

POLICY FORUM: INVITED COMMENTARIES & SIDEBARS

Scaling What Works: Evidence-based Prevention, Data, and Collaboration in North Carolina's Medicaid Transformation

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NC Medicaid's investments in whole-person care and data infrastructure have driven meaningful progress in improving health at lower costs. Amid growing fiscal pressures and upcoming policy reforms, continuing to advance evidence-based prevention, strengthen data infrastructure, and foster multistakeholder collaboration will be needed to drive sustainable, cost-effective, whole-person care transformation.

Introduction

North Carolina is a national leader in advancing Medicaid reforms to support innovative, whole-person care. Over the last decade, NC Medicaid has transitioned from a fee-for-service model, where providers billed the state for each service provided, to Managed Care, where the state pays insurance companies at a set per-person rate, with the goal of using person-level insurance payment reforms to enable new care models that keep people healthier at lower cost: “paying for health.”¹ This has included implementing coordinated health and social care interventions that prevent chronic disease complications while reducing health care costs, as well as leveraging integrated data systems to support and sustain access to high-quality, whole-person care.

NC Medicaid must invest in reforms that improve health and lower costs—or face growing challenges in access, affordability, and health. To meet this challenge, the state will need to build on strategies that enable progress in whole-person care while ensuring fiscal responsibility. We highlight 3 key areas of progress that provide a foundation for more sustainable, effective Medicaid and state programs: 1) advancing evidence-based prevention strategies; 2) supporting these strategies through coordinated data infrastructure investments; and 3) accelerating progress through multistakeholder and multipayer collaboration.

Amid growing fiscal pressures and upcoming policy reforms, the state can leverage its strong foundation along with new transformation funds to advance high-value, cost-efficient reforms.²

Advancing Evidence-Based Prevention Strategies

North Carolina has been piloting two initiatives—the North Carolina Integrated Care for Kids model (NC InCK) and the Healthy Opportunities Pilots (HOP) program—that have demonstrated the feasibility and value of implementing thoughtful reforms to identify people at high risk of costly medical complications like emergency visits and hospital admissions, coordinating medical and social services to help prevent those complications, and providing targeted non-medical supports to address unmet needs.^{3,4} Together, these innovative models have been shown to improve health, reduce health care spending, and strengthen investment in local communities.

NC InCK, 1 of 7 Centers for Medicare & Medicaid Services (CMS) Innovation Center InCK demonstration models nationwide, aims to improve whole-child health for Medicaid-insured children in 5 central North Carolina counties, including reducing unnecessary hospitalizations and out-of-home placements. The model uses targeted cross-sector care management and longitudinal support for children at rising or high risk of poor health outcomes to impact child and family health improvements and cost savings.⁵ NC InCK utilizes 3 core strategies: 1) population-level integration of clinical, social, educational, and justice data to risk-stratify children most likely to benefit from care management, including those at rising risk where focused interventions can help prevent progression; 2) targeted, longitudinal, cross-sector care management for families of identified children, emphasizing whole-family needs and connection to both clinical and non-clinical resources; and 3) sustainable support for this approach through an alternative payment model designed to align health care incentives with whole-child health outcomes like delivery of interventions to promote school readiness and connection to resources for health-related social needs, which in turn have significant longitudinal health and economic benefits.

HOP has also demonstrated impacts on health outcomes and medical costs through targeted community-based approaches that integrate health and social care. The pilot, part of North Carolina's Section 1115 waiver, tests the impacts of evidence-based, non-medical interventions related to food and nutrition, housing, transportation, and interpersonal safety and stress on health outcomes and costs.⁶ HOP eligibility is based on health risks and health care utilization patterns that can be mitigated through targeted non-medical supports.

HOP has operated in 3 predominantly rural regions of North Carolina, each with a network lead organization that develops and supports a coordinated network of community-based organizations (CBOs) to deliver services. Through this approach and related investments, HOP has strengthened community trust and reinvestment.^{7,8} HOP has invested substantially in these regions, supporting both targeted service delivery and strengthened community capacity. Capacity-building funding has supported network

leads' and CBOs' investments related to workforce development, data and technology systems, training and technical assistance, evaluation and oversight, and other organizational infrastructure, in turn enabling more effective and efficient use of non-medical services to reduce overall costs.

