North Carolina Department of Health and Human Services (DHHS)
Advanced Medical Home Technical Advisory Group (AMH TAG) In-Person Meeting #4
June 26, 2019

Meeting Attendees	Organization
TAG Members, North Carolina DHHS, and Manatt Project Team	
Sheryl Gravelle-Camelo, MD (*by phone*)	KidzCare in Macon County
David Rinehart, MD (*in-person*)	North Carolina Academy of Family Physicians
Gregory Adams, MD (*in-person*)	Community Care Physician Network (CCPN)
Zeev Neuwirth, MD (*by phone*)	Carolinas Physician Alliance (Atrium)
Calvin Tomkins, MD, MHA (*by phone*)	Mission Health Partners
Peter Freeman, MPH (*absent*)	Carolina Medical Home Network
Jan Hutchins, RN (*in-person*)	UNC Population Health Services
Joy Key, MBA (*in-person*)	Emtiro Health
Glenn Hamilton, MD (*absent*)	AmeriHealth Caritas North Carolina, Inc
Michael Ogden, MD (*in-person*)	Blue Cross and Blue Shield of North Carolina
Michelle Bucknor, MD (*by phone*)	UnitedHealthcare of North Carolina, Inc
William Lawrence, MD (*in-person*)	Carolina Complete Health, Inc
Thomas Newton, MD (*by phone*)	WellCare of North Carolina, Inc
Eugenie Komives, MD (*absent*)	MCAC Quality Committee Member
Aaron McKethan, PhD (*absent*)	Advisor to the State
Kelly Crosbie, MSW, LCSW (*in-person*)	DHHS
Nancy Henley, MPH, MD, FACP (*in-person*)	DHHS
Kelsi Knick, LCSW (*in-person*)	DHHS
Jaimica Wilkins, MBA, CPHQ (*absent*)	DHHS
Jonah Frohlich, MPH (*by phone*)	Manatt Health Strategies
Sharon Woda, MBA (*in-person*)	Manatt Health Strategies
Lammot du Pont, MIA (*by phone*)	Manatt Health Strategies
Dori Reyneri, MPP (by phone)	Manatt Health Strategies
Kathryn Blanford, MPP *(in-person)*	Manatt Health Strategies
Public Attendees	
Ryan Jury (*in-person*)	Advance Community Health
Donald Reuss, MS *(by phone)*	Vaya Health
Katherine Knox (*by phone*)	Atrium Health
Robert Rich, MD *(by phone)*	UnitedHealthcare of North Carolina, Inc
Steven Bentson, MD *(by phone)*	Blue Cross and Blue Shield of North Carolina
Robert Rich, MD (*by phone*)	UnitedHealthcare of North Carolina, Inc
Jason Foltz, MD *(by phone)*	Eastern Carolina University Physicians
Anthony Meachem *(by phone)*	Eastern Carolina University Physicians
Karen Michael, RN, MSN, MBA *(by phone)*	AmeriHealth Caritas
Elizabeth Hudgins, MPP *(in-person)*	North Carolina Pediatrics Society (NCPeds)

Agenda

- Recap: AMH TAG Meeting #3
- Overview: Tailored Plan Care Management Strategy
- Overview and Discussion: Value Based Payments in Managed Care
- Break
- Overview and Discussion: Medicaid Accountable Care Organization Design
- Public Comments
- Next Steps

Please refer to the June 26 AMH TAG Meeting #4 slide deck available here.

Recap AMH TAG Meeting #3 (slides 1 – 5)

Dr. Nancy Henley of North Carolina DHHS convened the meeting at 1:00 pm, welcomed meeting attendees, and asked attendees to introduce themselves to the group. Dr. Henley then turned the floor over to Sharon Woda of Manatt Health Strategies to review the topics discussed in the previous TAG meeting. Ms. Woda briefly recapped comments on reporting requirements from the previous AMH TAG meeting, and informed members that DHHS would develop a crosswalk of PHP- and practice-level reporting requirements to ensure these requirements do not overlap. Ms. Woda also summarized the topics discussed at the June 21 TAG Data Subcommittee meeting, with Mr. du Pont providing a more in depth summary via phone. Ms. Woda then asked Kelsi Knick of North Carolina DHHS to lead the discussion on BH I/DD Tailored Plan care management.

