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SPECIAL SUPPLEMENT

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What is Medicaid?

Introduction

Medicaid has been getting a fair share of its time in the media spotlight these days, yet many who hear news stories about Medicaid still may be unsure about just what Medicaid is—or is not. So what exactly *is* Medicaid? This supplement of the NCMJ is meant to be both a primer on Medicaid and a baseline for discussion.

We invited Lanier Cansler, former Secretary of the North Carolina Department of Health and Human Services and a former state legislator, to share his long and varied experience with the North Carolina Medicaid program. Secretary Cansler reminds us that Medicaid provides health insurance for only some low-income individuals. Medicaid recipients must be "categorically eligible" for coverage. Income and resource eligibility requirements vary for different categorical groups. Because of both income and categorical restrictions, Medicaid currently covers only 30% of all poor adults in the state.

Medicaid is under close scrutiny by the public and politicians because of the costs it imposes on the state. Medicaid financing is shared between the federal and state governments, with the federal government paying almost two-thirds of the costs of health care services for Medicaid recipients. In State Fiscal Year 2011, Medicaid spending comprised approximately 13% of North Carolina's state general fund expenditures (22% of total expenditures when federal funds are included). The problem, which is not unique to North Carolina's Medicaid program, is that Medicaid has historically grown faster than state revenues. Indeed, health care costs in both the public and private sectors are growing more quickly than other segments of our economy. In recent years, North Carolina's Medicaid program has bucked the national trends, and its costs are now rising less rapidly—in total and per capita—than Medicaid costs in most of the rest of the country.

While Medicaid consumes a considerable portion of the state's budget, it has helped to improve access to health care services. North Carolina has a nationally recognized Medicaid health care delivery system—Community Care of North Carolina—that helps to link Medicaid recipients to a medical home. This system has improved care for many North Carolinians, especially those with chronic illnesses. Infants, children, and teens grow up healthier if poverty is not a barrier to receiving well-child care and sick care. Pregnant women have healthier births if they can easily seek prenatal care. Adults with chronic illnesses who receive care and disease management can better manage their chronic illnesses. And Medicaid enables many frail elderly individuals or those with disabilities to be served in their communities.

With the spotlight shining on Medicaid, we all need to know more about it. I hope that this supplement will answer some questions and spur new ones.

Peter J. Morris, MD, MPH, MDiv
Editor in Chief

ISSUE BRIEF

A Look at North Carolina's Medicaid Program

Lanier M. Cansler

As North Carolina's population grows, so too does the number of low-income residents who need the assistance of the state's Medicaid program. Growing enrollment and the rising costs of health care delivery place the Medicaid program in the spotlight of state budget deliberations. Proposals set forth in the budget debate should take into account both the complexity of the Medicaid program and, perhaps more importantly, the critical role that Medicaid plays in providing health care for North Carolinians. Medicaid is not only the primary health care safety net for the poor; it is also a key factor in prevention and improved health for a major segment of the population, and it is a financially stabilizing factor for our health care delivery system, which provides care for all North Carolinians. This article provides insight into North Carolina's Medicaid program, its importance, and its complexities. It demonstrates that controlling the Medicaid budget is not a simple task, and efforts to do so should take great care to protect both access and quality of care for the poor and the financial stability of North Carolina's health care delivery system.

I have been monitoring the Medicaid policy and funding debate in North Carolina since 1997, when I became involved in the review and development of North Carolina's Medicaid policy as cochair of the North Carolina House Appropriations Subcommittee on Health and Human Services. Doing so has given me a much better understanding of the programmatic, budgetary, and political complexities of that safety-net entitlement program for the state's low-income citizens. And I have learned that there are many different views of North Carolina's Medicaid program and the challenges it faces.

Many people depend on Medicaid for health care services for themselves or their children, some of them for a short time during a national economic downturn or a period of personal financial difficulties, and others for longer intervals, perhaps while receiving care in a skilled nursing facility during the final months or years of life. All of these individuals view Medicaid as a critical program that offers access to care that would not otherwise be affordable. They understand that without this program and its covered services, their primary source of health care would likely be the hospital emergency department rather than the office of a pediatrician or a primary care physician. Without Medicaid, it would likely be difficult or impossible for them to obtain access to such services as preventive care, care focused on the management of a chronic disease, or assistance when age or disability has left them unable to care for themselves.

For health care providers, particularly in low-income or rural areas of the state, Medicaid serves as the stabilizing financial factor that permits them to continue to provide health care services to the poorest of North Carolina's residents—services that include primary care, specialty care, hospital care, skilled nursing and other long-term care, behavioral health care, and many other critical services covered under the program. Many providers of care, including community hospitals, skilled nursing and assisted living facilities, and others, would likely not survive financially without the money they receive from the Medicaid program. The survival of these providers is important not just to Medicaid consumers but also to the other North Carolinians who seek care from them.

Advocates of a healthier population see Medicaid as a program that provides health care and preventive care for those individuals who would otherwise be likely to face constant health challenges resulting from uncontrolled chronic disease, failure to obtain important vaccinations, and lack of simple, but critical, preventive screenings and treatments that result in both better health for the individual and lower costs within the health care delivery system.

Those who understand the economics of Medicaid and are aware that currently more than $8 billion in federal tax dollars are returned annually to the state of North Carolina through partial funding of the program by the federal government [1] see Medicaid as one of the state's economic drivers, a program that creates jobs and sustains businesses while providing critical health care coverage for our low-income population. The Kaiser Family Foundation reports that in 2011, more than 10% of North Carolina's jobs were related to health care [2]. The North Carolina Office of Rural Health and Community Care notes that the health care industry is among the top 5 employers in 64 of the state's 100 counties [3]. And according to an article on the EconPost Web site, in 2008 health care was the fifth largest growth segment of North Carolina's economy [4]. Medicaid

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constituted approximately 18% of health care spending in the state in 2009 [5].

But in recent years, North Carolina's Medicaid program has come to be viewed by many in state government as a growing budget problem that must be controlled, rather than as a critical safety net, a stabilizing financial factor in our health care delivery system, a key component in prevention and improved health, or an economic driver that plays a role in our state's economy. We may share their concern about the long-term financial sustainability of the Medicaid program and our health care delivery system in general, but the control of Medicaid costs, and the approach to achieving that control, should maintain a focus on achieving the policy goals of the program, protecting the safety net, and maintaining the financial stability of our health care delivery system. To fail in any of these policy goals will likely ultimately result in even greater costs to North Carolina.

Understanding North Carolina's Medicaid Program

To effectively participate in the debate over Medicaid policy and the Medicaid budget, it is important to understand how North Carolina's Medicaid program operates. Undoubtedly, the existence of the Medicaid program has provided substantial benefit to the residents of the state over the years.

Title XIX of the Social Security Act became law in 1965 and created the Medicaid program as a cooperative venture jointly funded by the federal government and state governments to assist states in furnishing medical assistance to eligible needy persons. Within constraints imposed by the federal government, states are able to set their own eligibility standards for coverage; establish the type, amount, duration, and scope of services; and determine what the payments will be for the providers of those services. In 1969, the North Carolina General Assembly approved the creation of a medical assistance program, and the state submitted a Medicaid plan to the federal government [6]. The plan was approved, and it began operations on January 1, 1970. Initially the program was under the direction of the North Carolina Division of Social Services. In 1978, as the program continued to grow in size and complexity, management of Medicaid was transferred to the newly created Division of Medical Assistance (DMA) within what was then known as the Department of Human Resources. By 1978, the state's Medicaid program covered approximately 456,000 low-income North Carolinians at an annual cost of approximately $307 million [6]. According to the Kaiser Family Foundation, in fiscal year (FY) 2009 North Carolina's Medicaid program provided coverage to more than 1.8 million individuals sometime during the year [7]. The total program cost was approximately $10.9 billion in FY 2010 [8].

