/25/11

16. RETURN TO:
Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 10/31/11

18. DATE APPROVED: 05/24/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/12

20. SIGNATURE OF REGIONAL OFFICIAL: Jackie Glaze

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS:

Holly, Mary V. (CMS/CMCHO)

From: CMS SPA_Waivers_Atlanta_R04 [SPA_Waivers_Atlanta_R04@cms.hhs.gov]
Sent: Thursday, May 24, 2012 7:02 PM
To: Holly, Mary V. (CMS/CMCHO); Noonan, Darlene F. (CMS/CMCHO); Gilbert, Rosario G. (CMS/SC)
Subject: FW: MMDL System alert: id NORTH CAROLINA; state North Carolina; draftId 34; status APPROVED

From: mmdl.support@thomsonreuters.com[SMTP:MMDL.SUPPORT@THOMSONREUTERS.COM]
Sent: Thursday, May 24, 2012 7:01:42 PM
To: Teresa.Smith@dhhs.nc.gov
Cc: CMS SPA; Farkas, Mary Pat P. (CMS/CMCS); Hentz, Cynthia J. (CMS/CMCS); CMS SPA_Waivers_Atlanta_R04; Holly, Mary V. (CMS/CMCHO)
Subject: MMDL System alert: id NORTH CAROLINA; state North Carolina; draftId 34; status APPROVED Auto forwarded by a Rule

Document 'Health Home Services Forms (ACA 2703)' for 'NORTH CAROLINA' status changed to 'APPROVED' on 'Thu, 24 May 2012 18:01:42 GMT' by 'MaryHolly'('Mary.Holly@cms.hhs.gov'). (Alert refId 86; draftId 34)

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MEDICAID MODEL DATA LAB

Id: NORTH CAROLINA
State: North Carolina
Health Home Services Forms (ACA 2703)
Page: 1-10

TN#: NC-11-0050 | Superseeds TN#: NC-00-0000 | Effective Date: 10/01/2011 | Approved Date: 05/24/2012

Transmital Numbers (TN) and Effective Date

Please enter the numerical part of the Transmital Numbers (TN) in the format YY-0000 where YY = the last two digits of the year for which the document relates to, and 0000 = a four digit number with leading zeros. The dashes must also be entered. State abbreviation will be added automatically.

Supersedes Transmital Number (TN)

00-0000

Transmital Number (TN)

11-0050

Please enter the Effective Date with the format MM/dd/yyyy where MM = two digit month number, dd = the two digit day of the month, and yyyy = the four digit year. Please also include the slashes (/).

Effective Date

10/01/2011

3.1 - A: Categorically Needy View

Attachment 3.1-H

Page

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

- [x] Health Home Services

How are Health Home Services Provided to the Medically Needy?

Same way as Categorically Needy

i. Geographic Limitations

Statewide Basis

If Targeted Geographic Basis,

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

- [x] Two chronic conditions
- [x] One chronic condition and the risk of developing another
- [ ] One serious mental illness

from the list of conditions below:

- [ ] Mental Health Condition
- [ ] Substance Use Disorder

- [x] Asthma
- [x] Diabetes
- [x] Heart Disease
- [x] BMI Over 25
- [x] Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

Health Home services are delivered through the Community Care of North Carolina program. CCNC has structured its chronic illness strategy to give providers the capability to draw on care management resources based on their assessment of need in their patients. We identify patients through direct referrals, by mining administrative claims data (e.g., risk stratification tools, frequent hospital and emergency room admissions), through screenings and assessments, and through chart reviews that identify gaps in care. As per the Affordable Care Act statute, CCNC will only enroll persons in the Health Homes program if they have two chronic conditions or have one chronic condition with risk for a second chronic condition. We have developed the below list of qualifying chronic conditions based on analysis of prevalence of chronic illness in our population accessing Health Home services in the CCNC program.

Health Homes Qualifying Conditions
1. Blindness
2. Chronic cardiovascular disease
3. Chronic pulmonary disease
4. Congenital anomalies
5. Chronic disease of the alimentary system
6. Chronic endocrine and metabolic disease
7. Chronic infectious disease
8. Chronic mental and cognitive conditions, not including mental illness or developmental disability
9. Chronic musculoskeletal conditions
10.Chronic neurological disorders

Consistent with the Affordable Care Act requirements for Health Homes, eligibility for Community Care of North Carolina enrollment includes all categorically-eligible Medicaid recipients including dually eligible individuals and persons enrolled in 1915c waivers.

Enrollment in the Health Homes program is voluntary through enrollment in CCNC. Health home services will be delivered through the CCNC program, which is voluntary due to the availability of the Carolina Access program. Both CCNC and Carolina Access are described as PCCM programs in North Carolina's Medicaid State Plan. Carolina Access lacks the care management infrastructure and provider mandates that characterize our Health Homes services. PCCM as a whole is voluntary for dually eligible individuals, Indians who are members of federally recognized Tribes, children eligible for Supplemental Security Income (SSI) under title XVI, and children in foster care or other out-of the-home placement. For all others, PCCM (either CCNC or Carolina Access) is mandatory. However, all individuals can select the Carolina Access program and opt out of participation in Health Homes. Medicaid recipients may also apply for a Medical Exemption to enrollment in PCCM (that is, either CCNC or Carolina Access).

For certain diagnoses we will enroll based on the presence of that diagnosis alone in claims and we will be presuming risk of a second based on the inherent risk of the first diagnosis. We will presu1me risk of a second diagnosis for the following diagnoses.

