North Carolina Medicaid – Initial Value-Based Payment Guidance

On August 9, 2018, the North Carolina Department of Health and Human Services (DHHS) released a Request for Proposal (RFP)[1] soliciting applications for Prepaid Health Plans (PHPs) to serve NC Medicaid and NC Health Choice members via Medicaid Managed Care.

The RFP Scope of Services Addendum[2] details requirements for PHPs, including a number of requirements related to value-based payments (VBP). This guidance provides additional detail and context for those VBP requirements that will be of immediate interest in Year 1 of PHP operations.

DHHS is developing a longer-term VBP roadmap that will outline the approach to measuring and incentivizing the use of VBP arrangements in the coming years and note that expectations for provider and PHP VBP capabilities and adoption will increase over time.[3]

To date, there is not a single defined VBP model that PHPs must use when contracting with providers. As noted in the RFP, payment arrangements that fall within levels 2 through 4 of the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) framework all qualify as VBP. However, in the future, the VBP roadmap may narrow the definition of VBP to focus on a more specific menu of VBP contracting options and may define targets or other future-year incentives and requirements related to the use of VBP arrangements.

Future year targets and VBP requirements (including potential changes to the definition of VBP) will aim to accelerate the use of VBP in NC Medicaid well beyond the current baseline of the early target detailed in the RFP and in this guidance. These early requirements are meant to build a strong foundation for rapid VBP adoption. More advanced providers and systems should consider building the infrastructure for higher-risk arrangements prior to launch of managed care and in the early years of implementation.

PHP and stakeholder input on the broader VBP strategy will be critical, particularly with respect to how the Advanced Medical Home (AMH) initiative aligns with and will support VBP in North Carolina. As such, DHHS will engage the AMH Technical Advisory Group (TAG) on this topic when it convenes now that PHP contracts have been awarded.

The RFP outlines NC Medicaid's focus on increasingly tying provider payment to measures related to value, while also giving plans flexibility to contract differently with different provider types based on their capacity to take on risk, the services they offer and other differences. PHPs will play a critical role in driving forward DHHS' VBP goals as they establish their own PHP VBP strategies and work to meet the

[1] North Carolina Department of Health and Human Services (NCDHHS), "Request for Proposal #30-190029-DHB: Prepaid Health Plan Services," released August 9, 2018: https://files.nc.gov/ncdhhs/30-19029-DHB.pdf.

[2] NCDHHS, "Request for Proposal #30-190029-DHB: Section V. Scope of Services," released August 9, 2018: https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf.

[3] NCDHHS, "North Carolina's Proposed Program Design for Medicaid Managed Care," released August 2017: https://files.nc.gov/ncdhhs/MedicaidManagedCare_ProposedProgramDesign_FINAL_20170808.pdf.

Year 2 target outlined in the RFP. This guidance provides details on both this Year 2 Target and the PHP VBP strategies.

> *To advance the Department's vision for quality and to ensure that payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value, the Department is encouraging accelerated adoption of value-based payment (VBP) arrangements between PHPs and providers, and requiring that PHPs' Provider Incentive Programs be aligned with the Quality Strategy and related measures. Use of VBP and Provider Incentive Programs will align financial incentives and accountability around the total cost of care and overall health outcomes and ensure that PHPs and providers are recognized and rewarded for quality gains.*
>
> *RFP Scope of Services Addendum - Page 175*

VBP Target

> *The Department defines VBP arrangements as payment arrangements between PHPs and providers that fall within Levels 2 through 4 of the multi-payer Health Care Payment (HCP) Learning and Action Network (LAN) Alternative Payment Model (APM) framework, which can be found at http://hcp-lan.org/workproducts/apm-framework-onepager.pdf.*
>
> *The Department requires that by the end of Year 2 of PHP operations, the portion of each PHP's medical expenditures governed under VBP arrangements will either increase by twenty (20) percentage points, or represent at least fifty percent (50%) of total medical expenditures.*
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> *RFP Scope of Services Addendum - Page 175*

- ***How will NC measure VBP for purposes of the target at the end of Year 2?***

  VBP will be measured in accordance with the HCP-LAN APM framework, linked above. All payment arrangements that fall within levels 2 through 4 of the framework count as VBP for the purposes of this target. For details of how payments under the AMH program relate to the target, please see the AMH section below.

