

Community Care of North Carolina: An Evolutionary Platform for Medicaid Innovation

Stephen Somers, Lorie Martin, Taylor Hendricks

Medicaid matters more and more to a growing number of Americans, including those with chronic conditions. States find it challenging to provide cost-effective, quality care to the nation's highest-need, highest-cost patients. Community Care of North Carolina is a leading innovator in purchasing high-value health care services at the community level.

The national Medicaid narrative has been tumultuous over the past couple of years because of ongoing state budget problems, the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, the recent Supreme Court decision regarding the ACA [1], the 2012 presidential election, and ongoing federal budgetary brinksmanship with respect to entitlement spending. An important part of the narrative that has received less attention, however, is the story of the quiet transformation of Medicaid as it has changed from a large domestic policy program kept largely in the shadows into a program that is emerging into broad daylight as the foundation for expanded health coverage in the United States.

Once inextricably linked to welfare, and stigmatized accordingly, Medicaid has become an increasingly popular program that is valued by policymakers and the public alike. Medicaid now matters to people, because it touches more and more of their neighbors, children, and older family members. With the expansion of the program that will take place in many states across the country in January 2014, Medicaid will begin providing health insurance to as many as 80 million individuals—nearly a quarter of all Americans.

Medicaid's "rehabilitation" began in 1996, when President Clinton and his Congressional partners delinked the program from welfare [2]. Clinton's popular Children's Health Insurance Program (CHIP), which has been blended with Medicaid in most states, accelerated that trend. Over the next decade, many state Medicaid agencies transitioned from being hidebound bureaucracies buried in welfare departments to more proactive and sometimes even independent agencies as they began to capitalize on their ever-increasing purchasing power. They were often the largest health insurers in their respective states, and they began to fulfill their potential for being laboratories of innovation in contracting, performance measurement, and integration of care for beneficiaries with chronic conditions.

State Medicaid agencies have always had to be cost-conscious. Early on, that cost-consciousness may have been driven by the fear of being caught perpetrating waste, fraud, or abuse. More recently, it is being driven by the increasingly large portion of state budgets that Medicaid is consuming—because of federally legislated expansions of coverage, economic downturns, and the inexorable inflation of health care costs. Although Medicaid consistently performs better than its commercial counterparts in terms of controlling its cost growth, it is constantly looking for more cost-effective ways to fulfill its mission [3]. During this period of Medicaid transformation, the Center for Health Care Strategies, a national nonprofit health policy organization working to improve publicly financed health care, has been in the enviable position of being able to work with leading-edge states all across the country as they have developed more cost-effective health care purchasing models, such as pay-for-performance, risk adjustment, and targeted case-management arrangements.

Few state Medicaid agencies have been more consistently innovative than the North Carolina Division of Medical Assistance and its partner organization, North Carolina Community Care Network, Inc. By turning almost entirely away from full-risk managed care and focusing on building on its networks of community-based primary care providers in sophisticated ways, North Carolina became a beacon for other states, particularly those committed to the primary care case management (PCCM) approach. This includes not just states wary of relying on managed care organizations, but also those looking for ways to preserve and strengthen their networks of safety-net-oriented providers—those most willing and able to serve Medicaid's low-income beneficiaries.

Since the early 1990s, North Carolina has been actively building on the foundation of its PCCM approach to Medicaid beneficiaries. The launch of Community Care of North Carolina (CCNC) put North Carolina on the map, along with Arkansas, Indiana, Oklahoma, and Pennsylvania, as a state with an *enhanced* PCCM model. CCNC relies on 14 regional

Electronically published March 18, 2013.

Address correspondence to Dr. Stephen Somers, Center for Health Care Strategies, 200 American Metro Blvd, Ste 119, Hamilton, NJ 08619 (sasomers@chcs.org).

N C Med J. 2013;74(suppl):S16-S18. ©2013 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2013/74S03

physician-led networks made up of primary care providers, hospitals, and local health and social services departments that are responsible for addressing the care needs of, and coordination of care for, all physical health services enrollees. Each beneficiary is linked with a primary care provider who serves as the beneficiary's medical home and works with a case manager to coordinate acute, preventive, chronic, and specialty care needs. Through its established data monitoring and reporting system, CCNC is able to engage in continuous quality improvement and innovation on both the provider level and the system level [4].