1. Chronic Endocrine and Metabolic Disease: Diabetes -- According to the American Diabetes Association, individuals with diabetes are at risk for high blood pressure, heart disease, blindness, nervous system damage (neuropathy), depression, kidney disease and stroke.
2. Chronic Cardiovascular Disease: Hypertension -- According to the American Heart Association, hypertension is a strong risk factor for coronary heart disease, depression and stroke.
3. Chronic Pulmonary Disease: Asthma -- Children and adolescents are at risk for depressive symptoms because of the chronicity and need for daily medication. According to the Behavioral Risk Factor Surveillance System Report, persons with asthma have significant increased risk for developing major depressive disorder.
4. Chronic Cardiovascular Disease: Anemias/chronic blood disorders -- Poorly managed anemia stresses the heart and can lead to coronary disease and heart failure, according to the National Heart, Lung and Blood Institute.
5. Chronic Neurological Disorders: Chronic Pain -- Chronic pain disorder has a high rate of co-occurrence with major depression and substance use disorders, according to the American Psychiatric Association.
6. Chronic Pulmonary Disease: Pulmonary disease/Chronic Bronchitis -- Multiple epidemiological analyses have found highly elevated risk for co-morbid cardiac disease and hypertension for persons with COPD, chronic bronchitis, and related chronic pulmonary conditions.
7. Chronic Infectious Disease: Perinatal infections -- Perinatal infections involve risk of poor weight gain and elevated risk of long-term neurological damage, according to the American Academy of Pediatrics.
8. Chronic Endocrine and Metabolis Disease: BMI > 25 -- According to the American Heart Association, obesity increases the risk of diabetes, hyperlipidemia, hypertension, cardiovascular and cerebrovascular disease.

For all other diagnoses we will require documentation of 2 qualifying non-SPMI diagnoses through claims for enrollment in Health Homes.

We will not consider conditions specific to pregnancy as qualifying conditions—gestational diabetes, gestational hypertension, eclampsia, and related conditions. However, we will monitor them as presenting a risk of developing a chronic condition. Gestational diabetes is a major risk factor for chronic diabetes, and gestational hypertension is a risk factor for longer term hypertension. For clients identified as having a single Health Homes qualifying condition, the presence of gestational diabetes, gestational hypertension, eclampsia, and related conditions will make them eligible for Health Homes.

iii. Provider Infrastructure

- [ ] Designated Providers as described in §ection 1945(h)(5)

- [x] Team of Health Care Professionals as described in §ection 1945(h)(6)

Provider Infrastructure
(Indicate whether designated providers, team of health care professionals or health team. SAMHSA has suggested to include team composition and roles in its guidance.) Designated Providers:
Team of Health Care Professionals:
The Team of Health Care Professionals centers on the Primary Care Provider. Each Community Care enrollee is linked to a primary care provider to serve as a medical home that provides acute and preventive care, manages chronic illnesses, coordinates specialty care and referrals to social, community, and long-term care supports, provides comprehensive care management, and provides 24/7 on-call assistance. Providers are paid a Per Member Per Month fee for medical home services, separate from Medicaid fee-for-service payments. North Carolina's Health Homes program incorporates three elements of wraparound clinical services that work together with Primary Care Medical Homes.
1. Regional, provider-run non-profit community networks that are comprised of physicians, hospitals, social service agencies, and county health departments interact both with beneficiaries and providers with the goal of achieving long-term quality, cost, access, and utilization objectives in the management of care for Medicaid recipients.
2. Care management infrastructure, including at the statewide and regional network levels as well as embedded at the provider level, which complement the care management provided directly by PCPs and their care teams. The CCNC network level care managers work in concert with PCPs to identify and manage care for high-cost, high-risk patients, as required in an agreement between the regional network and the primary care practice. CCNC care managers are locally-based. Care managers serve multiple roles. They visit patient homes, when

appropriate, to perform medication reconciliation and assessments. They work with PCP care teams to plan and coordinate referrals for community and social supports and assist with referrals, as needed. They work onsite with practices and their staffs to integrate system design changes so that evidence-based practice guidelines can be implemented and communicate face-to-face with patients and their families and/or caregivers. CCNC embedded care managers work in practices with large numbers of chronically ill patients to support the PCPs in managing the highest risk and cost patients, by working with an interdisciplinary team that is led by the PCP to jointly develop individualized care plans. Each Community Care network hires care management staff based on the targeted quality improvement and care management initiatives it is pursuing. Most networks employ a mix of network level and embedded care managers who are nurses and social workers, including behavioral health social workers with master's degree. Networks also employ pharmacists, who engage in management of medication adherence and prevention of adverse drug events for chronically ill recipients, including post-acute medication reconciliation. Beginning in March 2011, North Carolina has implemented a Pregnancy Care Management program, which includes local care management in collaboration with obstetrics providers working with CCNC-enrolled pregnant women who have been identified as high risk. Care managers are expected to closely monitor the pregnancy through regular contact with the physician and patient to promote a healthy birth outcome. Individuals in Pregnancy Care Management are also typically enrolled in the primary care health home. Pregnancy Care Management provides supplemental, specialized care management within the CCNC program. This program does not seek to duplicate medical home services but rather to link ob/gyns into the CCNC care management infrastructure and to fund Pregnancy Care Management at CCNC. PMPM payments to CCNC for Pregnancy Care Management that are associated with pregnant women who have qualifying conditions are considered part of the Health Home.

3. A non-profit statewide coordinating agency that works with the State Medicaid Agency (DMA), the regional networks and with primary care providers and case managers to implement a wide array of disease and care management initiatives. The North Carolina Community Care Networks (NC-CCN) is a non-profit organization whose activities include providing targeted education and care coordination, implementing best practice guidelines, and monitoring results.

☐ Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

Comprehensive care management involves active participation from PCPs, care managers, and patient and family/caregivers and includes:
• Patient identification and comprehensive assessment through direct referrals, by mining administrative claims data (e.g., risk stratification tools, frequent hospital and emergency room admissions), through screenings and assessments, and through chart reviews that identify gaps in care;
• Developing an individualized care plan: The health care team — including the care manager, primary care provider, patient and family/caregiver — agree on goals in a 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. [See further details below.]
• Reassessment and monitoring: The health care team monitors the patient's progress toward goal achievement on an ongoing basis, adjusting care plans, as needed; and
• 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;

An average AFDC (Aid to Families with Dependent Children) caseload per care manager ranges between 5,000 to 7,500 enrollees per care manager, and an average ABD (aged, blind and disabled) caseload ranges from 1,500 to 3,500 enrollees per care manager. These caseloads are assigned with the assumption that only five to ten percent of the population will require care management at any given time. The care managers provide interventions at varying levels of intensity, some of which occur face-to-face while others are telephonic.

