

Attachment B

SCOPE OF WORK

Section 1 – General Statement of Purpose and Intent
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The Community Care of North Carolina (CCNC) Program is designed to establish, support and maintain provider-network case management service agreements with local providers to develop organized health care delivery systems for enrolled populations that coordinate the full continuum of care with processes to favorably influence cost and quality of care. CCNC provides for the purchase of certain clinical, disease, and case management services for select recipients and is not a grant.

The Program provides for the establishment of disease and care management support systems that implement quality improvement initiatives and test new approaches to population management. The Program offers a fee-for-service model with an enhanced case management fee. CCNC Networks coordinate the full continuum of care in concert with the primary care providers (medical homes) while achieving budget and performance goals and benchmarks. To qualify for payment under this contract, Networks must demonstrate the capacity to manage select populations by meeting the following project objectives:

- Develop a care management plan to meet budget, utilization and performance targets;
- Develop systems to manage enrollee care;
- Promote disease management strategies, such as: referral authorization processes; after hours protocols, and targeted management to focus on those in greatest need;
- Implement quality improvement (QI) initiatives and participate in program-wide QI activities, such as asthma, diabetes, heart failure, hypertension, post myocardial infarction, emergency room utilization, and pharmacy;
- Focus on high cost and high risk enrollees;
- Develop strategies and quality improvement initiatives to include individuals simultaneously enrolled in both Medicare and Medicaid (the dually-eligible population);
- Provide primary care, referral and authorization of services through a Network of providers;
- Develop relationships and partnerships with community agencies to leverage community resources;
- Participate in pharmacy initiatives to contain costs and improve quality;
- Assure appropriate expenditure of the enhanced care management fees; and
- Participate in new initiatives as they are identified by the clinical directors or as mandated by the North Carolina General Assembly.

Section 2 -- General Statement of the Law
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Community Care of North Carolina is implemented by the Division of Medical Assistance and the Office of Rural Health and Community Care under Title XIX of the Social Security Act. This Contract shall be supplementary to the usual terms and conditions of participation in the Medicaid program. The Contractor agrees to abide by all applicable State and federal Medicaid laws, regulations, rules, policies, and procedures.

Section 3 -- Definitions

The following terms have the meaning stated for the purposes of this contract:

- 3.1 Clinical Directors – The CCNC leadership body in which each Network is represented by its Clinical Director. This body establishes the CCNC clinical policy and provides oversight for CCNC decisions and activities.
- 3.2 Community Care of North Carolina (CCNC)– A program established within the Department of Health and Human Services Office of Rural Health and Community Care with the goal of improving health care access, quality, and cost-effectiveness. CCNC has administrative oversight responsibility for the operational aspects of this contract in collaboration with the Division of Medical Assistance (DMA).
- 3.3 Community Care Network (Network) – A non-profit community organization where private and public providers collaborate to serve a target population in a defined service area.
- 3.4 Covered Services – Services covered by Medicaid for Eligible Recipients or the Health Choice population which the Contractor agrees to coordinate pursuant to the terms of this contract.
- 3.5 Eligible Recipients – Persons eligible in the following Medicaid categories:
- Work First for Family Assistance (formerly AFDC)
 - Family and Children's Medicaid (MAF)
 - Infant and Children (MIC)
 - Medicaid for the Blind and Disabled (MAB, MAD, MSB)
 - Residents of Adult Care Homes (SAD)

Enrollment of Eligible recipients in the following categories is voluntary:

- Medicare / Medicaid Dual Eligibles (Non-QMB);
 - Medicaid Pregnant Women (MPW);
 - Title IV-E Adoption Subsidy (IAS); and
 - Foster Care-Non Title IV-E (HSF)
 - Indians who are Members of Federally Recognized Tribes
 - Children under the age of 19 years, who are eligible for Supplemental Security Income under Title XVI
 - Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.
 - Community Alternative Program (CAP) Enrollees
- 3.6 Enhanced Care Management Fee – The fee paid by the Department to the Contractor per enrollee per month, which shall be payment in full for the Enhanced Care Management Services provided by the Contractor. The Contractor shall submit to the State annual budget reports and shall be held accountable for appropriate administration of the care management fee.

