

Medicaid Managed Care Policy Paper

North Carolina's Medicaid
Accountable Care
Organizations (ACOs) for
Standard Plans and Providers:
Building on the Advanced
Medical Home Program to
Drive Value-Based Payment

North Carolina Department of
Health and Human Services

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Executive Summary

Background: North Carolina will transition its Medicaid and NC Health Choice programs from a predominantly fee-for-service delivery system to Medicaid managed care. As part of the transition to managed care, the North Carolina Department of Health and Human Services (the Department) seeks to create financial incentives for improving health outcomes and reducing the total cost of care by accelerating the adoption of value-based payment (VBP) models. Prepaid Health Plans (PHPs) and providers are encouraged to develop and enter into VBP arrangements tailored to their specific populations and needs. As part of its larger strategy to promote VBP in Medicaid, the Department has designed an optional Medicaid Accountable Care Organization (ACO) program that can be used to streamline negotiations between PHPs offering Standard Plans and providers and align with State priorities. This State-defined ACO program will launch as soon as mid-2021.

Vision: The ACO program seeks to drive value in Medicaid by promoting accountability for health outcomes and total cost of care. To minimize market disruption, the Department aims to align Medicaid ACOs with other total cost of care arrangements in North Carolina, while accounting for the unique characteristics of the Medicaid population. The Department also seeks to provide PHPs and providers with flexibility to negotiate ACO payment arrangements, while offering sufficient parameters to streamline ACO contracting.

Overview: The Department envisions that Standard Plan Medicaid ACOs will be composed of tightly integrated networks of Advanced Medical Homes (AMHs), specialists, and other non-AMH providers. The Department will establish criteria for ACOs' structure, governance, financial solvency and minimum number of attributed members, and will administer an ACO certification process. PHPs will then be responsible for contracting with ACOs that meet the State's criteria and overseeing their compliance with program requirements.

The proposed ACO program includes two payment tracks, which establish different expectations for ACOs that include larger hospitals and ACOs that do not. To determine track eligibility, the Department will use a measure of the ACO's control over the total cost of care for its attributed members. This calculation is described more under the heading *Track Eligibility* in this paper.

- **Track 1** will be open only to ACOs with less control over total cost of care. These ACOs will primarily consist of physician-led organizations, independent and rural providers and hospitals, and Federally Qualified Health Centers (FQHCs). Track 1 ACOs will have an opportunity to earn shared savings payments linked to health outcomes and total cost of care. These ACOs will initially only take on upside "risk" (i.e., shared savings) but over time will be expected to take on downside risk.
- **Track 2** is designed for ACOs with greater control over total cost of care but is open to any ACOs that are ready and willing to take on downside risk. As such, this track may primarily consist of large hospital-affiliated ACOs but is open to non-hospital-affiliated ACOs as well. Relative to Track 1, Track 2 ACOs will have a greater opportunity to earn shared savings based on health outcomes and total cost of care. However, after an initial two-year glide path, Track 2 ACOs will be required to take on minimum levels of downside risk more quickly than Track 1 ACOs.

This policy paper provides detail on the proposed Standard Plan ACO program, including ACO organizational requirements, payment parameters, total cost of care calculation, and participation incentives for early adopters. The Department welcomes feedback on the proposed program and will refine the final ACO design based on stakeholder feedback. We encourage stakeholders to provide any feedback by emailing Medicaid.Transformation@dhhs.nc.gov by **February 19, 2020**.

I. Introduction and Background

A key goal of North Carolina’s transition to Medicaid Managed Care is ensuring that the State moves toward “purchasing health” and away from purchasing discrete healthcare services. A major way that the North Carolina Department of Health and Human Services (the Department) will pursue this goal is by encouraging the accelerated adoption of value-based payment (VBP) arrangements between Prepaid Health Plans (PHPs) and providers. VBP arrangements align financial incentives to pay for improved quality of care and health outcomes, rather than the quantity of care provided. They also offer greater flexibility for providers to focus on improving their patient’s health, rather than on providing specific services paid for under fee-for-service arrangements.

