# *Inside North Carolina's Big Effort to Transform Health Care*

**By Steve Lohr**

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RALEIGH, N.C. — North Carolina seems like an unlikely laboratory for health care reform. It refused to expand Medicaid coverage under the Affordable Care Act, and ranks in the bottom third among states in measures of overall health.

But the state has embarked on one of the country's most ambitious efforts to transform how health care is defined and paid for.

North Carolina is in the early stages of turning away from the traditional fee-for-service model, in which doctors and hospitals are paid for each office visit, test or operation. Instead, providers will often be paid based on health outcomes like controlling diabetes patients' blood sugar or heart patients' cholesterol. The better the providers do, the more they can earn. If they perform poorly, money could eventually come out of their pocket.

The goal is to keep people healthy and out of the hospital and to save money on health care spending.

The idea is not new, as some hospital systems and other states have moved toward paying based on outcomes. Some were prodded by federal incentives. The evidence so far is mixed, with more success improving the health of some patients than cutting overall costs.

The North Carolina project is the biggest bet yet on the concept. It is being championed by the state's Department of Health and Human Services, which oversees payments for Medicaid, and Blue Cross Blue Shield of North Carolina, the state's largest private insurer.

"I want to buy health with our dollars, not necessarily buy health care," said Dr. Mandy Cohen, the secretary of North Carolina's Department of Health and Human Services.
Cliff Owen/Associated Press

Together, they oversee payments for about two-thirds of the state's insured population. That gives them considerable sway over how care is delivered in North Carolina and leeway to go beyond what has been tried elsewhere.

"No state is moving as far as fast as North Carolina," said Dr. Mark McClellan, a head of Medicare and Medicaid during the George W. Bush administration and a professor of health policy at Duke University.

The North Carolina effort is led by two former officials in the Obama administration: Dr. Mandy Cohen, the secretary of the state's health department, and Dr. Patrick Conway, the nonprofit insurer's chief executive, who also served in the Bush administration. There is no formal coordination between them. But they share similar views on the health care industry, and decided to make the move to the new payment model around the same time.

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## Focus on Primary Care

Primary care clinics like the Ardmore Family Practice in Winston-Salem are at the front line of the North Carolina campaign. Their physicians and nurses are expected to play a larger role in managing care, and stand to gain financially.

In some ways, the small Ardmore clinic has long been doing some of the things the new push supports.

It has built deep roots in the community. Dr. Robert Rosen, one of the physicians, delivered Catherine Vickers, an assistant practice manager in the office, 24 years ago. The other Ardmore physician, Dr. Amy Sapp, describes her work as "firsthand longitudinal health care," taking care of people over years, knowing them, their families, their living circumstances and their life changes.

Dr. Patrick Conway, chief executive of Blue Cross and Blue Shield of North Carolina, shares similar views of the health industry with Dr. Cohen.
Drew Angerer for The New York Times

The new payment model pushes them to do even more on both fronts — and do it in a more systematic way, like asking patients detailed screening questions about depression, alcohol consumption, food and housing. So on annual wellness visits, the doctors now spend more time with patients, and receive an extra $20 in addition to the clinic's standard charge of about $150.

In total, the state's changes are likely to increase the share of total health care dollars that go to primary care physicians — as opposed to specialists, hospitals and other places — to 10 to 13 percent from 6 to 8 percent over several years, according to estimates by health policy experts.

But the state's push is also going to force the Ardmore practice in new directions. The clinic, with its 5,300 patients, will be grouped with a few others into a so-called accountable care organization. These groups have shared training and technology programs, and have the patient populations whose health outcomes will determine reimbursement in the new model.

Blue Cross and the state are moving to contracts with doctors' groups and hospitals that include cuts in reimbursement if quality outcomes fall short, typically after two years of incentive payments to expand physician services.