Both programs have been applying a rapid learning and evaluation approach for ongoing refinement of whole-person, prevention-oriented care for people and families. In turn, they provide an evidence-based pathway for expanding capacity to improve health while reducing medical cost growth.

NC InCK's implementation is grounded in mixed-methods, rapid-cycle evaluation of outcome and cost impacts to drive continuous improvement. It relies on deep cross-sector partnerships to advance its quality improvement strategies. NC InCK regularly monitors engagement of families across key risk domains, demographic factors, and health care utilization metrics like emergency department visits and hospitalizations, and total cost of care. NC InCK simultaneously conducts interviews with both caregivers and providers to better understand family and staff perspectives, with families sharing that participation positively affects the health and well-being of both children and their family members. This whole-family care model enables more effective and timely identification of at-risk family members, reduces service duplication within households by coordinating through a single point of contact, and decreases administrative burden and associated costs of providing overlapping support to multiple household members.

Similarly, mixed-methods evaluations of HOP demonstrate that coordinated, non-medical supports can meaningfully improve outcomes and generate savings. Interim evaluation findings show that HOP helps to address critical non-medical risks (e.g., food and nutrition insecurity), contributing to downstream reductions in preventable health care utilization and spending among participating Medicaid members.^{9,10} Research from Duke-Margolis and others shows that the impacts also extend beyond individual participants, with examples of improved well-being and stability among families and communities.^{7,8} An economic impact analysis conducted in one HOP region also demonstrates that the program contributes to broader, cross-sector economic and employment impacts.¹¹ HOP infrastructure has also been leveraged to enable more effective responses to community stresses, including response to COVID-19 and natural disasters like Hurricane Helene.^{12,13}

Together, the lessons emerging from NC InCK and HOP highlight the value of cross-sector coordination in strengthening care models and of data integration to tailor resource delivery. NC InCK's rapid-cycle implementation research can be adapted and scaled to HOP and other programs to accelerate learning about what works, for whom, and under what circumstances, informing program refinements to achieve improved outcomes and generate cost savings. Building on these evidence-based, data-

driven approaches will be critical in future Medicaid reforms to better identify at-risk patients and implement effective, person-centered care reforms.

Supporting Evidence-based Prevention Strategies through Coordinated Data Infrastructure Investments

The NC InCK and HOP programs exemplify North Carolina's growing capacity to leverage cross-sector data integration to target services, improve outcomes, and enhance cost efficiency. Another example of these capabilities was North Carolina's leadership in applying automated, or "ex parte," renewals during post-COVID-19 Medicaid redeterminations by leveraging and integrating existing data sources to verify and re-enroll eligible individuals. This approach reduced procedural disenrollments tied to the unwinding process, Medicaid churn rates, and costs and local administrative burdens associated with eligibility determinations, demonstrating the critical role of data infrastructure investments.¹⁴ These innovations, together with other statewide infrastructure such as NCCARE360 and the NC Health Information Exchange Authority (NC HIEA), are strengthening the health care sector's ability to better assess health risks and coordinate interventions across medical and social needs.

NCCARE360 is a statewide coordinated care network which supports cross-sector referrals for HOP and other initiatives.¹⁵ The platform enables bidirectional, closed-loop referrals that connect providers with CBOs to address non-medical risks, including food insecurity and housing instability. By embedding these social referrals within clinical workflows and enabling users to 'close the loop' and signify a connection to a local CBO, NCCARE360 has the potential to transform fragmented care processes into an integrated, person-centered model that supports whole-person health initiatives and other local care coordination efforts.

