Improving Health and Promoting Value: An Update on the Population Health Approach Guiding North Carolina's Medicaid Transformation

North Carolina Department of Health and Human Services

April 25, 2025

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Executive Summary

North Carolina's Department of Health and Human Services' (NCDHHS) mission is to "…improve the health, safety and well-being of all North Carolinians."[1] NC Medicaid has built a population health approach to advance this mission. Population health management can be defined as "…initiatives designed to achieve a vision and set of goals to improve the health of a defined group of people or groups of people, typically focused on improving quality and achieving value in the healthcare delivery system."[2]

North Carolina's population health approach is grounded in evidence and best practices, offering a streamlined framework for delivering consistent high-quality care that is tailored to the unique needs of certain populations. NC Medicaid provides coverage for a broad swath of the state – more than three million people, including more than 50% of all children; 30% of people with disabilities; and more than 60% of nursing home residents. Medicaid expansion, which launched in December 2023, resulted in over 640,000 residents—many of whom have been uninsured for years—enrolling in Medicaid coverage within the first year of implementation. The Medicaid population is diverse and their needs are heterogeneous.

Most North Carolinians enrolled in Medicaid today receive health coverage through managed care health plans which provide a robust set of integrated services including physical health, behavioral health, long term services and supports, pharmacy benefits, and connection to non-medical services that improve health. The transition to managed care is the springboard for whole-person centered care in North Carolina, integrating physical and behavioral health, improvements in connections to community-based services, increased accountability for priority health outcomes, and investments in primary care – while testing and scaling the state's population health approach to improve the outcomes and experience of Medicaid enrollees. As NC Medicaid moves ahead with its managed care system, it is focused on re-affirming efforts to improve member outcomes, preserving strong provider participation in the Medicaid program to maintain access to high-value care, and updating population health initiatives to best serve members and help advance their health. This paper describes the purpose and progress of four foundational population health strategies in NC Medicaid's transformation:

- **Strategy 1: Reinforcing and Strengthening Primary Care**
- **Strategy 2: Investing in Community-Based Care Management**
- **Strategy 3: Identifying and Addressing Non-Medical Drivers of Health**
- **Strategy 4: Using Data to Design Evidence-Based Programs**

These strategies are interdependent—each advancing a shared set of aims and together helping Medicaid members receive the right care in the right setting at the right time for each individual member while improving overall population health. For each strategy, the paper outlines the goals and key initiatives to advance those goals; achievements and lessons learned to date; and planned next steps to realize, working together with community partners, a healthier North Carolina.

Background

NC Medicaid is a leader in health care transformation, working to improve the health of all North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health considering members' unique needs.

On July 1, 2021, NC Medicaid began its transition to managed care,[i] guided by the twin goals of improving population health outcomes and managing program costs. NC Medicaid's population health strategies leverage this managed care infrastructure, and the implementation of its related initiatives are primarily implemented through the health plans.

NC Medicaid's managed care program recognizes the diverse needs of its members, offering different types of health plans adapted to different member populations,[ii] and providing a robust set of physical health, behavioral health, long term services and supports, pharmacy benefits, and connection to non-medical services that improve health. As of March 2025, over 2.5 million North Carolinians—the majority of Medicaid members—receive integrated physical and behavioral health through these health plans.[3] Recognizing the unique needs of American Indian communities, NC Medicaid offers a specialized option for members of the federally recognized tribe the Eastern Band of Cherokee Indians (EBCI) Tribal Option, which is the first of its kind in the nation, giving eligible members access to culturally appropriate, coordinated care.

On July 1, 2024, NC Medicaid launched Behavioral Health and Intellectual/Developmental Disabilities (I/DD)[iii] Tailored Plans (Tailored Plans) to serve individuals with serious mental illness (SMI),[iv] severe substance use disorders (SUD),[v] I/DDs, and traumatic brain injuries (TBI)[vi]. Most recently, NC Medicaid announced plans to launch the Children and Families Specialty Plan (CFSP), a statewide managed care plan for children, youth and families served by the child welfare system, on Dec. 1, 2025.[4] Populations with full Medicaid benefits who have not yet moved to managed care have traditional fee-for-service coverage under NC Medicaid Direct for their physical health and dental needs, and coverage under Local Management Entity/Managed Care Organizations (LME/MCOs) for their behavioral health, I/DD, and TBI

[i] On July 1, 2021, the Department, as mandated by North Carolina Session Law 2015-245, Session Law 2018-48, and Session Law 2020-88, transitioned most individuals receiving Medicaid coverage to fully capitated and integrated Standard Plans and to the EBCI Tribal Option, a non-risk bearing primary care case management (PCCM) model that represents the first Indian managed care entity (not subject to all federal managed care requirements) in the nation and established a new delivery system for enrolled populations. Managed care-eligible Medicaid members with intellectual and developmental disabilities (I/DD), traumatic brain injuries (TBI) and/or significant behavioral health disorders, who meet the criteria specified by North Carolina Session Law 2018-48 are enrolled in Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans (or Tailored Plans). The Children and Families Specialty Plan (CFSP) will be a single, statewide managed care plan designed to support Medicaid-enrolled children, youth, and families served by the child welfare system.

[ii] Unless otherwise noted, "health plans" refers to fully integrated Medicaid managed care plans, such as Standard Plans, Tailored Plans, and the Children and Specialty Families Plan (upon launch).

[iii] Intellectual and Developmental Disabilities are conditions that are chronic, begin at birth or during childhood, and adversely affect an individual's life and functioning. Developmental disabilities can be caused by a mental impairment, a physical impairment or a combination of both mental and physical. For more information and resources see our website at https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-use-services/intellectual-and-developmental-disabilities-idd

[iv] Serious Mental Illness is defined by the Substance Abuse Mental Health Services Administration as "someone over 18 years of age having within the past year a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities."

[v] A substance use disorder is a complex condition in which there is uncontrolled use of a substance despite harmful consequences.

