

Innovating Medicaid: The North Carolina Experience

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Medicaid plays an influential role in improving the health of North Carolina's population. In the midst of changing legislation, this commentary highlights 4 Medicaid initiatives that are reducing cost, improving care across settings, and reinforcing North Carolina's tradition of innovative programming.

Medicaid is jointly funded between the federal government and each state and is designed to offer health coverage for individuals or families with low incomes. In September 2016, Medicaid enrollment in North Carolina reached 2,020,076—which reflects a 26.57% increase from 2013. Approximately 69% of those enrolled in Medicaid are children, as eligibility criteria for children are less restrictive [1]. When compared with 2015 census data, Medicaid enrollment is approximately 20% of North Carolina's overall population of 10 million. In other words, 2 of every 10 residents in North Carolina are receiving health coverage via Medicaid. This reality suggests that Medicaid, as a significant provider of health coverage, plays an important role in improving the health of North Carolina residents.

Medicaid and Population Health

As health care continues to make an inevitable transition from volume to value, population health is increasingly becoming a focal point, especially as it relates to access and quality of care. Compared to those without insurance, Medicaid recipients are more likely to experience continuous, high-quality care and less likely to have unmet needs for medical, dental, and prescription drug services [2]. Meeting these needs promotes continuity of care and limits fragmentation, thus fostering better health outcomes. Prior research indicates that removing cost-related barriers encourages Medicaid recipients to visit a primary care physician, which increases preventive services such as mammograms and cholesterol monitoring by 60% and 20%, respectively [3]. By providing increased access and higher quality care, Medicaid acts as a mechanism for recipients to engage the health care system earlier and more often, which results in a healthier population over the long term.

Medicaid addresses not only access and quality issues but also social issues. Underlying social determinants of health impact the severity of Medicaid recipients' chronic

conditions, which, if not addressed, can drive health care utilization. For example, one barrier that frequently hinders timely access to care for Medicaid recipients is lack of transportation. For those without private transportation, Medicaid will cover the cost of public transportation to medical appointments, provided the recipient completes the necessary paperwork with the Department of Social Services (DSS) beforehand.

Medicaid also provides targeted care management services for high-risk recipients to help ensure these types of services are coordinated. A care manager, acting as a health advocate, helps Medicaid recipients navigate the health care system to address both medical and social issues such as lack of housing, food instability, and domestic violence.

Spirit of Innovation

Through the years, North Carolina has been viewed as a leader of innovative thinking in the deployment of Medicaid resources and the management of populations. The following initiatives provide current examples that reinforce this spirit and demonstrate North Carolina's tradition of innovative programming.

Community Care of North Carolina: The Medical Home

Community Care of North Carolina (CCNC) is a state-wide, home-grown, community-based program with a history of developing primary care medical homes for Medicaid recipients. CCNC medical homes support primary care providers through an interdisciplinary population health foundation that incorporates both data management and holistic patient intervention strategies (see Figure 1). With 14 regional networks across all 100 counties in North Carolina, CCNC equips providers to offer comprehensive, coordinated, high-quality care and provides "boots on the ground" support.

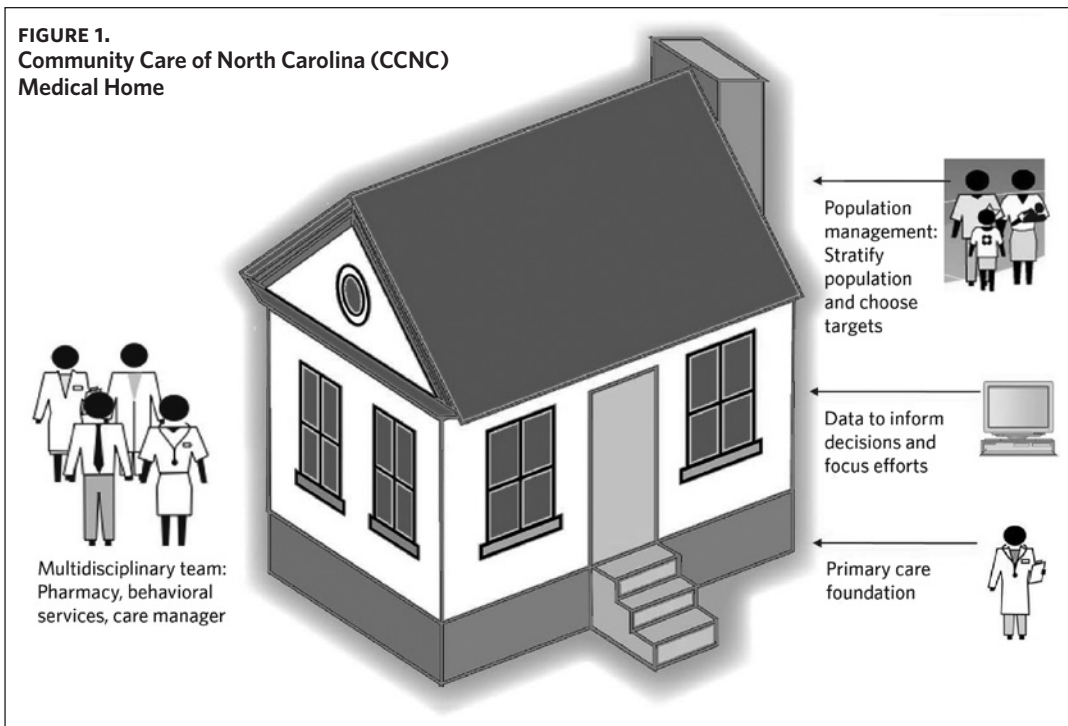
Empowered by CCNC Medicaid claims data, providers can identify Medicaid patients who are considered high-risk