This policy paper relates only to PHPs offering Standard Plans (referred to throughout this paper as “PHPs”). The Department allows PHPs and providers flexibility to develop and enter into value-based arrangements tailored to their specific populations and needs. While PHPs and providers may select the specific arrangements they use to advance VBP, the Department offers several state-led initiatives that PHPs and providers can use to streamline contracting efforts and align with State priorities, including the Advanced Medical Home (AMH) Tier 3 program and the ACO program described in this paper. Additionally, the Department continues to encourage PHPs and providers to use other advanced payment models. For more information on the Department’s overall approach to accelerating the adoption of VBP for Standard Plan members, refer to the companion [North Carolina’s Value-Based Payment Strategy for Standard Plans and Providers in Medicaid Managed Care](#). The Department’s value-based payment strategy for Tailored Plans will be released in forthcoming policy papers.

A Note on Naming Conventions

The Department has previously referenced “AMH Tier 4” as the vehicle for more advanced payment models under managed care. **The “ACO Program” described in this paper replaces the “AMH Tier 4” concept** and is used throughout this paper in order to clearly differentiate between the new Standard Plan ACO program and the existing AMH program structures.

Beginning in 2021 the Department will establish the Medicaid ACO program as a key element of its overarching value strategy. ACOs will build on the existing AMH program infrastructure to further align incentives to achieve improved health and accountability for total cost of care, while offering greater flexibility for ACOs willing to take on downside risk. This program, while remaining rooted in primary care and tailored to the Medicaid population, would encourage providers to build on their experience with Medicare and commercial accountable care organizations (ACOs) and go further to drive whole-person health in the Medicaid context.

The purpose of this paper is to solicit feedback from stakeholders on North Carolina’s Medicaid ACO program, which the Department will use to inform the next phase of program design and, ultimately, implementation. We encourage stakeholders to provide any feedback by emailing Medicaid.Transformation@dhhs.nc.gov by **February 19, 2020**.

II. Design Principles

The Department sought to design an optional care delivery and payment arrangement that would drive value in Medicaid in line with the State’s overarching VBP Strategy and the North Carolina provider landscape. The Department also considered the following design principles when developing the ACO program:

- **Ensure NC Medicaid “purchases health”** – NC Medicaid is committed to “purchasing health” for its members, meaning that it aims to align financial incentives to better achieve whole-person health and wellbeing. This includes paying for improved health outcomes rather than for discrete services; paying for all elements that contribute to a person’s health including medical (e.g. immunizations) and non-medical (e.g. food or housing) services; and paying to keep people healthy rather than primarily treating them when they are sick. A key care delivery model that helps to achieve this goal is an ACO. ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to their patients.¹
- **Build upon the AMH program, while providing flexibility to providers accepting early downside risk.** In order to continue the State’s focus on whole-person health, with strong primary care at the center of these efforts, ACOs should build on the care delivery and population health infrastructure established under the AMH program.² The Department recognizes that strong primary care is essential to the success of North Carolina’s health care system and seeks to strengthen the role of AMHs in driving whole-person health and total cost of care.
- **Provide the opportunity for PHPs and providers to negotiate and innovate, while establishing parameters to streamline contract negotiations and reduce administrative burden.** The Department aims to provide PHPs and providers with sufficient flexibility to develop payment arrangements that make the most sense for them and their patients. It also seeks to ensure that both PHPs and providers are able to agree to contract terms and that prolonged negotiations do not delay implementation. This proposal attempts to balance these considerations by outlining parameters for ACO contracting while not dictating specific terms. These parameters will also promote consistency in health outcome measurement and other elements of ACO contracting to reduce burden for providers who may contract with multiple PHPs. PHPs and providers remain free to enter different types of VBP or ACO arrangements by mutual agreement and are not constrained to using only this ACO framework.
- **Align with broader market movement towards ACOs in North Carolina, while accounting for the unique needs of the Medicaid population.** There are currently 26 Medicare Shared Savings Program (MSSP) ACOs serving North Carolina, and at least one North Carolina commercial payer is pursuing ACO arrangements. North Carolina’s Medicaid ACO program aims to allow existing ACOs to translate their payment approaches and infrastructure into the Medicaid context, minimizing provider burden and increasing program uptake.³ At the same time, Medicaid populations are different from Medicare and commercial populations, and the Medicaid ACO program includes several unique features to focus on pediatric populations, individuals with unmet resource needs, and individuals with behavioral health needs.
- **Take into account the diversity of North Carolina Medicaid providers.** The Department seeks to ensure that the ACO program acknowledges the diverse needs of Medicaid providers across North Carolina while continuing to pursue the Department’s overarching goals of accountability for cost and health outcomes. The program sets different expectations for provider-led

