North Carolina's Health Care Transformation to Value:
Progress to Date and Further Steps Needed

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North Carolina has received national attention for its approach to health care payment and delivery reform. Importantly, payment reform alone is not enough to drive systematic changes in care delivery. We highlight the importance of progress in four complementary areas to achieve system-wide payment and care reform.

National health care expenditures continue to rise alongside lagging health outcomes and persistent evidence of waste and inefficiency [1-3]. The current fee-for-service (FFS) payment system is viewed as a key driver of these problems, because it provides limited financial support for care redesign or incentives to reduce health care spending or to improve quality. The National Academy of Medicine's initiative, "Vital Directions for Health and Health Care," has described reforms in payment, along with other important reforms, to achieve better health and reduce health disparities [4]. The NAM's November event, "Vital Directions for Health and Health Care: The North Carolina Experience," highlighted the role of state leadership, and North Carolina's in particular, in the transition to high-value health care [5].

States are well poised to drive progress in value-based payment (VBP) adoption. They operate large health care programs, have demonstrated the ability to legislate to enact major changes with systemwide implications, and have the familiarity with local conditions to tailor solutions to the state's unique context. Despite this leadership, VBP arrangements in most states remain heavily tied to the FFS payment system, for example, through shared savings arrangements. The incremental shifts may account for the limited impact on health care spending growth and outcomes from payment reforms to date.

The Vital Directions initiative's focus on North Carolina reflects the substantial support among policymakers, payers, providers, and purchasers in the state for more rapid progress in VBP reform, with current contracts across Medicaid, commercial insurance, Medicare, and Medicare Advantage set to make unprecedented systemwide shifts toward downside risk payment arrangements, in which organizations are financially accountable for financial and quality performance. One element of this aggressive VBP reform pathway is North Carolina Medicaid's VBP strategy in which so-called prepaid health plans (private Medicaid managed care plans) are required to have 90% of medical expenditures in alternative payment models that at least incorporate pay for performance; 45% in models that at least incorporate shared savings; and 15% of their provider payments in VBP contracts with two-sided risk, all within five years [6]. Moreover, the adoption of VBP extends beyond Medicaid, as commercial plans have also introduced their own value-based initiatives in the state, with Blue Cross and Blue Shield of North Carolina (Blue Cross NC), UnitedHealthcare, Aetna, and Cigna all expanding accountable care organizations (ACOs), bundled payments, and other value-based models [7]. Moreover, 30 Medicare ACOs currently operate in North Carolina, and an increasing proportion of Medicare Advantage payments flow through alternative payment models [7]. This rapid movement to VBP has created a recognition among health care stakeholders statewide that they must work together to promote the successful transition to value-based care. This is especially true within the context of NC Medicaid's Healthy Opportunities Pilots to address social drivers of health in managed care. Even with the ongoing budget impasse and delay of Medicaid managed care, we still see strong support in the state for VBP and organizations working together to prepare for the transition.

However, payment reform alone is not enough to transform care delivery. Shifting to value-based care models requires major health system transformation and cross-sector collaboration to improve population health and address health-related social and resource needs. Through an environmental scan and in-person convening of key stakeholders in state health reform, we developed a framework that identifies foundational elements for value-based care. This framework, developed with support from the

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West Health Policy Center and West Health Institute, identifies four areas in which policymakers, health care organizations, and other stakeholders need to focus in order to further advance payment and delivery system reforms. North Carolina health care stakeholders, including the Duke-Robert J. Margolis, MD, Center for Health Policy and Blue Cross NC, are advancing VBP and health care transformation with key steps in each of these areas.

Leadership and Governance

State and industry leaders have to make a compelling case for VBP that resonates with key stakeholders. In North Carolina, the Department of Health and Human Services (NC DHHS) built a case for payment and delivery system reform by engaging health care providers statewide, setting specific priorities for performance improvement, and facilitating ongoing public engagement. As an example, the innovative Healthy Opportunities Pilots that utilize Medicaid dollars to address select health-related social and resource needs are a key piece of NC DHHS's strategy [8]. The Healthy Opportunities Pilots appeal to health care providers and community-based organizations alike given the potential to break new ground on delivering whole person care. Aligning with the goal of "purchasing health," these pilots and the associated reimbursement mechanisms have mobilized public-private partnerships to enable cross-sector collaboration, such as the development of NCCARE360, which we later discuss in more detail.

Strong provider leadership is instrumental in the state transition to value. The North Carolina Medical Society, which represents physicians and physician practices across the health care delivery system, has aligned with NC DHHS's Medicaid transformation, demonstrating widespread provider appetite for value-based care and the willingness to work together to achieve success in this endeavor [9]. Because of the leadership and mobilization promoted by NC DHHS, stakeholders across the state are working together to move toward value-based care and better population health despite the state budget impasse that suspended implementation of Medicaid transformation.

At an organizational level, employers and health care payers alike are exploring opportunities to encourage fundamental shifts in health care payment and delivery models. The North Carolina Chamber of Commerce is encouraging employers to demand more value in health care, and convenes key stakeholders with the goal of making North Carolina a "top-ten state for health care value" [10]. Blue Cross NC, the state's largest commercial insurer, announced that a total of eight of the largest health systems have joined its new value-based program called Blue Premier. The Blue Premier model embodies a commitment to joint accountability for key metrics of quality, patient experience, and total cost of care, including an aggressive shift to downside risk. The Blue Premier program is significant for its scale, with the health systems signed onto the program accounting for nearly $8 billion in spend across the state (internal data, Blue Cross NC). Other commercial payers are engaging in value-based initiatives as well, especially in the Medicare Advantage space. For example, Aledade (a company that helps practitioners participate in ACOs) has partnered with Humana's Medicare Advantage plans in North Carolina to allow physicians to use resources from both organizations to promote more coordinated care [11]. Aledade also works with Blue Cross NC within its Medicare Advantage plans and Blue Premier to offer independent primary care practices data-driven support and facilitate further participation in VBP arrangements.