North Carolina's Medicaid budget is large and continues to grow with demand, but the federal government shares in both the cost of the services provided and administrative costs. The level of federal financial participation is referred to as the Federal Medical Assistance Percentage (FMAP). FMAP is established annually and varies by state, because the rate for each state is based on its per-capita income. The minimum FMAP is 50% for covered services. North Carolina's FMAP for FY 2013 has been set at 65.51% [9]. However, certain services receive a higher FMAP. For example, federal funds pay 90% of the costs of family planning services and 100% of the costs of services provided through Indian tribal facilities (such as the Health and Medical Division of the Eastern Band of Cherokee Indians) [10]. Normally the federal government pays 50% of administrative costs, but in some cases it pays a higher percentage of those costs. For instance, the federal government pays 100% of the costs to verify immigration status; 90% of the costs to verify citizenship; 90% of the costs to design, develop, and install Medicaid Management Information Systems (MMIS); and 75% of the ongoing costs of managing and operating such systems [10]. States that choose to expand Medicaid under the Patient Protection and Affordable Care Act of 2010 will receive a FMAP of 100% for the first 3 years to pay for services for newly eligible enrollees. The FMAP would then begin to decline, stabilizing at 90% in 2020 [11].

To receive coverage under the Medicaid program, an individual must currently generally meet 4 eligibility criteria. First, the person must be a US citizen, or an immigrant who has been lawfully present in the United States for at least 5 years. Second, the individual must meet "categorical" eligibility requirements: He or she must be a child under the age of 21 years, a pregnant woman, the parent of a child under the age of 19 years, an adult 65 years of age or older, or an individual with a disability who meets the Social Security disability standards [12]. Single, childless, nondisabled, and nonelderly adults do not generally qualify for Medicaid. Approximately 500,000 low-income adults would be eligible for Medicaid if North Carolina chose to expand Medicaid. Expanding coverage to this group would actually result in net savings to the state of $65 million during the first 8 years the expansion was in effect [13].

Third, the individual's income must be lower than the income thresholds established by the state. These thresholds vary among the eligibility categories. For children under the age of 21 years, coverage is available to those with countable household incomes of up to 200% of the federal poverty guidelines (often referred to as the federal poverty level, or FPL). For FY 2013, that 200% figure is $47,100 for a family of 4, and $22,980 for an individual [14]. It should be noted that children younger than 19 years of age may, depending on their age and income, qualify either for Medicaid coverage or for coverage under North Carolina's Child Health Insurance Program (CHIP), which is known as Health Choice. The parents of children under the age of 19 years can qualify for Medicaid coverage only if their countable income is less than approximately 50% of the FPL if they are working (for 2013, that figure is $11,775 for a family of 4, or $5,745 for an individual) or less than about one-third of the FPL if they are

not working. For individuals in the aged and disabled eligibility category, coverage is available if countable income is below 100% of the FPL (for 2013, that figure is $11,490 for an individual, or $15,510 for a family of 2) [14].

Finally, the Medicaid program considers the individual's resources, including money in the bank and other financial holdings. Again, the resource limits vary among the eligibility categories. Children and pregnant women do not have resource limits, because it is recognized that most families with young children living in poverty do not have sufficient resources to meet ongoing health needs. Older adults or people with disabilities cannot have more than $2,000 in countable resources. The limit is $3,000 for a couple [12].

Over the 42 years that the Medicaid program has operated in North Carolina, eligibility standards and covered services have been modified and expanded numerous times, taking into account overall changes in health and health care delivery as well as the changing needs of the people of the state [6]. In some cases, changes have resulted from increased federal requirements. Because Medicaid is a collaborative effort between the federal government and state governments, and because the federal government provides a substantial portion of the funding for the program, any change in the program that the state legislature wants to make generally requires approval by the federal government. Examples of changes that have been made over the years include the following: the implementation in 1983 of what is now known as the Community Alternatives Program for Persons with Intellectual and Developmental Disabilities (CAP/IDD); legislative approval in 1984 for funding of services for pregnant women and children; the inclusion of coverage for hospice services beginning in 1988; the implementation in 1991 of the demonstration project for the Carolina ACCESS program, a managed care program; the expansion of available health care coverage for children when the legislature approved the creation of Health Choice in 1998; and in 1999, the expansion of Medicaid coverage eligibility for those in the aged and disabled category with incomes up to 100% of the FPL [6].

Covered services under North Carolina's Medicaid program include both the mandatory services that are required to be covered by the federal government and optional services that have been approved by the state legislature over the program's history. In general, states are mandated to provide coverage for physician services; hospital inpatient and outpatient services; laboratory and x-ray services; early and periodic screening, diagnosis, and treatment services for children under 21 years of age; family planning services and supplies; nursing facility services for adults age 21 years and older; home health care; and transportation services. Medicaid must also provide coverage for services provided by federally qualified health centers (such as community health centers), rural health clinics, pediatric and family nurse practitioners, and nurse midwives.

Optional services covered in North Carolina include such services as prescription drugs, behavioral health and substance abuse services, dental services, vision care, therapy services, intermediate care facilities for persons with intellectual and developmental disabilities, personal care services, hospice care, prosthetic devices, and durable medical equipment.

The Medicaid Budget

Almost every state in the country is engaged in efforts to better control its Medicaid budget. Many of the current Medicaid cost-reduction efforts by governors and legislatures across the country have been driven by the major economic recession and slow recovery that we have experienced over the past 4 years. Medicaid program enrollment and utilization of services grow more rapidly in poor economic times. Unfortunately, when the economy is doing poorly, state government revenues decline. Medicaid costs continue to consume large amounts of state budgets, and the program competes with education and other services for funds.

North Carolina is no exception. Our state government spends an extraordinary amount of time and effort attempting to control the cost of Medicaid as well as the costs of Health Choice and of the North Carolina State Health Plan for employees. Some of these efforts have included reducing provider reimbursement rates, limiting utilization of certain services by capping utilization or by implementing prior authorization requirements, redefining services or provider requirements, and eliminating access to certain services entirely. Although many of these efforts may have a favorable impact on the budget, that favorable impact is often short-lived, for many such efforts simply shift costs from one area to another with no actual overall benefit. Within North Carolina's health care delivery system, major reductions in Medicaid coverage and funding may simply result in costs shifting to the private and commercial sectors.

In recent decades North Carolina has been one of the fastest-growing states in the country. With a rapidly growing population, the low-income population has grown as well, steadily increasing the number of individuals who are financially eligible for the Medicaid program. According to DMA, in 1999-2000 more than 1.22 million individuals were covered under North Carolina's Medicaid program [6]. By 2009, that number had grown to more than 1.81 million individuals, an increase of approximately 50% [7]. Although some of that increase was the result of the legislature's expansion of the program for those in the aged and disabled eligibility category, much of the increase resulted from the state's population growth and the decrease in personal income levels during poor economic times. From 1999 to 2009, North Carolina's population grew from an estimated 7.949 million people to 9.435 million, an increase of nearly 1.5 million, or about 19% [15].