¹ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index>

² <https://medicaid.ncdhhs.gov/advanced-medical-home>

³ The ACO program aligns most closely with the new MSSP BASIC and ENHANCED tracks, which were established in the 2018 MSSP final rule and took effect in 2019. For more information, see : <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/Performance-Year-2019-Medicare-Shared-Savings-Prog/rg8k-5kp9>

organizations, independent and rural providers and hospitals, and FQHCs than for large hospital-affiliated providers and recognizes the need for additional support and training for smaller providers and early adopters.

III. ACO Program Overview

The proposed ACO program would build on a foundation established by the AMH program and give AMH practices the option to come together with specialists and other providers to earn shared savings for taking accountability for their Medicaid members' health outcomes and total cost of care. Additionally, under the ACO program, the Department will establish a set of defined structural and payment parameters and PHPs would be required to contract with all ACOs that meet these parameters.

The Department proposes establishing different expectations for large hospital-led ACOs, which would be expected to take on downside risk more quickly, and ACOs led by provider-led organizations, FQHCs, or smaller or rural hospitals, which would be permitted to participate initially through a shared-savings model and have a longer glide path to downside risk. As such, there are two payment tracks within the ACO program for these different provider types (see *Table 1* below).

Track 1 provides an initial upside-only option for provider-led organizations, FQHCs, or ACOs led by smaller or rural hospitals, giving them an opportunity to gain experience and build the capacity necessary to enter more advanced VBP arrangements. The Department seeks comment on the appropriate length of time to allow Track 1 ACOs to only take upside risk, before requiring the assumption of downside risk.

Track 2 is a two-sided risk model, which offers larger hospital-affiliated ACOs and any other providers with more VBP experience an opportunity to earn a greater share of savings compared to Track 1 in exchange for taking on downside risk. While the Department will determine which ACOs are eligible to participate in Track 1, Track 1-eligible ACOs that are ready and able to participate in higher-risk arrangements will be permitted to enter Track 2. To determine track eligibility, the Department will use a measure of the ACO's control over the total cost of care for its attributed members. This calculation is described more under the heading *Track Eligibility* below.

Unique NC Medicaid ACO Program Features

To meet the specific needs of the NC Medicaid population, the Department has incorporated several unique features into the ACO program, including:

Participation incentives for new ACOs choosing to accept shared savings early and for advanced ACOs choosing to take on downside risk early

Use of **pediatric performance indicators as a gateway for savings** to drive improvements in care for children

Behavioral health leadership requirements to drive further integration of physical and behavioral health care

ACO Healthy Opportunities Strategic Plan to ensure ACOs are focused on meeting health-related resource needs for their attributed members

Requirement that **PHPs must contract with all ACOs that meet the State-defined Medicaid ACO program parameters**

