Advanced Medical Home (AMH) Technical Advisory Group (TAG)

Meeting #4: Value Based Payments

June 25, 2019, 1:00 – 4:00 pm

Williams Building, 1800 Umstead Drive, Room 123B

AMH TAG Membership Rollcall

Name	Organization	Stakeholder
Sheryl Gravelle-Camelo, MD	Pediatrician KidzCare in Macon County	Provider (Independent)
David Rinehart, MD	President-Elect of NC Family Physicians North Carolina Academy of Family Physicians	Provider (Independent)
Gregory Adams, MD	Member of CCPN Board of Managers Community Care Physician Network (CCPN)	Provider (CIN)
Zeev Neuwirth, MD	Senior Medical Director of Population Health Carolinas Physician Alliance (Atrium)	Provider (CIN)
Calvin Tomkins, MD, MHA	Assistant Medical Director Mission Health Partners	Provider (CIN)
Peter Freeman, MPH	Vice-President/Executive Director Carolina Medical Home Network	Provider (CIN)
Jan Hutchins, RN	Executive Director of Population Health Services UNC Population Health Services	Provider (CIN)
Joy Key, MBA	Director of Provider Services Emtiro Health	Provider (CIN)
Glenn Hamilton, MD	Vice President of Corporate Medical Policy AmeriHealth Caritas North Carolina, Inc	PHP
Michael Ogden, MD	Chief Medical Officer Blue Cross and Blue Shield of North Carolina	PHP
Michelle Bucknor, MD	Chief Medical Officer UnitedHealthcare of North Carolina, Inc	PHP
Thomas Newton, MD	Medical Director WellCare of North Carolina, Inc	PHP
William Lawrence, MD	Chief Medical Officer Carolina Complete Health, Inc	PHP
Eugenie Komives, MD	Senior Medical Director for Duke Connected Care MCAC Quality Committee Member	MCAC Quality Committee Member

Agenda

1	Recap: AMH TAG Meeting #3	1:00 pm – 1:05 pm
2	Overview: Tailored Plan (TP) Care Management Strategy	1:05 pm – 1:20 pm
3	Overview and Discussion: Value Based Payments (VBP) in Managed Care	1:20 pm – 1:50 pm
4	Break	1:50 pm – 2:05 pm
5	Overview and Discussion: Medicaid Accountable Care Organization (ACO) Model Design	2:05 pm – 3:50 pm
6	Public Comments	3:50 pm – 3:55 pm
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Recap: AMH TAG Meeting #3

Summary of Discussion

- **Oversight:**
  - *Corrective action plans (CAPs), Tier reassignment:* TAG members gave the feedback that DHHS should establish some basic "reasonableness" expectations for CAPs across PHPs including a clear expectation that providers will have a chance to correct issues.
  - *AMH/CIN to PHP reporting requirements:* TAG members suggested DHHS review current reporting requirements (including frequency of reporting) and avoid duplicate efforts (e.g., DHHS should consider PHP NCQA reporting requirements).
- **Charter and Issues for the AMH TAG Data Subcommittee:** TAG members approved the Charter and goals for the Data Subcommittee. TAG members identified an interested in discussing additional secondary priority data sharing topics (e.g., NCCARE360 and NC HealthConnex)