- 3.7 Enrollee – A recipient who chooses or is assigned to a participating provider in the Network.
- 3.8 Health Choice – North Carolina Health Choice is a free or reduced price comprehensive health care program for children.
- 3.9 Medicaid Identification (MID) Card – The Medical Assistance Eligibility Certification card issued monthly by the Division to Recipients. This card will specify the enrollee’s choice of a primary care provider in Carolina ACCESS, Medicaid’s managed care program that links enrollees with a personal doctor referred to as a Primary Care Provider or PCP.
- 3.10 Medical Assistance – Name given to the Medicaid program in North Carolina, administered by the Division of Medical Assistance, to provide payment for covered services to eligible recipients in the State of North Carolina, established pursuant to Title XIX of the Social Security Act, 42 USC Subsection 1396, et. seq.
- 3.11 Medical Home - Name used to describe the location where enrollees can receive continuous, comprehensive and coordinated health and illness care supervised by a PCP.
- 3.12 North Carolina Community Care Networks Inc. (NCCCN Inc) – a non-profit corporation comprised of representatives of CCNC Networks which provides the CCNC Program standardized data collections, management and reporting services and serves as a collaborative forum for the development of quality, access, and efficiency enhancement initiatives.
- 3.13 Participating Provider –Person or organization entering into a written agreement with the Network to deliver covered services to enrollees or a participating member of the Network, including community partners such as: health departments, local hospitals, DSS, and LMEs.
- 3.14 Preventive Services – Services rendered to prevent or delay the onset of disease. Examples of preventive services include: (1) for adults: adult health screening, pap smears, vaccines for the prevention of pneumonia, diphtheria-tetanus, and influenza, mammograms,; and (2) for children under 21 years: Health Check (EPSDT) screening and age-appropriate immunizations, urinalysis, lead screening, and hematocrit. The CCNC Program aims to implement targeted disease management activities, including preventive health maintenance.
- 3.15 Primary Care Provider (PCP) – The participating physician, family nurse practitioner, physician assistant, nurse midwife, or group practice/center selected by or assigned to the enrollee to provide and coordinate all of the enrollee’s covered services and to initiate and monitor referrals for specialized services when required.
- 3.16 Quality Improvement (QI)– The process of continuously finding ways to improve and provide better patient care and services, including assuring that health care services are appropriate, timely, accessible, medically necessary and high quality.
- 3.17 Risk Assessment – The process of evaluating the clinical and social risk factors which contribute to an enrollee’s need for health care and case management resources.

- 3.18 Service Area – The defined geographic area within which the Network and the CCNC have agreed that the Network shall coordinate the provision of Covered Services needed by the Target Population through participating providers or referral arrangements.
- 3.19 Subcontractor – Any person or entity which has entered into a subcontract with the Network.
- 3.20 Target Population – Group of individuals enrolled, assigned, or otherwise contracted to be managed by the Network.

Section 4 – Performance Requirements of the Contractor

The Contractor shall:

- 4.1 Operate as a non-profit entity, or as a component of a non-profit entity.
- 4.2 Support the CCNC providers and Target Population in the Contractor's management area.
- 4.3 Designate, in writing, individuals who will serve the following functions within the Network:
 - Network Director, Executive Director, or individual with a similar title to serve as primary administrative liaison between the Contractor and the CCNC.
 - Network Clinical Director who is a member physician to serve as the Contractor's medical director responsible for maintaining contact with local providers and represent the Contractor at the select program-wide meetings;
 - Chronic Care Clinical Champion to work with practices and community providers in the implementation of the chronic care program;
 - Chronic Care Coordinator to organize community resources, oversee arrangements with practices in regard to the management of enrollees with chronic illness, and assist with implementing the chronic care program within the network; and
 - Network Information Technology Manager to serve as the primary liaison between the Contractor, NCCCN Inc, and the Department and provide leadership in dealing with privacy and security concerns. The designee could be on staff, work in partnership with the Network, or be contracted.
- 4.4 Maintain a Steering Committee, Administrative Oversight Committee, Board, or similar management entity with membership that represents the spectrum of network participants including network providers, community health organizations, hospitals, health departments, departments of social service, public health, Local Management Entities (LMEs), and partnering agencies, such as senior centers, home health agencies, and Aging Disability Resource Centers (ADRC).

