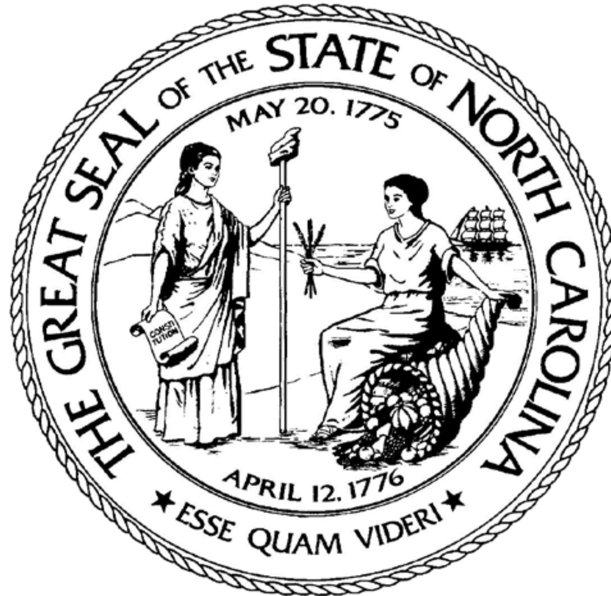
LEGISLATIVE REPORT
NORTH CAROLINA HEALTH TRANSFORMATION CENTER
(TRANSFORMATION INNOVATIONS CENTER)
PROGRAM DESIGN AND BUDGET PROPOSAL

SESSION LAW 2015-245, SECTION 8

FINAL REPORT



State of North Carolina

Department of Health and Human Services

May 1, 2016

EXECUTIVE SUMMARY

The North Carolina Department of Health and Human Services is excited to provide the Joint Legislative Oversight Committee on Medicaid and NC Health Choice with a proposal to develop a health care transformation innovations center, as required by Session Law 2015-245 (House Bill 372).

The North Carolina Health Transformation Center (NCHTC) will be an integral part of the most significant reform in the history of the state's Medicaid system. Beginning with the transition to managed care from fee-for-service, this health care model will launch new systems of care, expand the role of certain providers, and create more defined competencies for those who provide health care services across the state.

Our goal is to transform health care and improve the health of citizens across North Carolina using a broad evidence-based consensus process to identify priorities for improvement of health outcomes. The health delivery system incentives will be aligned with these outcomes and activities, and will be organized around the quadruple aim of better patient experience, better care, better provider engagement and predictable costs. The NCHTC will drive health outcome improvements by nurturing promising innovations throughout the state health care system.

This proposal addresses the culture of health care innovations in North Carolina, insights from other states' experiences, what North Carolina needs to successfully develop a health transformation center, technology impacts, proposed governance structure, proposed budget and staffing, and next steps. The Department is defining the functional and operational details, organizational structure, and governance of the Medicaid reform plan. Similar to the Section 1115 demonstration waiver program, the NCHTC will be a North Carolina solution.

The NCHTC will be an outward facing center of excellence for clinical and technical improvements, designed for performing continuous quality improvement activities that will:

- Spur innovative programs
- Enable health care leadership transformation and development
- Foster clinical information sharing
- Disseminate grant funding and incentive payment programs
- Provide collaboratives and technical assistance to providers and prepaid health plans as they incorporate metrics defined for health care improvements
- Measure prepaid health plan performance
- Evaluate the effectiveness of the waiver program

The NCHTC also will perform a pivotal role to promote continued partnerships with existing community-based providers and care organizations. North Carolina has a successful history in the organization, management and medical care delivery at the community level, which also is recognized at the national and state levels. This model emerged and evolved over several decades to create a vigorous, collaborative network of more than 6,000 providers and care organizations that includes non-profits, health and education centers, and foundations that grow

health leadership. Utilizing advanced care and payment analytics, the NCHTC will leverage and grow these existing community-based entities with their associated efforts, protocols, and provider and consumer relationships.

The Department will use a phased approach to implement the NCHTC. Initial improvement targets will focus on program areas with the greatest opportunity for positive impact.

We are looking forward to collaborating with the North Carolina General Assembly, and clinical and technical partners, to design an NCHTC that will help enable NC Medicaid reform and serve the people of North Carolina for years to come. NCHTC development will begin immediately.

