ISSUE BRIEF

North Carolina's Transformation to Medicaid Managed Care

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As North Carolina's Medicaid program transitions from fee-for-service to managed care, the Department of Health and Human Services is committed to building an innovative, whole-person-centered and well-coordinated system of care that addresses both medical and non-medical drivers of health. Delivering on that vision, and improving the health and well-being of North Carolinians, means shifting from thinking of payers as exclusively buying medical services to thinking of them as buying health for their beneficiaries. Operationalizing this complex work will require strong partnership from stakeholders across the state and will also provide North Carolina an opportunity to help drive a national agenda centered around how to buy good health.

North Carolina is embarking on the largest change in the history of our Medicaid program. This year, the state begins transitioning Medicaid from traditional fee-for-service (FFS) to a managed care program. The North Carolina Department of Health and Human Services (NC DHHS) will remain responsible for all aspects of the Medicaid and NC Health Choice programs but will delegate the direct management of health services and financial risks to prepaid health plans (PHPs). Since 2015, when the North Carolina General Assembly enacted legislation directing this transition [1], NC DHHS has collaborated with and solicited extensive feedback from stakeholders across the state to shape the program design. As a result, NC DHHS has developed a detailed program for Medicaid managed care that is responsive to the needs of the beneficiaries, as well as clinicians, hospitals, counties, and health plans.

As North Carolina transitions to managed care, NC DHHS is committed to improving the health and well-being of North Carolinians through the creation of an innovative and well-coordinated system of care. Realizing this vision requires many interdependent efforts and changes. This includes programmatic changes within managed care to drive integration that focuses on whole-person health, such as integrating physical health and behavioral health services, establishing a groundbreaking Advanced Medical Home (AMH) program, and making smart investments in evidence-based non-medical drivers of health. It also requires incentivizing quality and value and supporting clinicians and beneficiaries during and after the transition to managed care. At the core of all these efforts is the mission of buying good health for people in the Medicaid program.

One of the most significant aspects of North Carolina's managed care transition for driving whole-person care is the integration of physical health and behavioral health within Medicaid. For the first time, Medicaid participants in North Carolina will be able to enroll in managed care plans that provide integrated physical health services, behavioral health services, and pharmacy benefits through one insurance plan. As highlighted in the Rob Robinson article, "Tailored Plans: The Next Step in a Long Evolution," for too long we have systemically carved out behavioral health from the rest of physical health, ignoring the clear links between them, and paying for services through different systems [2]. This has inherently hurt coordination and created a significant barrier to delivering comprehensive care. Moving to an integrated system of behavioral and physical health allows clinicians to more easily refer patients to behavioral health professionals and work with care managers to develop plans addressing both types of health needs. This enhanced coordination can bring down spending by reducing duplication and help patients navigate the system with greater ease.

NC DHHS is also implementing a groundbreaking AMH program that will strengthen the role of primary care in local care management. Building on the success of North Carolina's existing medical home model—Carolina ACCESS—the AMH program will preserve broad access to primary care services and current medical home program payments for practices while also introducing new performance incentives for practices to become more focused on cost and quality outcomes over time. These incentives will be tied to specified measures, including total cost of care and health outcomes measures, which will in turn link to PHPs' quality incentives. In her article, "More Than Health Care Services: North Carolina's Focus on Improving Whole-person Health and Patient Experience," Karen Michael of

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AmeriHealth Caritas expands on the AMH in more depth [3].

Buying good health also requires the recognition that health is affected by many factors beyond the medical care provided within the four walls of a hospital or clinic. Research shows that up to 80% of a person's health is determined by social and environmental factors and behaviors that emerge as a result [4]. To ensure the most efficient managed care program, NC DHHS has identified five priority domains for making smart investments in healthy opportunities: housing, food, transportation, employment, and interpersonal safety. In "Social Determinants of Health: Addressing Barriers Through Screening, Referrals, and Care Coordination," UnitedHealthcare's Kevin Moore expands on the importance of aligning these services [5].

Everyone who is enrolled in Medicaid managed care will be screened to assess their non-medical needs, helping us better managed individual health risk, tailor care coordination efforts, navigate beneficiaries to needed services, and make strategic investments in the community. We also want to give providers the necessary tools to help their patients connect with the resources they need to be healthy—even if those resources are outside the four walls of a clinic or hospital. To support that goal, NC DHHS is working in collaboration with private sector partners to implement a new resource platform called NCCARE360. The first statewide network of its kind, NCCARE360 will serve as a data repository and platform for closed-loop referrals and sharing of key information to knit together the local community-based resources that can address these non-medical needs, such as food banks. PHPs will also play a key role in new, large-scale pilots to test and evaluate the impact of providing select evidence-based, non-medical interventions related to high-needs Medicaid enrollees. The pilots will allow for the establishment and evaluation of a systematic approach to integrating and financing evidence-based, non-medical services into the delivery of health care. Anne Thomas and coauthors describe NCCARE360 in more detail in "NCCARE360: Building Healthier Communities Through Collaboration" [6].