At a minimum, officers should include a President, Vice President, Secretary, and Treasurer. A description of expectations for operation of the management entity can be found at http://info.dhhs.state.nc.us/olm/manuals/ooc/fnp/man/Fiscal_Non-Profit_Admin-01.htm#P121_21835 and include the following:

 - Establish and maintain personnel policies and oversight of employees
 - Establish and maintain financial management policies
 - Assure Network operations comply with federal, state, and local laws and regulations
 - Approve and monitor annual budget
 - Evaluate and monitor Network performance, including program and financial operations.
- 4.5 Maintain a Medical Management Committee chaired by the Clinical Director and composed of Network providers that meet no less than quarterly to implement and supervise program initiatives.
- 4.6 Establish contracts with providers of health services that assure a commitment to case manage clinical care pursuant to the Community Care of North Carolina program and this Contract. Copies of signed

provider contracts must be sent to the CCNC Program Office to enroll the provider in the Network and qualify for monthly enhanced case management fees.

- 4.7 Maintain a network of health service providers to meet the medical needs of the Target Population.
- 4.8 Notify the CCNC Program Office with fifteen (15) days of any change within the Network organizational structure.
- 4.9 Develop a policy and maintain a process to document and address complaints forwarded from the Division of Medical Assistance to the Network.
- 4.10 Create a Network infrastructure to manage and support the Target Populations by:
 - Ensuring Network staff includes one or more: pharmacist(s), nurses, social workers, and quality improvement specialist(s).
 - Establish an ongoing process with community providers and agencies to coordinate the planning and provision of care management and support services for the target population.
 - Support mental health integration by managing individuals with co-morbidities that include behavioral health conditions.
- 4.11 Establish Network processes to support the care management of those in the Target Population that are at highest risk and cost, to include, but not be limited to the following:
 - Create an interdisciplinary team to help manage and optimize patient care;
 - Perform health assessments and screenings, as appropriate;
 - Develop patient-centered care plans;
 - Promote a process to develop the skills necessary for patient self-management of chronic conditions; and
 - Utilize data summaries and reports created by the CCNC or NCCCN Inc. to identify those individuals at greatest risk.
- 4.12 Develop a Transitional Care Program to support enrollees in the Target Population when discharged from the hospital to include, but not be limited to:
 - Collaborating with hospital discharge planners;
 - Ensuring appropriate home based support and services are available;
 - Implementing medication reconciliation in concert with the PCP and network pharmacist to assure continuation of needed therapy following hospital discharge;
 - Developing a Care Plan when there is a need for complex or high intensity care management;
 - Ensuring appropriate follow-up appointments are made with PCP and / or specialists;
 - Promoting the ability and confidence in self management of chronic illnesses in the Target Population; and
 - Providing care management and coordination support until the recently discharged enrollee achieves stability in their home and community.
- 4.13 Employ a pharmacist to work in concert with Network leadership to implement the following:
 - Pharmacy Management Programs for those receiving multiple medications.

- Coordinate and support pharmacy initiatives, such as Over the Counter (OTC) Standing Orders, Prescription Advantage List (PAL) prescribing, and electronic prescribing (e-Prescribing) efforts, as outlined by the CCNC program office.
- Assist physicians in creating and managing drug regimens of patients with chronic disease states (e.g.: diabetes, asthma, CHF, etc.). This may include, but shall not be limited to, activities such as meeting with patients, adjusting medication dosages in concert with PCP, peak flow monitoring, and performing other services within the professional area of expertise.
- Perform medicine reconciliation assessments as requested by Network physicians and/or case managers to optimize the patient's drug regimen.
- Educate community pharmacists on CCNC and/or Medicaid pharmacy initiatives.
- Serve as a resource to Network physicians and case managers on general drug information and Medicaid drug policy issues

4.14 Implement clinical management initiatives identified as CCNC priorities by the Clinical Directors.

The current quality improvement initiatives are:

- | | |
|-----------------|----------------------------|
| • Asthma | • High Service Utilization |
| • Diabetes | • High Cost Patients |
| • Chronic Care | • Pharmacy Utilization |
| • Heart Failure | |

4.15 Collaborate with CCNC to enable provider participation in periodic external chart reviews to monitor the effectiveness of quality improvement initiatives.

