

Is Primary Care Adapting to Medicaid Managed Care in North Carolina? Implications for Expansion and Future Managed Care Transitions

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Realizing North Carolina's comprehensive vision for Medicaid transformation requires strengthening the state's primary care infrastructure. This can be done by building upon the value-based care incentives in the Advanced Medical Home model, strengthening payor data, aligning quality measures, easing administrative burdens, investing in primary care and its workforce pipeline, and ensuring payment models adequately support serving Medicaid expansion and the growing number of Medicaid health plans.

The State of North Carolina set an auspicious goal of using its authority and its \$17 billion in Medicaid spending power to transform the Medicaid program from a system that pays for health care services to a program that purchases health for its beneficiaries [1]. The North Carolina Department of Health and Human Services (NCDHHS) designed the state's Medicaid transformation as a phased transition to a comprehensive system of care that would address the medical, behavioral, and social drivers of health for beneficiaries. Most critical to true health care transformation, the model creates new financial incentives for primary care providers to engage in value-based health care and pilots the use of health care dollars to address the social drivers of health such as food, transportation, housing, and intimate partner violence. Under the plan, primary care practices can serve as Advanced Medical Homes (AMHs) responsible for driving quality, reducing costs, and coordinating care for their attributed populations. Placing these levers of control in the hands of community-based primary care through the AMH model is the most critical aspect of transforming health care from a volume-based payment model to a value-based system. As North Carolina continues to roll out its Medicaid transformation, including the integration of the Medicaid expansion population, these provider-led efforts must remain a key feature of the model design to assure clinicians, payors, and consumers that true transformation will occur and be sustained.

Background

Because North Carolina is such a large state with 80 out of 100 counties considered rural and 38 out of 100 counties lacking adequate access to primary care, ensuring

access to care remains critically important to the Medicaid transformation plan [2]. The rollout of the prepaid health plans (PHPs) coincided with the COVID-19 pandemic, when practices were already under extreme duress, struggling to adequately serve their patients, protect their workforce, and sustain their financial viability under unprecedented circumstances. Throughout the pandemic, a revolution in health care delivery occurred with the almost overnight adoption of the video visit and its underlying technology and billing requirements. The "great resignation" of the workforce that coincided with COVID-19 severely impacted practice staffing, straining access to care. Meanwhile, the politics surrounding the vaccination debate created a vaccine hesitancy ripple effect that continues to limit the system's ability to fully immunize adults and children against influenza and other diseases.

Amid this backdrop, NCDHHS adopted several simplifying principles during the rollout of Medicaid managed care to reduce administrative burdens for practices, such as centralized credentialing, a common set of quality measures, and a single formulary across payors. NCDHHS also offered the optional AMH model to empower providers with the incentives and resources to improve care quality and reduce costs. Under the AMH model, the PHPs tasked with providing managed care services to most beneficiaries can delegate care management to practices. With this delegation, practices receive an up-front, per-member per-month fee that provides them the resources necessary to add staff, improve care delivery, and reduce cost. The funding supports proactive patient outreach and engagement, increased preventive care screenings and immunizations, strengthened disease management supports to improve health outcomes for patients with chronic illnesses, and better coordination of care for patients across the care continuum, which collectively results in reducing disease burdens and unneces-

Electronically published March 11, 2024.

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sary utilization and cost. In addition, PHPs offer value-based payment arrangements, such as quality bonus programs and shared savings arrangements, to incentivize participation and give providers increasing responsibility for overall population health and total cost of care [3].

Primary Care Perspective

From a primary care perspective, the launch of the PHPs moved practices from a single Medicaid payor (NCDHHS) to working with five additional entities with varying programmatic offerings, attribution methodologies, quality bonus structures, and billing systems. These new and complex administrative burdens fell upon a primary care landscape already frayed by the stresses and strains of the COVID-19 pandemic, provider and workforce shortages, increasing rates of physician burnout, health care industry consolidation, and shifts in the primary care economic landscape that challenge the financial viability of independent primary care.

Practices that signed up for the AMH model were also challenged to adjust to new value-based care payment arrangements that included bonuses for quality measure performance and potentially upside and downside risk-sharing arrangements. Under these payment arrangements, payors attribute a panel of patients to practices, and primary care practices become “accountable” for those attributed patients’ quality measures and total cost of care. This includes specialty care, imaging, lab, pharmacy, and hospital costs that are often outside the control of primary care. Successful practices adopt processes for seeing their attributed patients, improving care quality, and strengthening the coordination and management of their care across the care continuum.