TABLE OF CONTENTS

I. Background 1

II. Culture of Improvement and History of Innovation in North Carolina 1

III. Insights 2

- A. Overall Practices 3
- B. Oregon Health Authority (est. April 2013) 3
- C. Delaware Center for Health Innovation (est. July 2014) 3
- D. Oklahoma Center for Health Innovation and Effectiveness (est. October 2014) 3
- E. Additional Insights 4

IV. What North Carolina Needs 4

V. Technology Impacts and Considerations 5

VI. Proposed Approach 7

- A. Performance Measurement and Analytics 8
- B. Stakeholder Engagement to Motivate Innovations and System Improvements 8
- C. Liaison Center 8
- D. Center of Excellence 9
- E. Tools 9
- F. Implementation Approach 9

VII. Governance 10

VIII. Budget and Staffing 10

IX. Next Steps 11

I. BACKGROUND

North Carolina Session Law 2015-245/House Bill 372, approved Sept. 23, 2015, directs the transformation of the state's current Medicaid and NC Health Choice programs to provide budget predictability while ensuring quality care. The Department of Health and Human Services will submit an 1115 demonstration waiver application to the Centers for Medicare & Medicaid Services by June 1, 2016. This demonstration waiver will transform the NC Medicaid delivery system to managed care for most of the eligibility categories of the Medicaid and NC Health Choice program.

Section 8 of the session law also directs the Department to develop a transformation innovations center – the North Carolina Health Transformation Center (NCHTC) – to assist providers and prepaid health plans achieve the ultimate goals of better health and better care for North Carolinians, better provider and clinician engagement, and predictable costs for the state. This proposal presents the Department's NCHTC program design and near-term budget to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

The General Assembly instructed the Department to use the Oregon Transformation Center as a design model for the NCHTC, and to consider features such as:

- Learning collaboratives and peer-to-peer relationships.
- Clinical standards and supports.
- Innovator agents.
- Council of Clinical Innovators.
- Community and stakeholder engagement.
- Conferences and workshops.
- Technical assistance.
- Infrastructure support.

In addition to the Oregon Health Authority's Transformation Center, the Department also held discussions with transformation organizations in Oklahoma, Arkansas, Delaware and Pennsylvania. The information gathered helped prepare the NCHTC program design.

II. CULTURE OF IMPROVEMENT AND HISTORY OF INNOVATION IN NORTH CAROLINA

North Carolina has a long and successful history of innovation in health care and clinical quality improvement. An assessment of the current innovations structure and initiatives across the state shows that many elements required for the NCHTC already exist and are well integrated throughout our communities and providers. Some of these were developed under Department guidance and funding, while others were developed by private, commercial and non-profit organizations.

North Carolina has the advantage of building on the existing innovations and initiatives for the NCHTC governance structure to create a rich set of offerings and mechanisms. Current state health care innovation and infrastructure initiatives include:

- Regional networks of physicians, nurses, pharmacists, hospitals, health departments, social service agencies and other community organizations that work together to provide cooperative, coordinated care through a medical home model.
- Academic health systems, hospital learning networks, large private health systems, statewide health care learning centers and major private foundations that drive innovation in care.
- Specialty medical associations, clinician organizations and other provider organizations that advance best practices.
- Existing mental health capitated payment program innovations that can be applied to physical health.
- Major private businesses that drive health care improvement in pharmaceuticals and information analytics.

Over the past several decades, a broad set of clinical improvement expertise has developed throughout the state. These crucial practices will be evaluated for inclusion in the NCHTC design.

III. INSIGHTS

North Carolina's extensive history of innovation in health care provides many insights that include these key lessons:

- Engagement of the primary care practice spectrum, from Federally Qualified Health Centers and health departments to traditional practices with few, yet high-cost patients.
- Systematic development of services that wrap around primary care practices, including care management and informatics that address both gaps in care and impact.
- The power of social learning networks in spreading innovations across the state.
- Importance of addressing the most difficult problems, such as transitions and behavioral health, and remaining dedicated to resolving them over time to achieve meaningful results.

The Department also reviewed efforts to transform Medicaid in Oregon, Oklahoma, Arkansas, Delaware and Pennsylvania to gain insights from the experiences of other states with similar undertakings. While differences exist between this group of states and North Carolina, including overall population numbers, the most significant advantage for North Carolina is an established, strong collaboration and innovation infrastructure.