Overview: Tailored Plan Care Management Strategy (slides 6 – 10)

Ms. Knick began by directing the group's attention to the Behavioral Health (BH) Intellectual/Development Disability (I/DD) Tailored Plan (TP) care management paper, available here, which provides an overview of BH I/DD TP care management design. Ms. Knick reviewed the BH I/DD Tailored Plan eligibility requirements (**slide 8**) and noted the core principles for BH I/DD Tailored Plan care management align closely with the core principles of standard plan care management. Ms. Knick then reviewed three approaches to care management in BH I/DD Tailored Plans (**slide 10**):

- *"AMH+" certified primary care practice provides tailored care management*. Ms. Knick noted that AMH Tier 3 practices that are capable of delivering tailored care management services will be able to apply for "AMH+" certification through DHHS. TAG members inquired whether some of the "AMH+" functions could be contracted out to a clinically integrated network (CIN) or other partner. Ms. Knick informed members that DHHS will release an AMH+ Certification Manual that will provide guidance on oversight of and delegation to CINs and other partners.
- *Care Management Agencies (CMAs) provide tailored care management.* Ms. Knick informed members that DHHS will issue guidance on which types of organizations in the community will be eligible to become CMAs and how these organizations can become CMAs.
- *BH I/DD Tailored Plans provide tailored care management.* Ms. Knick noted that while DHHS hopes as many BH I/DD Tailored Plan members as possible receive local care management, North Carolina is still developing its local, tailored care management infrastructure, so some members may receive care management through their BH I/ DD tailored plan.

Ms. Knick then turned to Ms. Kelly Crosbie of DHHS to provide an overview of North Carolina Medicaid's approach to value based payments in Standard Plans.

Overview and Discussion: VBP in Managed Care (slides 13 – 17)

Ms. Crosbie described the guiding principles DHHS considered when developing its VBP strategy (**slide 13**). Ms. Crosbie highlighted DHHS' desire to set ambitious VBP goals, while factoring in current market readiness for taking on VBP arrangement, as well as DHHS' efforts to strike a balance between allowing flexibility for innovation and offering sufficient guidelines for developing VBP arrangements. Ms. Crosbie then turned to Ms. Woda to review VBP guidance for the first five years of managed care operations.

Ms. Woda briefly summarized VBP guidance for contract years 1-2 (**slide 14**), available here. Next, Ms. Woda informed TAG members of proposed VBP requirements for contract years 3-5 (**slide 15**), noting that, beginning in Contract Year 3, DHHS will limit its definition of VBP to those arrangements that include a link to quality performance or total cost of care. Ms. Woda also reviewed proposed VBP targets for contract years 3-5, highlighting that DHHS envisions having nearly all payments to providers in VBP arrangements by the end of contract year 5, with a portion of those payments in risk-bearing VBP arrangements.

- TAG members expressed concern about the timeline for implementing VBP contracts, and particularly risk-based arrangements, adding that PHPs will need time to collect and analyze data on spending patterns and quality performance before they can successfully identify areas of care in which they may be able to reduce costs or improve quality.

- Several TAG members thought that target levels for non-risk-based arrangements were achievable, as most existing Medicaid contracts already include pay-for-performance components.

- TAG members generally agreed that establishing a longer term vision for VBP that allowed for pay-for-performance to count as a VBP arrangement was the right direction for Medicaid.

Finally, Ms. Woda shared some example VBP models that PHPs and providers could use to meet VBP targets (**slide 16**).

- TAG members noted that risk-based models linked to the total cost of care for a population can be challenging for pediatricians, as the majority of children are relatively healthy, leaving little room for cost reductions in the pediatric population.

- TAG members also raised the potential administrative challenges of having different VBP contracts across multiple PHPs. Ms. Woda then turned to Ms. Reyneri to lead an overview and discussion of one proposed VBP model, the Medicaid ACO.

Overview and Discussion: ACO Model (slides 20 – 26)

Ms. Reyneri began the overview of the ACO model by describing how DHHS has incorporated its VBP principles into the model's design (**slide 21**). In particular, she noted that DHS has sought to connect the ACO model to the AMH model of care and align with other ACO models operating in the state, such as the Medicare Shared Savings Program (MSSP), while tailoring the model to the Medicaid population.

Next, Ms. Reyneri presented the basic structure of the ACO model and described the two participation tracks, noting that the lower risk track would be targeted to ACOs that are not affiliated with hospitals, and the higher risk track is targeted to ACOs that are affiliated with large hospital systems (**slide 22**).