Ways Health IT Will Link

The Care Management Information System (CMIS) is a Web-based portal accessible to all networks, allowing care managers to maintain a health record and single care plan. A monthly import of Medicaid enrollment and claims data populates the CMIS patient record with demographic and primary care provider information as well as a view of the individual's hospital, emergency department and pharmacy claims. Elements of CMIS information, including care team contact information is available in the Informatics Center Provider Portal to assist PCPs in their care provision.

The following is a list of the types of Comprehensive Care Management activities documented in CMIS. All of these activities can be used in queries and reports.
• Initial screenings and assessments.
• Patient care plan.
• Information gathered during in-person visits or telephonically.
• Results from chart audits, including gaps in care.
• Interventions and strategies used in the care management processes.
• Patient's progress in achieving individual goals.
• Care management activities (including number of patients receiving comprehensive assessments, PHQ9s/depression screening, patient self-management notebook, transitional support, pharmacy consult, medication review, home visit, education, face-to-face encounters, etc.).
• Patients meeting "priority" criteria for assessment who were touched by the care manager and the intensity level of the care management activity.
• Percentage of patients being managed at "heavy- or medium-" intensity levels.
• Percentage of hospitalized patients who were touched by a care manager in a specified period of time.
• Communication gathered from other providers and resources.
• Needed follow-ups and reminders.

Community Care monitors and evaluates the performance and activities of all care managers through the CMIS. Each manager's patient activity is standardized, and networks and the central office have the ability to create parameterized queries at the patient, practice, network or care manager level. These reports enable both care managers and supervisors to examine activities and interventions on a macro level and compare progress and outcomes of interventions.

Care Coordination

Service Definition

Care Coordination, a core component of Care Management, is the implementation of the individualized care plan (developed by the health care team with active PCP, care manager, and patient and family/caregiver involvement) 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, with their primary responsibility being to ensure implementation of the care plan for achievement of clinical outcomes consistent with the needs and preferences of the client. CCNC care manager care coordination interventions are identified and documented in CMIS.

The Mental Health Integration program aims to improve the screening and treatment of mental health conditions in the primary care setting

and enhance the medical care of individuals with behavioral health problems. CCNC is working to implement the Four Quadrant Clinical Integration Model as the foundation for communication, collaboration, assessment, referral and clinical management of care. After an initial pilot period, the model is being implemented statewide, with primary care practices having incorporated behavioral health treatment in the primary care provider office setting while also supporting enhanced referral processes for more complex patients to specialty mental health services and behavioral health care coordination. The CCNC central office and networks use psychiatrists to coordinate implementation of the four quadrant model and to identify patients with behavioral and physical health care needs for the PCPs.

Ways Health IT Will Link

CCNC staff, including Care Managers, nurses, social workers, and pharmacists have routine access to recipient utilization history and care management history through the CMIS web portal. This access drives care coordination efforts and is complemented by information made available to providers through the Informatics Center Provider Portal to assist with care coordination, which was released in August of 2010. This portal was built with the treating provider in mind, offering elements of CMIS, Pharmacy Home, and the Reports Site, 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 a Medicaid patient health record which includes patient information, care team contact information, visit history, pharmacy claims history, and clinical care alerts. Importantly, the use of Medicaid 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, ED visits, primary care and specialist visits, laboratory and imaging) that occurred outside of their local clinic or health system. Contact information for the patient's case manager, pharmacy, mental health therapy provider, durable medical equipment supplier, home health or personal care service provider is readily available. Providers can discern whether prior prescriptions were ever filled, and what medications have been prescribed for the patient by others. Built-in clinical alerts appear if the claims history indicates patients may be overdue for recommended care (e.g. diabetes eye exam, mammography).

Health Promotion

Service Definition

Health Promotion services assist patients to participate in the implementation of their care plan and place a strong emphasis on skills development for management and monitoring chronic health conditions. Health promotion is an integral service provided by PCPs and their care teams or CCNC care managers. Most of the quality improvement initiatives conducted by the networks include a health promotion component, which educates PCPs and their care teams about ways to promote health with their patients and also gives PCPs easily accessible tools to use with their patients. Health promotion services include CCNC care managers and PCPs or their care teams providing 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, promoting lifestyle interventions, including but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity.

Ways Health IT Will Link

CMIS provides a standardized framework for care manager workflow management and documentation, incorporating tools for patient assessment, goal setting, and health coaching. Care managers utilize comprehensive health assessment and functional assessment tools, as well as disease-specific screening and monitoring modules, and evidence-based, tailored health coaching for patient self-management support. Elements of CMIS information, including health promotion activities by CCNC care managers is available in the Informatics Center Provider Portal to assist PCPs in their care provision. In addition, there are an array of web-based tools that CCNC provides for network providers.

The following is a list of the types of Health Promotion activities documented in CMIS and available in queries and reports:
• patient self-management tool kit
• medication review
education, including preventive care, disease management and/or self-management training such as educating patient on medications and potential side effects, teaching about the medical home, and reviewing disease red flags to report to the PCP.

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Service Definition

A transition occurs any time a patient moves from one care setting to another or when s/he moves from one area to another within the same care setting.

Every CCNC hospital admission is assessed for transitional care need using real-time data from multiple sources. Transitional care is initiated, in some cases on the first admission, for patients with chronic conditions at high risk of readmission and for conditions in which the admission is ambulatory-care sensitive.

Networks provide transitional care management to all hospitals in their region. Networks are mandated to maintain active referring relationships with all hospitals to facilitate access to primary care following hospital discharge or emergency department services. Onsite embedded care management is provided through 55 CCNC transitional care nurses who work full-time in hospitals with a large volume of admissions for the ABD population. Hospitals with embedded transitional care managers account for 80% of Medicaid ABD inpatient admissions.

The primary role of the care manager in the transitional care process is to:
• Facilitate interdisciplinary 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 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.

The Community Care networks connect the PCP/medical home to the community. To support more effective transitions, networks have forged links with all North Carolina hospitals to obtain timely information about their hospitalized patients.