Another issue related to program budget growth is that North Carolina's population is also aging rapidly, and the older our population, the higher our health care costs will

be. The North Carolina Division of Aging and Adult Services reports that people 65 years of age or older made up 13.3% of the state's population in 2011 but will constitute 19.6% of the state's population in 2031 [16]. By 2025, 1 in 4 North Carolinians will be 60 years of age or older, and 86 of North Carolina's 100 counties will have more people 60 years of age or older than people under the age of 18 years [17]. This growing population of older adults will have a substantial impact on the cost of Medicaid's long-term care services in coming years. The Kaiser Family Foundation reports that in FY 2010, approximately 29.1% of North Carolina's Medicaid expenditures were for long-term care [18]. Although most individuals 65 years of age or older are covered by the national Medicare program, Medicare offers only limited coverage for long-term care costs. Berry and Woody talk about the role of Medicaid in addressing the needs of older adults in their commentary in this issue [19].

Kaiser Family Foundation data for FY 2009 show that approximately 27% of those enrolled in the North Carolina Medicaid program were categorized as aged or disabled [20], and that the cost of services for those 2 categories of recipients made up approximately 63% of the program's total costs that year [21]. With a rapidly aging and growing population that can be expected to include an increasing number of individuals with disabilities, Medicaid enrollment of this more expensive population will continue to grow. The reality of an aging coverage group confronts not just the Medicaid program, but also the North Carolina State Health Plan for employees, which has no federal financial participation.

Another consideration in the assessment of Medicaid budget growth is the cost of health care innovations, including new technology, new drugs, new procedures, and new ways to diagnose and treat health issues. The enhancement of our health care delivery system often results in new costs and demands within the system. This also plays a role in the growth of the Medicaid budget.

Finally, growth in the Medicaid budget has occasionally been driven by legislative decisions to supplement state-funded programs with federal dollars through expansion of services offered under the Medicaid program. For example, in the late 1990s, the North Carolina General Assembly expanded Medicaid to provide coverage of personal care services in adult care homes. The Medicaid funding, with the federal match, provided some relief of budgetary pressures on the state and counties in State/County Special Assistance (SA) funding. Prior to this expansion, the SA funding was the primary source of funding for assisted living care. So although the Medicaid program has grown, that growth may have provided some relief in other areas of the state's budget. This fact is often overlooked in the Medicaid budget debate.

Identifying Solutions

When debating the Medicaid budget, it is easy to point fingers at program management and to express concerns about this growing part of the state's overall budget. However, once the issues surrounding Medicaid budget growth are carefully analyzed, it becomes obvious that enrollment growth and overall trends in health care delivery have had the greatest impact on the cost of the program. While reimbursement for Medicaid services are higher for some of North Carolina's provider community than in some other states, Medicaid remains near the bottom of reimbursement rates compared to all other payers for service including the national Medicare program. Many would argue that the low Medicaid and Medicare reimbursement rates have had the impact within the health care delivery system of shifting costs to private and commercial payers and thus increasing the cost of insurance premiums for individuals and employers.

Even though North Carolina's Medicaid expenditures have continued to grow, program management succeeded in limiting program growth to approximately 3.5% during the period from 2007 to 2010, when the national growth rate in Medicaid spending was 6.8%, almost twice that of North Carolina [22]. The program has worked to control growth through such initiatives as the implementation of prior authorization on certain high-cost and overutilized services, adjusting provider rates when determined appropriate, enhanced care management focused on prevention and chronic disease, and adoption of technology to enhance the ability to identify improper utilization and fraudulent activities. While a recent report by the State Auditor raises issues about administrative costs, over 50% of the costs in that report were costs incurred by the state's 100 counties in meeting their responsibilities with respect to Medicaid management, and by the Local Management Entities in their administrative oversight of the state's mental health care delivery system. Central management in the Division of Medical Assistance and the necessary work performed in other DHHS divisions related to Medicaid management make up only about 3.2% of Medicaid program costs (Division of Medical Assistance, unpublished data, 2013). Because of federal participation in these costs, any cost allocation plans are approved by CMS.

The Medicaid budget cannot be controlled simply by making artificial adjustments to funding or eliminating covered services, because changes that on the surface appear to reduce costs often in reality result in cost shifting, with no net gain. Although Medicaid is, in fact, a large insurance operation, unlike other insurers the program does not have a reserve fund to cover ups and downs in the volume of medical claims. If claims unexpectedly go up, the increase may be inaccurately viewed by some as a budget problem resulting from management failure.

In reality, there are 4 ways to control or perhaps even reduce the Medicaid budget. The first is to reduce enrollment by eliminating or tightening the requirements for some categories of eligibility. Because the federal government does not allow states to "grandfather" coverage for individuals already receiving Medicaid under existing eligibility rules, making a

change of this sort results in services being taken away from individuals who currently have access to them. Even if state officials are willing to accept the political consequences of taking such an action, the Affordable Care Act limits the states' ability to make these types of eligibility decisions [23].

The second way to control the Medicaid budget is to eliminate or reduce coverage for certain services. This is not an option with respect to mandatory services or the necessary services for children. The major services under the optional services classification would be pharmacy services (prescription drugs), behavioral health and substance abuse services, and personal care services for those receiving in-home or assisted living care. The cost of these services constitutes over 80% of the cost of all optional services offered under North Carolina's Medicaid program [24]. Although the legislature has modified some optional services over the past several years, the cost shifting that would follow the elimination or even the substantial reduction of any major optional service means that it is likely that there would be no aggregate savings and, in some cases, such as the elimination of pharmacy services, a substantial increase in costs on the mandatory services side of the program might be the result.

The third way to control costs is to reduce reimbursement rates for the provision of health care services. As mentioned earlier, North Carolina Medicaid is already paying one of the lowest rates of any payer to health care providers for their services. In the late 1990s, the legislature approved an increase in physician rates to encourage physicians to serve Medicaid patients [6]. That effort by the legislature had a significant impact on access to care for the state's low-income individuals, with perhaps the greatest impact on access for children. Each implemented reduction in Medicaid reimbursement rates has the potential to reduce access to care in physicians' offices. If access to primary care is impacted, the alternative again becomes increased utilization of hospital emergency departments for nonemergency care, along with decreases in preventive care and chronic disease management. The concern about negatively impacting access to care has resulted in the federal government requiring a study of impact on access to care whenever a state submits Medicaid plan amendments that reduce provider reimbursement rates. If access to care is an issue, approval of plan amendments to reduce reimbursement rates may be denied.

The fourth way to control Medicaid costs is to ensure that utilization of services is appropriate and follows best practices related to the diagnosis and treatment of health issues. This is partly a matter of program integrity, which is a major responsibility of DMA. They must ensure that the billing for services is appropriate and has been submitted by qualified providers, and that the actual delivery and utilization of services was appropriate and effective for the health issues of the individual Medicaid consumer. Over the past several years, North Carolina's Medicaid program has expanded its technological capabilities to identify possible system abuse and overutilization or improper utilization of services by providers and consumers. But even after abuses or improprieties have been identified and confirmed, existing processes and legal maneuvers on the part of providers can make it challenging to recoup money paid for inappropriate or unnecessary services. However, abusive providers lose their ability to continue to bill Medicaid inappropriately, thus reducing subsequent program costs.

Although efforts to ensure program integrity are important, North Carolina has learned that management of care provides the greatest benefit with respect to appropriate utilization. Effective care management is the preferred approach to controlling costs as it controls costs by improving health while avoiding utilization of services that are not appropriate or necessary. The creation and continued development of Community Care of North Carolina (CCNC) has been the state's centerpiece in the development of medical homes and coordination of care under the Medicaid program. The approach to care management initiated by CCNC has been duplicated in numerous states and is often referred to as the gold standard. CCNC initially focused on access to care through the creation of a primary care medical home and the management of chronic diseases such as diabetes and asthma. But over the years CCNC has developed the capability of improving health outcomes while controlling costs through appropriate management of care. CCNC understands the state's goals in Medicaid program management and continues to evolve into an organization capable of achieving both access and quality of care while controlling costs.