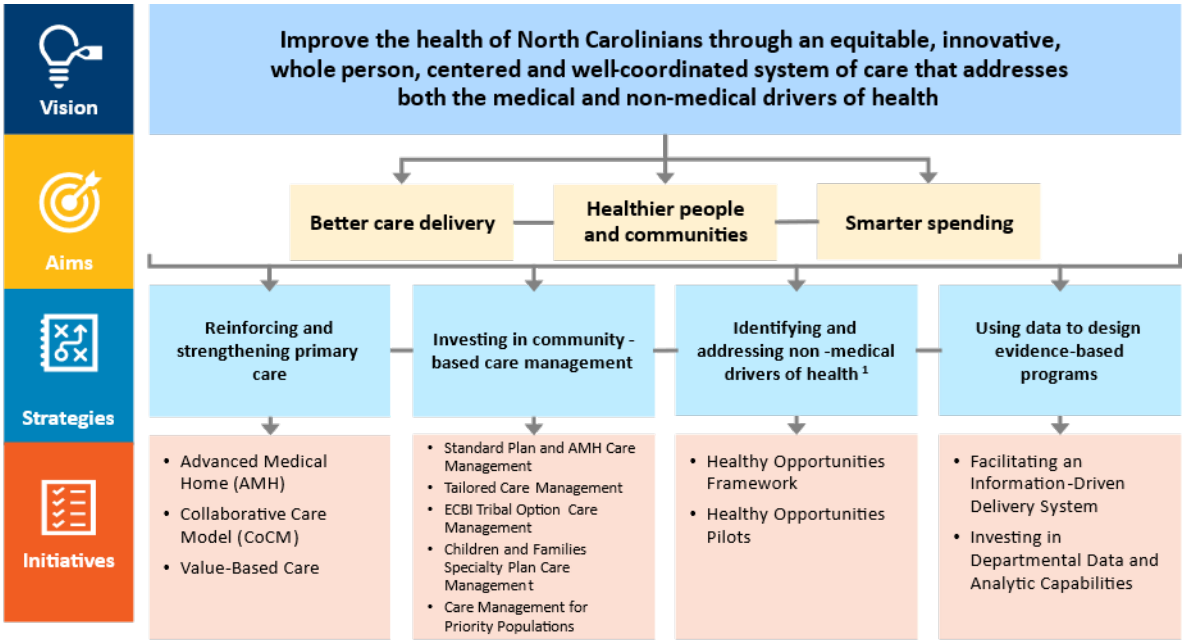
[vi] A traumatic brain injury is an injury to the brain that is caused by an external physical force such as hitting your head or other types of blunt force trauma. For more information about NC Department of Health and Human Services TBI services, see our website at https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-use-services/traumatic-brain-injury.

needs.[vii] All health plans must achieve accreditation by the National Committee for Quality Assurance (NCQA)[viii] to ensure adherence to consistent, evidence-based standards (timing for achieving accreditation varies by health plan type).

NC Medicaid's Managed Care Quality Strategy is the foundation of NC Medicaid's transformation efforts, organized around three measurable aims—better care delivery, healthier people and communities, and smarter spending.[5] To make progress towards these aims, NC Medicaid has pursued the following four population health strategies:

- **Strategy 1: Reinforcing and Strengthening Primary Care**
- **Strategy 2: Investing in Community-Based Care Management**
- **Strategy 3: Identifying and Addressing Non-Medical Drivers of Health**
- **Strategy 4: Using Data to Design Evidence-Based Programs**

Figure 1: NC Medicaid's Population Health Strategies



1. North Carolina's Healthy Opportunities Framework seeks to increase the identification and consistency of reporting on social needs, manage individuals' identified social needs, and pay for services to address social needs provided in the community. For more information, review Strategy 3, starting on page 17.

[vii] **NC Medicaid Direct** is NC's health care program for NC Medicaid beneficiaries not enrolled in managed care. It includes care management by Community Care of North Carolina (CCNC) for populations with physical health needs and by Local Management Entity/Managed Care Organizations (LME/MCOs) for populations with behavioral health needs, intellectual and developmental disabilities (I/DD), and traumatic brain injuries (TBI). People who qualify for NC Medicaid Direct include children/youth in foster care (until the launch of the CFSP), children/youth receiving adoption assistance (until the launch of the CFSP), children who get Community Alternatives Program for Children (CAP/C) services, federally recognized tribal members or others who qualify for services through Indian Health Service (IHS), former foster care youth (until the launch of the CFSP), people in the Health Insurance Premium Payment (HIPP) program, people in the Program for All-inclusive Care for the Elderly (PACE), people who are medically needy, people who get Community Alternatives Program for Disabled Adults (CAP/DA) services, people who get Family Planning Medicaid only, and people who get Medicaid and Medicare.

[viii] The National Committee for Quality Assurance is a national, non-profit organization that uses measurement and accreditation to drive quality improvement for government and private sector clients. For more information see: https://www.ncqa.org/about-ncqa/.

Across these population health strategies are numerous initiatives that NC Medicaid has implemented to support Medicaid members in receiving whole-person centered, coordinated care. These initiatives will be described in greater detail in the subsequent sections of the paper.

Strategy 1: Reinforcing and Strengthening NC Medicaid's Primary Care Foundation

A robust and high functioning primary care delivery system is a prerequisite to comprehensively managing longitudinal health for individuals, improving the health of populations, and supporting an efficient and effective delivery system.

Goals

Primary care is the cornerstone of an effective and efficient health care system and central to NC Medicaid's strategy to achieving better care delivery, healthier people and communities, and smarter spending.[6] According to expert consensus, "high quality primary care is the provision of whole-person-centered integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."[7] Primary care is unique in that it serves people throughout their lives and those with different circumstances – from healthy children to older adults, and individuals with multiple health conditions to those with disabilities. It provides relationship-based care that considers the comprehensive needs and preferences of individuals, families, and communities and serves as the foundation for broader population health initiatives.

Primary care teams that have successfully implemented comprehensive care management have shown improvements in overall health by preventing disease through vaccinations, screenings, preventive care, and connections to nutritious food and other social services. They also manage chronic diseases effectively to avoid costly hospital-based services, resulting in reduced total health care costs.[8,9]

North Carolina has a high statewide rate of primary care provider participation in Medicaid and in Medicaid care management programs relative to national averages, an advantage that must be maintained and enhanced.[ix] However, regional shortages of primary care providers, especially in rural communities, remain a challenge that requires continued investment and attention.[10]

NC Medicaid's primary care strategy is centered on ensuring members have access to high-quality and dependable medical homes, which offer preventive and primary care services, coordinated care with specialists, as well as care management services *(see Strategy 2: Investing in Community-Based Care Management*). Looking ahead, NC Medicaid will build upon and strengthen the Advanced Medical Home program, expand behavioral health integration, and incentivize improved outcomes and advancing value-based care *(described in more detail below)*. Advanced Medical Homes (AMH) are providers of primary care services who meet requirements for serving as a Medicaid member's medical home and provide a minimum set of care coordination services. The AMH program allows AMH

[ix] According to data from a 2022 North Carolina Academy of Family Physicians survey (https://www.ncafp.com/north-carolina-medicaid-transformation), nine out of ten North Carolina family physician providers serve Medicaid members. The national average of primary care provider Medicaid acceptance rates is 76%.

practices the opportunity to be delegated for broader care management services that strengthen the medical home in meeting quality improvement goals.

Initiatives

Strengthening Primary Care: Advanced Medical Homes

NC Medicaid's Advanced Medical Home program was launched alongside Standard Plans with the goal of maintaining and building upon the strengths of Medicaid's legacy primary care system. A medical home offers members a trusted team that provides regular ongoing care and is a partner in health care decisions. To be considered an Advanced Medical Home, a provider must deliver appropriate, timely, and high-quality primary care that meets members' needs.[11] Advanced Medical Homes choose their 'Tier'[x] based on their capacity, capabilities, and desire to meet specific program requirements.