A. Overall Practices

Several common practices emerged during the review:

- Engage a coalition of public and private leadership.
- Leverage existing collaboration and innovation infrastructure to identify and channel innovations.
- Define and measure desired health outcomes.
- Establish an independent group to set health outcomes and related metrics for care reorganization and improvement incentive programs.
- Recognize the crucial role of a strong health information exchange.
- Ensure stakeholders are aware that the transformation will take many years.

B. Oregon Health Authority (est. April 2013)

The Oregon Transformation Center (OTC) supports all health care endeavors. Its primary goal is to promote the spread and sustainability of innovations. The OTC exists within the Oregon Health Authority and funding is provided through the state budgeting process.

The Oregon Health Authority has seen many positive improvements in transforming its health care system by establishing a primary care foundation with regional coordinated care organizations which integrates with medical providers, local health departments, behavioral health, hospitals and payers. Results include a drop in emergency room use and in hospitalization for specific diseases, and some improvement in quality measures.

C. Delaware Center for Health Innovation (est. July 2014)

The Delaware Center for Health Innovation (DCHI), a 501(c)(3) entity, uses a clinical committee to improve care integration and patient focus. The DCHI has established "health hubs" in neighborhoods, started efforts to further develop health care workers' skills through education and recruitment, established a monitoring system for the payment model, and a patient/consumer advisory group to provide an "informed voice."

D. Oklahoma Center for Health Innovation and Effectiveness (est. October 2014)

The Oklahoma Center for Health Innovation and Effectiveness (CHIE) is tasked with improving the health of Oklahomans through innovative methods and research. The CHIE exists within the Oklahoma State Department of Health and funding is provided through the state budgeting process.

The CHIE's primary task is to support Oklahoma's shift to value-based payments from fee-for-service. This includes developing health information exchanges by 2020 for data analysis, and further developing a health care workforce with the skills needed to improve the efficiency and effectiveness of health services throughout the state, workforce development, and health efficiency and effectiveness.

E. Additional Insights

Additional insights include:

- Disperse ideas throughout the state to improve overall population health.
- Align quality and other measures with providers and payers.
- Integrate behavioral health services.
- Build leadership bench strength by identifying and developing transformative individuals across professions and regions.
- Improve financing in rural areas.
- Extend core statewide utilities for care transformation by investing in areas such as a health information exchange and community advisory councils.

These and other lessons shared by the reviewed states will be considered in the NCHTC design.

IV. WHAT NORTH CAROLINA NEEDS

Changing the Medicaid and NC Health Choice delivery and payment system will affect nearly every aspect of health care, from the role of primary care providers to where and how care will be regularly delivered. Supporting this transformation will require new systems of care, expanded roles of certain providers, and create more defined competencies for those entities who provide health care services across the state. North Carolina's advantage is its existing community-based health care organizations, learning networks, working collaborations focused on patient centered care, and active stakeholders within our communities. These groups already provide much of the foundation other states had to develop for their transformation efforts.

In addition to continuing the growth of this foundation of collaboration and innovation, the following goals are essential for successful Medicaid reform. These will be considered as the NCHTC role is defined:

- Foster, encourage and drive creation of *new and innovative methods* to improve care and contain costs in areas such as workforce development, clinical and operational best practices, and health care leadership; and to monitor and address administrative requirements to mitigate potential burdens to providers.
- Drive *continuous improvement of care* by our clinicians, hospitals and other providers by facilitating ongoing education on improving population health, the organization of health care, and providing clear guidelines for health outcomes driven by financial incentives.
- Provide *access to collaboratives and technical assistance* to working groups, and other programs for providers and organizations that will help their transition to managed care.
- Foster and encourage evidence-informed programs, policies, clinical interventions and practices for *rural health populations*. According to the NC Task Force on Rural Health, approximately one-in-five North Carolinians, almost 2.2 million people, live in a rural county and areas that are less likely to have access to health services, are more likely to

engage in risky health behaviors, and have a higher mortality rate than North Carolinians living in non-rural areas.