CCNC care managers also schedule visits with patients in the hospital and then follow up with home visits within three days of discharge. One of the key functions is to perform medication reconciliation on hospitalized patients that seek to make sense of all the different medications the patients may take (from the medicine cabinet, the PCP's list, hospital discharge instructions, specialists and behavioral health providers, over-the-counter meds, etc.). Post-discharge home visits not only support medication reconciliation efforts but also provide care managers with valuable knowledge about the patients' home environments and support issues.

The PCP is informed about an admission by CCNC care manager provision of a copy of the hospital discharge summary, either electronically or by mail, depending on what format is available. CCNC transitional care staff update the patients' medical homes about hospitalizations, other prescribed medications, social and environmental concerns, and other agencies providing services such as personal care, home health care and behavioral health support, and make sure that the PCP receives discharge summaries. Network Pharmacists review medication lists and alert the PCP of discrepancies and other findings. Transitional care staff shares information among a variety of local agencies, including behavioral health providers and long-term care support providers.

Ways Health IT Will Link

Transitional care is triggered by CCNC network access to "real-time" admission/discharge/transfer data from most hospitals in their respective communities. Additional "real-time" data is accessed through the use of Thompson-Reuters data or embedded hospital care managers have direct access to hospital census data. These three data sources provide access to real-time data across all hospitals statewide, which is then screened by CCNC care managers to determine the need for transitional care services. Post-acute care coordination and medication reconciliation relies on electronic data sources, including the PCP problem and medication lists and hospital discharge instructions, and information from face-to-face assessments of transitional care recipients at the hospital bedside by CCNC care managers, at the recipient's home and at follow-up appointments at the medical home.

The following is a list of the types of Transition Care activities documented in CMIS. All of these activities can be used in queries and reports.
• Patient care plan.
• Information gathered during in-person visits or telephonically.
• Transitional support
• Medication review
• Medication reconciliation
• Home visit
• Percentage of hospitalized patients who were touched by a care manager in a specified period of time.
• Communication gathered from other providers and resources.
• Needed follow-ups and reminders.

Individual and Family Support Services (including authorized representatives)

Service Definition

Individual and family support services activities are provided by PCPs and their care teams or CCNC care managers and include, but are not limited to: advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them 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.

PCPs have a key role in CCNC initiatives to support appropriate referrals. Many network activities are geared toward supporting and educating PCPs how to promote access to community services and resources in their role as Health Home provider. In different practice areas this guidance takes different forms.

For patients in need of long-term care and aging services, Regional networks have each formed a LTC Steering Committee to connect CCNC network primary care practices to local Aging and Disabilities Resource Centers and Area Agencies on Aging. CCNC Network Clinical Directors lead the Steering Committees. CCNC networks also produce Resource Manuals for network practices tied to the local and regional continuum of medical, social and long-term care services. Every CCNC Resource Manual incorporates detailed information regarding local resources. North Carolina received the CMS "State Demonstration to Integrate Care for Dual Eligible Individuals" Grant, which is enabling us to plan further improvements in this area.

CCNC networks provide detailed protocols regarding effective approaches to supporting recipients with chronic illness with regard to self-management of chronic illness and access to community and medical resources to support improved health and well-being. Care managers develop relationships with recipients and, when possible, their family and social supports through face-to-face and telephonic interactions.

Ways Health IT Will Link

The Care Management Information System incorporates a record of all care management interventions, including provision of Individual and Family Support Services.

The following is a list of the types of Individual and Family Support Services activities documented in CMIS. All of these activities can be used in queries and reports.
• Referral to community resources and social supports
• Advocacy
• Conducting medication education
• Providing Patient Tool Kits (including Patient Self-Management tool kit) and
• Scheduling support (including for transportation services)

Referral to Community and Social Support Services

Service Definition

Community Care works holistically. We require network providers, with care management support, to attend not only to the delivery of physical health care services but to address social, mental and community issues that may impact health and medical care. Care management recognizes the social and environmental factors that affect population health. As part of our care management approach, Community Care works to increase access to appropriate community and social support services, and to utilize and organize community resources. Local agency and resource knowledge is a key advantage of our use of locally-based care managers, and they share this knowledge with network providers by providing Resource Manuals containing relevant contact information for an array of community and social support services.

Ways Health IT Will Link

The Care Management Information System incorporates a record of all care management interventions, including referrals to community and social support services.

v.Provider Standards

Consistent with the requirements of the Affordable Care Act and the November 16, 2010 Health Homes State Medicaid Directors Letter, North Carolina has established methods to support providers of health home services in addressing the following components of health homes:
• Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
• Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
• Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
• Coordinate and provide access to mental health and substance abuse services;
• Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
• Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
• Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
• Coordinate and provide access to long-term care supports and services;
• Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
• Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
• Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

These supports include an extensive infrastructure, described in further detail in the Provider Infrastructure and other sections above, which includes 1) regional, provider-run non-profit community networks that promote collaborative patient-centered care planning among community providers, 2) an extensive care management system to support practices in helping to manage patients with complex medical, social, behavioral health, and long-term care service and support needs and transform their practice systems, and 3) a non-profit statewide coordinating agency that works with DMA, the regional networks and with primary care providers and case managers to implement a wide array of disease and care management initiatives and activities, including providing targeted education and care coordination, implementing best practice guidelines, and monitoring results. In addition, CCNC provides ongoing data and feedback to practices via its Informatics Center Provider Portal that provides timely and relevant information on how patients and interventions are being implemented and highlights opportunities for improvement. Through a secure web portal, treating providers in the primary care medical home, hospital, emergency room, or mental health system can access a Medicaid patient health record which includes patient information, care team contact information, visit history, pharmacy claims history, and clinical care alerts.