- **Advanced Medical Home Tiers 1 and 2** must meet minimum care and member access requirements, including (but not limited to) meeting a minimum of direct patient care office hours per week, providing preventive services, and managing referrals.
- **Advanced Medical Home Tier 3** practices, in addition to meeting Tier 1 and 2 requirements, accept responsibility for care management for Standard Plan populations.
    - More than 1,650 (approximately 57% of) Advanced Medical Home practices participate as a Tier 3, serving as the primary care medical home for over 1.7 million members.
    - Some Advanced Medical Home Tier 3 practices opt to contract with a Clinically Integrated Network[xi] or other partners to perform a subset of these activities.
- **Advanced Medical Home "Plus"** practices meet the Tier 3 Advanced Medical Home requirements and have experience with populations with significant behavioral health needs, I/DD, and TBI and deliver care management for these populations within the Tailored Plans and NC Medicaid Direct.
    - As of January 2025, 13 Advanced Medical Home Plus practices participate in NC Medicaid.[xii]

Primary care providers that qualify as Advanced Medical Homes receive enhanced payments through medical home fees (for all Advanced Medical Home practices) and can receive care management-related payments (Advanced Medical Home Tier 3 and Advanced Medical Home Plus practices only). Additionally, Standard Plans and Tailored Plans are required to offer Advanced Medical Home Tier 3 and Advanced Medical Home Plus practices Performance Incentive Payments to reward continued improvement in quality performance on a defined set of measures that align with the NC Medicaid

[x] Additional information on AMH Tiers can be found in the AMH Provider Manual available on our website at https://medicaid.ncdhhs.gov/advanced-medical-home.

[xi] AMH practices may choose to work with Clinically Integrated Networks and other partners to help collect, compile, analyze, and exchange data. Clinically Integrated Networks may include hospitals, health systems, integrated delivery networks, independent practice associations, and other provider-based networks and associations. NC Medicaid understands Clinically Integrated Networks and other partners to offer a wide range of differing packages of administrative support to AMH practices, clinical staffing resources, care delivery wraparound services, and/or technology services.

[xii] The full list of Advanced Medical Home Plus and Care Management Agency practices can be found here: https://medicaid.ncdhhs.gov/certified-tailored-care-management-providers/download?attachment.

Quality Strategy.[xiii] These investments in primary care are intended to fund and incentivize population health activities that bring value to Medicaid members and prevent avoidable and costly hospital and emergency department visits. Activities may include supporting quality improvement activities, chronic condition management programs, implementation of social needs screening tools, and hiring additional care management team members to manage health-related patient needs that cannot be addressed during a regular medical appointment. Additionally, Standard Plans are required to spend a minimum percentage of their capitation payments on primary care services, ensuring they are accountable for strong investments in primary care across populations.[12]

Expanding Behavioral Health Integration: Collaborative Care Model

To increase access to and destigmatize behavioral health services for Medicaid members, NC Medicaid is incentivizing the adoption of the Collaborative Care Model in primary care settings where Medicaid members are most likely to access care. The Collaborative Care Model allows members with mild to moderate behavioral health conditions to access an integrated care team that operates more efficiently and effectively than traditional, siloed models of care. Together with Advanced Medical Home requirements, the Collaborative Care Model can help drive whole-person centered health within primary care settings.[xiv]

The Collaborative Care Model adds behavioral health care managers and a psychiatric consultant to the primary care team to seamlessly address common behavioral health conditions, such as depression and anxiety disorders. Psychiatric consultants can identify more complex member needs (e.g., mood disorders, schizophrenia) and connect these members to appropriate levels of care. The Collaborative Care Model has one of the strongest evidence bases of any integrated behavioral health model, with more than 100 randomized clinical trials demonstrating its effectiveness.[13] NC Medicaid has promoted alignment of Collaborative Care Model policies across payers (e.g., supporting coverage of the same codes, aligning billing requirements), increased reimbursement for the Collaborative Care Model and supported training and technical assistance for practices to stand up the model.[14] NC Medicaid is also working with the Division of Mental Health, Developmental Disabilities and Substance Use Services (DMHDDSUS) and Community Care of North Carolina (CCNC) to leverage $5 million of recent behavioral health state budget investments to support provider start-up costs for Collaborative Care Model adoption.[15] All of the above has increased Collaborative Care Model adoption across the state; in 2019, approximately 20 practices were providing Collaborative Care Model services to Medicaid members each month and in 2024, that number increased over three-fold to an average of 72 practices each month.[16]

[xiii] The NC Medicaid Quality Strategy can be found here: https://medicaid.ncdhhs.gov/reports/quality-management-and-improvement.
[xiv] Becoming an Advanced Medical Home is not required of practices that want to implement the Collaborative Care Model, and vice versa, but the two models are complementary and build on one another.

Advancing Value-Based Care

Innovative primary care payment is critical for practice improvements that lead to the outcomes that matter to Medicaid enrollees and their families. In recognition of North Carolina's innovation and leadership in primary care, the state was selected in 2023 as one of eight participating states in Making Care Primary, a multi-payer model led by the Centers for Medicare & Medicaid Services (CMS) Innovation Center (or 'CMMI').[17] Advanced Medical Homes were already well aligned with many elements of the Making Care Primary model, including emphasis on local care management, advanced, team-based primary care, quality improvement, incorporating social determinants of health screening, and increasing investments in primary care through payments beyond fee-for-service. In March 2025, CMS announced they would be terminating the Making Care Primary model.

While the Medicare Making Care Primary model will not be continuing, NC Medicaid is committed to advancing value-based approaches that improve quality outcomes for members. NC Medicaid's near-term approach to advancing value-based care is focused on 1) further concentrating practice-level efforts to drive evident improvement in health care outcomes, 2) addressing administrative burden caused by variation in Advanced Medical Home Performance Incentive Payments across health plans, and 3) supporting higher levels of Advanced Medical Home participation in quality incentive programs.

NC Medicaid is designing a standardized financial incentive arrangement to be available as an option to all Advanced Medical Homes [18], including smaller practices and those with limited value-based payment experience. It will be based on a targeted set of quality measures and health plans may be required to offer the incentive program to all Advanced Medical Home practices, if supported by available state funding and CMS approval. The new model will advance NC Medicaid's quality strategy, including closing care gaps and reducing disparities for priority populations. NC Medicaid has released additional information on this standardized incentive arrangement through a draft policy guide.[xv]

Progress and Lessons Learned

NC's primary care is the foundation for NC Medicaid health system improvement, and opportunities remain to update the program to meet member and provider needs.

The launch of managed care and Advanced Medical Home programs sustained strong primary care participation rates in Medicaid, enabling widespread access to primary care across health plans. Continued primary care investments are important to maintain this scale, as well as to enhance and standardize the program. In a 2022 survey of all independent primary care practices, medical groups and health care systems that provide primary care or obstetrics and gynecology (OB/GYN) care in NC Medicaid, rates of contracting with each health plan ranged from 73.3% to 94.5%.[19] As of November 2024, nearly all (99%) of Standard Plan members are assigned to one of the approximately 1600 Advanced Medical Home practices to provide primary care in Standard Plan networks.

[xv] The AMH Standardized Performance Incentive Program Policy Guide was published on March 21, 2025, and can be found at: https://medicaid.ncdhhs.gov/amh-standardized-performance-incentive-program-policy-guide-draft/download?attachment.