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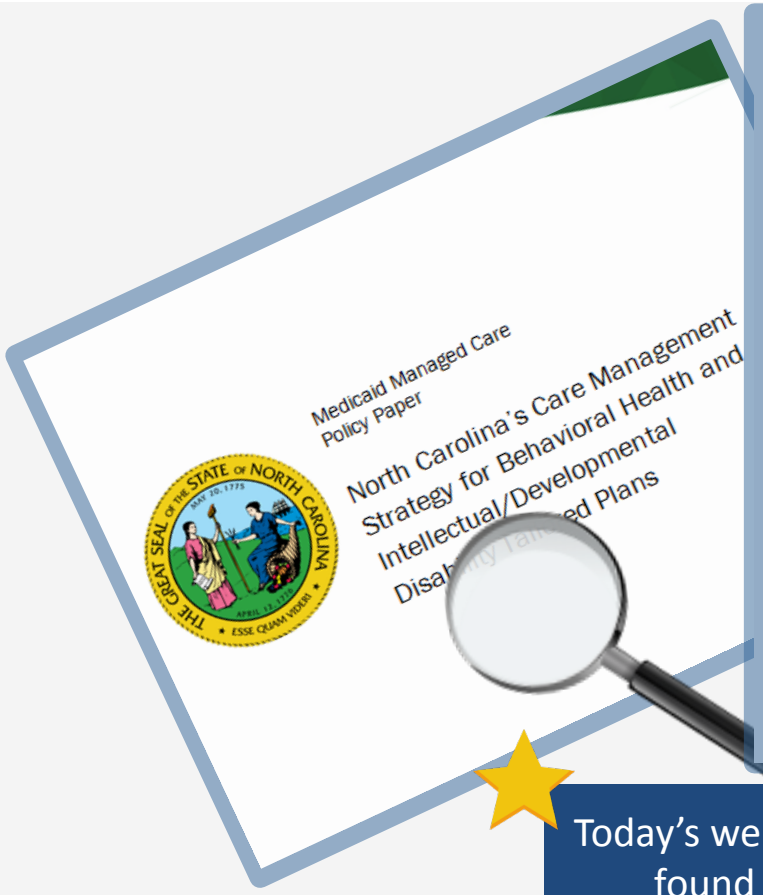
BH I/DD Tailored Care Management Paper

On May 29, 2019, North Carolina's Department of Health and Human Services (the Department) released "North Carolina's Care Management Strategy for Behavioral Health and Intellectual/Developmental Disability (BH I/DD) Tailored Plans."



The paper provides an overview of the BH I/DD Tailored Care Management design developed to date, including:

- Guiding principles
- Transition to whole-person care management
- Federal Health Home structure
- Provider-based care management
- Care management process flow
- Care manager qualifications and training
- Conflict-free care management
- Payment for care management

Today's webinar reviews key concepts in the paper. The full paper can be found on the Department's Medicaid Transformation webpage.

Standard Plans and BH I/DD Tailored Plans

Both Standard Plans and BH I/DD Tailored Plans will be integrated managed care products and will provide a robust set of physical health, behavioral health, long-term services and supports, and pharmacy benefits.

Standard Plans

- Will serve the majority of the non-dual eligible Medicaid population

BH I/DD Tailored Plans

- Targeted toward populations with:
  - significant behavioral health conditions—including serious mental illness, serious emotional disturbance, and severe substance use disorders
  - intellectual and developmental disabilities (I/DD), and
  - traumatic brain injury (TBI)
- Will offer a more robust set of behavioral health and I/DD benefits than Standard Plans and will be the only plans to offer current 1915(b)(3), 1915(c) Innovations and TBI waiver, and State-funded services

BH I/DD Tailored Care Management

The care management model in BH I/DD Tailored Plans will be known as "Tailored Care Management."

Core Principles

- Broad access to care management
- Single care manager taking an integrated, whole-person approach
- Person- and family-centered planning
- Provider-based care management
- Community-based care management
- Community inclusion
- Choice of care managers
- Consistency across the state
- Harness existing resources

Overview of Tailored Care Management Approach

Department of Health and Human Services

Establishes care management standards for BH I/DD Tailored Plans aligning with federal Health Home requirements

The BH I/DD Tailored Plan will act as the Health Home and will be responsible for meeting federal Health Home requirements

BH I/DD Tailored Plan Health Home

Care Management Approaches

BH I/DD Tailored Plan beneficiaries will have the opportunity to choose among the care management approaches; all must meet the Department's standards and be provided in the community to the maximum extent possible.