Each CCNC Network executes agreements with local PCPs to work collaboratively with the Network to provide health home services. In addition to meeting basic requirements of Medicaid primary care providers (e.g., 24 hours per day/7 days per week coverage, admitting privileges, etc.), Network providers must do the following as part of their participation in the Network:
• Cooperate with the CCNC Network in the development and utilization of care management systems and tools for managing the care of Medicaid enrollees. Cooperation includes:
o identification of a "practice champion" for the Chronic Care Program;
o attending meetings detailing initiatives, expectations ,and performance, as requested by the network;
o assisting in the development of a transitional care program; and
o providing clinical information necessary to establish effective care management processes for the provision of cost-effective and quality health.
• Comply with the policies and procedures developed by the Network's Medical Management Committee and / or Steering Committee that aim to effectively manage the quality, utilization, and cost of services, including but not limited to inpatient admissions; emergency room visits; specialty and ancillary referrals; early detection and health promotion; Health Check (EPSDT); chronic and high cost diseases, at risk patients; and pharmacy prescribing patterns.
• Cooperate with the Network's patient risk assessment process to identify and track those Medicaid recipients that would most benefit from targeted care management and disease management activities.
• Participate, as requested by the Network, in interdisciplinary teams to help manage and optimize patient care of those enrollees at highest risk and cost.
• Authorize and coordinate with the Network care managers in carrying out the enhanced care management activities targeting Medicaid recipients enrolled with the practice.
• Participate in the implementation of Network approved care management plans for at-risk and/or high cost enrollees.
• Work in concert with the Network to:
o develop specific strategies to address special needs of the Medicaid population;
o develop local referral processes and communications with specialists;
o promote enrollee's ability and confidence in their self-management of chronic illness(es);
o develop plans to meet CCNC utilization and budget targets;
o evaluate and implement appropriate changes in service utilization; and,
o develop and refine CCNC measures, utilization reports, management reports, quality improvement goals, and care management initiatives.

vi. Assurances

☑ A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

☑ B. The State has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

☑ C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

Data Source:
Claims

Measure Specifications:
CCNC tracks avoidable hospital readmissions throughout the year and sets annual targets for each Network for certain measures. All of these measures will be produced to capture Health Homes enrollees separately.

For most measures, the State receives monthly reports at the Network level and each of the Networks review the data at the network, provider, and patient level and use the information to target interventions.

Potentially Preventable Readmissions within 30 days post-discharge
• All ages (with dually eligible Medicare claims included to extent CMS develops capacity to share them as currently proposed.)
• Preventable readmissions (readmissions within 30 days) as a percent of total admissions, excluding: same-day transfers, long-term care admissions, rehabilitation, state mental hospital, hospice admissions, and observation stays are not considered hospital admissions.

Potentially Preventable Readmissions w/in 30 days as a percent of potentially preventable hospital admissions, any diagnosis, excluding mental health.
Baseline: SFY 2010. Reported quarterly.
Target:
• 4% reduction from baseline rate by end of year 1 (SFY 2011);
• maintain 4% reduction from baseline rate by end of year 2 and year 3
Targets are currently for ABD non-duals. Duals targets will be set after additional experience and spread statewide.

Heart Failure 30-day readmissions
Hospital admissions within 30 days of prior discharge date with CHF primary or secondary diagnosis, as percentage of CHF hospital discharges. Reported quarterly on a rolling 12 month basis.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

Data Source:
Claims

Measure Specifications:
We 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. Cost measures will include:
1. Total PMPM costs (subtracting behavioral health costs and residential services)

2. Acute care costs
3. ED Costs
We will report cost trends on an annualized basis.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

The Care Management Information System (CMIS) is a Web-based portal accessible to all networks, allowing care managers to maintain a health record and single care plan that stays with the patient as he or she moves from one area of the state to another. A monthly import of Medicaid enrollment and claims data populates the CMIS patient record with demographic and primary care provider information as well as a view of the individual's hospital, emergency department and pharmacy claims. Community Care monitors and evaluates the performance and activities of all care managers through the CMIS. Each manager's patient activity is standardized, and networks and the central office have the ability to create parameterized queries at the patient, practice, network or care manager level. These reports enable both care managers and supervisors to examine activities and interventions on a macro level and compare progress and outcomes of interventions.

The Informatics Center Provider Portal was released in August of 2010. This portal was built with the treating provider in mind, offering elements of CMIS, Pharmacy Home, and the Reports Site, 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 a Medicaid patient health record which includes patient information, care team contact information, visit history, pharmacy claims history, and clinical care alerts. Importantly, the use of Medicaid 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, ED visits, primary care and specialist visits, laboratory and imaging) that occurred outside of their local clinic or health system. Contact information for the patient's case manager, pharmacy, mental health therapy provider, durable medical equipment supplier, home health or personal care service provider is readily available. Providers can discern whether prior prescriptions were ever filled, and what medications have been prescribed for the patient by others. Built-in clinical alerts appear if the claims history indicates the patient may be overdue for recommended care (e.g. diabetes eye exam, mammography).

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Goal Based Quality Measures

Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

Goal 1:

Reduce Avoidable ED Utilization

Clinical Outcomes

Measure

Any Diagnosis
Emergency Department (ED) visit rate, non-dual ABD, non-ABD

Data Source

Claims

Measure Specification

Numerator:
Number of ED visits

Visit Codes
- CPT: 99281-99285
- UB Revenue: RC45x, RC981

Denominator:
Non-Dual ABD, non-ABD member months/1,000

How Health IT will be Utilized

Experience of Care

Measure

Access
Getting Needed Care
Getting Care Quickly

Data Source

CAHPS 4.0 Survey

Measure Specification

ADULT MEASURES

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?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

CAHPS Core Question 6: In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

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?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

CHILD MEASURES

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 he or she needed?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

CAHPS Core Question 6: In the last 6 months, not counting the times 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 your child needed?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

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 his or her health plan?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

The 1915b/c waivers conduct a Satisfaction Survey annually through a third party. The results are available by Medicaid and Non-Medicaid, though not by Medicaid eligibility group.