- Develop new methods to increase *access to care* for underserved populations, including collaboratives, community engagement and examining new tools such as telemedicine.
- Develop a robust *analytics competency to identify areas of innovations and system improvements* by region and organization to encourage the use of evidence-based practices.
- Assist providers, prepaid health plans and community organizations in the *development of person centered health communities*. It is generally recognized that a strong primary care system is fundamental to improving the health of populations, and North Carolina is a national leader in developing a medical home care model.
- Build additional mechanisms for *engaging with stakeholders*, including community outreach to help drive innovations.

There also is the need to establish a set of health outcomes and metrics to establish incentives, to measure performance of the overall Medicaid program and prepaid health plans.

Additional considerations:

- Potentially implement policy for evidence-based improvements and emerging challenges, such as subspecialty medication management.
- Enhance Department capacity to monitor the national and state health care landscape to identify opportunities for improvement and innovations.

There are many critical components needed to drive Medicaid reform. The NCHTC will hold a vital role in this transformation and its sustainability, and its contributions will have an immediate impact.

V. TECHNOLOGY IMPACTS AND CONSIDERATIONS

The development of deep and detailed program data is needed to manage the benefits of capitation, risk-based payments and contractual accountability. Several technology areas will be affected by the move to capitated arrangements. Some will directly affect NCHTC capabilities, while others will indirectly influence the data and processing that underlie the information that the NCHTC and the Department will use. Success of this transformation requires tight integration of systems and data needed for operational and analytical purposes. The most significant of these technology impacts and considerations are:

- The draft waiver application includes the role of an enrollment broker to facilitate enrollment in prepaid health plans. Enrollment brokers will introduce new processes and technology components that need to be integrated into the current Medicaid eligibility and enrollment systems and processes (NC FAST).
- State systems will be required to process a greater volume of capitation payments and encounter data. (“Encounter data” is conceptually the same as paid claims records that are

created to pay providers on a fee-for-service basis.) The Department's NCTracks multi-payer Medicaid management system currently processes medical, dental and pharmacy claims, and capitation payments and encounter data for behavior health services. NCAnalytics is the business intelligence, analytical and reporting platform for the NCTracks online transaction processing system. It provides a data warehouse, several data marts and portals, and reporting and dashboard capabilities for financial budgeting. It provides program integrity needs for fraud and abuse management, including surveillance and utilization review, extraction of information to external entities, and feeding information used for compliance reporting to the Centers for Medicare & Medicaid Services.

It is anticipated that NCTracks will be able to absorb the increased volume of encounter processing. Testing activities will be defined and conducted to properly test NCTracks with encounter data for the different types of encounter transactions that will occur once capitated payments begin.