Approach 1:
"AMH+" Primary Care Practice
Practices must be certified by the Department to provide Tailored Care Management.

Approach 2:
Care Management Agency (CMA)
Organizations eligible for certification by the Department as CMAs include those that provide BH or I/DD services.

Approach 3:
BH I/DD Tailored Plan-Employed Care Manager

The Department anticipates allowing—but not requiring—CMAs and AMH+ practices to work with a **CIN or other partner** to assist with the requirements of the Tailored Care Management model, within the Department's guidelines.

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Goals of Today's Discussion on Value Based Payments

- ***Discuss the Department's vision for VBP in managed care***
- ***Discuss the proposed Medicaid ACO model and key features of model design***
- ***Discuss role of AMHs in VBP and the Medicaid ACO model***

Guiding Principles for VBP Strategy

The State aims to transition nearly all Medicaid payments into VBP contracts by the end of Contract Year 5 (summer of 2024), with many of these contracts incorporating shared savings and shared risk.

- **Ensure NC Medicaid "purchases health"**– reward providers for delivering appropriate, high-quality care, rather than providing discrete health services.
- **Establish ambitious, but achievable, goals—**rapidly accelerate the use of VBP during the early years of managed care while ensuring goals are still achievable for PHPs and providers.
- **Recognize market readiness for VBP and align across payers —** build from and align with existing VBP arrangements in place today in Medicare and the commercial market, while accommodating the unique needs of North Carolina's Medicaid beneficiaries and providers.
- **Create platform for market innovation**—allow PHPs and providers flexibility to enter into arrangements that align with their VBP readiness and with their specific populations and services.
- **Build from and leverage State programs focused on improving the value of care—**align with and build on programs and initiatives such as AMH, Healthy Opportunities and other state-wide investments.

In reviewing the VBP Strategy outline, please consider whether the State has successfully balanced these principles.

Reminder: Year 1-2 VBP Approach

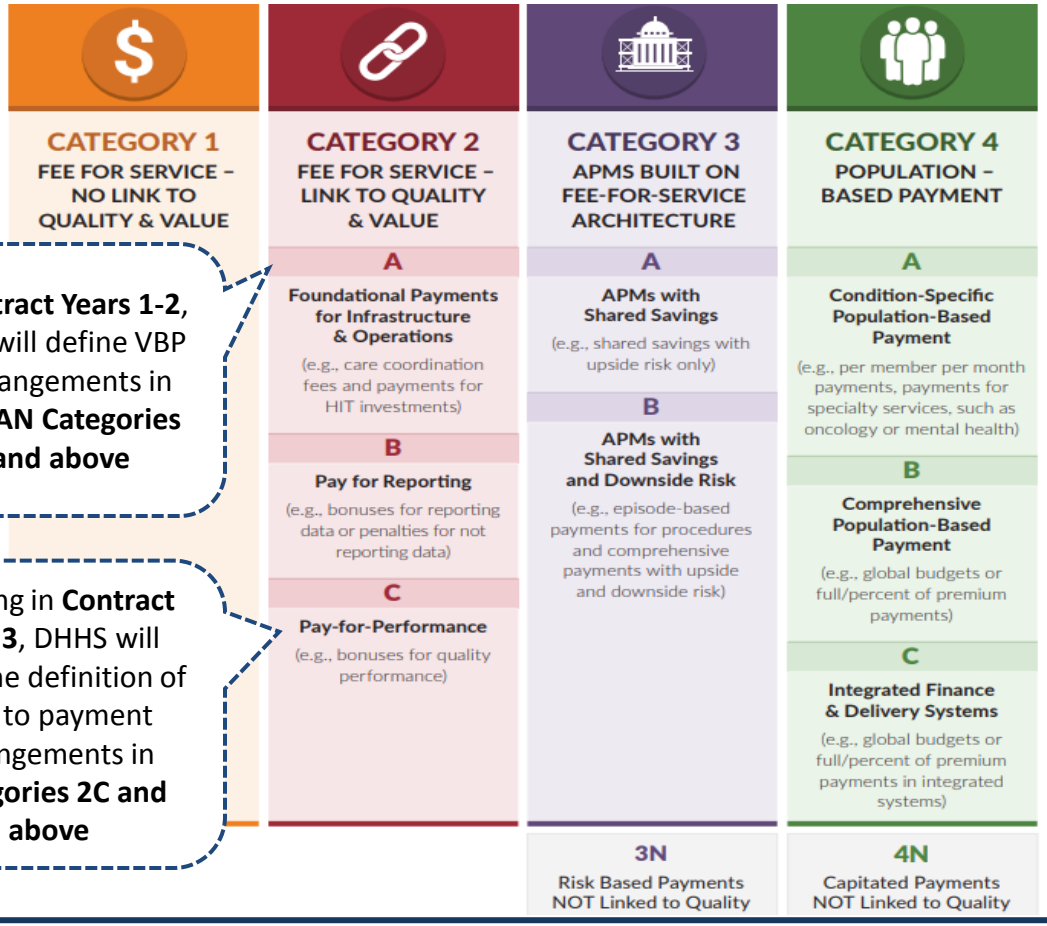
DHHS will begin setting targets for PHPs' use of VBP in Contract Year 2, though PHPs and providers that are ready to enter VBP arrangements may begin VBP contracting from the outset of the managed care program.