4.16 Compare performance with quality, access, cost, and utilization benchmarks established by the Clinical Directors and develop improvement strategies to achieve goals. NCCCN Inc. will serve as a data repository for the CCNC Program and be available to assist Contractor in this benchmark comparison and creation of performance reports and comparisons, which will assist in achieving the goals of standardization and uniformity.

4.17 Review quarterly performance measures submitted to the Office of the Secretary on the Aged, Blind, and Disabled program, pharmacy utilization, and quality improvement initiatives (see Section 6. Evaluation).

4.18 Distribute and review reports to participating providers to assure provider comprehension and encourage collaboration in goal achievement.

4.19 Educate new providers about CCNC priority initiatives through orientation, training, and technical assistance.

4.20 Collaborate with CCNC, its designee, NCCCN, Inc., DMA, and other Networks in developing and refining:

- Program measures
- Utilization and management reports
- Innovative health care and utilization management strategies
- Quality improvement goals and measures
- Opportunity for shared program operations and support

- Initiatives aimed at containing cost and improving quality
- 4.21 Review annually and ensure compliance with the NC State policy for non-profit organizations receiving state funds as described in the DHHS On-Line Manual *Fiscal Non-Profit Administration* available on the web at <http://info.dhhs.state.nc.us/olm/manuals/ooc/fnp/man/index.htm>.
- 4.22 Prepare and submit an annual budget to the CCNC Program Office for approval at least 30 days prior to the start of each fiscal year that specifies how the enhanced care management fees will be spent to develop and maintain administrative and care management activities.
- Provide, at minimum, the expenses and revenues specified in a sample budget provided by the CCNC Program Office, including a breakdown of direct or contracted salary by the following categories:
 1. Clinical: case managers, pharmacist, QI
 2. Administrative / paraprofessionals that directly support clinical staff
 3. Executive and other administration
 4. Others, such as Information Technology and Human Resources
 - Obtain written approval from the CCNC Program Office prior to revising any budget line-item more than 10%.
 - Maintain accurate records of expenditures in accordance with federal financial reporting and governmental accounting standards as defined by Generally Accepted Accounting Principals (GAAP)
- 4.23 Within forty-five business days following the end of the Contractor's budget year, submit to the CCNC Program Office a copy of audited financial statements or the equivalent for a public institution, along with an actual vs. budgeted year-end reconciliation. The report shall be signed by the Contractor's financial manager or accounting department.
- 4.24 Carry over no more than two months operating expenses at the close of the fiscal year and obtain the prior written approval of the CCNC Program Office to carry over any funds in excess of the two months reserve for uses other than those listed on CCNC's Pre-Approved Reserve Fund list.
- 4.25 Perform other services upon the mutual agreement of the parties to this contract. Additional services may include new care management initiatives, pilot projects, enhanced disease management initiatives, clinical improvement initiatives, cost containment strategies, and other activities identified by the Network, CCNC, NCCCN Inc., and DMA to promote and advance the goals of the CCNC Program. The scope of these additional services and compensation for these services shall be documented by written amendments to this Contract.
- 4.26 Use or disclose data provided by CCNC, the Department, or their designee for the sole purpose of accomplishing the purpose and goals identified in this contract. The Contractor will only receive identified information related to its network members or individuals that it is officially mandated to serve and in its service region. The Contractor shall only give network providers Protected Health Information for the purposes of treatment and managing the care of individuals with whom the providers have a provider-patient treatment relationship. The Contractor and providers shall not receive or utilize data for the purposes of separate research or grant projects, except as directed or approved by the DMA. NCCCN, Inc. shall be performing for the CCNC Program certain data collection, measurement, and

reporting functions. Disclosure by the Contractor and Participating Providers to NCCCN, Inc. pursuant to this agreement is hereby authorized and directed.