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FIGURE 1.
Community Care of North Carolina (CCNC)
Medical Home



based on specific gaps in care. With actionable data stratified by risk, providers can make informed decisions that help focus efforts on the patients with the greatest needs. Regional networks deploy resources to help providers manage data, and these efforts culminate in quality improvement initiatives to improve patient outcomes.

A key component of CCNC’s medical home model is transitional care. Care managers visit high-risk Medicaid patients at the hospital bedside and visit them again at home after discharge. These face-to-face encounters include comprehensive health assessments, medication management, and patient and family education [4]. Timely outpatient follow-up connects the patient back to the medical home where information is exchanged between the care manager and the provider. Backed by a multidisciplinary team-based approach, patient management is holistic, addressing both the physical and behavioral sides of care.

Outcomes for CCNC’s medical homes have been positive. Based on a 2015 state audit that examined data from 2003 through 2012, CCNC’s medical home program saved \$312 per year per beneficiary, a nearly 9% savings. In addition, the program realized a 25% reduction in inpatient admissions and a 10.7% decline in prescription drug use [5]. These results indicate a favorable return on investment with improved patient outcomes.

Community Pharmacy Enhanced Services Network

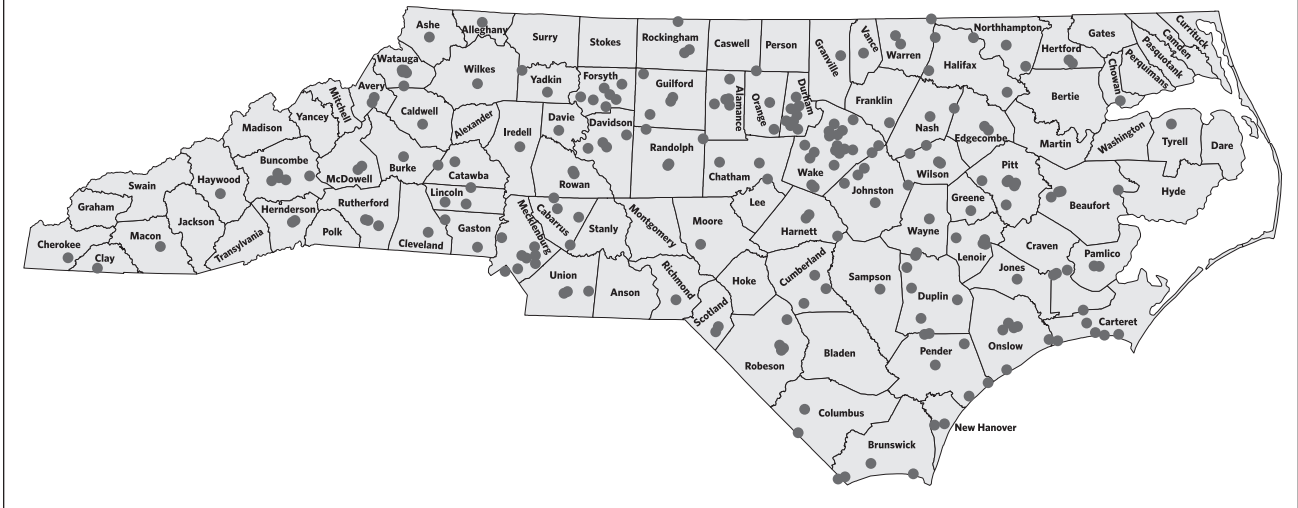
The highest-risk, most chronically ill Medicaid patients see their primary care provider an average of 4 times per year, while they visit their pharmacy for prescription fills an average of 35 times per year [6]. Each of these pharmacy visits is an important opportunity to check in with the

patient about medications, overall health status, stability of chronic illnesses, and adherence to the overall plan of care. These frequent check-ins provide opportunities for a collaborative care model in which community pharmacy is part of the medical home team.