By the end of Contract Year 2, DHHS envisions that the portion of each PHP's medical expenditures governed under VBP arrangements will increase by 20 percentage points or represent at least 50 percent of total medical expenditures.

- The baseline for the 20 percentage point increase will be set at the end of Contract Year 1, when first data on VBP payments is available
- PHPs and providers are encouraged to adopt the types of arrangements best suited to their needs, VBP readiness, and the populations they serve
- AMH contracts that include Performance Incentive Payments (e.g. some Tier 2 and nearly all Tier 3 contracts) count as VBP under State VBP targets in all years of managed care
- Early guidance noted that targets would increase over time, and would be linked to withholds starting in Year 3 of managed care

Defining and Measuring VBP Adoption

DHHS defines VBP using the Health Care Payment-Learning Action Network (HCP-LAN) Alternative Payment Models framework. Beginning in Contract Year 3, DHHS will limit the definition of VBP to only those arrangements that clearly link payment to quality or total cost of care.



In **Contract Years 1-2**, DHHS will define VBP as arrangements in **HCP-LAN Categories 2 and above**

Starting in **Contract Year 3**, DHHS will limit the definition of VBP to payment arrangements in **Categories 2C and above**

VBP Targets Going Forward

- DHHS will set **targets** for the percentage of PHPs' medical payments that should be made through VBP arrangements in each Contract Year.
- Annual VBP targets will also include **sub-targets** for the percentage of payments in shared savings and risk-bearing arrangements (Categories 3-4).
- **Targets will increase over time so that by the end of Year 5 of managed care (summer of 2024), nearly all PHP/provider contracts will be expected to have a VBP component**

Source: HCP-LAN Alternative Payment Model Framework Refresh, available at https://hcp-lan.org/apm-refresh-white-paper/

Example VBP Model Options

PHPs and providers will have flexibility to tailor VBP models to their specific populations and needs. While DHHS has identified several models PHPs may adopt to advance value based payments to providers, participation in these models is not required.

Statewide Models

PHPs and providers may participate in state-led VBP initiatives or leverage existing state delivery models when designing VBP arrangements.