However, the transition to managed care resulted in some challenges for primary care providers. Rather than contracting directly with NC Medicaid to cover all their patients, some practices may now contract with as many as nine Medicaid health plans (all five Standard Plans and four regional Tailored Plans), the EBCI Tribal Option, and NC Medicaid Direct.[xvi] While strong network access across health plans supports member choice in selecting a primary care provider, contracting with multiple Medicaid health plans can be challenging for individual practices. Through regular forums with community partners, including the NC State Transformation Collaborative and Advanced Medical Home Technical Advisory Group (TAG), providers have raised concerns that administrative burden and complexity is rising as the number of contracts and data systems the provider must navigate grows.[20]

This complexity is also seen in the Advanced Medical Homes Performance Incentive Payments, which vary across health plans. This variation informed NC Medicaid's initial approach to the proposed standardized performance incentive model. NC Medicaid explored other value-based payment arrangements that reward primary care providers for quality over volume[21] including prospective primary care payment, Accountable Care Organizations or alternative Advanced Medical Home Tiers with advanced payment models. Such models are often most successful when there is alignment across a high proportion of a provider's patient panels and with adequate levels of primary care reimbursement. As NC Medicaid considers more advanced payment models, it will incorporate these learnings into its future approach.

In 2024, NC Medicaid leadership chaired the legislatively mandated Primary Care Payment Reform Task Force (Task Force) alongside providers, health plans, and other state health care leaders to assess the current state of primary care in North Carolina and make recommendations to better track current spending on primary care services among all payer types (e.g., Medicaid, Medicare, commercial).[22] The Task Force developed a Primary Care definition by which all payers could pull data in a consistent way to measure and compare spending on primary care. The Task Force published a report in April 2024 outlining its recommendations for building a strong primary care system for the entire state, not just the NC Medicaid program.[23] The recommendations included that the General Assembly consider targeting an increase in primary care investment equal to one percent of total health care spending per year, recognizing that increased investment in primary care is correlated with better performance on quality and patient experience, lower hospital and emergency department use, and lower total cost of care.[24]

Looking Ahead

NC Medicaid will explore strategies to increase investment in primary care, decrease primary care provider burden, and maintain its focus on improving health and decreasing costs.

To maintain strong member access to Advanced Medical Homes through robust provider participation, NC Medicaid will continue to work with health plans to support primary care to ensure statewide provider availability and strengthen the primary care infrastructure. NC Medicaid will continue to monitor Advanced Medical Home requirements so the program remains aligned with evidence and best

[xvi] Providers may contract with as few or as many health plans as they prefer. Patients may proactively select a provider or be auto-assigned to an in-network provider for the health plan they selected.

practices for high-quality primary care. Additionally, NC Medicaid will continue to standardize processes to reduce administrative burden on providers.

Looking ahead, NC Medicaid will maintain several approaches with the overall goals of improving health outcomes for Medicaid members and enhancing cost-effectiveness. Specific to primary care, these approaches include strategically leveraging funding opportunities in collaboration with state leadership, standardizing quality-based incentives for Advanced Medical Homes, and addressing other operational efficiencies for providers.

Strategic investments include maintaining support for Collaborative Care Model start-up costs primary care providers need to successfully implement integrated behavioral health services in primary care. Additionally, NC Medicaid will finalize the standardized Advanced Medical Home performance incentive program to make incentives available to Advanced Medical Home practices more effective and less complicated to participate in. Future value-based payment efforts may explore a prospective primary care payment option to move providers away from fee for service.

NC Medicaid will continue to focus on strengthening and standardizing the core building blocks of its primary care system, including identifying and addressing sources of operational administrative burden for providers, such as ensuring each member is assigned by health plans to an appropriate medical home. NC Medicaid will also support providers as new priority population programs are launched, including the Children and Families Specialty Plan and screening, diagnostic and primary care services for justice-involved youth as required by the 2023 Consolidated Appropriations Act. Advanced Medical Home practices will play a critical role as the medical home for youth in these programs by working closely with their care managers to connect them with needed medical and non-medical services. The Department will work closely with the NC General Assembly and other partners to finalize the implementation approach for the 1115 Waiver Reentry services CMS approved in December 2024.

As the Advanced Medical Home program continues to evolve, NC Medicaid will strengthen the rigor in which it monitors and evaluates program performance to ensure health plans and practices are meeting quality goals and adhering to NC Medicaid's vision for Advanced Medical Homes. Collaboration is key to the success of these efforts and NC Medicaid will continue to work closely with primary care providers, health plans and community partners.

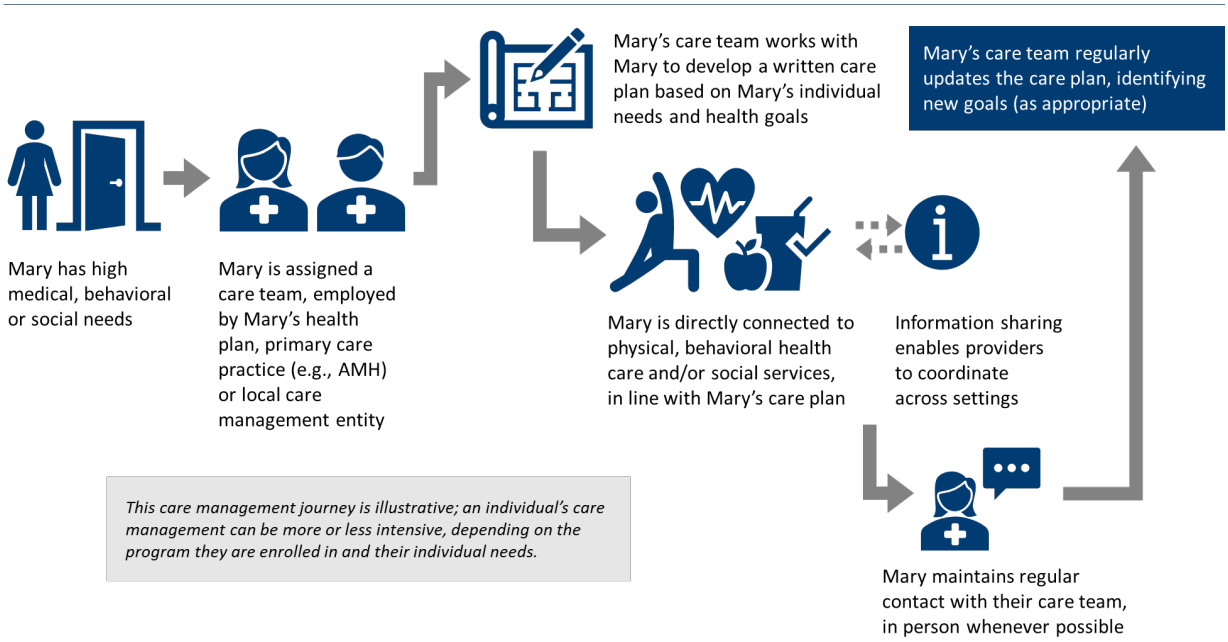
Strategy 2: Investing in Community-Based Care Management

Community-based care management ensures members' comprehensive needs are identified, and they receive navigational support to timely and appropriate care from a care team that understands the context and community in which they live.

Goals

Research has shown that a trusted relationship between members and care managers is key to successful care management – defined as a team-based, whole-person centered approach "designed to assist patients and their support systems in managing medical conditions more effectively".[25] Care managers perform inherently relationship-based tasks including: care planning, referral and follow-up services, management of chronic disease and special needs, coordination across settings, and other "bridging" functions that aim to connect what can sometimes feel like independent points of care into a more seamless, coordinated experience for the patient *(See Figure 2 for an example care management journey).* Care management serves as the "glue" for integrated care, fostering coordination and collaboration among care team members across disciplines and settings, and helping Medicaid members and their families manage health conditions more effectively.[26] Care management not only connects members to needed care and services but also helps them avoid intensive and costly care in a hospital or emergency department.