Additional information about CCNC may be found in the commentary in this issue by Dobson, Levis, and Wade [25]. The commentary by Seligson and Pully illustrates how CCNC has made a difference by improving health outcomes and reducing unnecessary expenditures for children with asthma [26]. And Somers, Martin, and Hendricks discuss how North Carolina's approach to managing the care of Medicaid recipients compares with that of other states [27].

DMA has succeeded in managing a constantly growing Medicaid program with a limited staff and a tight administrative budget. The program's direct central administrative costs make up approximately 3.2% of total costs, a proportion that is substantially less than that of the reported administrative costs of any large insurance company or managed care organization. As mentioned earlier, the average annual increase in North Carolina's overall Medicaid budget from 2007 to 2010 was 3.5%. This compares very favorably to Medicaid growth rates in other Southeastern states: Virginia had a Medicaid growth rate during that period of 9.2%; Louisiana, 9.0%; Florida, 8.6%; Arkansas, 8.4%; South Carolina, 7.5%; Kentucky, 6.9%; Tennessee, 6.1%; West Virginia, 5.5%; Alabama, 4.9%; and Georgia, 3.6%. Nationally, the average annual growth rate was 6.8% [22]. North Carolina's per-capita growth rate was even lower. The average annual per-capita growth rate in North Carolina's Medicaid program from 2006 to 2009 (the latest year data are available) was 2.2%. This compares to 4.2% in the Southeast and 3.1% nation-

ally. North Carolina's per-capita annual increase in Medicaid expenditures was also lower than the state's overall per-capita increase in health care expenditures during the same period (2.2% vs 3.2%) [28].

The size of the Medicaid budget is a reflection of the larger problem of the cost of our national health care delivery system. The approach North Carolina has taken—improving the quality and effectiveness of care through building a strong care management network—has demonstrated to the nation the importance of care management in avoiding unnecessary care and controlling inappropriate utilization of services, thereby controlling growth in costs. This has been accomplished with minimum administrative costs, allowing available funding to be totally focused on the delivery of care. NCMJ

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INVITED COMMENTARY

Community Care of North Carolina in 2013

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Community Care of North Carolina has transformed the delivery of health care to the Medicaid population through its physician-led integrated system of networks and medical homes that are improving the quality and containing the costs of care delivered to the state's most vulnerable and needy citizens.

Over the past year, much attention has been focused on Medicaid at both the state and national levels. For most states, Medicaid represents both an opportunity and a challenge. As enrollments increase, states grapple to develop a strategy that will bring both quality and efficiency to a public program that represents an ever increasing part of state budgets. The national Medicaid dialogue explores such concepts as patient-centered medical homes, health homes, accountable care organizations, payment reform, and care coordination.

In 2013, Community Care of North Carolina (CCNC) will reach its 15th year of operation as a statewide system of medical homes and local-community not-for-profit networks of physicians, hospitals, social service agencies, and other community provider organizations. These networks have been organized by North Carolina providers in order to better serve Medicaid patients in the state. CCNC networks and the Office of Rural Health and Community Care's HealthNet program for the uninsured work together closely at the community level. CCNC's web-based informatics center and care management information system support both programs, so meaningful information can follow uninsured individuals across providers and payers as they move in and out of Medicaid. CCNC is currently serving approximately 1.4 million citizens (including 144,000 Health Choice for Children enrollees and 90,000 uninsured residents) through 14 regional nonprofit networks of 1,600 medical homes and 5,500 physicians. CCNC has become a national model of a private-public partnership between a state and its health care providers—a partnership that uses a patient-centric population-management approach and is physician-led and community-based. The principles of CCNC are arguably the same ones that are being employed across the country to improve patient-centered care, improve health outcomes, and reduce costs.

Over the past 5 years, CCNC has demonstrated both significant improvements in quality and reductions in Medicaid expenditures. CCNC outperforms Medicaid managed care plans on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) quality measures for asthma, diabetes, hypertension, and cardiovascular disease [1]. Between 2007–2010, North Carolina had the lowest average annual growth in Medicaid spending of any state in the country [2].

CCNC, which links each patient to a primary care practice, actively seeks to engage the highest-cost and highest-risk individuals to participate in the program. These are the patients for whom CCNC's population-management interventions will have the greatest impact. Sustainable savings come primarily from learning to deliver care in smarter, more coordinated ways that are patient-centric and community-based. Providing high-quality team-based care to the right patient at the right time, in the most appropriate setting, continues to result in positive outcomes.

What Makes CCNC Different?

CCNC is led by local physicians who provide care to North Carolina's Medicaid recipients, along with other health providers in the community. This bottom-up governance has been the key to getting buy-in at the practice level. With this buy-in, CCNC has begun to make significant changes in the way that the community-based health care delivery system functions. CCNC is built on a foundation of every patient having a "medical home." This approach identifies a primary care physician, nurse practitioner, or physician assistant who assumes responsibility for delivering and overseeing the care for a panel of patients over the long term.

The 14 local CCNC networks across the state provide wraparound support to primary care practitioners and their Medicaid patients. More than 800 care managers, 30 medical directors, 20 clinical pharmacists, and 10 local psychiatrists provide support that covers all urban and rural areas of the state. In addition, the networks hire nonlicensed personnel to support health care teams and population management efforts. These are local people managing local patients—and driving improvements in the system. The physicians are engaged in creating standardized expecta-

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tions regarding the implementation of evidence-based best practices. They lead local teams and decide how to collaborate to get the best results.

Efforts to improve care and to reduce unnecessary expenditures are owned by those who directly care for patients—physicians, nurse practitioners, and physician assistants, with support from care managers and other members of the care team. CCNC care managers know the patients, the community, and the resources that are available locally. Care managers "on the ground" connect the dots between the patient, the primary care practitioner, specialists, hospitals, providers of home health assistance, and other community resources. This wraparound support emphasizes the various responsibilities that health care professionals and organizations have to their patient population. Those responsibilities include informing enrollees about their health, sharing resources and expertise, addressing medical and social needs, and providing and coordinating needed health care services. Managing a population involves more than just the delivery of physical health care services; providers are also required to address social, mental health, and community issues that may impact health and medical care. Simply put, population management recognizes the social and environmental factors that affect an individual's health status.

The state of North Carolina and CCNC identify clinical priorities based on the incidence of a condition, the cost of the care that is available for it, and its amenability to specific health interventions. CCNC's informatics center provides quality and care management data to networks and practices. Physicians get regular performance and patient-specific feedback that helps to drive improvements in the care they deliver. An essential component has been stratifying the CCNC population to identify (and track) those patients who will benefit the most from population-management interventions. As part of its population-management approach, CCNC does the following things: it works to ensure that every patient has a medical home and understands the value of a medical home; it analyzes the health care needs and experiences of the enrolled population, and it defines subsets of the population that may need and benefit from population-management support and interventions (care and disease management); it develops local care-management initiatives and supports, and it utilizes and organizes community resources to best serve the population; it tracks and evaluates program performance and adjusts program initiatives accordingly; it ensures that patients receive appropriate preventive screenings; and it supports healthy lifestyles and provides self-management coaching.