- **AMH Tier 3**: AMHs are foundational to driving value in Medicaid, and Tier 3 contracts include Performance Incentive Payments that qualify as VBP
- ★ **Medicaid ACO Model**: A new State-led Medicaid ACO model will launch in Year 3. See subsequent slides for details
- **Adding VBP to Existing Delivery Models**: PHPs may add value-based components to contracts for other statewide initiatives such as the Pregnancy Management Program or Local Health Department CM programs

Other Possible Models

PHPs and providers may opt to develop other types of VBP arrangements tailored to key Medicaid populations or services.

- **Pay-for-Performance**: Pay-for-performance models may be most appropriate for lower-cost populations, such as pediatric, and for providers with less VBP experience
- **Bundled Payments:** Adding a quality link to the existing Medicaid maternity payment bundle NC would qualify as VBP, as would other bundled payment models
- **Population-Based Models**: Population-based, or capitated models that reimburse providers for TCOC for a defined population can give providers more flexibility to care for their patients

VBP in Managed Care: Discussion Questions

- *Does the proposed strategy successfully balance State policy goals?*
- *Are there other payment models that the State should highlight as possible VBP models under the NC Medicaid VBP framework?*

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ACO Model & Evolution of AMHs

The ACO model will align with and build on the care delivery requirements and population health infrastructure established under the AMH program, with AMH Tier 3 requirements serving as the minimum standard of care for ACOs.

Primary care providers participating in an ACO will be required to obtain AMH Tier 3 certification

ACO Payment Model

More advanced payment model linked to total cost of care and quality

AMH Tier 3

Medical Home Model with Care Management Responsibilities*

Practices are required to meet Carolina ACCESS requirements *and* take on care management and population health management responsibilities. Practices receive Medical Home Fees, as well as Care Management Fees and Performance Incentive Payments tied to quality performance.

AMH Tiers 1 & 2
Basic Medical Home Model*

Practices required to meet Carolina ACCESS requirements and in turn receive Medical Home Fees.

Underpinned by Vision for Medicaid Transformation:

Drive an innovative, whole-person centered, and well-coordinated system of care which addresses both medical and non-medical drivers of health

*The Department envisions that requirements for each AMH Tier will evolve over time

Applying Guiding VBP Principles to ACO Design

Goal: Design a model that would drive value in Medicaid while accommodating the NC provider landscape and advancing key State policy priorities and VBP goals.

Design Principles

- **Maintain fidelity to AMH model**–build on the care delivery requirements and population health infrastructure established under the AMH program
- **Provide flexibility to negotiate and innovate, while establishing guardrails to streamline negotiations—** allow PHPs and providers flexibility to develop payment arrangements best suited for the patients they serve within guardrails for payment set by the State
- **Alignment with broader market movement towards VBP in NC—**Recognize that many providers already participate in MSSP and other total cost of care models, and align with these models while accounting for key differences between the Medicare and Medicaid populations
- **Account for diversity of NC Medicaid providers—** acknowledge and accommodate the broad range of needs of Medicaid providers, while continuing to push improvements in cost and quality

In reviewing the model design, please consider whether the proposed model successfully balances these principles.