- 4.27 Establish relationships with its providers that permit the transmission of the Protected Health Information in accordance with the Federal HIPAA Privacy and Security rule <http://www.hhs.gov/ocr/privacy/index.html>.
- 4.28 Manage all data in accordance with the privacy and security requirements of the **BUSINESS ASSOCIATE ADDENDUM** (Attachment __.) and the HIPAA Privacy and Security Rule. (Health Insurance Portability and Accountability Act of 1996, P.L. 104-91, as amended (“HIPAA”), and its implementing regulations, 45 CFR Parts 160, 162, and 164.) .
- 4.29 Protect health information against theft and misuse. All Medicaid applicant and recipient names, Medicaid identification numbers, and medical claim information is confidential “protected health information” that may be used and disclosed only in accordance with DMA, DHHS, State, and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996, P.L. 104-91, as amended (“HIPAA”), and its implementing regulations, 45 CFR Parts 160, 162, and 164. Furthermore, all social security numbers, employer taxpayer identification numbers, drivers license numbers, and any other numbers or information that can be used to access a person's financial resources are “personal identifying information” that may be used and disclosed only in accordance with N.C. Gen. Stat. §§ 75-60 through -65 (the NC Identity Theft Protection Act) and N.C. Gen. Stat. § 132-1.10. The Contractor, its employees, agents, and contractors must protect all such information against theft and misuse.
- 4.30 Promptly notify DMA in writing of any unauthorized disclosure or misuse of any protected health information or personal identifying information. The requirement to notify DMA in writing is satisfied by notifying the DMA Director and the DMA IT Security Official and the DMA Privacy Official in writing of any unauthorized disclosure or misuse of any protected health information or personal identifying information. **ADDRESS OR PHONE NUMBERS**
- 4.31 Notify all affected persons, the Attorney General’s Office, and all consumer reporting agencies as required by N.C. Gen. Stat. § 75-65 if the Contractor discovers a security breach, as that term is defined in N.C. Gen. Stat. § 75-61.

Section 5 – Reimbursement and Responsibilities of The Division

The Department shall:

- 5.1 Pay an Enhanced Care Management Fee to the Contractor each month for each enrollee in the Contractor’s network
- 5.2 Pay an Enhanced Care Management Fee to the Contractor’s Participating Providers each month for each individual enrolled with the Provider.

- 5.3 Pay the Contractor and the Participating Providers in the first Medicaid check-write of the month. Payments are contingent upon the Contractor adhering to the terms of this contract.
- 5.4 Provide the Contractor with regular reports on recipient enrollment, recipient referrals, emergency room use, procedure profiles, case management, and provider prescription practices.
- 5.5 Provide technical assistance and support to the Contractor.
- 5.6 Provide appropriate data, through NCCCN Inc, to allow networks to perform population and care management activities.
- 5.7 Report performance measures quarterly to the Office of the Secretary on the Chronic Care Program, pharmacy utilization, and quality improvement initiatives (see Section 6. Evaluation).

Section 6 – Evaluation

ORHCC will submit the following reports quarterly (1, 2, 3) and annually (4) to the Office of the Secretary.

1. Potentially Preventable Readmissions as a Percent of Total Hospital Admissions, among enrolled non-duals, any diagnosis
 - 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 DRGs indicates: malignancy, trauma, obstetrical, burn, newborn

Target:

- 5% reduction from network's baseline rate (SFY 08) by end of year 1 (SFY 10)
- 10% reduction from baseline rate by end of year 2 (SFY 11)
- 15% reduction from baseline rate by end of year 3 (SFY 12)

2. ED rate, enrolled ABD (dual +nondual)

Target:

- 5% reduction from network's baseline rate (SFY 08) by end of year 1 (SFY 10)
- 10% reduction from baseline rate by end of year 2 (SFY 11)
- 15% reduction from baseline rate by end of year 3 (SFY 12)

3. Generic Medications as Percent of All Fills, all Medicaid non-duals

Target:

- 2.5 percentage point increase from network's baseline rate (SFY 08) by end of year 1 (SFY 10), or 80%, whichever is lower
- 5 percentage point increase from baseline rate by end of year 2 (SFY 11), or 80%, whichever is lower
- 7.5 percentage point increase from baseline rate by end of year 3 (SFY 12), or 80%, whichever is lower

4. Quality of Care Measures, enrolled dual + non-dual

- per QMAF methodology (chart review measures only), pertaining to: asthma, diabetes, hypertension, heart failure, ischemic vascular disease

Target:

- Improvement over network baseline (CY 2009) demonstrated in 50% of chart review measures in CY 2010 and 75% of chart review measures in CY 2011