Data and Analytics

Data and analytics capabilities are needed to support VBP models. Providers need timely data to identify ways to improve health and measure performance, and payers need data to evaluate providers and payment reform results.

New VBP models encourage stronger partnerships between health plans, providers, and community-based organizations. They also generate new information demands as health care provider organizations take on greater accountability for population-health functions. The Blue Premier program has required extensive investment of human and financial capital to reform legacy data management and analytic systems and deliver reporting on attribution, quality performance, and contract performance.

Some infrastructure for effective data sharing is currently in place in North Carolina through the Health Information Exchange (HIE), NC HealthConnex [12]. Medicaid providers are required to send data to NC HealthConnex, but to create a more robust data exchange, data from commercial payers, the state employee health plan, and self-insured organizations should also be shared with NC HealthConnex.

Additionally, the Duke-Margolis Center for Health Policy has engaged representatives from NC DHHS, NC HealthConnex, health systems, independent practices, clinically integrated networks, and health plans to provide coordination and assistance to organizations volunteering to design, test, and operationalize bulk data standards for bidirectional data sharing between providers and payers. The collaboration will identify the most important data elements to inform provision of services at the point of care. In the short term, sharing of key data feeds (such as admission, discharge, and transfer [ADT] feeds) can facilitate success while a broader data infrastructure is built.

Central to VBP and delivery system reforms is shared technology infrastructure that enables cross-sector collaboration to address social drivers of health. NCCARE360, a statewide referral platform to connect community-based organizations and health service organizations, is a model platform for the country [13]. The opportunity to rapidly scale workflows that connect social and health services, and to develop new ways to acquire and integrate these data, can enhance our understanding of how to improve population health.

Payment Reform Implementation and Alignment

Given the variety of payment reforms available, states need to carefully consider how to align components of these models to the extent possible, limiting systemwide administrative burden and encouraging competition based on performance. As more payers shift to VBP, providers will increasingly participate in VBP arrangements with multiple payers, which may require providers to report disparate sets of quality measures and data. Moreover, reform features such as patient attribution or benchmarks are often not aligned across payment models. Friction points such as these present barriers to improving health and limit the ability of value-based care reforms to drive changes in care delivery.

For this reason, health care leaders need to promote alignment on key performance measures and reform components across VBP models both in the state and nationally. In North Carolina, the Medicaid ACO structure mirrors that of Medicare's largest ACO program, the Medicare Shared Savings Program (MSSP), aligning on features when possible despite differences in patient populations [14].

Tradeoffs exist between creating alignment and VBP models that are responsive to different health care infrastructure, population groups, and community contexts. Payers can explore opportunities for alignment in spite of these differences, such as developing performance measures that matter for all populations while also allowing for tailored approaches when alignment may worsen health disparities.

For example, when implementing a new payment model, smaller and more rural providers often need additional time and support [15]. North Carolina Medicaid has shown commitment to implementing reform for these groups by allowing flexibility in timelines and requirements. In particular, Track 1 ACOs (which are for smaller, or more rural practices) will have additional time before taking on financial risk [14]. While all providers need dramatic change in payment arrangements, modifying the glide path for these practices will ensure they can be successful in value-based care and boost the long-term viability of health care transformation.

To help reduce systemic burdens associated with performance measurement, the Duke-Margolis Center for Health Policy is collaborating with health care provider and payer organizations to promote and make widely available evidence-based, aligned, meaningful provider performance measurement and other key payment reform components. This workgroup is supported by mechanisms for sharing best practices that minimize systemic burden and promote a measurable and significant impact on quality of care, key health outcomes, and affordability.

Supporting Policies

Encouraging payment reform requires a range of supporting policies, such as strategies to increase competition, build the appropriate workforce, and encourage consumer engagement.

A competitive health care marketplace will facilitate effective VBP [16, 17]. The state will need to enact policies to ensure market competition is sufficient, with different considerations needed for urban and rural areas. In particular, North Carolina will need a diverse, skilled, and appropriate workforce to carry out changes in care delivery. Value-based reforms typically require the use of innovative care teams, with an increased emphasis on nurse practitioners, physician assistants, community health workers, and other non-clinician providers. In the future, North Carolina may consider broadening scope of practice laws to better support the workforce needed for health care transformation, especially in rural areas.

Policymakers can also explore policies to encourage greater patient engagement in care. VBP and associated delivery models should enable consumer engagement through health information access (cost and quality of health care providers), patient-reported outcome measures, and incentives for utilizing high-value care.

Conclusion

An arguably distinctive feature of the North Carolina health policy landscape is that most stakeholders want to work together to foster value-based care transformation and have taken steps to promote the transition; this spirit of collaboration and engagement is a public good. While the state continues to hammer out the details on payment models, we can continue working together to build the supports needed for payment reform. Further work is needed in the key areas of leadership and governance, data and analytics, payment reform alignment and implementation, and supporting policies. NCMJ

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