ACO Two Track Shared Savings/Shared Risk Payment Model

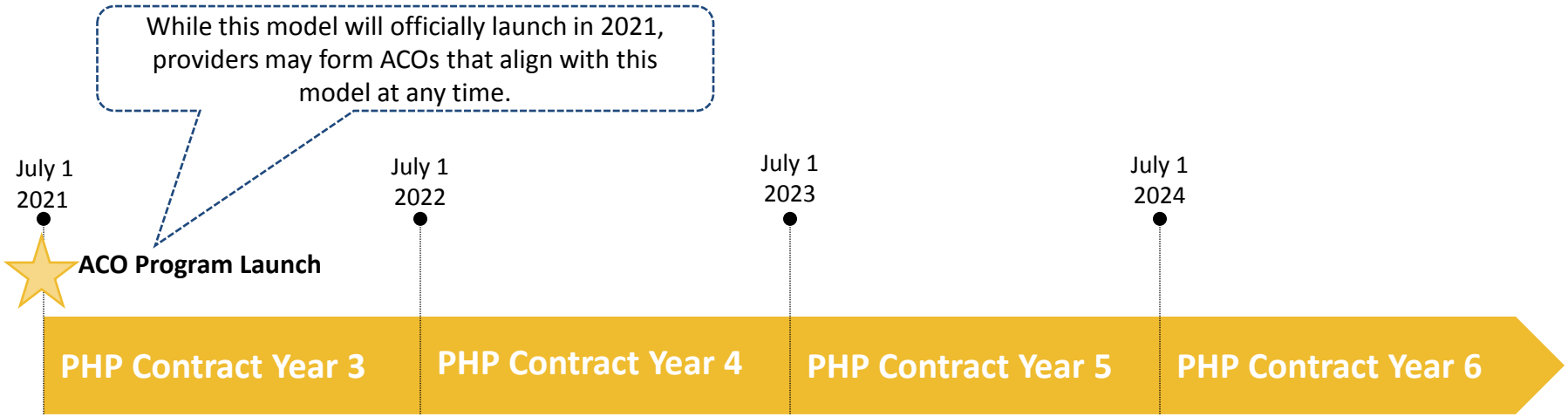
The proposed ACOs have a two track payment model that aims to recognize readiness for risk among different types of providers. In both tracks, payments will be linked to total cost of care and quality.

Track 1 *No/minimal risk*	Track 2 *Higher risk*
• Shared savings payment arrangements (upside only) or minimal risk at ACO option, with link to TCOC and quality • Lower opportunity for savings relative to Track 2 • Aimed at ACOs that primarily consist of non-hospital-affiliated providers/those that capture a smaller percentage of their attributed patients' TCOC within their network of member providers	• Shared savings and downside risk, with link to TCOC and quality (i.e., mandatory downside risk) • Higher opportunity to earn savings relative to Track 1 • Aimed at ACOs that primarily consist of hospital-affiliated providers/those that capture a greater percentage of their attributed patients' TCOC within their network of member providers

For both tracks, DHHS will approve ACO entities and outline required components of ACO contracts. PHPs will be responsible for negotiating contracts with ACOs.

ACO Program Timeline

DHHS anticipates this program will launch in Contract Year 3 and has outlined an ambitious, but achievable path towards increasing the level of risk ACOs take on, allowing Track 2 ACOs a two year glide path before they must take on downside risk.