Over the years, CCNC has, with its partners, implemented integrated care management strategies that address the following issues: chronic diseases and how best to care for them, evidence-based best practice guidelines, pharmacy management, emergency department utilization, prevention and health promotion, transitional support, palliative care, and high-cost or high-risk patients, including high-risk obstetrics patients. The challenge for a successful population-management approach is how to determine which subsets of the population will benefit from the targeted interventions. Identifying those who will benefit most from the program's services is an ongoing process. CCNC's population-management approach builds on its patient self-management component through member education and care-management support. When implemented successfully, this approach equips individuals with chronic conditions with the ability to manage them more effectively, gradually lowering the percentage of high-risk and high-cost patients in the population and reducing the demands on the care system.

An Example of Effective Collaboration: Transitional Care

Recently CCNC, working with its partner physicians and hospitals, identified an opportunity to reduce unnecessary readmissions. Successful pilot projects and research studies have demonstrated that readmissions can be reduced with targeted interventions that improve the care processes [3, 4]. In North Carolina, 190,000 Medicaid recipients are admitted to the hospital every year, and 31,000 of those recipients have multiple hospital admissions. Nearly 1 out of every 10 admissions is followed by a readmission within 30 days of discharge. An additional complicating factor is the frequency of cross-hospital traffic: In 23% of cases of readmission within 30 days of discharge, the patient's second admission is to a different facility.

In 2008, CCNC implemented a statewide rollout of a population-based transitional care initiative designed to provide support for enrollees as they transition from one setting to another. The initiative primarily targeted transitions from the hospital to the community. Working with partner hospitals, CCNC identified and implemented several key components of a model for such transitions. Networks were advised to take the following steps: embed care managers in large hospitals with a high volume of Medicaid admissions and discharges; provide comprehensive medication management for patients following their discharge from the hospital; provide patients and their families with face-to-face self-management coaching before discharge from the hospital, or in the home or clinic post discharge; make follow-up appointments for the patient with the appropriate medical home and/or specialist; improve communication with the health care team that is responsible for the patient during hospitalization; and ask for documentation of discharge planning. In addition, CCNC began compiling data on transitional care and provided informatics support to networks to help them collect such data.

In an evaluation of CCNC's transitional care program, patients who received transitional care were statistically significantly less likely than were patients not receiving such care to return to the hospital during the year following discharge. The greatest impact was observed among

patients with complex chronic conditions; for every 1,000 such patients receiving transitional care, an estimated 174 readmissions were prevented within the next year. Findings were relevant even when the analysis controlled for demographic, clinical, and hospital characteristics (CCNC, unpublished data). CCNC, working closely with North Carolina's hospitals, has successfully implemented a robust statewide transitional care program targeting patients with complex chronic conditions.

Strategic Priorities for 2013

For 2013, CCNC's goals are to continue to focus on the state's priorities of improving the outcomes of care while lowering the cost of care. CCNC will now work on expanding clinical management into other areas of the program, increasing provider accountability, reducing variability in care, expanding its networks in order to serve larger populations, enhancing shared informatics resources, and creating budget predictability for the state. In collaboration with the North Carolina Department of Health and Human Services (DHHS), the Division of Medical Assistance (DMA), and CCNC's provider partners, CCNC will be conducting several major initiatives in 2013.

First, CCNC will enter into a new contract with DMA that moves responsibility for program operation and performance from the 14 networks to the central organization. The primary goals of this shift in responsibility are to strengthen consistency in performance across networks and medical homes and to better position CCNC to respond to and meet state priorities. As part of this transition, a smaller, network-balanced CCNC board governance structure has been created to enhance accountability and enable swifter informed decision-making.

In addition, CCNC will work with DHHS and DMA leaders to bring other parts of the Medicaid program under CCNC's clinical management, beginning with those services that have the greatest potential for program savings. And CCNC will work with its health partners, with long-term care and community-based service providers, and with DMA to launch a "dual-eligible" initiative to integrate care for people who are eligible for both Medicare and Medicaid. This initiative, with support from the Centers for Medicare and Medicaid Services, will enable North Carolina to integrate Medicare and Medicaid services and financing in an attempt to improve the care outcomes of more than 200,000 dually eligible beneficiaries. CCNC will also work with state leaders to develop a closer alignment between the clinical services, care management, and analytics of Medicaid and those of the State Health Plan of North Carolina and other state-sponsored health programs. Significant efficiencies, and a greater impact, can be achieved if CCNC assets are utilized and if providers are actively engaged across multiple programs.

CCNC will work with its partners and with state leaders to identify and implement new payment models that promote the achievement of outcome and cost-containment goals by providers and networks. These models may include budgets, shared savings, and incentive payments or outcome-based payments to primary care physicians and other providers.

CCNC will seek out and enroll specialists who want to work with CCNC and its partners to improve care, quality, and outcomes for the Medicaid population. The organization will also continue to build effective partnerships with local management entities and managed care organizations—and with behavioral health providers, long-term care and home care providers, and community-based providers—to improve the coordination and outcomes of care for Medicaid patients with complex medical, behavioral, and social conditions.

And because meaningful data and analytics are the lifeblood of the care improvement process, CCNC will continue to work with SAS Institute, Treo Solutions, and key academic partners to build the strongest informatics support possible for its providers and networks.

Lessons Learned and Final Comments

CCNC is in continuous quality improvement mode, working with engaged providers and consumers to identify barriers and solutions to health care at the local level. Six lessons have emerged from our experience.

First, it is important to avoid a top-down approach. Those who are expected to be the ones to improve should be given ownership of the quality improvement process. Improving care and care outcomes is a community development initiative in which the opportunity for improvement rests squarely on the ability to engage community providers. Unless those who are expected to improve the processes of care feel ownership for the program, the prospects for lasting advancements are lessened.

Second, you cannot do it alone—you must have partners. If improving care for chronic illness is the focus, then building community partnerships is instrumental to success. Patients with multiple medical and social problems typically require care support, and they also require care plans that coordinate care between providers. This level of performance calls for community providers to work together in a way that rarely happens in most local care systems. Partners must be willing to develop the structures, processes, and resources that can help achieve meaningful and sustainable coordination and integration in the delivery and management of care.

Third, scale is important, but so is local flexibility. The ability to have a flexible local network structure and to develop clinical initiatives that can be scaled statewide requires attention to local variations in health care infrastructure and knowledge of how best to leverage local resources to ensure that patients receive consistent care. While each network has flexibility in how they use their local resources, each network is held accountable to achieve the same performance goals. Responsibility for identifying and addressing outlier performance is also shared across all networks.

Fourth, systems and supports for improvement must be

put in place. Although the improvement process is initially dependent on the commitment of physicians and other community providers to improve care and care processes, actual improvement will be minimal unless systems and supports are built. A major emphasis of the CCNC model has been building, through community networks, the local medical, pharmacy, behavioral, and care management support that patients and physicians must have to improve care and care outcomes for patients with chronic illnesses. There is also a growing recognition that physicians need support, whether from care teams within the practice or from community-based care managers and clinicians. New care support structures are needed to improve the management of chronic illness. Much of this support will need to be provided where patients live and where physicians practice.

Fifth, feedback is essential. You can assemble an impressive roster of clinicians committed to improvement and put in place the systems and supports needed to deliver improvements, but if you have not instituted effective ways to measure improvement and to communicate progress to participants, your prospects for success are dim. Reliable and continuous performance data are absolutely essential to driving the care-improvement process. Data are important for measuring progress. Also, timely and meaningful patient utilization data are essential for physicians and networks trying to enhance the delivery, management, and coordination of patient care.

Sixth, it is insufficient to make changes only to Medicaid. One benefit of North Carolina's Medicaid initiative aimed at changing how care is delivered and managed is that when physicians change the processes of care for their Medicaid patients, they usually apply those changes to all of their patients. Thus other insurers and payers benefit from what Medicaid has initiated and financed. The flip side of this is that if physicians receive messages and incentives from insurers and other payers that conflict with the messages and incentives they are receiving from Medicaid, the impact of any Medicaid changes will be muted.