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 2:

Reduce Avoidable Hospitalizations

Clinical Outcomes

Measure

1) Inpatient Admissions per 1000 Member Months, Enrolled Non-Dual ABD
2) Asthma: Asthma Hospitalization
3) Heart Failure:Heart Failure Admissions

Data Source

1) Claims
2) Claims
3) Claims

Measure Specification

1) Numerator: Number of hospital inpatient discharges with a qualifying condition based on ICD9 codes

Inpatient Visit Codes:
• Claim Type: S
• CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291, 92304-99310, 99315, 99316, 99318, 99324-99238, 99334-99337
• UB Revenue: RC118, RC128, RC138, RC148, RC158, RC19x, RC524, RC525, RC55x, RC66x, RC10x, RC100-RC114, RC119, RC120-RC124, RC129, RC130-RC134, RC139, RC140-RC144, RC149, RC150-RC154, RC159, RC16x, RC20x – RC22x, RC80x, RC987

Denominator: Non-dual ABD CCNC member months/1,000

2)Numerator: Number of hospital inpatient discharges with a principal diagnosis code of asthma
Denominator: Non-dual ABD CCNC member months/1,000
(Reported quarterly on a rolling 12 month basis)

3)Numerator: Number of hospital inpatient discharges with a principal or secondary diagnosis code of CHF
Denominator:Non-dual ABD CCNC member months/1,000
(Reported quarterly on a rolling 12 month basis)

How Health IT will be Utilized

1) Selected quality measures are made available to case managers and providers through the CMIS and the Informatics Center Provider Portal to assist with health home service delivery.
2) N/A
3) Selected quality measures are made available to case managers and providers through the CMIS and the Informatics Center Provider Portal to assist with health home service delivery.

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 3:

Increase Integration of Primary Care and Behavioral Healthcare

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

CAHPS 4.0 Chronic Conditions supplemental questions

Data Source

CCNC supplemental questions to CAHPS 4.0 survey

Measure Specification

ADULT MEASURES

CAHPS Supplemental Question CC6:
In the last 6 months, were any decisions made about your health care?
• Numerator: Number of 'Yes' responses
• Denominator: Number of survey responses

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?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

CHILD MEASURE

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?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

How Health IT will be Utilized

Random sample needed for administration of the CAHPS survey is generated using administrative data contained in the Informatics Center.

Quality of Care

Measure

Practices with co-located behavioral health providers

Data Source

Survey of CCNC practices

Measure Specification

Numerator: Number of practices with collocated behavioral health providers
Denominator: Number of practices

How Health IT will be Utilized

Goal 4:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 5:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 6:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 7:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 8:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 9:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 10:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Measure

Experience of Care

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Service Based Measures

Service

☑ Comprehensive Care Management

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Care Management
Patients meeting CCNC priority criteria who received a Comprehensive Health Assessment or an Intervention.

Data Source

Claims and CMIS Report

Measure Specification

Numerator: Number of patients who have any completed intervention or a comprehensive health assessment during reporting period.

Denominator: Number of patients that meet the following conditions:
-Flagged as a priority patient on the S1 chronic care report.
-Must have been enrolled at least 3 months from 'Patients Reported Month' to 'Assessment Month'.

How Health IT will be Utilized

Within CCNC, the entire population is grouped into high-risk and high-cost categories based on Medicaid historical claims data. The Informatics Center produces quarterly Chronic Care Reports with more than 70 data elements providing information on all ABD enrollees regarding cost, utilization and diagnosis data to help define a sub-set of the population for further screening. The report identifies approximately 17 percent of the population for screening and designates the top five percent as the highest priority.

The Chronic Care Report is utilized by CCNC care managers and providers to target populations and interventions.

Service

☑ Care Coordination

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

CAHPS Quality of Care
Coordination of Care supplemental questions

CAHPS Behavioral Health supplemental questions

Data Source

CAHPS 4.0

Measure Specification

ADULT MEASURES

CAHPS Supplemental Question OHP5 (follow-up from Question OHP3 asked in section 5):
How satisfied are you with the help you received to coordinate your care in the last 6 months?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

CAHPS Supplemental Question MH2:
In the past 6 months, did you need any treatment or counseling for a personal or family problem?
• Numerator: Number of 'Yes' responses
• Denominator: Number of survey responses

CAHPS Supplemental Question MH3:
In the past 6 months, how often was it easy to get the treatment or counseling you needed through your health plan?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

CHILD MEASURES

CAHPS Core Question CC17:
In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?
• Numerator: Number of 'Yes' responses
• Denominator: Number of survey responses

CAHPS Core Question CC18:
In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?
• Numerator: Number of 'Yes' responses
• Denominator: Number of survey responses

CAHPS Core Question CC14
In the last 6 months, did you get or try to get counseling for your child for an emotional, developmental, or behavioral problem?
• Numerator: Number of 'Yes' responses
• Denominator: Number of survey responses

CAHPS Core Question CC15
In the last 6 months, how often was it easy to get this treatment or counseling for your child?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☑ Health Promotion

Clinical Outcomes

Measure

1) Mammography among women 40-69
2) Pap smear among women 21-64
3) Colorectal cancer screening among men and women 50-75
4) Well-child visits in the first 15 months of life
5) Well-child visits in the Third, Fourth, Fifth and Sixth Years of Life
6) Adolescent well-care visits

Data Source

1) through 6) Claims

Measure Specification

1) Numerator: Number of women with one or more mammograms over prior 2 years
Denominator: Women ages 42-69 at end of measurement period, excluding women with bilateral mastectomy in claims history

2)Numerator: Number of women with one or more pap tests over prior 3 years
Denominator: Number of women ages 24-64 at end of measurement period, excluding women with prior hysterectomy

3)Numerator: Number of patients meeting any one of these criteria:
• FOBT within 1 year
• Flex sig within 5 years
• Colonoscopy within 10 years
Denominator: Number of patients ages 51-75 years at end of measurement period
patients with diagnosis of colon cancer

4)Numerator: Number of patients who had 0, 1, 2, 3 4 5, and 6 or more well-child visits during the first 15 months of life.
Denominator: Number of Patients who turned 15 months old during the measurement year and who were enrolled at least 13 out of 14 months between 31 days old and 15 months old.

5)Numerator: Number of patients who received one or more well-child visit with a PCP practitioner
Denominator: Patients ages 3-6 enrolled 10+ months.