Figure 2: Care Management Journey



NC Medicaid aims to reinforce these trusting relationships between members and their care teams by prioritizing local care management, provided in the community and built around existing relationships between physicians and patients, throughout key population health strategies. Care management is a requirement of Advanced Medical Homes Tier 3 practices and the most common source of community-based care management in North Carolina. NC Medicaid used a statewide primary care case management program model since the 1990s and leveraged this community asset during the transition to managed care.[27] Since then, depending on the population, community care management evolved to include support delivered at other sites of care, in a member's home or in community settings, especially those that facilitate face-to-face interactions.

Care management can be more or less intensive, depending on the population and individual's needs. NC Medicaid has developed robust whole-person centered requirements for delivering care management across the delivery system, including several foundational care management programs designed for specific populations:

- **Standard Plan Care Management:** For those enrolled in Standard Plans, Advanced Medical Home Tier 3 practices are the primary provider of care management services for members with high physical health, mild to moderate behavioral health, or social needs. Approximately 80% of all Standard Plan enrolled members are delegated to Advance Medical Home Tier 3 practices for care management. Standard Plans provide care management to the remaining 20% of members assigned to Advanced Medical Home Tier 1 and 2 practices.
- **Tailored Care Management:** Tailored Plans and NC Medicaid Direct enrolled members with persistent SMI, SUD, I/DD, and TBI conditions receive Tailored Care Management, which is designed to address their specific needs.
- **Children and Families Specialty Plan (CFSP) Care Management:** When launched, children and youth enrolled in the CFSP will have access to comprehensive care management; CFSP care managers will coordinate closely with County Division of Social Services (DSS) case workers, including via co-location where possible.
- **EBCI Tribal Option Care Management:** Individuals residing in service area counties in western North Carolina who are federally recognized tribal members or others eligible for Indian Health Service can obtain primary care case management through the EBCI Tribal Option.

NC Medicaid has additional care management initiatives focused on specific subpopulations, some of which predate the transition to managed care. For NC Medicaid Direct beneficiaries, NC Medicaid partners with CCNC and LME/MCOs to support care management.

Care managers can be a valuable resource to primary care providers and other physicians. Care managers extend care teams, allowing everyone on the team to work at their highest scope of practice. When care managers coordinate referrals, connect members to non-medical community services, or help them manage their prescriptions, physician capacity is free to perform tasks that only they can do. Community Health Workers (CHWs) are one example of a care management team member that can leverage their trusting relationships and connections within the community to assist the care management team broadly. Ultimately, NC Medicaid's goal is to build an efficient and community-based set of care management options that meet the needs of Medicaid beneficiaries.

Initiatives

Standard Plan Care Management

Standard Plans are required to provide Medicaid members access to appropriate care coordination support across multiple settings of care and provide comprehensive care management services to members identified as having high needs. Most Medicaid members are enrolled in Standard Plans, and most receiving care management services do so through Advanced Medical Home Tier 3 practices, which are delegated by the Standard Plan to provide care management to assigned members. Standard Plans and Advanced Medical Home Tier 3 practices receive funding for meeting specific requirements, including identifying high needs members to receive care management services, developing whole-person centered care plans based on assessed needs, and helping members navigate their care journey.

Tailored Care Management

Members eligible for Tailored Care Management receive support from care managers trained in persistent SMI, SUD, I/DD and TBI. Designed with input from members, providers, and advocates, Tailored Care Management addresses the whole-person centered needs of enrollees in Tailored Plans and NC Medicaid Direct, inclusive of disability-specific and non-medical supports. Tailored Care Management may be delivered by Advanced Medical Home Plus practices, Care Management Agencies (which specialize in behavioral health or I/DD services), or care managers within Tailored Plans. Advanced Medical Home Plus practices and Care Management Agencies are certified by NC Medicaid to provide Tailored Care Management, and NC Medicaid's goal is that most Tailored Care Management will be delivered through these community-based care managers. Advanced Medical Home Plus practices and Care Management Agencies also have the option of contracting with a Clinically Integrated Network or other partner to support the delivery of Tailored Care Management.

In practice, Tailored Care Management provides integrated and intensive care management that helps patients meet their personal and health goals while reducing unnecessary high-cost care. For example, a Tailored Care Management provider worked with one young man who was reporting to the emergency department multiple times per month and whose family was struggling to access resources to support his needs. The care manager maintained nearly daily contact with the family to de-escalate the patient's behaviors and provide resources for where the family could receive support outside of a hospital setting. Since working with the family, the young man has not return to the emergency department at the same frequency and is working on getting employed.[28]

Eastern Band of Cherokee Indian (EBCI) Tribal Option Care Management

The EBCI Tribal Option is a health plan managed by the Cherokee Indian Hospital Authority (CIHA) to meet the primary care management needs of federally-recognized tribal members and others eligible for services through Indian Health Service (IHS). The EBCI Tribal Option builds on the Tribe's strong medical model and delivers high-quality care at the local level. EBCI care managers ensure services are coordinated across multiple settings of care: primary care, specialty care, behavioral health, pharmacy, long-term care, home health, and community-based resources. Members with high medical, behavioral, or social needs have access to care management that includes the involvement of an EBCI Tribal Option

multidisciplinary care team and the development of member-focused story and corresponding written care plan.

Care Management for Other Priority Populations

Medicaid members who receive coverage outside of Standard Plans and Tailored Plans also have access to population-specific, community-based care management. For example, members enrolled in the EBCI Tribal Option receive support from care managers trained in holistic health, which recognizes that a member's well-being is dependent on much more than clinical care, including education, economic stability, social and community connection, and spiritual well-being.[29]

NC Medicaid also has a long history of supporting pregnant women through the Care Management for High-Risk Pregnancy program, which utilizes standardized risk screening to help identify Medicaid beneficiaries at risk for adverse birth outcomes and refer them to the program. The Care Management for At-Risk Children program similarly provides care management services for children ages zero to five at risk of poor outcomes due to health conditions or adverse childhood events, accepting referrals from providers and social service agencies. Both programs are historically administered through Local Health Departments. With the transition to managed care, NC Medicaid is implementing changes to contracting and oversight for these two programs to ensure continued high-quality care management for eligible members within the managed care environment.[30]

Also operating in five counties is the North Carolina Integrated Care for Kids (NC InCK) model, a pilot focused on prevention, early identification and treatment of behavioral and physical health needs, and integrated care management for children and youth ages 0-21.[31] NC InCK links alternative payment models to measures of child well-being with the goal of improving quality which will conclude at the end of calendar year 2026.

Progress and Lessons Learned

Care management is reaching Medicaid members that need it. Implementation has shifted from building to refining, aligning, and strengthening accountability.

NC Medicaid implemented its care management offerings so that all members who want or need care management services can receive them from a trusted provider capable of meeting their specific needs. In the new managed care environment, local providers received technical assistance and operational guidance which helped the new care management programs achieve the strong levels of community-based provider participation. As the program matures, NC Medicaid is refining operations and synergizing across programs.