Aligning payment incentives and quality measures at the practice level is critical to impacting population health and total cost of care. Practices drive the delivery of health care and need the resources and staffing to improve care quality and reduce unnecessary utilization and cost. Given the per-member per-month practice payments and the value-based payment structure, physicians and their care teams can set up the proper workflows to address quality measures and reduce unnecessary utilization. Connecting care-management services and supports to the practice also ensures that clinical advice comes from a trusted care team member and that care is coordinated by staff who are aware of the services and supports available where patients reside. By contrast, if care is managed only at the health plan level, the levers of control are more removed and limited to what can be controlled via plan design, benefit coverage, and care management support that is more remote and disconnected from practice and patient.

However, adopting these value-based care delivery principles—particularly in small, independent practices—requires substantive changes in how care is organized and delivered. Such changes often leave practices trying to operate in two worlds: the fee-for-service world, in which pay-

ment is limited to the volume of services delivered, and the value world, which requires reorganizing the care team to proactively manage patient care, drive quality measures, improve health outcomes, and reduce unnecessary utilization and cost. Implementing such changes when incentives and payment structures are not aligned across payors is a long-term reform process that does not occur overnight. These transformational changes are particularly challenging in North Carolina where small practices aim to ensure access to care across the state but often lack the staffing required to adopt and deploy the necessary operational changes, particularly given current workforce shortages. As a result, many practices require the assistance and support of a larger health system or a clinically integrated network (CIN) to adopt these transformational changes.

The Emergence of CINs in the AMH Model

Clinically integrated networks (CINs) emerged as critical partners in helping independent primary care practices adopt the AMH model and the changes required to succeed in value-based care. In North Carolina, numerous independent primary care practices rely on CINs such as the Community Care Physician Network (a physician-led and -managed statewide CIN) to support the necessary population management infrastructure needed to manage their populations. CINs provide contracting support, analytics and clinical decision tools, care management and quality improvement assistance, and data integration and reporting support. In addition to supporting individual practices, CINs provide a platform for sharing best practices for leveraging performance improvement across all practices in their networks.

CINs align practice needs and create a unified voice among payors and state leadership. They also offer a “one to many” partnership with which stakeholders can align to support practices across the state. Several stakeholder organizations, such as the North Carolina Academy of Family Physicians, the North Carolina Pediatric Society, and the North Carolina Area Health Education Centers, partnered with CINs to support policy initiatives and funding opportunities during the Medicaid transition. With the transition to managed care and the stressors of the pandemic, CINs were also able to pivot and respond to clinician and practice needs, such as staff recruitment, telehealth platforms, and other supports. As a result, busy practices now rely on their CIN to be their voice, share their concerns, help them find solutions, and ensure accountability across payors and partners.

Implications and Policy Recommendations

Now that Medicaid managed care has been in play for two years, we have advanced the delivery of value-based care in Medicaid in North Carolina, but work remains to be done to support full Medicaid transformation. To take on accountability for quality, utilization, and cost, providers need

continued up-front funding to support their care redesign efforts, improved data to help them drive quality and reduce cost, quality measures that align across payors so that they can effectively drive performance across all patients, and reduced administrative burdens where possible [4]. As we expand PHP enrollment to include the Medicaid expansion population and face the upcoming launch of the Tailored Plans and the Children and Families Specialty Plan, the following recommendations would better support primary care practices in successfully adopting the transformational changes in Medicaid care delivery:

Advanced medical homes. Continue to build on the AMH model where primary care practices lead care management activities and are incentivized for quality and cost savings. Consider advancing the model to include additional financial incentives, such as prospective payments for primary care services that will provide flexibility in financing to help fund transformational changes. Payment incentives are key to supporting innovation in care delivery strategies and preserving primary care participation in an increasingly complex model.

Strengthen payor data. Trusted and reliable data are foundational to successful adoption of value-based care. Primary care groups cannot move toward risk-based arrangements without the tools to manage risk. PHPs need to continue to work to improve patient assignment methods in order to reduce errors such as assigning adults to pediatric practices, and work on sharing complete and reliable utilization and cost data, which is currently often incomplete.

Quality measurement. Align quality measures so that providers can focus on fewer, more meaningful measures and can leverage their care transformation investments across a greater share of their patient populations. Selecting quality measures that can be reported by claims or in other cost-effective ways would also reduce costly reporting barriers. The flow of data between electronic medical records and payors is a significant challenge. Independent primary care practices participate in nearly 80 different electronic health record (EHR) systems and extracting clinical data via EHR connections is costly and labor intensive. The state health information exchange (NC HealthConnex) must continue advancing its work to support AMHs and their CINs with data exchange and quality reporting, and PHPs should integrate those feeds into their quality-measurement programs.