- ***Must PHPs meet the higher of these two target measures?***

  No. Plans must meet either of the following two targets by the end of Year 2:

  - Relative to baseline, increase of at least 20 percentage points in medical expenditures under VBP; or
  - At least 50 percent of total medical expenditures under VBP arrangements

- ***What is the baseline for the 20 percentage point increase option?***

  The baseline for the 20-percentage point increase option will be set in the VBP Assessment submitted 90 days after the end of Contract Year 1, as described in more detail in the section that follows. Please see Attachment A for the format of this assessment.

- ***How does NC define total medical expenditures? Are there any excluded costs, services, or provider types in the total medical expenditure denominator?***

  The denominator for the targets will be derived from the VBP Assessment (Tab 2 "VBP Payments and Covered Lives", Cell E23).

  Total medical expenditures should include all payments for medical services that flow from PHPs to providers, minus the following category of excluded payments:

- Additional utilization-based payments to certain providers, as described in the RFP Section D. Providers, Subsection 4. Provider Payments.

- ***What VBP expenditures are included in the numerator of the target?***

  The numerator for the targets will be derived from the VBP Assessment (Tab 2 "VBP Payments and Covered Lives", Cell E20).

  Generally, the numerator should include all payments that flow from PHPs to providers under a VBP payment arrangement, or, in the case of a total cost of care model, the total cost of care for the patient population assigned to the model.[4] The payment categories excluded from the denominator should also be excluded from the numerator (see previous question). For details of how payments under the AMH program relate to the target, please see the AMH section below.

  If multiple payment arrangements are in use for different populations for a single provider, the value of the payments made for populations under VBP arrangements only should be included in the numerator. See examples below. If a payment arrangement includes multiple VBP mechanisms at different HCP-LAN levels (e.g. includes pay-for-performance measures and shared savings), it should be categorized in the dominant HCP-LAN level (the level at which the majority of VBP payments are made).

  Note that Provider-Led Entities (PLEs) may not include the total PHP premium in the numerator. Like all PHPs, PLEs should document and include individual contracts between the plan entity and participating provider entities that qualify as VBP according to the Department's definition, even if the plan entity and provider entities are commonly owned.

  - *Example 1*: A PHP has contracted with a provider using a VBP arrangement which provides both fee-for-service (FFS) payments and a quality incentive payment for their patient population. Because this entire payment arrangement counts as VBP, both the FFS and incentive payments should be included in the numerator.
  - *Example 2*: A PHP has contracted with an integrated group of providers under a contract that holds the providers at risk relative to the total cost of care for an assigned group of patients. The numerator should include all PHP payments for the assigned group of patients.
  - *Example 3*: A PHP has contracted with a maternity care provider as part of the Pregnancy Management Program. All payments to maternity care providers participating in this program qualify as VBP by the State's definition and should be included in the numerator.
  - *Example 4*: A PHP has contracted with a hospital to pay for maternity care in a single bundled payment, and all other hospital services are reimbursed on a FFS basis. The value of the maternity bundled payment for the patient population receiving services under the bundle would count as VBP under the Department's definition and should be broken out and included in the numerator. The remaining FFS payments for other patient populations should not be included in the numerator.

- ***When will the Department assess compliance with the target and how?***

[4] PHPs should count the costs for enrollees attributed to a total cost of care model only once, under that model.

Compliance will be assessed with the target using the data submitted by PHPs in the year-end assessment for Year 2, which must be submitted to the Department 90 days after the end of Contract Year 2, as described in more detail in the section that follows.

- ***What is the penalty for PHPs that do not meet the Year 2 VBP target?***

  The Year 2 VBP Target is a contract requirement. Failure to meet this requirement can result in DHHS sanctions and the imposition of liquidated damages, as determined by DHHS. PHPs will be subject to financial withholds tied to VBP requirements in Year 3, per requirement j. on page 177 of the *RFP Scope of Services Addendum*. The Year 3 target and any other VBP requirements beginning in Year 3 will be communicated in the coming months.

- ***What happens if a PHP downgrades contracts to weaken VBP provisions after reporting?***

  DHHS will monitor PHP decisions to downgrade payment contracts as part of its overall monitoring of PHP activities, and may consider PHPs' pattern of downgrading in its ongoing compliance activities and in subsequent contracting decisions. The PHP VBP Strategy will also require annual reporting on provider contracts and will be used to monitor major changes in PHP-provider contracts.