Over 1.7 million members are enrolled in an Advanced Medical Home Tier 3 practice, meaning approximately 80% of Standard Plan-enrolled members, if eligible, have access to local care management through their primary care practice or a supporting Clinically Integrated Network or other partner.[32] As of June 30, 2024, 80,000 individuals received Tailored Care Management, helping them navigate the health care system, engage in care consistently, and live more successfully in the community.[33]

Prior to launching Tailored Care Management, care coordination was not in-person, was primarily telephonic, and was focused on a small subset of health needs for populations with significant behavioral health, I/DD, and TBI needs. With Tailored Care Management, eligible individuals have access to whole-person centered, community-based care management and can choose to receive this support from either their Tailored Plan[xvii] or a provider organization (either an Advanced Medical Home Plus practice or Care Management Agency). With two full years of experience, NC Medicaid continues to refine the model to better serve enrollees and ease provider burden, informed by primary care provider, Advanced Medical Home Plus practice, Care Management Agency and LME/MCO input gathered through Town Halls and Technical Advisory Group meetings. Past refinements to improve performance of the model included:

- Updates to the Tailored Care Management assignment requirements to better identify and preserve relationships between beneficiaries and the organization (LME/MCO, Advanced Medical Home Plus practice, or Care Management Agency) that is a "best fit" for providing Tailored Care Management.
- Updates to the payment rate in the early years of the program to reflect higher than anticipated time and effort necessary to deliver the model.
- Updated programmatic requirements to reduce health plan and provider confusion and administrative burden.

NC Medicaid is in the early stages of evaluating the impact of the model, informed by ongoing monitoring of engagement rates and other data across plans and Advanced Medical Home Plus practices, and Care Management Agencies.

Implementing initiatives of this scale, while maintaining legacy care management programs and piloting new models, highlighted improvement opportunities for member care and underscores the need to streamline the provider experience with managed care programs. NC Medicaid is looking for opportunities to simplify and align care management approaches to accommodate the need for scale and impact while continuing to meet the specialized needs of diverse populations.

Looking Ahead

Strengthening alignment and harmonization across care management programs will continue to improve member outcomes and provider experience.

Looking ahead, NC Medicaid will enhance and align current and new care management programs, using insights gleaned through program monitoring. Recognizing that specific populations have differing needs, NC Medicaid is looking to extend the reach of specialized care management to additional populations, including by providers with specific training and/or lived experience. Examples include: care management for CFSP-enrolled members that will require significant coordination, and co-location, where appropriate, with County DSS agencies to ensure access to services despite changes in foster care

[xvii] Eligible individuals in NC Medicaid Direct can access Tailored Care Management through their LME/MCO.

placement or health care settings; launching care management for recently incarcerated individuals who are transitioning back to the community; and exploring opportunities for potential participation in the federal Certified Community Behavioral Health Clinic (CCBHC) demonstration.[xviii]

Foundational aspects of all North Carolina care management programs include: defined patient panel for care; coordination of care and referrals; health promotion and health education; closing health care gaps; outreach and education of episodic or ongoing care management services; comprehensive assessments to identify member needs; care plan development for members identified with needs; and connections with community-based referrals. To minimize complexity, NC Medicaid is committed to harmonizing its care management system across existing and new programs by reviewing the foundational elements above to ensure consistency of care management delivery. Aligning care management programs will reduce administrative burden for providers, improve oversight and evaluation of care management programs, and ensure members are receiving care that best meets their needs.

NC Medicaid will strengthen its assessment of these programs to better understand how care management is affecting health outcomes, whether programs are meeting key performance goals, and in support of implementing program refinements. Ongoing evaluation efforts include the Advanced Medical Home Evaluation with the UNC Sheps Center for Health Services Research, which evaluates whether Standard Plan care management and delegated Advanced Medical Home Tier 3 care management are increasing access to care management services and improving quality. Initial data show these care management strategies resulted in increased delivery of care management services relative to before managed care launch.[34] NC Medicaid's community engagement strategy is an integral part of its program evaluation process, ensuring that feedback from providers, patients, and stakeholders leads to continuous improvements in care management services and population health initiatives. In particular, the Advanced Medical Home and Tailored Care Management Technical Advisory Groups serve as important forums for regular engagement with key partners. As NC Medicaid concentrates on care management alignment, future assessment efforts will focus on a priority set of metrics that ensure programs are meeting key objectives and driving improved outcomes.

[xviii] North Carolina received a CCBHC planning grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2023 to prepare for future participation in the CCBHC demonstration. CCBHCs are required to provide a comprehensive set of outpatient mental health and SUD services, in addition to care management integrated across physical and behavioral health.

Strategy 3: Identifying and Addressing Non-Medical Drivers of Health

Goals

Addressing the non-medical drivers of health for Medicaid members is a foundational component of the state's Population Health Strategy.

Access to high-quality medical care is critical, but research shows up to 80 percent of a person's health is determined by social, economic, behavioral, and environmental factors and the needs that emerge as a result.[35] NC Medicaid is focusing on these social drivers of health (SDOH), the conditions in which people live and the wider set of forces and systems shaping the conditions of daily life that directly influence health outcomes, and the resulting health-related social needs (HRSN), or non-medical factors that affect an individual's ability to maintain their health and well-being, such as lack of access to healthy food or stable housing.[36]

SDOH can negatively impact well-being (e.g., worsening health care access and outcomes affecting employment or impacting caretaking roles) and can increase downstream medical costs. SDOH also can perpetuate health differences for certain populations, particularly for children and adults at risk for poor health outcomes and individuals in rural and historically underserved communities. Social drivers of health can be a barrier to accessing necessary medical care because individuals may, for example, be more concerned about addressing an immediate food or housing need than addressing an ongoing medical concern. Acknowledging these risk factors, NC Medicaid set a bold vision to increase the 'Healthy Opportunities' afforded to North Carolinians, specifically to increase the identification and consistency of reporting on social needs, to manage social needs once identified in an individual, and to pay for community-based services to address social needs. North Carolina integrated its Healthy Opportunities initiatives within its overarching population health approach to ensure that Medicaid members receive whole-person centered care. NC Medicaid is a national leader in creating Healthy Opportunities and several of its core initiatives have been replicated by states across the country.

Initiatives

Healthy Opportunities Framework

North Carolina's Healthy Opportunities framework has focused to date on four priority domains (housing stability, food security, transportation access, and interpersonal safety[37]). The state has invested in several coordinated SDOH initiatives. Highlights include:

- **Screening for SDOH:** NCDHHS worked with a technical advisory group to develop a standardized set of SDOH screening questions and now requires that health plans screen all members annually for unmet SDOH needs using these questions. Strengthening reporting of the SDOH screenings performed by Standard Plans was included as a pay-for-reporting measure in the

Standard Plan Withhold Program, where health plans may earn back withheld capitation funds (full or partial amount) according to their performance against specified targets.[38]

- **Managing SDOH Needs:** As part of a public-private partnership, NCDHHS created NCCARE360, the first in the nation statewide coordinated care platform to electronically connect individuals to community resources and establish a dedicated closed-loop process so providers can track whether those important connections happened.[39] NC Medicaid also requires all Advanced Medical Home Tier 3 practices to perform comprehensive assessments on each member identified as a priority for care management. This comprehensive assessment includes assessing the member's housing, food, transportation, and interpersonal safety needs. NCDHHS expanded the footprint of Community Health Workers across North Carolina through support for trainings and tools for integration into Advanced Medical Homes. Community Health Workers serve as critical community-based care team members who help individuals navigate to needed SDOH services statewide and are explicitly permitted to be part of the care management team in managed care via the Standard Plan and Tailored Plan contracts. CHWs are working directly at the Medicaid health plan level and in other provider and community-based settings, including local health departments, in NC Medicaid today.
- **Paying for SDOH Services and Other Investments:** NC Medicaid launched the Healthy Opportunities Pilots which established a model for the delivery, payment, and evaluation of supports to address non-medical needs of qualifying members in three regions of the state (*see Healthy Opportunities Pilots section below*).