Special considerations for the expansion population. Sustaining the ability of practices to earn quality bonuses and shared savings opportunities over time will be key to practice retention throughout Medicaid transformation. The Medicaid expansion population represents a 20% growth in PHP patient volume and may include a large segment of the population who lacked previous access to preventive care. Including this population in quality and cost calculations could greatly skew the performance of AMHs downward and create a step back for value-based payment incentives. This population should be excluded from such calculations

until AMHs have had ample opportunity to engage in care, close quality gaps, receive quality data, and address any untreated care needs.

Ease administrative burden. Primary care practices have just adapted to reimbursement and enrollment systems across five new managed care plans. With the addition of the Children and Families Specialty Plan and the Tailored Plans over the next 12 months, a primary care practice may be contracted with 7-10 Medicaid health plans using multiple claims and enrollment processes. Some practices may close their doors to more complex patients like foster children or those with serious mental illness or intellectual and developmental disability to avoid the administrative burden and risk of reimbursement problems. It is critical that the state, the PHPs, the Tailored Plans, and Children and Families Specialty Plans and provider groups continue to collaborate to standardize operational processes such as claims payment, prior authorization, and attribution. The increased administrative burden is particularly concerning given recent studies showing that it would take 23 hours per day for a physician to provide high-quality acute, preventive, and chronic disease care for a typical panel of patients and 3.2 hours on administrative tasks such as prior authorization and EHR documentation [5].

Strengthen North Carolina's primary care infrastructure. Overall, primary care's lack of capacity is a major risk to the success of managed care in North Carolina. Strained from the pandemic, practices—especially in rural areas—are still struggling to recruit and retain primary care providers, and rates of burnout have increased from 46% in 2011 to 63% in 2021 [6]. Fortunately, there are significant efforts underway through North Carolina's new Center on the Workforce for Health initiative and recent actions by the North Carolina General Assembly to increase the primary care workforce [7]. Fundamentally, primary care practices run on a thin margin and efforts to align Medicaid reimbursement with Medicare and strengthen payments for care management and value-based outcomes will ensure that practices continue to participate in upcoming managed care transitions. Primary care payment will be especially important when taking on the additional complexity of Tailored Plan patients and beneficiaries of the Children and Families Specialty Plan. Finally, it is imperative that state leadership and organizations that support primary care continue to collaborate effectively so that policymakers understand what is happening on the ground in community-based primary care. NCMJ

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Acknowledgments

The authors hold leadership roles in Community Care of North Carolina, the sponsor of the Community Care Physician Network, a clinically integrated network of independent primary care providers in North Carolina. No further interests were disclosed.

References

1. Cohen MK. North Carolina's transformation to Medicaid managed care. *N C Med J*. 2019;80(5):277-279. doi: 10.18043/ncm.80.5.277
2. *Healthy North Carolina 2030: A Path Toward Health*. North Carolina Institute of Medicine; 2020. Accessed January 22, 2024. <https://nciom.org/wp-content/uploads/2020/01/HNC-REPORT-FINAL-Spread2.pdf>
3. North Carolina's Transformation to Medicaid Managed Care. NC Medicaid. Accessed December 12, 2023. <https://medicaid.ncdhhs.gov/transformation>
4. Mahadevan RR (2021, August 8). Key considerations for supporting Medicaid Accountable Care Organization Providers. Center for Health Care Strategies. Published June 2013. Accessed January 31, 2024. <https://www.chcs.org/resource/key-considerations-for-supporting-medicare-accountable-care-organization-providers/>
5. Porter J, Boyd C, Skandari MR, Laiteerapong N. Revisiting the time needed to provide adult primary care. *J Gen Intern Med*. 2023;38(1):147-155 <https://doi.org/10.1007/s11606-022-07707-x>
6. Berg S. Pandemic pushes U.S. doctor burnout to all-time high of 63%. American Medical Association. Published September 15, 2022. Accessed December 12, 2023. <https://www.ama-assn.org/practice-management/physician-health/pandemic-pushes-us-doctor-burnout-all-time-high-63>
7. NC Center on the Workforce for Health. North Carolina Institute of Medicine. Accessed December 12, 2023. <https://nciom.org/nc-center-workforce-for-health/>