To realize the vision for Medicaid managed care, the system must also be designed to incentivize and reward quality and value. To accomplish this, NC DHHS developed a data-driven, outcomes-based quality improvement strategy that requires the PHPs to meet relevant targets and benchmarks. The Quality Strategy sets a clear direction that is distilled into three central aims: better care delivery; healthier people, healthier communities; and smarter spending. To hold PHPs accountable, 18 months after managed care launch, certain quality measures will be subject to financial penalties if standards are not met. In her commentary "Quality Management and Improvement in North Carolina Medicaid Managed Care," NC Medicaid's Kelly Crosbie outlines the quality standards and expectations from NC DHHS [7], and WellCare's J. Thomas Newton and Troy Hildreth provide a PHP perspective on how these quality standards will be met in their commentary titled "Promoting Quality in Medicaid Transformation" [8].

PHPs will also be required to adopt value-based payment (VBP) arrangements, to ensure providers are focused on improving population health and appropriateness of care in the most cost-effective manner. PHPs must first develop a Value Based Purchasing Strategy that aligns to NC DHHS's short- and long-term goals of shifting from FFS to VBP. These strategies will detail required incentive programs for AMHs; describe how providers will be supported and encouraged to move through higher levels of the Health Care Payment-Learning and Action Network framework, which accelerates adoption of alternative payment models [9]; and provide annual expenditure targets in VBP arrangements. By the end of Contract Year 2, the portion of each PHP's medical expenditures governed under these arrangements must increase by 20 percentage points or represent at least 50% of total medical expenditures. This payment structure aims to align financial incentives and accountability around the total cost of care and overall health outcomes and ensure that PHPs and providers are recognized and rewarded for quality gains. Historically, the system has been designed to pay for care in pieces, which disincentivizes coordination and rewards quantity, but shifting toward VBP will facilitate a new focus on whole-person, comprehensive care. Rahul Rajkumar and Jesse Thomas from Blue Cross and Blue Shield of North Carolina expand on the significant impact that focusing on value can have in their piece "Promoting Value and Reducing Costs in Medicaid Transformation" [10]. This movement toward paying for value is happening across multiple types of payers, including private insurers like Blue Cross and Blue Shield, and cross-payer alignment is critical when implementing large systematic changes. The more closely payers can unify both their goals and the payment arrangements to achieve them, the easier it will be to implement these changes successfully.

For the programmatic changes and new initiatives described in this article to succeed, NC DHHS knows that clinicians and beneficiaries will need support during and after the transition to managed care and is committed to providing it. Both Gregory Griggs's sidebar "Medicaid Transformation from the Independent Practice Perspective: Opportunities and Obstacles" [11] and William Lawrence from Carolina Complete Health Network's piece "Improving Provider Experience in Care" [12] go in depth into the important role providers play in Medicaid transformation. NC DHHS has focused on mitigating or reducing administrative burden for clinicians whenever possible, including standardizing and simplifying processes across PHPs whenever appropriate, incorporating a centralized enrollment and credentialing process, and establishing a single statewide preferred drug list that all PHPs will be required to use. NC DHHS has also taken steps to preserve strong clinician participation in Medicaid and fair payments to providers of care

by establishing rate floors, using an auto-assignment algorithm for people to continue existing provider relationships, and setting policies that focus on continuity of care among providers and prescriptions. PHPs will educate beneficiaries on their rights and navigating the appeals and grievances processes and the newly established ombudsman program will provide education, advocacy, and issue resolution for beneficiaries. PHPs must also maintain a robust member services department, including a member call center and a dedicated member services webpage, and easy to understand member materials.

As NC DHHS strives to buy good health not only for Medicaid beneficiaries but for all North Carolinians, it is important to note perhaps the biggest barrier to delivering on that promise: too many people and families cannot access the care they need because they cannot afford health insurance. Expanding Medicaid to close the health insurance coverage gap would provide coverage to 500,000 North Carolinians (NC DHHS internal analysis), without requiring any state tax dollars [13], and by forgoing, we are leaving behind $4 billion in federal funding every year for the health of North Carolinians. The need to expand Medicaid is particularly urgent in the fight against the opioid crisis, as nearly half of those suffering from opioid overdoses presenting in emergency departments in North Carolina are uninsured [14]. Expanding access to coverage means expanding access to life-saving treatment. Expanding Medicaid is also critical for North Carolina's rural communities, where health insurance is often unaffordable and rural hospitals are struggling to keep their doors open. Medicaid expansion improves the stability of the private insurance market, lowering premiums by 7%-11% on average for people who buy their own health insurance [15], and lowers the likelihood of a hospital closure, especially in rural areas [16].

There are many lessons North Carolina can learn from other states that have already implemented managed care. This is a theme throughout many articles in this issue, such as Matt Salo's "What We're Learning About Medicaid Transformation" [17]; Andrew Olson and coauthors' research in "Value-based Payment Reform in a Managed Care Environment: Implications of Innovator States' Experiences with Episodes of Care" [18], or Debbie Grammer's article "How to Succeed Under Medicaid Managed Care" sharing experiences from the Area Health Education Centers right here in North Carolina [19]. North Carolina also has an opportunity to influence policy in other states. What we do here in North Carolina can have lasting impacts on Medicaid and health care policy on the national level.

Implementing big changes requires strong partnerships across many stakeholders. The work done to date to design and prepare for Medicaid managed care would not have been possible without collaboration and extensive feedback from many stakeholders across all sectors. Moving forward, continued collaboration and partnership will be critical. Together, we can transform the Medicaid program and build a healthier North Carolina. NCMJ

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