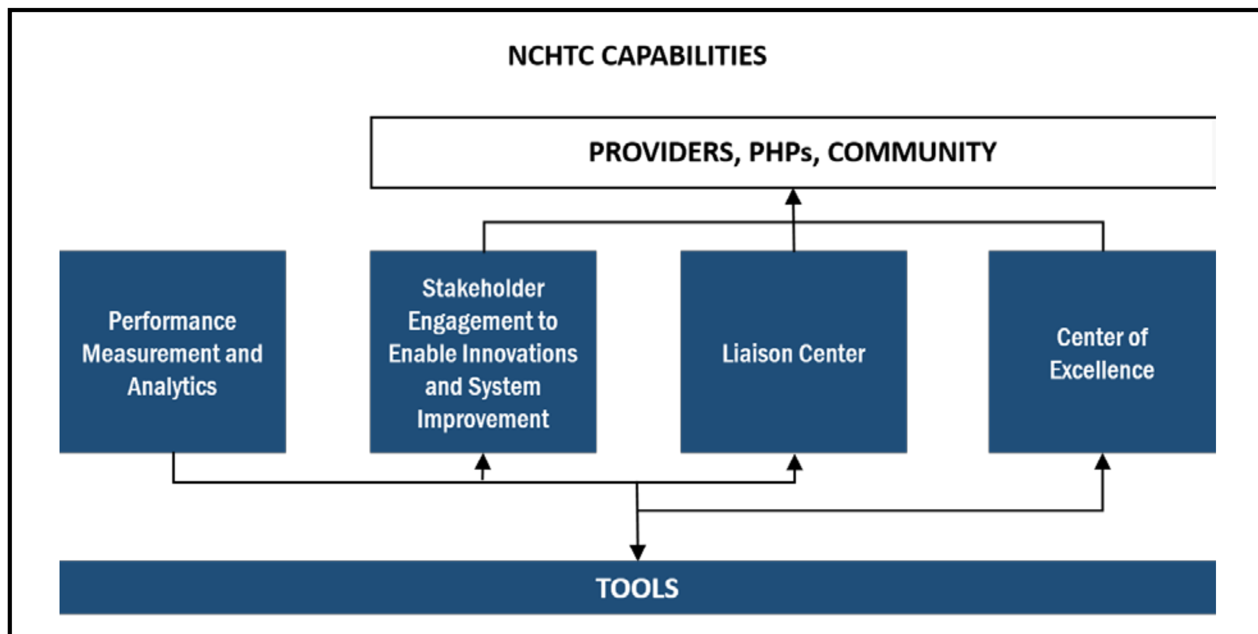
- The NCHTC will analyze and communicate meaningful performance, quality and other metrics needed to drive innovations and system improvements, and enable greater budget predictability. The design and development of a more comprehensive set of clinical and outcome data, together with advanced data analytics, will be needed to enable the distilling of medical costs and health care imperatives into meaningful and actionable information. There are several systems and sources of data, and contractual considerations, that need to be considered when determining how these existing components will be used to develop the necessary data and analytic platform:
  - **State Health Information Exchange (HIE).** Session Law 2015-241 s. 12A.4 and 12A.5, as modified by Session Law 2015-264, established a state-managed Health Information Exchange Authority (NC HIEA) to oversee and administer the NC Health Information Exchange Network. This law mandates all Medicaid providers to connect to the NC HIEA by Feb. 1, 2018, and all other state-funded health service providers to connect by June 1, 2018. The NC HIE Advisory Board has been established and appointments are forthcoming from the General Assembly. The Advisory Board will consult with the NC HIEA on the advanced administration and operation of the NC HIE Network. The HIE allows for secure electronic exchange of health-related information among health care providers, and collects local Medicaid hospital and ambulatory data. The HIE currently collects results, allergies, encounters, problems and medications data. Additional available data not currently collected include vitals, social history and immunizations.

- **Government Data Analytics Center (GDAC).** The GDAC provides integration of data from across several state agencies and provides a number of analytic capabilities. Currently, no Medicaid data exists in the GDAC. The Department anticipates that some of the data in GDAC, and other state data sources, will be useful if integrated with Medicaid data to provide a more comprehensive understanding of the determinants of health.
- **Medicaid Analytics Pilot (MAP).** Session Law 2015-241, Section 12A.17, provides funding to the Department "to develop a pilot program with GDAC and utilize the existing GDAC public-private partnership to apply analytics to maximize healthcare savings and efficiencies to the state and positive impacts on health outcomes." In partnership with SAS Institute, 27 months of Medicaid claims data have been loaded from the NCAnalytics system to perform the pilot. By May 31, 2016, the Department and GDAC will provide a final report on findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services.

VI. PROPOSED APPROACH

The Department is defining the functional and operational details of the Medicaid reform program, and its organizational structure and governance. Work will need to begin early to develop and implement the NCHTC. The NCHTC will need to be operational prior to the 1115 demonstration waiver implementation with appropriate staffing and budget levels.

The following provides a preliminary approach of the NCHTC role and capabilities.



A. Performance Measurement and Analytics

Performance Measurement and Analytics capabilities may include:

- Perform environmental scans across the community, beneficiaries, providers and prepaid health plans, and nationally, to identify leading practices, sources of new clinical or operational knowledge and innovations as they occur.
- Perform measurements against metrics to identify how prepaid health plans and the state are performing. Note that the Department will measure and incent health plan performance based on these metrics and expects that the health plans will do the same to the providers in their plans. A set of measures will be used to report various performance characteristics of the NC Medicaid program, and a set of measures will be used to report the various performance characteristics of the health plans against a set of health care metrics.
- Establish and track baseline performance measures.
- Identify opportunities for improvements by performing analysis using outputs from the measurement activities together with environmental scan information and other health care information.
- Evaluate reward mechanisms to appropriately incent plans and providers using lessons from other states, prepaid health plans and clinicians in this evaluation.