What has been particularly impressive over the years is CCNC's well-honed sense of how to focus its efforts to innovate where it will do the most good. A medical home is a nice thing for anybody to have in our complicated, fragmented health care system, but having a robust patient-centered medical home with genuine care-management capacity focused on those with chronic conditions will generate real progress toward achieving the Triple Aim framework articulated by the Institute for Healthcare Improvement: improved access to quality care, improved population health, and reduced costs. CCNC's understanding of the importance of the medical home in realizing these goals shows in many ways.

Having built up its infrastructure over the past 15 years, CCNC offers a platform the state can use to test innovative interventions aimed at improving quality at the point of care. Uniquely positioned as a state-level entity that directly interfaces with providers, CCNC can prioritize areas for quality improvement to be addressed by provider networks at the local level. CCNC's provider networks are well situated to address the specific needs of Medicaid beneficiaries in their communities, and each network is allowed to design and implement its own targeted care and disease management initiatives. Underlying the state's penchant for innovation is a rigorous focus on data, measurement, and evaluation, in order to keep track of what is working and what is not, and to maintain the flexibility to make midcourse corrections.

As a result, CCNC is a leader among Medicaid agencies nationally in investing in and supporting infrastructure for its primary care networks. One example is CCNC's participation in Reducing Disparities at the Practice Site, a 3-year initiative funded by the Robert Wood Johnson Foundation and developed by the Center for Health Care Strategies. The initiative focused on reducing disparities in care and on improving care within small practices serving a large percentage of racially and ethnically diverse Medicaid patients. The CCNC network in the Fayetteville area partnered with the Improving Performance in Practice initiative to assist those practices in implementing patient registries. CCNC care managers also worked directly with provider practices to better manage the care of patients and to offer patient self-management education. Through this work, these "high-volume, high-value" practices were able to easily identify their patients with diabetes, to create a team to ensure that those patients received the right services at the right time, and to use data to better

understand the quality of care being provided to them [5].

The state's Chronic Pain Initiative further exemplifies CCNC's rapid learning and its population health mindset. Following the discovery that high numbers of opioid poisonings were resulting in avoidable hospitalizations, and even deaths, throughout the state, CCNC developed the initiative as a multi-stakeholder endeavor to stem the inappropriate use of prescription pain medications. Primary care providers, hospitals, local health departments, faith-based programs, and law enforcement officers are being broadly engaged to reduce overdoses, improve chronic pain treatment, and better manage substance abuse issues [6]. This multifaceted program embodies CCNC's commitment to the Triple Aim through its dual goal of improving community health and achieving cost savings.

Anchored by a belief that engaging, educating, and empowering consumers will lead to sustained improvements in health, CCNC introduced a statewide training curriculum on motivational interviewing for its provider networks in 2011. Care managers, providers, and their staff members receive intensive training and coaching to enhance their capacity to support consumer motivation for change [7]. The program offers further proof of CCNC's continual push to innovate.

For the past few years, North Carolina has focused considerable energy on structuring CCNC's networks to integrate care for adults enrolled in both Medicare and Medicaid. Through CCNC's Medicare Modernization Act Section 646 Health Care Quality Demonstration project, under way since 2010 in 8 out of 14 CCNC regions, the state has been an early innovator in seeking ways to improve care for this high-cost population of dually eligible patients. More recently, North Carolina was 1 of only 15 states to receive a federal demonstration design contract, which it is using to explore options to integrate care for dually eligible beneficiaries [8]. The state is now looking to build on the successes of the quality demonstration project in order to integrate care statewide. Although the 646 pilot program has not shown cost savings yet, in its short implementation period, it has met 14 of 18 quality benchmarks and has shown improvement on 17 of those 18 measures. To identify what is working and where improvements are necessary, the state is employing an extensive beneficiary and stakeholder engagement process involving more than 180 individuals across the state [9]. Like many of the states developing dual-eligibility demonstration projects, North Carolina has been looking closely at how to better integrate the Medicaid and Medicare services that are most heavily used by individuals who are eligible for both programs—namely, behavioral health services and long-term supports and services.

Moving forward, North Carolina will also use CCNC's community-based, medical home structure to address the ACA's health homes option for beneficiaries with 2 or more targeted high-priority chronic conditions [10]. In many ways, CCNC is already a health home, with care management embedded in practices and a sophisticated data-driven focus on chronic

care management. As one of a handful of states to receive early approval for its health home state plan amendment, North Carolina is supplementing its uniform per-member per-month fee with an add-on payment that supports the local health department in providing specialized care management for individuals with complex needs.