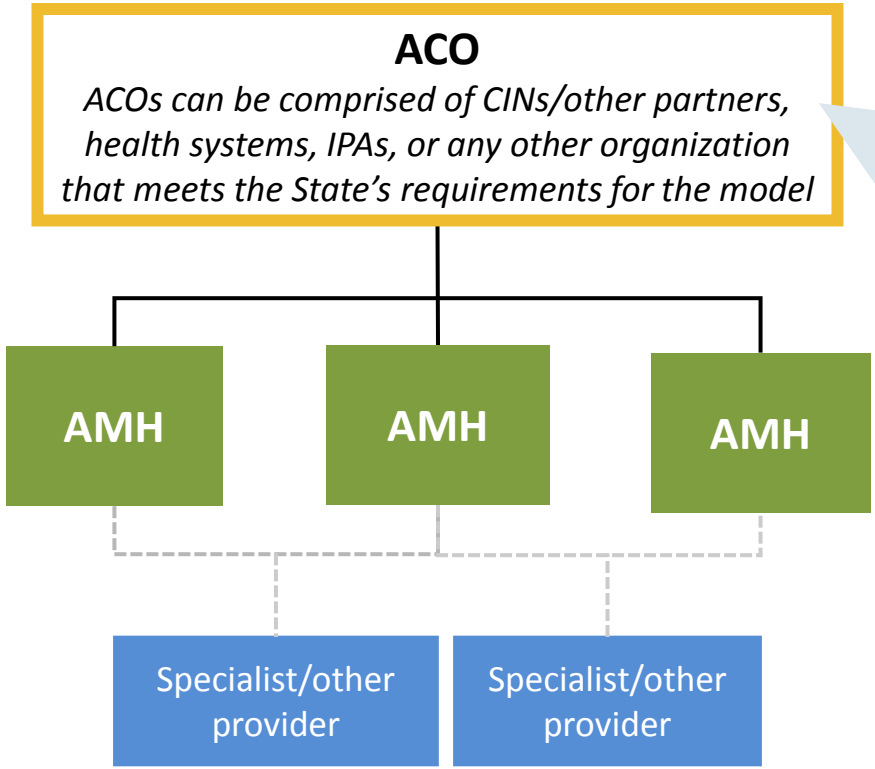


Track 1: Lower Risk
Track 1 arrangements would have minimal or no downside risk

Track 2: Higher Risk	
Track 2 ACOs would be allowed to operate low-risk arrangements similar to Track 1 for first two years	After initial glide path, Track 2 ACOs would be required to take on minimum levels of downside risk

ACO Composition

ACOs will be composed of integrated networks of AMH Tier 3 PCPs working closely with other types of providers. Patient attribution to ACOs will be based on AMH assignment.



- CINs/other partners are **one of many organization types** that can serve as an ACO
- CINs/other partners **may continue to serve Tier 3 AMHs** while operating an ACO
- As such, **the term "CIN and other partner" will retain its current meaning** in the AMH program

DHHS will also outline basic requirements for ACO structure, governance and management, population size and financial solvency (when risk bearing).

Meeting Unique Needs of NC Medicaid

To meet the specific needs of the NC Medicaid market, DHHS has incorporated the following features into the ACO model.

Model Features

- **Pediatric quality as a gateway for savings** – to ensure the model drives improvements in care for children, ACOs must meet certain performance thresholds on pediatric quality measures to be eligible to receive shared savings
  - DHHS is also considering other modifications to the ACO model to allow more pediatric ACOs to form
- **Chief Behavioral Health Officer—**to drive further integration of physical and behavioral health care, ACOs will be required to appoint both a chief medical officer and a chief behavioral health officer
- **Alignment with MSSP—**to reduce administrative burden on providers already participating in Medicare ACOs, PHPs and NC Medicaid ACO will be able to establish payment parameters that align with the payment parameters established in the 2018 MSSP final rule
- **Participation incentives—**to encourage providers with less experience in risk-based models to join and form ACOs, and encourage those with more experience to assume greater levels of risk early on, ACOs that join Track 1 at program launch and Track 2 ACOs that forgo the 2-year glide path will receive incentives such as:
  - Opportunity to weigh in on policy related to the ACO program via a State-led advisory
  - Technical assistance to help address key implementation issues
  - Invitation to participate in Department-led ACO learning collaboratives
  - Enhanced data, such as quality data aggregated at the ACO level

ACO Model: Discussion Questions

- *Does the proposed model successfully balance State policy goals while providing flexibility to the market and accommodating existing VBP arrangements?*
- *Does the proposed model appropriately address the unique needs of the NC Medicaid population?*
- *Does the proposed ACO model create sufficient incentives to improve pediatric care, or care for other populations that may not offer significant opportunity for shared savings?*
- *Are the proposed participation incentives strong enough to drive provider participation in the ACO program?*
    - *Are there other incentives that would encourage providers to form or join ACOs?*
- *What types of data would be most useful to ACOs?*

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Next Steps

1. **DHHS to publish white papers on VBP strategy and ACO model on Medicaid Transformation site:** https://www.ncdhhs.gov/assistance/medicaid-transformation/proposed-program-design/policy-papers
2. **AMH TAG Members to review papers and submit comments to Medicaid.Transformation@dhhs.nc.gov**
3. **DHHS to develop proposal of upcoming AMH TAG meetings**