The NC HIEA, which administers the statewide health information exchange NC HealthConnex, provides the state's foundational infrastructure for clinical data operability, advancing secure data exchange across hospitals, physician practices, behavioral health providers, and public health agencies.¹⁶ In alignment with the NC HIEA's Roadmap 2030, the NC HIEA aims to expand data integration efforts by connecting additional data sources that capture health-related social needs and other information critical to care management.¹⁷ For example, the NC HIEA is partnering with NC Medicaid on a use case to build the capability to access and integrate beneficiaries' non-medical needs screening data via NC HealthConnex for a small cohort of NC Medicaid providers.¹⁸ This collaboration is designed to reduce administrative burden by minimizing duplicative screenings, improve the patient experience, and provide a more complete picture of non-medical needs to guide appropriate interventions. Strengthening interoperability between NC

HealthConnex, health care providers, and other key partners such as NCCARE360 further expands the state's capacity for real-time data exchange and supports early identification of risk, improved population health management, and burden reduction through streamlined reporting and improved capacity for population health management.

In addition to identifying and scaling successful pilots and programs at the state level, North Carolina can look to recent federal policy priorities to build momentum. For example, CMS' Health Technology Ecosystem initiative creates new incentives for timely data exchange, supporting analytics, and patient engagement that North Carolina can leverage.¹⁹ The ecosystem will provide new digital apps and tools, as well as supports for patients and providers to access electronic health data, including regional and national electronic health data networks. CMS will support the availability of these tools and data resources for Medicare beneficiaries, but it aims to make them more widely available to improve care coordination and access to preventive care and chronic disease management. North Carolina can capitalize on this federal momentum to further expand its interoperable data ecosystem and on cross-sector partnerships to drive innovation, improve outcomes, and reduce overall costs.

Accelerating Progress through Multistakeholder and Multipayer Collaboration

Collaboration across stakeholders is essential for implementing care innovations like NC InCK and HOP and building the data infrastructure needed to track results and accelerate progress. Multistakeholder collaboration can enable sharing of best practices and alignment around effective programs across systems, payers, and policy by focusing investments on shared goals.

North Carolina's Medicaid reforms have benefitted from practical, bipartisan collaboration, including through the North Carolina State Transformation Collaborative (NC STC), a public-private initiative convened by Duke-Margolis to enable state, Medicare, and commercial insurance reforms to go further, faster. For example, the NC STC has aligned on ways to reduce administrative burdens and leverage similar reforms.²⁰ A key effort for the NC STC includes improving data sharing by helping state and commercial entities leverage new federal interoperability initiatives to strengthen care coordination, population health management, and reduce burden associated with performance measurement. The NC STC also works to elevate the need for data infrastructure supports for small, rural, and underserved providers, and to coordinate improvements in health-related social needs data to better target non-medical supports to address unmet needs, such as through initiatives like NC InCK and HOP. Overall, this multistakeholder approach demonstrates how coordinated, statewide collaboration can drive innovation, advances in value-based care, and sustainable health system transformation.

Conclusion

As states face pressures related to rising health care costs, access challenges, and policy changes, North Carolina has an opportunity to build on effective programs to advance innovative, prevention-focused, whole-person systems of care. By leveraging successful pilot programs, enhancing evaluation capabilities, strengthening data systems, and fostering multistakeholder collaboration, the state can expand targeted, cost-effective, and evidence-based initiatives for patient- and family-centered health and social care through Medicaid and other programs.

Simply reducing payment rates or benefits is unlikely to “bend the cost curve” in a way that improves health; evidence shows how expanding access to prevention-oriented supports that integrate clinical and social care can deliver better outcomes at lower costs. Tracking early and intermediate indicators such as patient engagement through rapid-cycle evaluation can provide opportunities to refine programs (e.g., better targeting for specific interventions, reducing intervention costs by using digital supports), ensuring that impact and return on investment are realized more quickly.

Additionally, initiatives like the Rural Health Transformation Program (RHTP) offer opportunities for strategic, upfront investments in regional and statewide initiatives and infrastructure, accelerating longer-term transformation.²¹ The state's investments in innovative, accountable, and well-coordinated health and social care systems position it to continue its national leadership in advancing cost-effective, evidence-based approaches to whole-person health.

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Mark McClellan is an independent board member for Alignment Health Care, Cigna, Johnson & Johnson, and PrognomIQ, and is an advisor for Arsenal Capital Group, Blackstone Life Sciences, and MITRE. He chairs the National Academy of Medicine's Leadership Consortium: Collaboration for a Learning Health System, and co-chairs the Executive Forum of the Health Care Payment Learning and Action Network.

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