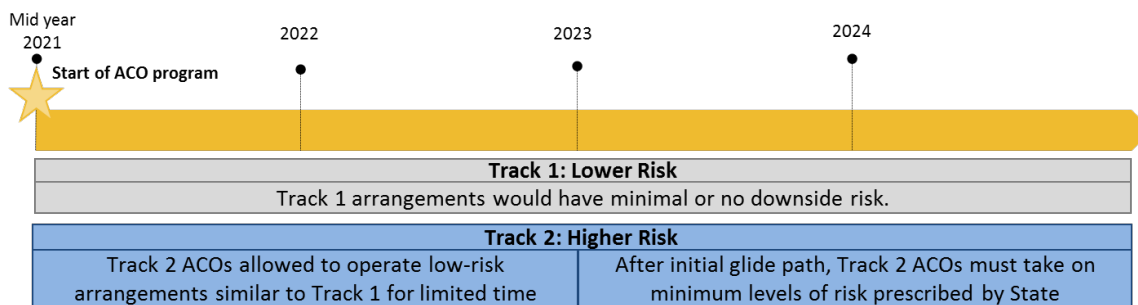
Table 1: Overview - ACO Payment Model

Track 1 <i>No/minimal risk</i>	Track 2 <i>Higher risk</i>
<ul style="list-style-type: none"> Upside-only shared savings or lower-risk payment arrangements for an initial period of time, with link to improvement in health outcomes and reduction in total cost of care Lower opportunity for savings relative to Track 2 Open only to ACOs that capture a smaller percentage of their attributed patients' total cost of care within their network of participating providers/ACOs that primarily consist of provider-led organizations, FQHCs, or independent or rural hospitals 	<ul style="list-style-type: none"> Payment arrangements with link to improvement in health outcomes and reduction in total cost of care and mandatory downside risk Higher opportunity to earn savings relative to Track 1 Open to any ACO, but likely to be most attractive to ACOs that capture a greater percentage of their attributed patients' total cost of care within their network of participating providers/ACOs that primarily consist of large hospital-affiliated providers

The ACO program would be overseen by the Department but would rely on PHPs, AMH practices, and other providers to execute on the State’s vision. The State would establish a range of criteria for ACOs related to their legal entity status, governance and management, financial solvency, and minimum number of attributed members and would monitor ACO activity in the market by administering an ACO certification process. PHPs would be responsible for encouraging and facilitating participation by providers who are ready to form an ACO, contracting with designated ACOs, and as appropriate, providing data and other support to ACOs. PHPs are also primarily responsible for ensuring ACO compliance with program requirements during initial contracting and on an ongoing basis.

The Department envisions that the ACO program could launch as soon as mid-2021. To encourage early adoption, Track 1 ACOs that join in the first program year would be able to participate in an “Early Innovators” program, which would offer them an opportunity to weigh in on State policy decisions, participate in learning opportunities, access additional data to inform population health management, receive technical assistance and practice supports, and potentially other benefits. Track 2 ACOs would also be encouraged to join the ACO program early to take advantage of a time-limited “glide path” with more favorable payment terms (similar to Track 1) that will only be available for the first two years of the program. Track 2 ACOs could also join the “Early Innovators” program by voluntarily bypassing this “glide path” and taking on full, Track 2 downside risk early. See *Figure 1* for an overview of the proposed timeline.

Figure 1: ACO Program - Proposed Timeline



IV. Provider Eligibility, Attribution, and ACO Organizational Requirements

The Department envisions that ACOs will be tightly integrated networks of AMH-certified primary care providers (PCPs) working closely together and with other types of providers. While the AMH primary care delivery model will be foundational to the ACO program, the Department also encourages ACOs to use the potential for shared savings to further innovate and incorporate a range of specialists who, in collaboration with PCPs, can help deliver coordinated, whole-person care for the ACO’s attributed members. The State also proposes to place minimum organizational requirements on ACO entities to ensure that they are able to carry out critical ACO functions but will allow any organization that meets these requirements to form an ACO (e.g. clinically integrated networks, existing MSSP ACOs, independent practice associations, or other entity types).

Primary Care Provider Eligibility and the ACO Care Delivery Model

The Department intends for strong primary care to be the foundation of ACOs. As such, it proposes that all primary care providers (PCPs) participating in ACOs that take on upside-risk only (i.e. shared savings), be required to achieve AMH Tier 3 certification through the existing AMH attestation process. Under AMH Tier 3, practices assume increased responsibility from PHPs for care management and population health management, delivered either directly or through a clinically integrated network (CIN) or other partner. Note that many types of providers may be Tier 3 AMHs and participate in ACOs, including behavioral health providers delivering integrated primary care services, OB/GYNs, Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs). The Department also encourages local health departments (LHDs), school-based health centers, specialists, and other, non-primary care providers to be included in ACOs to help improve the health and manage the total costs of their attributed Medicaid population. While the Department encourages these types of providers to join ACOs, it does not propose mandating or regulating what entities are included in ACO partnerships *at this time*. The Department recognizes the importance of FQHCs, school-based health

Role of Clinically Integrated Networks (CINs) and Other Partners

CINs and other partners play an integral role in supporting practices participating in the AMH program by offering capabilities such as data aggregation and analysis, care coordination, and local care management. The Department expects that many of these organizations will be well-positioned to form ACOs under the Medicaid ACO program and is supportive of this structure as part of the evolution of the AMH program. However, CINs/other partners would not be required to form ACOs and may continue to serve Tier 3 AMHs outside of the ACO program. Additionally, those that form ACOs may separately provide services to Tier 3 AMHs that have elected not to participate in an ACO.

centers, LHDs, rural health providers, and other partners to the Medicaid population and seeks feedback on how best to integrate these partners into ACOs and to encourage their participation in the ACO program.