6)Numerator: Number ofpatients who had at least one well-care visit with a PCP or an OB/GYN practitioner
Denominator: Patients ages 12-21 enrolled 10+ months

How Health IT will be Utilized

Experience of Care

Measure

CAHPS HEDIS measure set supplemental questions

Data Source

CAHPS 4.0

Measure Specification

ADULT MEASURE

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?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

CHILD MEASURE

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?
• Numerator: Number of survey respondents who answer "usually" or "always"
• Denominator: Number of survey responses

How Health IT will be Utilized

Quality of Care

Measure

1) Blood pressure control (good) - hypertension

2) Blood pressure control (good) - diabetes

Data Source

1) Chart review
2) Chart review

Measure Specification

1) Numerator: Number of patients in the denominator whose most recent blood pressure is adequately controlled. Both the systolic and diastolic BP must be less than 130/80.
Denominator: Patients age 18 through 85 with a diagnosis of hypertension

2)Numerator: Number of patients in the denominator whose most recent blood pressure is adequately controlled. Both the systolic and diastolic BP must be less than 130/80.

Denominator: Patients age 18 through 75 with a diagnosis of diabetes mellitus

How Health IT will be Utilized

CCNC moved from a paper chart abstraction tool to a fully electronic, streamlined system for chart review measures in 2009. Medicaid claims data is used to generate a random sample of eligible patients, and to pre-populate audit tool elements according to an individual's identified chronic conditions. Secure client-server software allows independent auditors to work offline when Internet access is not available in the clinic location. When access to Internet is available, the system automatically synchronizes data with the server. Data is fully encrypted offline and in transit. Data sent to the server automatically updates a variety of process, progress, and analysis web-based reports. Practices and CCNC networks then have immediate access to chart review results through a secure web-based report site, with patient-level information as well as practice, county, network, and statewide results with national comparative benchmarks.

Service

☑ Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Clinical Outcomes

Measure

1) Any Diagnosis
Potentially Preventable Readmissions as a Percent of Total Admissions, Enrolled Non-Dual ABD population

2)Heart Failure
Heart Failure 30-day readmissions

Data Source

1) Claims
2) Claims

Measure Specification

1)Numerator: Number of readmissions within 30 days of prior discharge (excluding mental health admissions)
Denominator: Number of hospital discharges for Non-dual ABD CCNC patients in the same network at the time of admission and readmission

Excluding:
• Same-day transfers, long-term care admissions, rehabilitation, state mental hospital, hospice admissions, and observation stays are not considered hospital admissions.
• Admissions are excluded from both the numerator and denominator if either the initial or readmission DRG indicates: malignancy, trauma, obstetrical, burn, newborn.
• Admissions with no discharge date are excluded.

Note: We plan to stratify reporting to separately track rates for non-mental health and mental health populations

2)Numerator: Number of hospital readmissions within 30 days of prior discharge date with CHF as principal or secondary diagnosis
Denominator: Number of CHF hospital discharges
(Reported quarterly on a rolling 12 month basis.)

How Health IT will be Utilized

Experience of Care

Measure

CAHPS 4.0 Chronic Conditions supplemental questions

CAHPS Quality of Care
Coordination of Care supplemental questions

Data Source

CAHPS 4.0 Survey

Measure Specification

ADULT MEASURES

CAHPS Supplemental Question CC18:
In the last 6 months, have you been a patient in a hospital overnight or longer?
• Numerator: Number of 'Yes' responses
• Denominator: Number of survey responses

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?
• Numerator: Number of 'Yes' responses
• Denominator: Number of survey responses

CHILD MEASURES

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?
• Numerator: Number of 'Yes' responses
• Denominator: Number of survey responses

How Health IT will be Utilized

Quality of Care

Measure

Medication Reconciliation after non-mental health hospital discharge of targeted patients

Data Source

Claims and CMIS Report

Measure Specification

Numerator: Number of patients with Medication Reconciliation or Medication Review documented in CMIS from the admission date to 30 days post discharge.
Denominator: Number of patients meeting all of the following conditions:
• Non-mental health hospitalization in Medicaid claims during report quarter.
• Mental health hospitalizations excluded are those with a primary diagnosis code from ICD-9 codes 290 - 319.
• Patient must be alive upon discharge.

Visits for patients assigned Heavy or Medium case status from date of admission to 30 days post discharge. This means Heavy or Medium case status must be updated at some point from date of admission to 30 days post discharge.

Note: The unit of analysis is hospital stays; therefore, a patient can contribute multiple times per quarter. If a patient is transferred to another hospital and/or has a same day readmission, the first hospital stay is NOT included in the measure. The patient must be enrolled with the network at the time of the hospitalization.

How Health IT will be Utilized

Service

☐ Individual and Family Support Services (including authorized representatives)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Referral to Community and Social Support Services

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

i. Hospital admissions

Description

1. Inpatient admissions per 1000 member months, excluding mental health diagnoses;
2. Potentially Preventable Readmissions within 30 days as a percent of potentially preventable hospital admissions, any diagnosis, excluding mental health.
3. Mental Health Readmissions within 30 days.
4. Hospital admissions with CHF primary or secondary diagnosis, per 1000 member-months
5. Hospital admissions with asthma primary diagnosis, per 1000 asthma member months

Data Source

Claims

Frequency of Data Collection

Monthly data collection and quarterly reporting

ii. Emergency room visits

Description

Emergency Department (ED) visit rate per 1000 Member Months, excluding mental health diagnoses.

Asthma ER visit rate per 1000 member months

Data Source

Claims

Frequency of Data Collection

Monthly data collection and quarterly reporting

iii. Skilled Nursing Facility admissions

Description

Skilled Nursing Facility Admission rate per 1000 member months, all SNF admissions.

Data Source

Claims

Frequency of Data Collection

Quarterly

i.

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

Hospital admission rates

We will capture hospital admission rates excluding behavioral health diagnoses. These will be reported for Health Homes enrollees as separate from other Community Care enrollees, per 1000 Health Homes per member per month.

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

ii. Chronic

evaluation. The Informatics Center contains Medicaid health care claims data and also real-time hospital admission/discharge/transfer data from 48 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.
Hospital admission rates monitored by Community Care at the program, Network, and provider level include:
1. Inpatient admissions per 1000 member months any diagnosis
2. Potentially Preventable Readmissions w/in 30 days as a percent of potentially preventable hospital admissions, any diagnosis, excluding mental health.