VBP Assessment and PHP VBP Strategy

The PHP shall complete an APM assessment based on the categories developed by HCP-LAN within six (6) months of Contract Award. The Department will provide specifications on the assessment methodology upon Contract Award.

i. The Department shall use the APM assessment to demonstrate the "baseline" amount of payment arrangements with providers in HCP-LAN Levels 1 through 4 and compare documented progress to the PHP's final APM Strategy on an annual basis.

ii. The PHP shall report the results of their APM assessment within six (6) months of Contract Award.

To ensure the PHP's response aligns with the Department's strategy and goals, the PHP shall provide a description of the PHP's Value Based Purchasing/Alternative Strategy over the initial three (3) year period and its alignment to the Department's short- and long-term goals to shift from a fee-for-service system to VBP. The VBP/APM Strategy must be submitted within six (6) months Contract Award.

i. The PHP VBP/APM Strategy shall incorporate required incentive programs for AMHs. The PHP may develop additional Physician Incentive Plans provided that any such Physician Incentive Plans are related to the aims and goals set forth in the Department's Quality Strategy and in compliance with the requirements set forth in 42 C.F.R. § 422.208 and 422.210.

The Strategy shall also contain the following elements:

i. The results of the HCP-LAN APM assessment.

ii. The PHP's goals, strategies and interventions for moving providers through higher levels of the HCP-LAN framework.

iii. The PHP's strategy to align Medicaid Managed Care payment models with the PHP's other payor contracts.

iv. The PHP's annual targets for amount of funding in VBP/APM arrangements by year, including a description of the payment model(s), their HCP-LAN classification, and targets across different models and provider types.

v. The PHP's plan for measurement of outcomes and ROI related to VBP/APM by year.

vi. Specific program(s) that will be offered to AMH Tier 3 practices, which must align to HCP-LAN Categories 2 through 4 and meet any other criteria specified within AMH program requirements.

vii. Specific program(s) that will be offered to other AMH providers and/or specialties.

viii. The PHP's expected percent of total premium flowing to providers through shared savings and other incentive arrangements.

ix. A description of the PHP's IT capabilities…

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- ***How must PHPs report to the Department on their use of VBP and plans to advance VBP?***

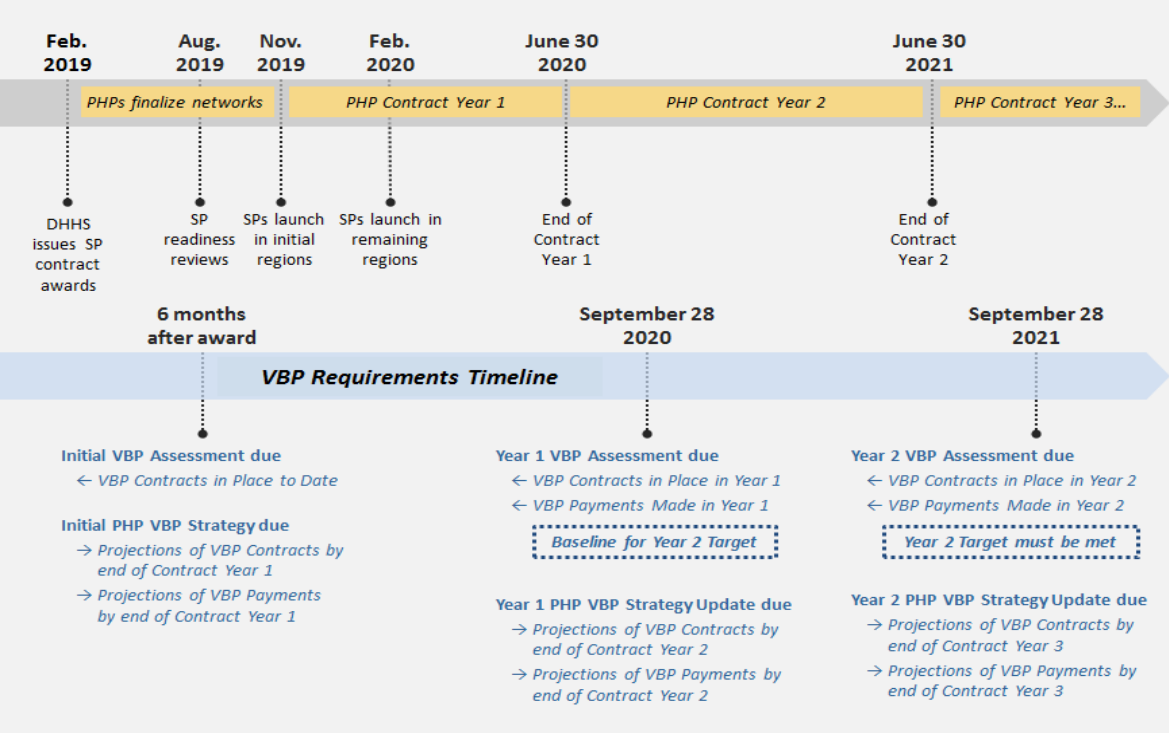
  The RFP outlines two ways in which PHPs are required to report to DHHS on their use of VBP arrangements and on their plans to advance the use of VBP in the future:

  - **VBP Assessment**: This is a retrospective reporting tool that PHPs must complete documenting VBP contracts in place and payments made under VBP arrangements during the relevant reporting period. The VBP Assessment tool that PHPs must complete is attached in Attachment A.

- **PHP VBP Strategy**: PHPs must also document their strategy to advance the use of VBP in the coming year and update the strategy annually. The VBP Strategy is a forward-looking document that will lay out the PHP's plans to advance the use of VBP contracting, in line with the state target set for each year. Templates for the projections to be included in the PHP VBP Strategy are in Attachment B. These templates mirror the format of the assessment tool but should be forward-looking.

- ***When must the VBP Assessment and PHP VBP Strategy be submitted?***
  - **Initial VBP Assessment and VBP Strategy Submission**: The first submission of both the retrospective assessment tool and the forward-looking VBP Strategy will be due six months after PHP contract award. PHPs should use the completed assessment as a starting point to develop their strategy for the coming year. PHPs do not need to complete Tab 2 of the assessment tool ("VBP Payments and Covered Lives") in this initial assessment, which focuses on payments made under VBP arrangements, as no payments will have been made at this point.
  - **Annual Updates to VBP Assessment and VBP Strategy**: Annual updates of the assessment and strategy will be due 90 days after the end of each contract year, covering VBP contracts and payments during the contract year in question. For PHP Contract Year 1 ending June 30, 2020, the annual VBP Assessment and VBP Strategy update will be due by September 28, 2020.

VBP Requirements Timeline



Note: "SP" denotes PHP standard plans.

- ***What should PHPs consider as they develop plans to move providers through higher levels of the HCP-LAN framework, per requirement ii?***
  PHPs should match the appropriate VBP model to individual provider readiness and establish a structure to help guide and prepare providers as they move through higher levels of the HCP-LAN framework.

  Expectations for provider and PHP VBP capabilities will increase over time. More advanced systems should be preparing to take on downside-risk prior to launch of managed care and should consider taking the opportunity to build the infrastructure for higher-risk arrangements in the early years of implementation.

  The AMH program represents one opportunity for providers to fund population health investments that will be critical in a risk-bearing VBP environment. While DHHS encourages PHPs to increase the amount of risk in VBP contracts where appropriate, PHPs should also consider provider capacity when developing VBP contracts. For some providers, such as small or rural providers, VBP arrangements in Level 2 of the HCP-LAN framework may be most suitable.

- ***How will PHP targets, per requirement iv, correspond with DHHS VBP targets?***

  As noted above, the VBP Strategy should indicate the PHP's plan for achieving the Year 2 target, and in subsequent years, for achieving any future targets and requirements set by the Department, using the templates provided in Attachment B.

  Provider types should be categorized based on the entity that holds the *primary* contract with the PHP in that payment arrangement, and all contracts should be included. Multiple providers may be covered under a single contract.

  In the VBP Strategy, PHPs must provide a narrative description of the type of providers and services included in the contract (e.g., primary care, hospitals, maternity providers, behavioral health, etc.); estimated population covered by arrangements, if available; and estimated dollar value of arrangements, if available.

- ***What are some examples of ROI measures PHPs can include in the plan, per requirement v?***

  Return on investment (ROI) measures should primarily focus on quality improvement, though financial metrics are also appropriate. Some examples of measurements of the ROI from VBP may include improvement in the results on quality measures from DHHS's quality strategy, or the amount of shared savings relative to the total cost of care included in VBP contracts. However, savings that compromise care will not be rewarded and DHHS will monitor PHPs to ensure care is not being compromised for savings.