The reality is that the opportunities for improvements in care and care outcomes will be even greater if the messages, incentives, expectations, supports, and performance reports that physicians receive from multiple payers can be aligned. If physicians were to receive a common set of quality objectives, incentives, collaborative supports, and performance reports regarding the care of most of their patients, the prospects for improvements in care and outcomes could be significant greater.

Going forward, CCNC will be building the capacity to develop an accountable budget model that provides the state with greater budget predictability for Medicaid. It will also be working with other insurers and payers to create multi-payer projects in which reimbursement, incentives, and care support are aligned. NCMJ

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INVITED COMMENTARY

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

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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

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INVITED COMMENTARY

Nikki's Story Shows the Success of Community Care of North Carolina

William A. Pully, Robert W. Seligson

This profile of a typical North Carolina Medicaid patient illustrates the holistic approach of Community Care of North Carolina, which results in better patient outcomes and cost savings.

To better understand how Community Care of North Carolina (CCNC) is helping children with asthma, consider Nikki (not her real name), a 12-year-old child living in poverty. Nikki is an actual Medicaid recipient with severe asthma. Challenge is a fact of life for her, but her story is one of success. It is a story that illustrates the rich benefits to Medicaid patients and to the state of North Carolina that come from the incredible success of the state's homegrown health coordination program. Through the efforts of CCNC, Nikki's story has become a narrative of health, hope, and savings.

In the 2 years prior to her enrollment in CCNC, Nikki visited hospital emergency departments 9 times and urgent care clinics 6 times. The cost to Medicaid for care of her asthma was $12,000, and even with all of that care, her asthma remained uncontrolled.

Rather than merely treating Nikki's illness each time she had problems breathing, North Carolina has aggressively looked toward lasting solutions, because we cannot afford a generation of sick children. CCNC therefore takes a holistic approach to Nikki's care. Her health care providers are treating her symptoms and also looking at other factors, such as her potential for childhood obesity, her attendance at school, and how she is affected by where she lives. With the whole picture in view, her chances for success increase exponentially.

Housing Conditions

Children like Nikki are likely to live in places that make them sicker. Asthma experts note that poverty is an important factor in disease severity. In poor neighborhoods, children are exposed to many asthma triggers, including cockroaches, air pollution from nearby industrial plants, cigarette smoking and second-hand smoke, gas and other chemical fumes, and lack of air conditioning.

Education and Productivity

Nikki's asthma may be costing her an education and dimming both her career prospects and the state's chances for future economic development. Asthma is the leading cause of absences from school due to chronic illness; absences due to asthma total about 10 million days per year nationwide [1]. Approximately 1 in 11 children is affected [2]. Nikki's chronic health problem may be one that she inherited. Children who have 1 parent with asthma have a 1 in 3 chance of developing the disease, and that risk rises to a 7 in 10 chance when both parents have asthma [3]. For adults, asthma is the fourth-leading cause of work absenteeism or "presenteeism"—just showing up but not really working [3]. Fourteen million workdays per year are missed or are less productive because of asthma [2]. Industries consider such data when choosing locations for new plants.

Childhood Obesity

A child with asthma who is also obese faces major health challenges that can be costly for Medicaid. Asthma experts say that weight increases can lead to respiratory tract inflammation and can cause changes in mechanical lung function, while also lowering the residual capacity of the lungs [4]. Alarmingly, childhood obesity rates among youth ages 2-19 years have climbed from 5% (1971–1974) to nearly 17% (2007–2008) [5]. Childhood obesity can lead to a life of other chronic problems, including increased blood pressure, headaches, double vision, sleep apnea, acid reflux, gallstones, type 2 diabetes, high cholesterol levels, and problems with bones and joints. Any one of these diseases would make it more costly to treat Nikki, and the likely combination of these conditions could make her less employable.

North Carolina's Solution

It is fortunate that primary care physicians in North Carolina have aligned with CCNC to help youngsters like Nikki. In-depth knowledge of her medical history and constant vigilance against all of the factors that might negatively influence her health can save Nikki from unnecessary complications. By focusing on the patient, CCNC spares the

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Medicaid program unnecessary expense and saves precious state health dollars.

After she enrolled in CCNC, Nikki's primary care physician helped to educate her and her parents about asthma self-management and medications. The CCNC case manager also called in county environmental services to assess Nikki's home for asthma triggers. Nikki and her family also gained access to indispensable and cost-effective resources that could save money later by preventing the complications whose costs have the greatest potential to skyrocket.

The results for Nikki and for the state are noteworthy. In the first 2 years of Nikki's work with CCNC physicians and case managers, she required only 1 visit to a hospital emergency department and just 3 trips to urgent care centers. The cost of her asthma care dropped to $2,000—just one-sixth of the amount that was spent on her care during the preceding 2 years. Some would call that cost savings. The former head of the federal Centers for Medicare and Medicaid Services, Donald M. Berwick, called it a reduction of waste; we are ceasing to do "stuff we don't need to do." Berwick and others believe that between 20% to nearly half of what we spend on health care is wasted, whether by being spent on unneeded treatment or through bureaucratic inefficiency [6].

For CCNC, Nikki's case is just 1 in more than a million success stories. CCNC is a public-private partnership that provides a framework that allows the private health care community to manage the care of many of North Carolina's Medicaid beneficiaries. The program has a variety of initiatives that focus on improving the health of patients while saving the state valuable dollars that can be focused on other health priorities. CCNC works to stem the use of hospital emergency departments, knowing that avoidance of high-cost care benefits patients and the state. CCNC also provides nurses and social workers to better manage the care of high-cost patients. In addition, CCNC provides medical homes for pregnant women and assists Medicaid patients in making the transition to other treatment sites following hospital care.

Substantial savings for the state have been the result. A recent third-party evaluation by Mercer estimated that CCNC's savings in Aid to Families with Dependent Children totaled $568 million over the past 4 years. Treo Solutions estimated that CCNC has saved approximately $1.5 billion in its Medicaid program (2007–2009) [7]. The structure of CCNC and the savings it has generated have made North Carolina the envy of many states. One of the accolades that CCNC has received is the Innovation in American Government Award from the Kennedy School of Government at Harvard University.

Although the praise is nice, the patients matter most. Nikki, her parents, and others whose care is managed by CCNC now have better lives. They are better able to go to school or to work with the hope of further improving their lives. In addition, the state reaps savings today and sees a brighter future for its citizens going forward. This partnership focuses its efforts on outcomes that are important to people, ensures that limited resources are used appropriately, and reinvests savings locally to further benefit enrollees. NCMJ

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INVITED COMMENTARY

Community-Based Services:
Stopgap for Runaway Medicaid Costs

Kim Dawkins Berry, Gayla S. Woody

The community-based services provided through the aging network offer a low-cost way to keep some people at home, depending on their needs. Currently 13,000 elderly individuals are on the statewide waiting list for home- and community-based services. Cuts to Medicaid will tax an overburdened aging network system, while leaving our most frail citizens without options for care.

North Carolina communities are witnessing a dramatic demographic shift toward an older population, which has been accompanied by an unparalleled increase in the costs of health care and long-term care. Between 2011 and 2031, the number of adults age 65 years or older is expected to grow by 78%, and those age 85 years or older by 71%, as the baby boomers age (Table 1). In contrast, the total state population is only expected to grow 21% during this same time period. As directors of 2 of the state's 16 Area Agencies on Aging (AAAs), we would like to share our perspective on the impact that changes in Medicaid have had on the availability and cost of services for older adults. We are in the unique position of experiencing the effects of changes in Medicaid on our local health and social services systems even though we have no direct responsibility for managing Medicaid programs or funds. This is because there are connections between Medicaid and the programs provided through the AAAs, as we will explain.