Under CCNC's health homes model, individuals with mental health conditions are not currently eligible for health homes, because of CCNC's limited integration of physical and behavioral health services. Like other states, North Carolina has further progress to make in integrating services and financing for individuals with behavioral health needs. Its Behavioral Health Integration Initiative is beginning to break down the silos between physical and behavioral health services and to support comprehensive health care homes within primary care practices for those with behavioral health needs [11].

To fuel this innovation engine, North Carolina, like a number of states (including Indiana, Maryland, and Washington), creatively leverages the wealth of academic resources in its own backyard. The state has an ongoing relationship with the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill (UNC-CH), which evaluates state programs and assists in efforts to help the state promote overall population health. Through its engagement with large academic health centers such as Duke University and UNC-CH, CCNC is able to drive innovation throughout the state.

As Medicaid stakeholders across the country explore new partnerships that will link accountability to quality at the point of care, CCNC is, again, already "out of the gate." Through its participation in the federally funded Multi-Payer Advanced Primary Care Practice Demonstration, the state is already testing an accountable care organization-type model, which is consolidating resources and financial muscle across all payers to transform primary care delivery. With a proposal in the running for the soon-to-be announced federally funded State Innovation Models initiative, CCNC is poised to innovate in ways that will further advance multipayer models for payment and delivery.

As we all know, the ACA embodies many aspirations—for expanding coverage, for improving care, and for reforming the health care delivery and payment systems. CCNC is ideally positioned to use these opportunities to meaningfully transform health care delivery. The program's evolution over the past 2 decades has improved the care of Medicaid beneficiaries throughout the state [12] and has spurred ideas in other

states nationwide. We look forward to continuing to watch and learn as the state builds on its CCNC foundation in order to change the face of health care for North Carolinians. **NCMJ**

Stephen Somers, PhD president and chief executive officer, Center for Health Care Strategies, Hamilton, New Jersey.

Lorie Martin communications director, Center for Health Care Strategies, Hamilton, New Jersey.

Taylor Hendricks, MS communications associate, Center for Health Care Strategies, Hamilton, New Jersey.

Acknowledgment

Potential conflicts of interest. All authors have no relevant conflicts of interest.

References

1. National Federation of Independent Business v. Sebelius, 567 US (2012).
2. Moore JD. Welfare reform and its impact on Medicaid: an update. Issue Brief Natl Health Policy Forum. 1999;26(732):1-9. http://www.nhpf.org/library/issue-briefs/1B732_WelfRef&Mcaid_2-26-99.pdf. Accessed January 11, 2013.
3. Garfield R, Clemans-Cope L, Lawton E, Holahan J. Enrollment-Driven Expenditure Growth: Medicaid Spending During the Economic Downturn, FFY2007-2010. Washington, DC: The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured; 2012. Publication 8309. <http://www.kff.org/medicaid/upload/8309.pdf>. Accessed January 11, 2013.
4. Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid. Washington, DC: The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured; 2009. Publication 7899. <http://www.kff.org/medicaid/upload/7899.pdf>. Accessed January 11, 2013.
5. Project Profile—Reducing Disparities at the Practice Site: North Carolina. Center for Health Care Strategies Web site. November 2009. http://www.chcs.org/usr_doc/North_Carolina_Profile.pdf. Accessed January 11, 2013.
6. Chronic Pain Initiative: Developing pathways for optimal pain management. Community Care of North Carolina Web site. <https://www.communitycarenc.org/population-management/chronic-pain-project/>. Accessed November 20, 2012.
7. Motivational interviewing. Community Care of North Carolina Web site. <https://www.communitycarenc.org/population-management/behavioral-health-page/motivational-interviewing/>. Accessed November 20, 2012.
8. 42 USC §1315a(b)(2)(B)(x) (2010).
9. North Carolina Department of Health and Human Services, Division of Medical Assistance. North Carolina State Demonstration to Integrate Care for Dual Eligible Individuals. May 2, 2012. Centers for Medicare and Medicaid Services Web site. <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NorthCarolinaProposal.pdf>. Accessed November 20, 2012.
10. 42 USC §1396w-4 (2010).
11. Behavioral health integration: meeting both behavioral and physical needs. Community Care of North Carolina Web site. <https://www.communitycarenc.org/population-management/behavioral-health-page/>. Accessed November 20, 2012.
12. Steiner BD, Denham AC, Ashkin E, Newton WP, Wroth T, Dobson LA Jr. Community Care of North Carolina: improving care through community health networks. *Ann Fam Med*. 2008;6(4):361-367.