The Department also recognizes that ACOs that take on downside risk should be granted certain flexibilities. The Department envisions that AMH providers participating in ACOs that are accepting early downside risk (e.g. through the “Early Innovators” program) would still perform local care management on behalf of PHPs and receive AMH Tier 3 care management payments to do so, but would be granted flexibility on AMH Tier 3 requirements.

The Department seeks feedback on this approach and on other flexibilities it may grant ACOs taking on early downside risk, for example bypassing certain administrative requirements, such as prior authorization.

Attribution

The Department proposes to attribute Medicaid members to ACOs based on PCP assignment under managed care. Once Medicaid Managed Care launches, members will have the opportunity to choose a PCP or will be assigned one by their PHP based on an algorithm defined by the Department;⁴ this selection or assignment will inform which members are ultimately attributed to ACOs. Members assigned to an AMH participating in an ACO will have their spending counted exclusively toward that ACO’s total cost of care. Members assigned to any PCP not participating in an ACO would not have any of their Medicaid spending attributed to any ACO.

ACO Organizational Requirements

Under the proposed program, any entity that meets certain State requirements designed to ensure ACO success would be permitted to form an ACO. The Department seeks to allow a broad range of healthcare providers and entities to form and participate in ACOs, including hospitals, health systems, clinically integrated networks and other partners, and other provider-led groups. The State proposes to establish a set of minimum requirements for ACO entities relating to their legal entity status, governance and leadership structures, and financial solvency (as applicable). The requirements are described in *Table 2* below and draw heavily on the entity requirements from the 2018 MSSP final rule.⁵

The Department also proposes to establish a minimum number of attributed NC Medicaid members for each track to ensure a normal distribution of savings and losses. It proposes that Track 2 ACOs must have at least 5,000 attributed members, which aligns with MSSP and other Medicaid ACO models that incorporate downside risk (though this number may need to be refined to account for differences in the NC Medicaid population). For Track 1, the Department is considering establishing a lower minimum threshold (e.g., 1,000 to 2,000 attributed beneficiaries). The Department seeks to spur participation by independent practices in the program and recognizes that it may be difficult for some to reach the 5,000 member threshold. However, it recognizes that small populations are more susceptible to significant variation in health costs. It seeks comment from stakeholders on the appropriate thresholds for both Track 1 and Track 2.

⁴ The methodology PHPs must use to assign Medicaid members to an AMH/PCP is outlined in the PHP contract with the Department in *Section V.C.6.c.iii AMH/PCP Choice and Assignment*, and includes consideration of prior AMH/PCP assignment, member claims history, family member’s AMH/PCP assignment, family member’s claims history, geographic proximity, special medical needs, and language/cultural preference.

⁵ <https://www.federalregister.gov/documents/2018/12/31/2018-27981/medicare-program-medicare-shared-savings-program-accountable-care-organizations-pathways-to-success>