In 2014, CCNC created the Community Pharmacy Enhanced Services Network (CPESN) to extend the reach of medication management interventions to the populations most in need. CPESN pharmacies provide support for unique medication use needs and work with the care team to improve global outcomes such as total cost of care, hospitalizations, and emergency department visits. The CPESN created a statewide infrastructure for community pharmacies willing to provide enhanced services at the point of care. Enhanced services can include medication adherence and coaching, medication reconciliation after hospital discharge, special packaging to promote medication adherence, and home delivery. Through a Health Care Innovations Award from the Centers for Medicare and Medicaid Innovation (CMMI), CPESN pharmacies are eligible to receive payment for conducting a comprehensive medication review with regular follow-up and care coordination around identified problems [7]. While progress is ongoing, the eventual goal of this program is a bidirectional stream of clear and clinically relevant communication between the CCNC medical home care team and the community pharmacy through ongoing sharing of patient care plans.

Although the CPESN is just entering the 3rd year of the CMMI grant, it currently consists of over 260 pharmacies across North Carolina (see Figure 2). This robust network of community pharmacies generates approximately 80,000 encounters monthly with chronically ill Medicaid patients,

FIGURE 2.
Pharmacies Participating in the Community Pharmacy Enhanced Services Network



including 1,500 patients who receive an in-depth consultation with a community pharmacist about their medication regimen. Early results suggest a 4%–5% increase in medication adherence over time among patients working with CPESN pharmacies (unpublished data). This auspicious beginning indicates a trajectory of continued growth as the CPESN expands the medical neighborhood and contributes to better health outcomes.

Pregnancy Medical Home

In 2011, CCNC, the Division of Medical Assistance (DMA), and the Division of Public Health (DPH) partnered together in an effort to improve birth outcomes in the Medicaid population. This partnership led to the pregnancy medical home (PMH) initiative, which is an outcome-driven effort targeting high-risk pregnant Medicaid recipients. Participating obstetric practices commit to quality improvement through evidence-based care, and they receive enhanced reimbursement rates and incentives for services. Incentives include \$50 for performing a standardized risk screening, which is based on priority risk factors such as smoking and chronic conditions, and \$150 for a postpartum office visit. Additional benefits—such as enhanced rates for vaginal deliveries (equal to the rate for cesarean sections) and an exemption from prior approval for obstetric ultrasounds—are intended to encourage provider participation. The PMH model promotes an environment of health and well-being for pregnant mothers and their babies.

To support this model, practices are assigned a pregnancy care manager from their local health department who helps meet the needs of patients identified as being at risk for poor birth outcomes. Improved coordination of care through regular contact between the care manager and the prenatal care provider facilitates the patient’s access to medical and community-based resources. Obstetric providers agree to work with DPH and their local CCNC regional network to