Healthy Opportunities Pilots

In 2022, NC Medicaid launched the nation's first comprehensive program, the Healthy Opportunities Pilots, to test the impact of providing select, evidence-based, non-medical interventions to qualifying members in three regions of the state.[40] Under the Healthy Opportunities Pilots, Standard Plans and Tailored Plans pay for services delivered by local social service providers, overseen by regional Network Leads. The Healthy Opportunities Pilots bring individuals that have not traditionally engaged with the health care system into care relationships.

The Healthy Opportunities Pilots build on the state's strong foundation of embedded, community-based care management, leveraging care managers who will be responsible for enrollees' physical, behavioral and social needs. Care management entities that participate in the Healthy Opportunities Pilots are responsible for assessing individuals for eligibility, recommending appropriate services, and coordinating Healthy Opportunities Pilots services and care alongside physical and behavioral care. For example, a single mother was experiencing homelessness and was staying at a local shelter with her children. When she needed lifesaving surgery in the hospital, her children could not stay at the shelter without her, leaving her in an impossible situation. Through the Healthy Opportunities Pilots, her care managers were able to help transfer her emergency housing voucher so she could secure income-based housing near the hospital for her and her family. Additionally, the Healthy Opportunities Pilots provided financial support for her security deposit and utility start-up fees. Now, the mother can focus on her health and schedule needed medical care to avoid costly emergency follow-up care from her surgery, all while keeping her family together under one roof.[41]

Healthy Opportunities Pilot services began with a phased launch—first offering food services on March 15, 2022, followed by housing and transportation services on May 1, 2022, and toxic stress and cross-domain services on June 15, 2022. Interpersonal violence services began on April 5, 2023.

Successes and Lessons Learned

Early evaluation results of the Healthy Opportunities Pilots show improvements in health outcomes and reductions in unnecessary utilization, social support needs, and total health care costs.

Early results from the Healthy Opportunities Pilots are impressive.[42] In just over two years, independent evaluators found North Carolina participants have a reduced risk of food insecurity, housing instability, and lack of access to transportation and fewer emergency department visits and inpatient hospitalizations, resulting in overall cost savings of $85 per member per month, after considering the cost of the Healthy Opportunities Pilots services. The longer a person was enrolled in the Healthy Opportunities Pilots, the greater the reduction of risk and the higher the cost savings. To date, over 34,000 individuals have enrolled in the Healthy Opportunities Pilots and over 660,000 services have been delivered.[43] More than 25,000 enrollees received boxes of healthy, nutritious food and over 16,500 enrollees received housing navigation, support, and sustaining services.[44] Based on these findings, researchers recommend maintaining and extending the Healthy Opportunities Pilots services across the state. Healthy Opportunities Pilots Network Leads in western North Carolina were critical partners in helping people in communities impacted by Hurricane Helene recover from the damage left behind.

Care managers serve as a link between the health plan and the human services organization providing the Healthy Opportunities Pilots service—providing integrated management of a member's social and health care needs. This trusting relationship provides an entry point to engage individuals in the health and social care continuum and a connection to other services not included in the Healthy Opportunities Pilots that could benefit the person's health, including primary and preventive care. Addressing the social needs of members is a core part of population health, and NC Medicaid intends to work with the NC General Assembly to explore the opportunity of making the Healthy Opportunities Pilots a key population health program for eligible members, not just those living in the initial Pilot regions. Lastly, NC Medicaid has reorganized its internal program teams to integrate the Healthy Opportunities Pilots program with the same team leading other population health efforts, including primary care innovation, quality, evaluation, and care management.

Looking Ahead

NC Medicaid expects to partner with the NC Legislature to support further investment and scale-up of the Healthy Opportunities Pilots initiative in the coming years.

NC Medicaid received federal authority to renew the Healthy Opportunities Pilots for an additional five years and gives the state options to expand the program statewide, scale services, and make other program improvements.[45] Prior to implementing these options, NC Medicaid will partner with the Legislature to collaborate on the Healthy Opportunities Pilots design and implementation. Furthermore, NC Medicaid is working to bring Healthy Opportunities Pilot services to members of the EBCI Tribal Option and Children and Families Specialty Plan in existing pilot regions during 2025. NC Medicaid will release an additional policy paper specific to the Healthy Opportunities Pilots design to engage policymakers and other partners prior to implementing these new options.

In addition, NC Medicaid is exploring opportunities to leverage the Healthy Opportunities Pilots to fill critical needs in rebuilding the infrastructure that was lost in the western part of the state due to Hurricane Helene. NC Medicaid will continue to explore opportunities to leverage strategies to address non-medical drivers of health.

Strategy 4: Using Data to Design Evidence-Based Programs

High quality, easily shareable and useable data is a key enabler of population health. NC Medicaid, health plans, and providers must work together to better collect and utilize data to improve care delivery and member experience.

Goals

Since the implementation of Medicaid managed care in 2021, NC Medicaid sought to transform how health information is shared and used by those delivering health care to North Carolinians across the state and how it, as a state agency, collects and uses data to support health care system oversight and accountability. NC Medicaid pursued this transformation by:

- Facilitating the development of a health care ecosystem where data is exchanged among health plans, providers, and care managers to support informed and responsive clinical care delivery;
- Investing in foundational Departmental capabilities to oversee health plan performance and monitor population health program progress;
- Collaborating with stakeholders to identify and address health care data and system challenges as they arise; and
- Evaluating NC Medicaid transformation efforts through rapid cycle assessments, including the transition to managed care, Medicaid Expansion, SUD initiatives, and the Healthy Opportunities Pilots.[46]

Advancing each of these efforts has required the focused dedication of state resources.

Initiatives

Facilitating an Information-Driven Health Care Delivery System

Through the design of its Advanced Medical Home and Tailored Care Management programs and health plan contracting, NC Medicaid set new requirements for data collection, data sharing, and data use among health plans, providers, and care managers to support patient care. Care management entities, for example, are expected have: 1) comprehensive health information about their assigned members' care needs and history of treatment, 2) Admission, Discharge and Transfer (ADT) event notification information to be responsive to patients' changing health conditions, and 3) the health information technology required to translate this information into actionable steps.