B. Stakeholder Engagement to Motivate Innovations and System Improvements

Stakeholder Engagement to Motivate Innovations and System Improvements may include:

- Identify internal and external stakeholders, and establish regular channels of communication to provide program transparency.
- Communicate results of performance measurement and analysis to the appropriate internal and external stakeholders.
- Gather information from stakeholders crucial to understanding the challenges and opportunities to improvements.
- Disseminate innovation and improvement information.

C. Liaison Center

Liaison Center capabilities may include services to providers, prepaid health plans, state agencies and communities to provide mechanisms the network will use to enact improvements to processes, procedures, systems or other items. For example:

- Provide access to collaborations and technical assistance to providers and prepaid health plans as they transition to value based payments.
- Provide assistance to state agencies as they transition to value based payments.
- Assist communities to develop person centered health communities.

- Serve as a liaison to providers and prepaid health plans, the community, patient advocate groups, and other agencies.

D. Center of Excellence

Center of Excellence capabilities will focus on the development and oversight of strategic programs, and may include:

- Health care leadership.
- Workforce development.
- Innovation pilots.
- Financial resources (grants, foundations, etc.) to nurture innovations.
- Clinical, operational and technology best practices for providers and other service organizations.
- Outcome collaborations.
- Learning and sharing conferences for providers.
- Spread of innovations.
- Continuous quality improvement.

E. Tools

The NCHTC will use tools with providers, prepaid health plans and the community to nurture and drive innovations and system improvements. The NCHTC will foster the development of a set of tools that may include:

- Analytical data tools.
- Stakeholder engagement tools.
- Clinical data sharing mechanisms.
- Access to clinical, operational and technical knowledge stores.

F. Implementation Approach

The Department recommends the NCHTC be implemented in phases with at least the following capabilities being operational before the 1115 demonstration waiver begins.

Performance Measurement and Analytics

- Perform a scan of current health care performance measures and enrollment metrics.
- Resolve whether a potential perpetual usage license contract of the Community Care of North Carolina Informatics data analytics toolset is needed.
- Define and enable other to-be-defined requisite technology tools that will enable the NCHTC analytics program.

Stakeholder Engagement to Enable Innovations and System Improvements

- Develop a stakeholder engagement plan.
- Engage appropriate key stakeholders to identify work needed before the 1115 demonstration waiver begins.

Liaison Center

- Begin gathering and categorizing current North Carolina innovation initiatives.
- Work with state agencies to stand up protocols and procedures needed for the NCHTC to operate when the new capitated payment system begins.
- Identify activities that may be needed by providers and prepaid health plans, state agencies and enrollment broker, as they begin to transition to value based payments.

Center of Excellence

- Begin to formulate approaches to coordinate across existing innovation organizations.
- Perform a scan of existing innovation organizations across the state.
- Perform a scan of in-flight innovation initiatives across the state to better understand current initiatives being considered, their source of creation and how innovators are currently collaborating.

VII. GOVERNANCE

The NCHTC will report to the Director of Health Benefits and there will be a formal advisory group established to advise the Medicaid program leadership on NCHTC activities.

There also will be a formal metrics and scoring group defined as part of the overall NCHTC design to establish incentive metrics, benchmarks and improvement goals for the prepaid health plans, and to be cascaded to the health plans' providers.

VIII. BUDGET AND STAFFING

The Department will submit a two-year budget during the state fiscal year 2017 legislative session for the design, development and implementation of the NCHTC. There are two distinct work efforts to develop this budget:

1. Evaluate the Department's current Medicaid systems, processes, and contracts, together with recommendations for actions.
2. Develop the approach and budget for the design, development and implementation of the NCHTC.

The NCHTC staff will be full-time employees supplemented by contract staff to be able to scale as needed for the work required. The NCHTC also will use consultants as needed to provide additional assistance.

IX. NEXT STEPS

The Department will create and maintain the NCHTC to promote health care innovations and system improvements. The NCHTC will help achieve care and budget predictability for the taxpayers of the state while ensuring quality care to those in need.

Upon submitting this report, the Department will begin the work to:

- Create a detailed two-year budget for the design, development and implementation of the NCHTC for the 2017 legislative session.
- Identify additional staff requirements to operationalize the contents of this proposal in order to begin high-level design work for the initial implementation phases of the NCHTC.
- Establish the formal metrics and scoring group that will establish incentive metrics, benchmarks and improvement goals for the prepaid health plans, and start defining appropriate outcome measures.