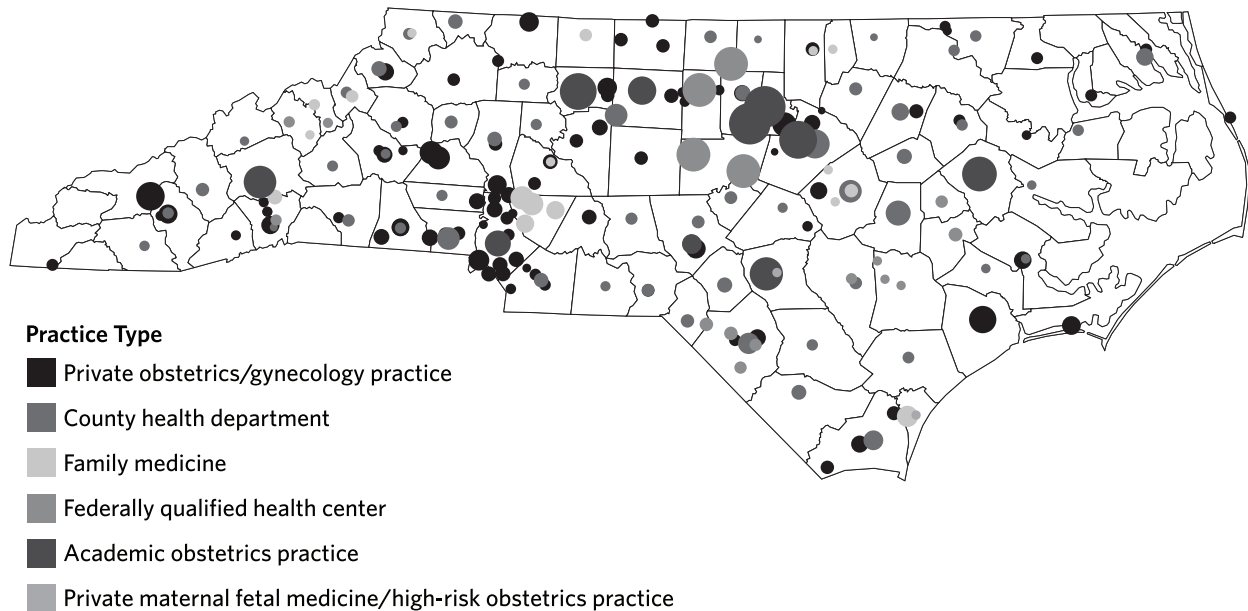
accomplish the following program goals: eliminate elective deliveries before 39 weeks gestation; for eligible patients, offer and provide 17P, a progesterone medicine that can help prevent preterm birth; and maintain a cesarean section rate of 20% or below [8].

Since its inception, the PMH initiative has gained significant traction, with 380 practices and 1,700 providers enrolled (see Figure 3). This accounts for more than 90% of maternity care provided to Medicaid patients. Recent data have indicated that the rate of unintended pregnancies among North Carolina Medicaid recipients has declined from 52.4% in 2012 to 46.8% in June 2016 [9]. This decline, coupled with the fact that 57% of all births in 2013 were financed by North Carolina Medicaid, highlights the influential impact that PMHs can have on improving birth outcomes [10].

Fostering Health North Carolina

Approximately 9,000 children are in foster care in North Carolina. Many of these children have special needs and physical, developmental, and behavioral symptoms brought on by unstable environments; thus, medical care for children in foster care costs 3 times more than that of children not in foster care. The North Carolina Pediatric Society, in partnership with local CCNC regional networks and local DSS, created Fostering Health North Carolina to address these symptoms. This program integrates communication and coordination of care by designating specific primary care practices as foster care medical homes. These medical homes focus on providing the frequency and types of foster care visits recommended by the American Academy of Pediatrics: an initial primary care physician visit within 72 hours of foster care placement, a second comprehensive primary care physician visit within 30 days of placement, and scheduled well-child visits at regular intervals. The primary care physician, the DSS case worker, and the local

FIGURE 3.
Pregnancy Medical Home (PMH) Provider Network



Note. Size of dot indicates the number of providers in each PMH. There are a total of 380 practices in the PMH provider network, representing over 1,700 providers and more than 90% of maternity care provided to Medicaid patients.

CCNC care manager share care plans to ensure that appropriate and timely screenings are performed and that they can be shared with the foster parent.

To date, 29% of children in foster care are connected with 1 of the 104 foster care medical homes across 41 counties in North Carolina. All 14 CCNC regional networks and over 50% of DSS offices in the state are collaborating to implement the foster care medical home model. Given the propensity for this population to transition often from one foster home to another, this level of engagement is encouraging and must be strengthened to ensure access to and quality of care for this vulnerable population with complex care needs.

1115 Medicaid Innovation Waiver

In October 2015, the North Carolina General Assembly passed legislation, which the Governor then signed into law, transitioning Medicaid from a fee-for-service model to a capitated system. On June 6, 2016, the North Carolina Department of Health and Human Services submitted the 1115 Medicaid Innovation Waiver for federal approval by the Centers for Medicare & Medicaid Services. Cited in the 1115 Medicaid Innovation Waiver under the proposed person-centered health community model are programs such as advanced pregnancy care management (eg, PMH), enhanced pharmacy services (eg, CPESN), comprehensive care management (eg, CCNC), and child and youth special health supports (eg, Fostering Health North Carolina), all of which have elements modeled on initiatives outlined in this commentary. As the conversation regarding health

reform continues to progress over the next several years, significant maneuvering will occur as stake holders position themselves in relation to the changing health care landscape. Within this context—triggered by the 1115 Medicaid Innovation Waiver and, more broadly, by the transition to value-based care—the strong tradition of North Carolina Medicaid innovation and the infrastructure that supports it will be needed to manage the health of the population today and in the future. **NCMJ**

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