- ***Does the percent of total premium flowing to providers, per requirement viii in the RFP, differ from the measures of total medical expenditures defined in this guidance and in the assessment?***

  No. While the RFP uses the term "total premium flowing to providers," this is defined as total medical expenditures, per the definition above. PHPs should include their projections for the percentage of payments that will be made under VBP arrangements as defined in the tables in Attachment B and as described in this guidance.

Care Management, Advanced Medical Home Model and VBP

- **Will AMH payments count as VBP for the purposes of the VBP assessment and the Year 2 Target?**

  DHHS is laying out a framework for payments under Tiers 1 – 3 of the AMH, which PHPs are required to follow.

  Payment to practices in AMH Tier 3 is by definition "VBP" since all Tier 3 practices will have the opportunity to earn Performance Incentive Payments,[5] as well as receive upfront Medical Home Fees and Care Management Fees on a per member per month (PMPM) basis. Therefore, following the approach set out above, DHHS will count within the numerator, as VBP, all payments[6] that flow from PHPs to those AMHs contracted at a Tier 3 level.[7]

  By contrast, payment to practices in AMH Tiers 1 and 2 will vary in Year 1 in the degree to which it is "value-based," since the inclusion of Performance Incentive Payments and Care Management Fees above the standard Medical Home Fee level is optional for PHPs in Tiers 1 and 2. Therefore, Tiers 1 and 2 AMH contracts will be counted as "VBP" only if they include a performance-based incentive program. For those contracts that do, DHHS will count all payments that flow from PHPs to those providers within the VBP numerator.

  For additional information on AMH payments, refer to the AMH FAQ.

- **What are the requirements around AMH Performance Incentive Payments?**

  PHPs are required to offer Performance Incentive Payment arrangements with all contracted Tier 3 AMHs. While not required, Performance Incentive Payments are also encouraged for Tier 1 and Tier 2 AMHs.

  DHHS will provide PHPs and AMHs broad flexibility to design and implement different Performance Incentive Payment arrangements, subject to the following guidelines:

  Performance Incentive Payment arrangements must be based on HCP-LAN Levels 2 through 4.

  - HCP-LAN Category 1 arrangements, or FFS with no link to quality or value, would NOT count as Performance Incentive Payments for the purposes of the AMH program.
  - PHPs must offer Tier 3 AMHs the opportunity to participate in arrangements that fall within HCP-LAN Levels 2A-C or 3A (i.e., arrangements with upside risk only).

[5] PHPs will be asked to exclude from their reporting of the numerator any Tier 3 practices that declined the performance-based incentive payment, but it is expected that this scenario will be rare.

[6] Except for the excepted categories above

[7] From time to time, PHPs may contract with certified Tier 3 practices at a Tier 2 level. This outcome may occur when 1) the PHP and AMH practice are unable to reach an agreement on Care Management Fee or Performance Incentive Payment amounts; or 2) The PHP determines through an audit that the state-certified AMH lacks the required capabilities for Tier 3. For the purposes of the VBP calculation such contracts will be treated as Tier 2 contracts, i.e. they will be counted as "value based" only to the extent that they include performance based incentives.

- PHPs may NOT require that any AMH take on downside risk (HCP-LAN Levels 3B and 4A-C) but are permitted to establish such arrangements by mutual agreement with the AMH.
- Performance Incentive Payments MUST be tied to the AMH quality measure set, which will be finalized prior to PHP awards (i.e., PHPs may NOT base Performance Incentive Payments on measures that are not included the AMH quality measure set).