The same year that Medicare and Medicaid were enacted, the Older Americans Act of 1965 [1] established a national aging network and charged it with helping to address a broad and ambitious agenda for promoting the well-being of persons 60 years of age or older. Amendments to the act, which were passed in 1973 [2], made states responsible for designating AAAs in multicounty planning and service areas, and charged the AAAs with helping to develop comprehensive and coordinated local systems for providing home and community services that address the needs of active and frail older adults. Each of North Carolina's 16 AAAs is part of its region's Council of Governments, whose board is composed of local elected public officials within that geographic boundary. Through information and assistance providers, the AAAs work directly in each county with consumers and providers to help identify needs and service gaps. Our staff members see firsthand the consequences that public policies, or the lack thereof, have on seniors and their families.

AAAs provide a range of services for older adults, including home-delivered meals, in-home services, care management, transportation, senior center activities, family caregiver support, health and wellness education, adult day care, adult day health care, and legal services. The funding for many of these services goes to local providers, such as Councils on Aging, departments of health, social service agencies, and other nonprofit and for-profit organizations. There are no entitlement requirements for these services; the only prerequisite is that the recipient be at least 60 years of age. In many cases, we see seniors who do not qualify for Medicaid but who hover in near-poverty until a catastrophic health event forces them into a long-term care institutional setting such as a nursing home. By providing short-time or supportive services, such as transportation to the doctor, personal care support in the home, or 1 daily meal containing the recommended dietary allowance of all nutrients, our programs keep people at home longer, in a healthier state, at less expense.

Our funding is small relative to that of Medicaid programs. In 1992 the North Carolina General Assembly combined several state and federal funding sources that were serving the population of individuals 60 years of age or older into a single program known as the Home and Community Care Block Grant (HCCBG). This was done to offer greater local flexibility to respond to consumer needs. HCCBG services have been especially important to the "near poor"—those who have incomes just above the federal poverty level but are unable to pay privately for assistance. Nevertheless, our statewide resources for HCCBG (about $60 million) are tiny compared with the nearly $3.7 billion spent on Medicaid services for those 60 years of age or older during State Fiscal Year 2010-2011. HCCBG funds are made up of approximately 56% state tax dollars and 44% federal tax dollars. Local governments provide a 10% required match for these funds.

At the same time that AAAs are providing services that

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TABLE 1.
Projected Increases and Demographic Changes in the Population of North Carolina

Segment of Population	2011 No. (%)	2031 No. (%)	Percent Increase (2011-2031)
Total	9,669,244 (100%)	11,729,907 (100%)	21%
Age ≥60 yrs	1,851,124 (19.1%)	2,988,476 (25.5%)	61%
Age ≥65 yrs	1,289,618 (13.3%)	2,296,795 (19.6%)	78%
Age ≥85 yrs	155,718 (1.6%)	265,686 (2.3%)	71%
Baby boomers (born 1946-1964)	2,377,235 (24.6%)	1,811,120 (15.4%)	

Source: North Carolina Division of Aging and Adult Services. A Profile of People Age 60 and Over, North Carolina, 2012. North Carolina Division of Aging and Adult Services Web site. http://www.ncdhhs.gov/aging/cprofile/2012Profile.pdf. Accessed February 17, 2013.

contribute to keeping the near-poor off of the Medicaid rolls, we are now seeing individuals who have been receiving Medicaid benefits in institutional settings being compelled to reenter the community-based delivery system without Medicaid resources. There are several policies that have led to this result. For instance, in 2009, in order to meet budget reduction goals, the North Carolina General Assembly froze the number of slots available for the Community Alternatives Program for Disabled Adults (CAP/DA), a Medicaid-funded program that provides resources making it possible for older North Carolinians to remain in the community through support services such as home care, transportation, meal preparation, and personal care. Without CAP/DA as a resource, adults with disabilities have had to fall back on HCCBG services or have been forced into long-term care facilities at greater cost.

Currently, the state is trying to address US Department of Justice (DOJ) allegations that it has been violating the Americans with Disabilities Act by allowing people with serious mental illness to be placed in adult care homes [3, 4]. If the majority of residents in such a home are determined to have been placed there because of mental illness, the home can be designated as an institution of mental disease, which will mean that it is no longer eligible to receive any reimbursement from Medicaid. Therefore many residents of adult care homes are facing relocation to another facility or relocation back to the community with loss of Medicaid benefits. As a result, long-term care ombudsmen from the AAA service system are receiving many requests for information and assistance from residents, families, and facilities.

In addition, as part of the DOJ settlement, eligibility requirements for personal care services (PCS) for residents of adult care homes are being tightened, which will result in loss of Medicaid benefits for some people. It has been reported that 62% of the almost 9,000 adult care home residents who have been found to no longer qualify for PCS are 55 years of age or older (39% were 65 years of age or older) [5]. These individuals will return without Medicaid coverage to their communities, where there are already more than 12,500 seniors statewide waiting for HCCBG services.

Another looming example of a change in Medicaid that would impact older adults is the proposed use of a brokerage system for Medicaid nonemergency transportation services. Expressing concern at that prospect, the North Carolina Association of County Commissioners has warned that "excluding Medicaid revenues from the consolidated model could lower human services transportation system funding by 20 to 50 percent, leading to job losses, higher state costs for other ridership services, and fewer transportation options for clients" (Thompson D, letter to Representative Nelson Dollar, October 12, 2012). This change in Medicaid policy has the potential to seriously reduce the availability of transportation to and from such locations as doctors' offices and pharmacies.

We are especially concerned with the lack of funding for community based services to help people remain in their homes. Although we do not question the value of spending money on nursing home care for the frailest elderly people, we do worry that North Carolina exhibits a bias toward institutional care by inadequately funding community resources. For State Fiscal Year 2011-2012, the North Carolina Division of Medical Assistance paid $1,068,105,297 for nursing home care provided to 38,428 people, at an average cost of $27,795 per person [6]. In contrast, the state invested far fewer resources on those who were not yet Medicaid eligible, resources that could help them to remain in the community. For example, home-delivered meals were served to 18,689 persons on a daily basis at a cost of $14,226,679, or $761 per person, during the same time period. Adult day care was provided to 562 persons on varying days at a cost of $1,864,573, or $3,318 per person, and 840 people received adult day health services at a cost of $2,749,412 or $3,273 per person. And in-home aides assisted 7,599 persons on varying days at a cost of $20,076,820, or $2,642 per person receiving assistance(Division of Aging and Adult Services, unpublished data, 2013). We recognize that the higher costs of nursing home care reflect the fact that people who reside in those settings require more care than many of the older adults who are served at home. Yet, by adequately funding home- and community-based services, we may be able to help older adults and people with disabilities maintain their

health status and functional abilities, thereby delaying or preventing the need for more costly care in a nursing home. Home- and community-based services can also extend the ability of families to continue their caregiving, thereby postponing or avoiding institutional placement.

These state funds, provided to local agencies through the North Carolina Division of Aging and Adult Services, and by the Division of Social Services, can help postpone or prevent nursing home placement and/or the need for Medicaid resources. In a recent *Health Services Research* article [7], Thomas and Mor concluded that "States that have invested in their community-based service networks, particularly home-delivered meal programs, have proportionately fewer low-care nursing home residents." To us, the most important thing is that people prefer to age at home and in the community rather than in institutions.