- A few TAG members mentioned that even large hospital systems may not be ready to take on two-sided risk models, and that some have struggled with advanced VBP arrangements to date.

- Upon learning that payments in both tracks would include a link to total cost of care and quality, one TAG member suggested DHHS review literature on the merits of decoupling cost and quality. Ms. Reyneri advised that DHHS had not yet determined how it would link cost and quality, and would consider this literature as it refined the payment model.
- Ms. Reyneri noted that while DHHS would set forth some basic guardrails for ACOs' structure and payment models, PHPs would be responsible for negotiating ACO contracts. TAG members advised DHHS that providers in ACOs would need similar contracts with multiple PHPs to ensure a sufficient number of their patients were covered by the ACO model. However, TAG members also expressed concern that contracting with multiple PHPs could lead to significant administrative complexity, particularly in aggregating and analyzing data from multiple PHPs.
- Some TAG members suggested that DHHS could help reduce the administrative complexity for providers with multiple ACO contracts by aligning the quality measures used across payers.

Ms. Reyneri then shared the proposed timeline for the ACO program (**slide 23**).

- TAG members raised concerns about the proposed Contract Year 3 (July 2021) launch date for the ACO program, citing lags in claims data and lack of sightlines into total cost of care as potential barriers to provider and PHP readiness. Ms. Reyneri stated that the ACO model will be optional, and that providers who are interested in the model but are not ready to start in Year 3 may form ACOs at a later date.
- Ms. Reyneri also highlighted the ACO program's glide path for risk, which allows Track 1 ACOs to remain in shared savings-only contracts indefinitely, and allow Track 2 ACOs to operate under minimal-risk contracts before taking on greater levels of financial risk in later years of operation.

Ms. Reyneri briefly summarized potential composition of ACOs (**slide 24**), noting that Clinically Integrated Networks (CINs) could be well positioned to aggregate practices into ACOs, before highlighting several features of the ACO model designed to address the unique needs of NC Medicaid (**slide 25**). These features include:

- *Pediatric quality performance as a gateway for savings*. Several TAG members appreciated the inclusion of pediatric quality as a prerequisite for receiving shared savings payments, and added that this feature of the model gave pediatric providers an opportunity to contribute to the ACO. Many TAG members also shared concerns that primary care providers, particularly pediatricians, do not stand to gain from the ACO model as they represent a small percentage of total costs, and shared savings may not "trickle down" to the PCP/pediatrician level.
- *Participation incentives and practice supports.* TAG members stated that many of the proposed incentives would not be sufficient to encourage ACO participation. Members also requested that enhanced quality be made available to all providers, not just early adopters of the ACO model. Many members suggested DHHS consider removing prior authorization requirements or introduce other participation incentives that would reduce administrative burden. Members agreed that incentives that could streamline administrative processes would likely spur significant uptake of the ACO model, and could help offset some of the administrative costs of negotiating ACO contracts with multiple PHPs. Some TAG members suggested that DHHS also consider offering ACOs greater flexibility to manage Healthy Opportunities spending, as addressing social determinants of health could help reduce ACOs' total cost of care.

TAG members also discussed the long-term vision for the ACO model.

- One member asked whether Track 1 ACOs that do not perform well for multiple years would be permitted to stay in the Medicaid ACO program. Ms. Reyneri stated that DHHS would need to think further about whether such organizations would still be designated as Medicaid ACOs.
- Another member raised concerns that as ACOs lowered their baselines and improved their patients' health, they would have little room to achieve shared savings. This member asked what DHHS' long term vision was for providers that deliver high quality, efficient care and have little left to gain from the ACO model. Ms. Reyneri and Ms. Woda noted that DHHS would continue to build out its long-term vision for VBP in managed care and release updated guidance in the future.

Next Steps (slide 29)

Dr. Henley then opened the floor to public comment and no additional public comments were offered. Ms. Reyneri then provided a recap of the discussion. Ms. Woda then shared the following next steps:

- ***DHHS*:**
  - Finalize and publish the VBP Strategy and ACO white papers
  - Develop a proposal of upcoming AMH TAG meetings
- ***Members***
  - Review and submit comments on the VBP Strategy and ACO white papers when published

The meeting adjourned at 4:00 pm.