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 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 congestive heart failure. 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.

iii. Coordination of care for individuals with chronic conditions

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.

iv. Assessment of program implementation

The Community Care program has been implemented statewide, across all regional networks. We have 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.

v. 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.

vi. 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 Quality Measurement and Feedback (QMAF) program was substantially expanded in 2009, in response to the needs of an expanded aged, blind and disabled 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 workgroup 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: 1) clinical importance (based on disease prevalence and impact, and potential for improvement), 2) 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), and 3) implementation feasibility, and 4) 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 NCHQA targets). Approximately 50 quality measures are currently tracked in the QMAF system.

vii. Estimates of cost savings

We 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. Cost measures will include:
1. Total PMPM costs (subtracting behavioral health costs and residential services)
2. Acute care costs
3. ED Costs.
We will report cost trends on an annualized basis.

Page

3.1 - B: Medically Needy View

Attachment 3.1-H

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

☐ Health Home Services

i. Geographic Limitations

If Targeted Geographic Basis,

☐ Two chronic conditions

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

- ☐ One chronic condition and the risk of developing another
- ☐ One serious mental illness

from the list of conditions below:

- ☐ Mental Health Condition
- ☐ Substance Use Disorder
- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Disease
- ☐ BMI Over 25
- ☐ Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

iii. Provider Infrastructure

- ☐ Designated Providers as described in §ection 1945(h)(5)
- ☐ Team of Health Care Professionals as described in §ection 1945(h)(6)
- ☐ Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

Ways Health IT Will Link

Care Coordination

Service Definition

Ways Health IT Will Link

Health Promotion

Service Definition

Ways Health IT Will Link

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Service Definition

Ways Health IT Will Link

Individual and Family Support Services (including authorized representatives)

Service Definition

Ways Health IT Will Link

Referral to Community and Social Support Services

Service Definition

Ways Health IT Will Link

v.Provider Standards

vi. Assurances

☐ A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

☐ B. The State has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

☐ C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Goal Based Quality Measures

Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

Goal 1:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 2:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 3:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 4:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 5:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 6:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 7:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 8:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 9:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 10:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Service Based Measures

Service

☐ Comprehensive Care Management

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Care Coordination

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Health Promotion

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

☐ Individual and Family Support Services (including authorized representatives)

Service

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Referral to Community and Social Support Services

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Description

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

i. Hospital admissions

Data Source

Frequency of Data Collection

ii. Emergency room visits

Description

Data Source

Frequency of Data Collection

iii. Skilled Nursing Facility admissions

Description

Data Source

Frequency of Data Collection

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

i. Hospital admission rates

ii. Chronic disease management

iii. Coordination of care for individuals with chronic conditions

iv. Assessment of program implementation

v. Processes and lessons learned

vi. Assessment of quality improvements and clinical outcomes

vii. Estimates of cost savings

4.19 – B: Payment Methodology View

Attachment 4.19-B

Page

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Payment Methodology

Payment Type: Per Member Per Month

Provider Type

Team of Health Care Professionals: The Health Home operates through a cohesive Team of Health Care Professionals. Payment to the team incorporates both base monthly per member per month (PMPM) payments and add-on payments that support specialized care management supports for special health needs. All specialized care management programs are coordinated by the Community Care Program working with the Medical Home.

Description

The Health Home per member per month (PMPM) is distributed to the members of the Team of Healthcare Professionals using the methodologies described below.
The Primary Care Physician (PCP) payment component is determined by calculating care management costs that are incurred in the individual practitioners' office. The Community Care of North Carolina (CCNC) network payment component is determined by calculating the care management staff, services and additionally the systems the care managers must have to support the services for the individual recipient.
The Pregnancy Care Management payment is an add-on payment supporting care management services for high-risk pregnancies. The add-on rate was developed through the integration of a state plan Targeted Case Management program into the CCNC framework, based on an actuarial analysis of state plan TCM costs
Payment amounts are tied to the staff and related costs of delivering chronic illness management responsibilities at the practice and network levels. We then adjust our estimates of intervention cost based on our analysis regarding chronic illness management payments in other comparable programs.Costs used for rate development include staff to provide the services, systems and services to support the staff in providing care management services, facilities and infrastructure in support of the care management services.
Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and non-governmental providers of care management and related Health Home services for people with qualifying chronic conditions.The agency's fee schedule rate was set as of April 2010 and is effective for services provided on or after that date. All rates are published on the NCDMA website at the following link: http://www.ncdhhs.gov/dma/provider/financial.htm.
If and when rates are updated, the update will be based on analysis of care management costs conducted by the Team of Health Care Professionals and its agency and practitioner components. We will continue to base payments on the costs of staff to provide the services, systems and services to support the staff in providing care management services, facilities and infrastructure in support of the care management services.
The criteria required for receiving a monthly PMPM payment are:
A. The person is identified as meeting health home eligibility criteria on the state MMIS and in the CCNC Care Management Information System;
B. The person is enrolled as a health home member;
C. The minimum health home service required to merit PMPM payment is that the person has received Care Management monitoring for treatment gaps; or another health home service was provided; and
D. The health home will report that the minimal service required for the PMPM payment occurred on a monthly health home activity report. The report will track and record the qualifying service on a monthly basis. The record will include whether the service was performed by CCNC or by another provider with provider number, the beneficiary number, and the date of service.

Health Home service payments will not duplicate any other payment either through the State Plan or waiver of the State Plan.
The North Carolina Division of Medical Assistance will prevent duplication of payments and of roles and responsibilities on an ongoing basis.

TIERED

Tiered based on Aged, Blind and Disabled (ABD)or non-Aged, Blind and Disabled status

Tiering of payments by ABD status is based on ongoing analysis of the number and duration of care management interventions in the primary care practice setting. We have determined that care management costs for ABDs are significantly higher than for other Medicaid eligibility categories.

☑ Tiered?

Payment Type: Alternate Payment Methodology

Provider Type

Description

☐ Tiered?