- **What is AMH Tier 4?**

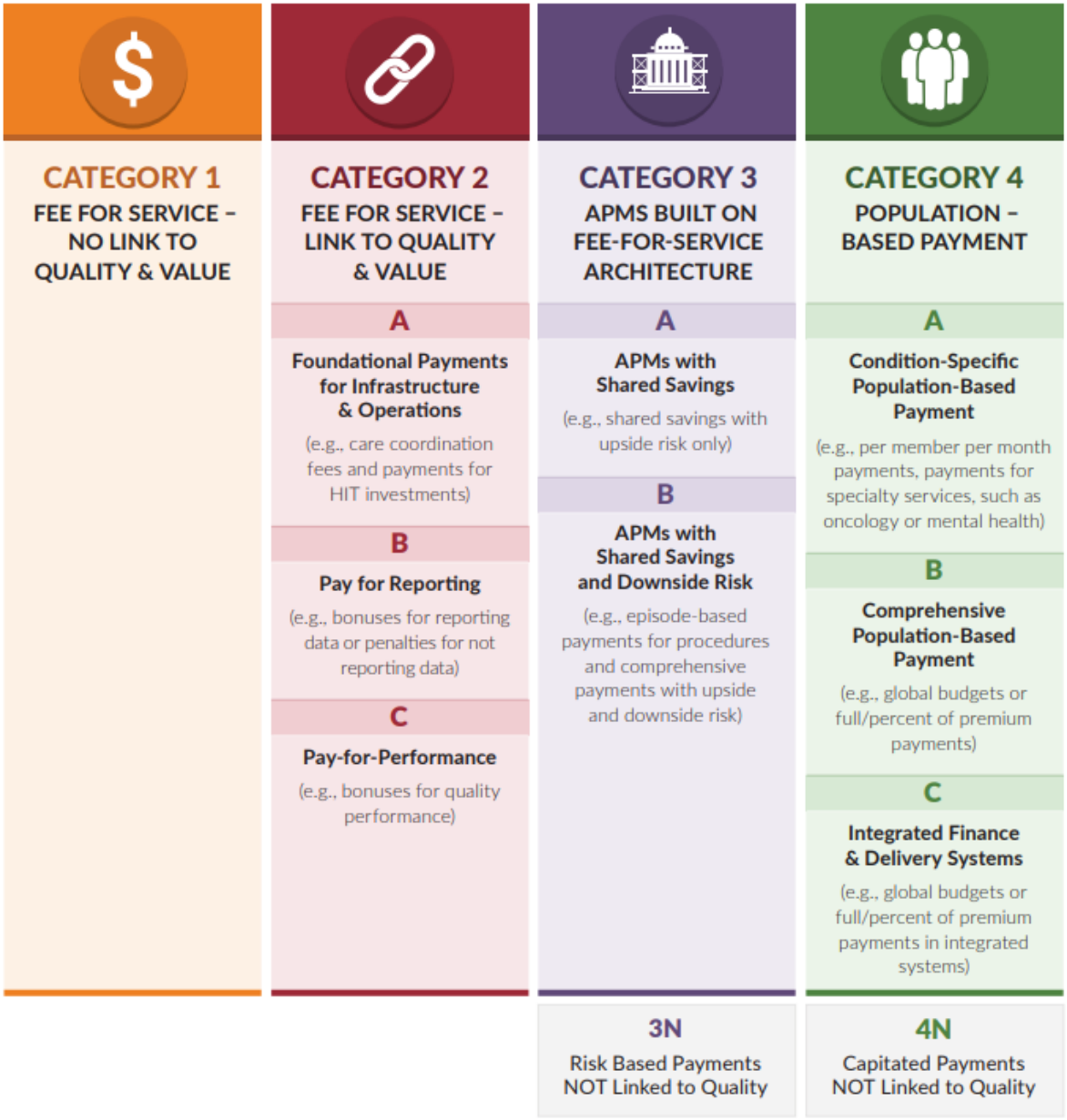
  Similar to AMH Tier 3, Tier 4 will continue to facilitate PHPs passing care management responsibilities down to the practice level but will be designed to capture more advanced payment arrangements between PHPs and AMHs.

  This option will launch in Year 3 of managed care, allowing DHHS time to gauge market reactions to AMH Tiers 1-3 and finalize key programmatic and payment details. While Tier 4 has not formally launched, nothing prohibits AMH Tier 3 providers that are capable of taking on advanced payment and risk-sharing models from engaging in those models with a PHP at their own discretion in the earlier years of managed care.

- **Will payments to Local Health Departments for care management for at-risk children and high-risk pregnancies count as VBP for the purposes of the VBP assessment and the Year 2 Target?**

  Similar to the treatment of AMH payments as VBP, payments to Local Health Departments for care management under these programs will only count in the numerator as VBP to the extent that the PHP's contract with the Local Health Department includes Performance Incentive Payments.

Appendix: HCP-LAN APM Framework



Please see the HCP-LAN APM Framework, which provides more details on the framework and its levels or visit the HCP-LAN website for more information on the HCP-LAN and the development of its framework.

Attachments

- **Attachment A: NC PHP VBP Baseline Assessment Tool**
- **Attachment B: Tables to be Included in the PHP VBP Strategy**