NC Medicaid, with federal financial support from CMS, is also investing in the capabilities of the state's health information exchange (HIE), NC HealthConnex, to make members' health information—including clinical data, HRSN screening information, and patient risk information—more accessible by health plans

and providers to support coordinated care, risk assessment and target interventions. North Carolina's investment in NC HealthConnex promises to make more timely and actionable information available to the health plans, providers, and care managers responsible for patient care, improving patient care and reducing duplicative services and administrative burdens on health care providers.

Investing in Foundational Departmental Data and Analytic Capabilities

Since the launch of managed care, NC Medicaid developed and implemented new health plan and provider reporting requirements, like the Benefits and Care Management (BCM) reporting, that supplement traditional data assets (e.g., health plan claims and encounter data) to provide the Department information that can be used to oversee Medicaid's care management programs and understand the health of the populations they serve. NC Medicaid recently completed a Data Analytics Framework Assessment for Population Health to define how it can formalize practices to translate these data into information that can be used for program oversight and decision-making.

Progress and Lessons Learned

As health care data needs continue to evolve, NC Medicaid is working with community partners to modernize its approach to collecting, sharing, and interpreting data.

Through its move to managed care, NC Medicaid established new data exchanges that support patient care and population health, as well as attribution and other activities needed for a managed care system to function effectively.

NC Medicaid faces the challenge of effectively using data to monitor program performance and take timely corrective actions, like refining care management design or adjusting incentive structures. NC Medicaid needs the right people, processes, and infrastructure in place to translate data into actionable information, which takes time and attention to build and sustain. NC Medicaid is making these investments and will continue to develop and extend the impact of the initiatives. Achieving these goals also requires complete and accurate data, and NC Medicaid and its partners in the field are collaborating to respond to that need.

Health care data and transmission standards evolved considerably since NC Medicaid's managed care and care management data and system requirements were set. NC Medicaid, like many Medicaid agencies nationally, is hearing from the field to update requirements to reflect more modern data exchange expectations, from requiring the broad adoption and use of Certified Electronic Health Record Technology with enhanced capabilities to support care management and address SDOH to ensuring ADT alerts are shared with authorized users in real time as health events occur.

Looking Ahead

Together with NC HealthConnex, NC Medicaid is taking significant steps to improve its health data infrastructure to provide the Department and its partners with better visibility into member outcomes and provider and plan performance.

Establishing a stronger and more responsive health data infrastructure in NC will allow providers and health plans to better care for their members, and support NC Medicaid's data-driven decision-making as it evaluates and refines its population health programs. Through the coming years, NC Medicaid expects to continue investing in its health data infrastructure and capabilities, elevating data sharing expectations among health plans and providers, strengthening internal analytic capabilities, and partnering with the NC Health Information Exchange (HIE), NC HealthConnex, to support the:

- Facilitated exchange of patient HRSN screening information among hospitals, care managers, and providers.
- Calculation of digital quality measures (dQMs) and access to member clinical data to support more advanced population health strategies.
- Improved care management member assignment data flows to clarify health plan and provider care management responsibilities.
- Identification of persistent health access inequities and differences in health outcomes for certain populations, including underserved communities, across North Carolina to inform targeted care management and HRSN service interventions.
- Improved data sharing of patient visits information between providers and care management entities to provide a view of a member's care needs.

NC Medicaid receives enhanced state match funding by CMS to support this effort.

Conclusion

The environment in which NC Medicaid operates is and will continue to be dynamic. NC Medicaid successfully launched both Standard Plans and Tailored Plans, implemented the groundbreaking Healthy Opportunities Pilots, and expanded Medicaid eligibility to more than 640,000 North Carolinians. In December 2025, NC Medicaid will launch the CFSP which requires unprecedented collaboration across health and child welfare systems. Standard Plan contracts expire Nov. 30, 2027, and require re-procurement. Current state statute requires dual-eligible members, who are enrolled in both Medicare and Medicaid, to be integrated into managed care, which will lead to attention on long term services and supports with an emphasis on community-based care.

The federal government approved a new 1115 waiver for North Carolina, providing the opportunity to build upon existing innovations impacting whole-person centered care.[47] This approval is a necessary, but not final step, to helping more North Carolinians stay healthy and further bending the health care cost curve for the state. With a menu of options for North Carolina to potentially take advantage of, NCDHHS will meet with stakeholders, partners, and most importantly legislators, to discuss what opportunities are now available and how we may be able to come together to implement them. An overview of the key components of this new 1115 waiver approval are below:

- Extends federal authority for North Carolina's successful Medicaid Managed Care program, allows for Healthy Opportunities Pilots that invest in non-medical drivers of health like food, transportation and housing to be taken statewide (beyond the current three regions);
- Opens access for people who are incarcerated to get Medicaid coverage for a limited set of services, including case management, up to 90 days prior to their release - providing them with critical health services and helping to break the expensive cycle of incarceration;
- Enables more behavioral health resources for North Carolinians and boosts the behavioral health and long-term services and supports workforce including through expanding loan repayment programs for providers;
- Makes it possible for children to remain covered by NC Medicaid for longer periods of time, reducing burdensome paperwork for families and counties; and
- Continues access to evidence-based substance use disorder treatments for Medicaid beneficiaries while they are in a qualifying facility.

As NC Medicaid pursues significant reforms and programmatic changes, community partnership, a robust workforce and a strong NCDHHS team will play crucial roles. From conceptualization through implementation, NC Medicaid's transformation efforts have been shaped by input received from health plans, providers, Clinically Integrated Networks, care managers and members. NC Medicaid will continue to leverage the Advanced Medical Home and Tailored Care Management Technical Advisory Groups, other communication and engagement platforms, and will solicit feedback on new initiatives through policy papers and programmatic guidance over the next several months.

At the same time, building successful population health programs and running an efficient Medicaid program requires a high-functioning team. This includes investments in the technological capabilities of NC Medicaid as well as human capital. Additionally, successful population health efforts will require

continued partnerships and investment in the health care workforce, provider organizations and the communities they serve.

In the fall of 2024, NC Medicaid's population health strategies were tested as parts of North Carolina experienced the devastating impact of Hurricane Helene.[48] The hurricane and resulting flooding wiped out generations of family homes and long-established businesses, uprooted communities, and created barriers to health care and social supports. NC Medicaid worked to identify people in need, provide information and supports to impacted communities, and secure policy flexibilities (including federal authorities) such as removing all prior authorization requirements for needed services to ensure people were safe and supported. NC Medicaid's care management programs, the Healthy Opportunities Pilots infrastructure, and data systems established as part of our Population Health Strategy were invaluable in supporting the response to Hurricane Helene. This illustrates how investments in population health programs not only support better member care, but a more resilient health care system for all North Carolinians.

NC Medicaid looks forward to continuing to work with its partners to build on its successes and learn from its challenges, and to foster a stronger Medicaid program that achieves the full promise of an equitable, innovative, whole-person centered and well-coordinated system of care that addresses both the medical and non-medical drivers of health. As the health care landscape evolves, NC Medicaid remains committed to working alongside providers, health plans, and community organizations to implement innovative solutions, improve health outcomes, and create person-focused system for all North Carolinians.

Community partners are encouraged to provide feedback on this paper by emailing Medicaid.NCEngagement@dhhs.nc.gov (subject line "Improving Health and Promoting Value: An Update on the Population Health Approach") by May 30, 2025.

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