The North Carolina initiative, Dr. Rosen said, holds "a lot of promise." Dr. Sapp agreed, saying the direction of the policy made "tremendous sense." But she added, "My fear is that it becomes this year's box to check, another bureaucracy that sits on top of everything else."

## New Tack for Big Providers

This year, Blue Cross announced that it had signed five of the largest health systems in the state to contracts linking payments to total costs of care for their patient populations and quality measurements, not to hospital stays or surgical procedures.


Ardmore will be grouped with a few other clinics into a so-called accountable care organization. Jeremy M. Lange for The New York Times

Duke University Health System is one of those big groups. "It's so clear that change is necessary," said Dr. Thomas Owens, president of Duke University Hospital in Durham.

In the new contracts, a provider is paid a set amount, typically a monthly fee per patient. How to spend and save money is largely up to the provider. That could open the door to a new relationship with payers, including insurers, Dr. Owens said, since there should not be a fight over approving each test or treatment, a daily torment for doctors in the fee-for-service world.

Over time, fewer members of the Duke staff may be employed in the "adversarial work" of billing and payment and more people can work on health care, he said.

Duke has made several efforts in recent years to curb costs through health practices, including pushing preventive programs and prescribing generic drugs, Dr. Owens said. A depression screening and counseling program, he noted, reduced the recurrence of symptoms by 50 percent within a year. Duke will continue and expand such programs, he said.

But Dr. Owens is worried that advanced treatment at an academic research hospital like his may be in danger from too inflexible a march to the new payment system. Recently, he said, a young mother with a severe case of flu experienced heart failure. She was flown to Duke Hospital and placed on a high-tech heart-lung machine, and she recovered.

"That is life changing for the family," Dr. Owens said. But it is also very expensive treatment, costing hundreds of thousands of dollars. "That doesn't get accounted for in a typical value-based payment model," he said, if it strictly applies per-patient reimbursement without exceptions.

Valerie Holden-Baity, a certified medical assistant at Ardmore, getting Seth Harris ready for a physical examination. Jeremy M. Lange for The New York Times

## Tracking Lifestyles

North Carolina is also taking on health-related risks in a person's daily life — like access to food, housing and transportation. The Trump administration has approved the state's plan to spend $650 million of state and federal funds for pilot projects to address these so-called social determinants of health.

State officials point to a demonstration project in Greensboro as the kind of effort they want to replicate and expand.

A hospital group, a housing nonprofit and university researchers identified 41 families with children who made frequent hospital visits for asthma. They visited the homes; identified potential asthma triggers like mold, dusty carpeting and poor ventilation; and made recommendations and repairs. Afterward, asthma-related hospital costs for those children dropped by more than 50 percent.

"The future is trying to do that across the system, not just for a few dozen families," said Kathy Colville, healthy communities director at Cone Health, the hospital group that participated in the asthma project.

The state is building technology to enable such efforts, by better linking community groups, doctors and insurers. A free online service, NCCARE360, has been introduced in 15 of the state's 100 counties, with statewide coverage planned by the end of 2020. It will connect public health departments and doctors and hospitals, which can make online referrals to service organizations and people in need.

NCCARE360 helps direct consumers to services — telling them, for example, what food pantries or homeless shelters are available within five or 10 miles. It can also help health departments and doctors track whether people referred to those services ever visited them. Before, the follow-up involved phone calls and voice messages, often taking days. Now, it is a matter of automated text messages and emails.

"It could be a game-changer instead of just sending people out of here with a brochure," said Stacie Saunders, director of public health at the Alamance County Health Department in Burlington.

Another tech-centered effort is being pushed by Blue Cross. The insurer will share claims information with health care providers, and the doctors and hospitals will share clinical data. That information will be the fuel for data analysis software that flags patients most in need of care or counseling. The software will be rolled out at the start of next year.

"Technology is just a tool in this transformation," said Jini Kim, chief executive of Nuna, the start-up designing the data-analysis software. "But if the technology doesn't work, this whole thing falls apart. We all feel that pressure."

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