Although those of us who work for AAAs are certainly among the strongest proponents of home and community living, we are also realists about what is possible with existing resources. One trend of late that concerns us greatly is the diminished ability of local governments to shore up insufficient state and federal funding. Reduced funding from United Way is compounding the problem for some of these providers. We are therefore advocating well-planned, well-orchestrated, and well-supported changes in public policy. We are also calling on the larger community not only to engage in the debate about what should or should not be done, but also to contribute to helping resolve individual and community challenges with regard to identifying or developing additional resources.

Irrespective of particular situations that will surely arise affecting individuals, organizations, and communities—such as the current crisis with regard to adult care homes—North Carolina faces a demographic future over at least the next 30 years that will test our creativity, resourcefulness, and resolve (Table 1). With some of the oldest of the nearly 2.4 million North Carolinian baby boomers (born between 1946-1964) already tapping entitlements and needing other services, we can only imagine the effect of this group on every aspect of society as we move forward—including, of course, the need for health care and human services.

We must do more than imagine; we must be deliberate and inclusive in our planning and in the development of strategies for more effectively managing health care and long-term care needs. We cannot afford to operate in silos or to be narrow or overly short-term in our thinking. In North Carolina we have convened commissions and established task forces to provide blueprints for our future. In 1993, the North Carolina Division of Aging published volume 3 of the *North Carolina Aging Services Plan*, which was titled *A Unified Social and Health Services System for Older Adults* [8]. And in 2001, the North Carolina Institute of Medicine published *A Long-Term Care Plan for North Carolina* [9], which was updated most recently in 2007 [10]. We have witnessed some progress over the past 20 years; however, there are still many compelling reasons to continue coordination and collaboration. We must improve the continuity of care for the increasing number of older adults with chronic conditions by better integrating social and health services. This can be done through technology, training, person-centered approaches, collaborative case management, and dialogue—physicians and hospitals need to have discussions with providers of community services.

The AAAs are currently involved in a number of efforts to promote better management for quality and cost-savings. They are supporting the emergence of Programs of All-inclusive Care for the Elderly (a Medicare program and a Medicaid state option). In addition, they are helping persons who are dually eligible for Medicare and Medicaid to connect to medical homes. The AAAs are also increasing their efforts to improve the transitions of dually eligible patients to and from hospitals and long-term care facilities. As coverage of the dually eligible by Community Care of North Carolina (CCNC) expands, there will be an increasing amount of overlap between the networks, and the AAAs will collaborate with CCNC to build a stronger bridge between medical care and community supports.

The health and wellness evidence-based training being provided by many AAAs across the state is being expanded. These programs empower seniors to change behaviors in order to live a healthier, longer life. The AAAs are also actively participating in transition projects for seniors moving to and from hospitals and long-term care facilities. AAAs use existing community partnerships, hospitals, medical homes, CCNC, and local service providers to reduce readmissions and strengthen overall health outcomes. The AAAs also want to expand relationships with the Veterans Administration to ensure access and quality of care for older veterans.

Our appeal to the health care community is simple—recognize, link to, and invest in our aging network. Doing so will truly pay major dividends for patients and practices. Although conceptually there is growing awareness that the well-being of older persons goes beyond the quality of their medical treatment to include personal safety, spirituality, and the strength of family caregiving, we have still not reached a point of sufficient confidence and sufficient connectedness between the health system and the social services system. In both systems, early intervention and support have the potential to reduce future need for Medicaid services for the near-poor and for those returning to the community.

There is not one simple answer. Through creativity, innovation, leadership, and a strong commitment to collaboration, North Carolina will find effective solutions to greatly enhance quality of life for North Carolinians. NCMJ

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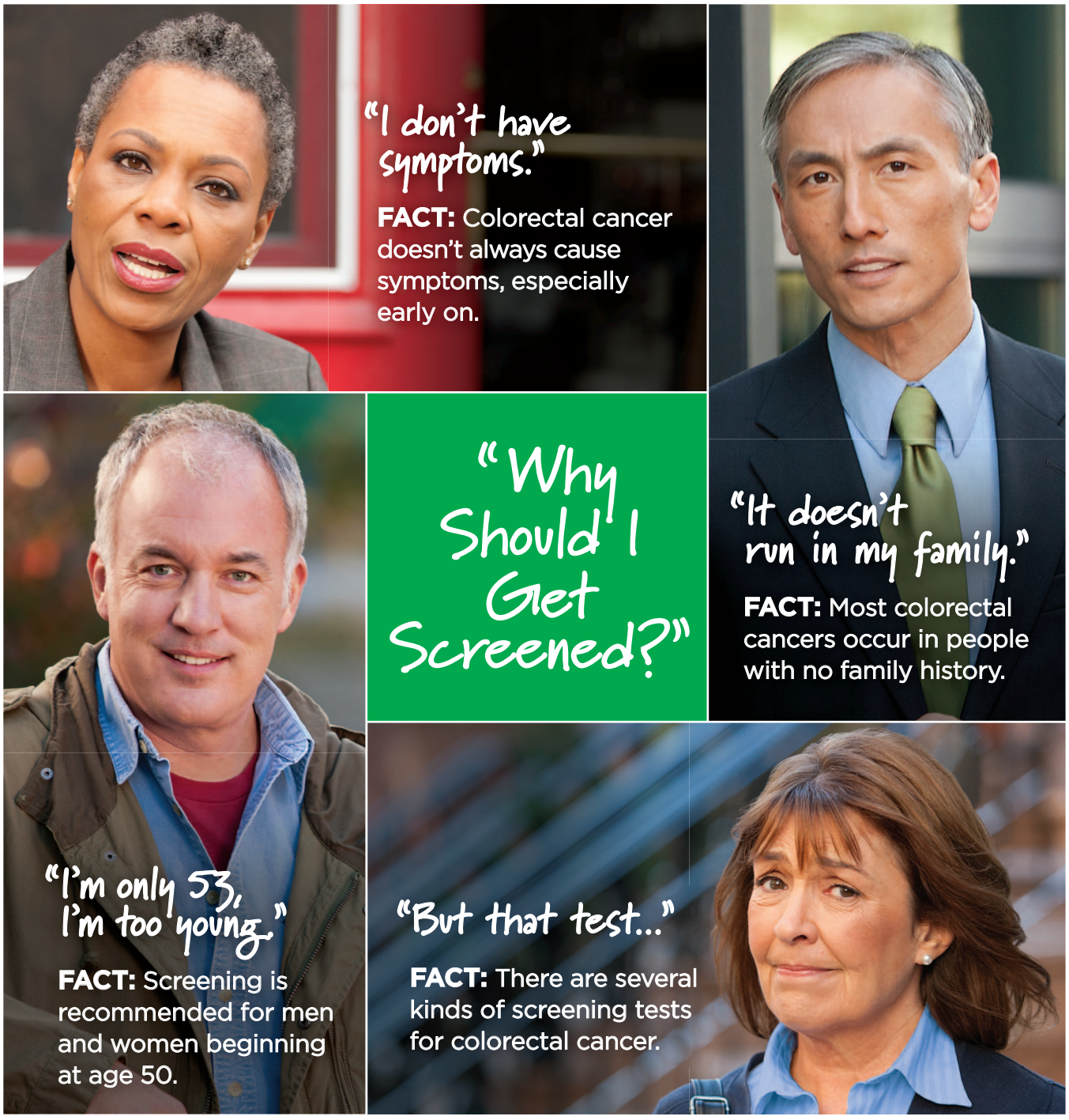

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