Table 2: ACO Organizational Requirements

Category	Requirements ⁶
Legal Entity	<ul style="list-style-type: none"> • An ACO must be a legal entity authorized to conduct business in North Carolina for the purposes of receiving/distributing shared savings, repaying shared losses, and fulfilling other ACO functions • An ACO formed by a single participant may use its existing legal entity and governing body, provided it satisfies other program requirements • An ACO formed by two or more participants may establish a new legal entity with its own governing body or a distinct governing body within an existing entity.
Governance	<ul style="list-style-type: none"> • An ACO must maintain an identifiable governing body to execute the functions of an ACO • The governing body must be the same as the governing body of the legal entity of the ACO, and be separate and unique to the ACO • The governing body must have a transparent governing process and responsibility for oversight and direction of the ACO • The governing body members must have a fiduciary duty to the ACO • Governing body structure: <ul style="list-style-type: none"> ○ At least 75 percent of the governing body must be held by representatives of participating AMHs ○ ACOs must include at least one Medicaid member representative or Medicaid consumer advocate aligned with the ACO’s population of focus (e.g., pediatrics, behavioral health, etc.) and one community representative • An ACO must have a conflict of interest policy that applies to members of the governing body
Management	<ul style="list-style-type: none"> • An ACO must have a leadership and management structure that includes clinical and administrative systems that align with and support aims of better care for individuals, better health for populations, and lower growth in expenditures • An ACO’s operations must be managed by an executive, officer, manager, general partner or similar party whose appointment/removal is under the control of the ACO’s governing body • Clinical management and oversight must be managed by a senior-level medical director who is a board-certified physician licensed to practice in North Carolina and physically present at a location of the ACO, an ACO participant, or an ACO provider/supplier • An ACO must have on staff a Behavioral Health Director focused on incorporating behavioral health integration and evidence-based practices into the ACO’s care delivery model • ACOs should also consider additional leadership based on their specific population needs • Management positions may be part-time • ACO leadership must demonstrate meaningful commitment (e.g., investment of time or effort) to the mission of the ACO to ensure its success
Solvency	<ul style="list-style-type: none"> • ACOs that take on downside risk must have one or more of the following: <ul style="list-style-type: none"> ○ Funds placed in escrow established with an insured institution ○ Line of credit evidenced by a letter of credit from an insured institution ○ Security bond issued by a company included on the U.S. Department of the Treasury’s list of certified companies⁷ • Department actuaries will determine required amounts associated with each repayment mechanism
Covered Lives	<ul style="list-style-type: none"> • For Track 1 ACOs, the Department is considering establishing a minimum threshold of 1,000 to 2,000 attributed members • Track 2 ACOs must have at least 5,000 attributed members

⁶ Apply to both Track 1 and Track 2 ACOs, unless otherwise specified.

⁷ Required amount for Track 2 repayment mechanisms to be determined prior to program launch

Healthy Opportunities Requirements

Each ACO must develop a “Healthy Opportunities Strategic Plan” for State review and approval, which should outline the ACO’s approach to ensuring attributed members’ health-related resource needs (such as needs related to housing, food, transportation and interpersonal violence/toxic stress) are met.

Two key factors will contribute to the ACO’s approach:

- **Whether the ACO opts to provide care management functions on behalf of its participating AMH practices.** If so, all care management responsibilities related to healthy opportunities for *all* of its Medicaid members, including those described below related to members in Pilot regions, would fall to the ACO. If not, these care management responsibilities are maintained at the AMH practice level.
- **Whether the ACO serves members in a region of the State where a “Healthy Opportunities Pilot” is implemented.** In those regions, PHPs are required to manage additional Pilot funds to cover evidence-based, non-medical services that are designed to have a direct impact on health outcomes and healthcare costs for a subset of eligible members. PHPs and care managers will work with members to identify who is eligible for Pilot services, identify which Pilot service they need, and connect them to a human service organization (HSO) that can deliver that Pilot service. One Lead Pilot Entity (LPE) per Pilot region will develop and manage the network of HSOs to which PHPs and care managers will refer Pilot enrollees. In Pilot regions, an ACO and PHP may agree to delegate some PHP responsibilities to the ACO, so the ACO can play a more active role in managing the Pilot services and potentially Pilot funds for their attributed population. (For more information on the Healthy Opportunities Pilots, see [North Carolina’s Healthy Opportunities Pilots: A Review of Proposed Design for Interested Stakeholders and the Request for Proposal for Healthy Opportunities Lead Pilot Entity.](#))

All ACOs, both inside and outside of Pilot regions, should consider strategies to address attributed members’ unmet health-related resource needs, such as partnering with HSOs and investing in or implementing initiatives and projects in the community. All of these efforts should be detailed in the Healthy Opportunities Strategic Plan, including a clear description of the roles and responsibilities for the ACO, PHP, and LPE (where applicable) for any Healthy Opportunities-related work.

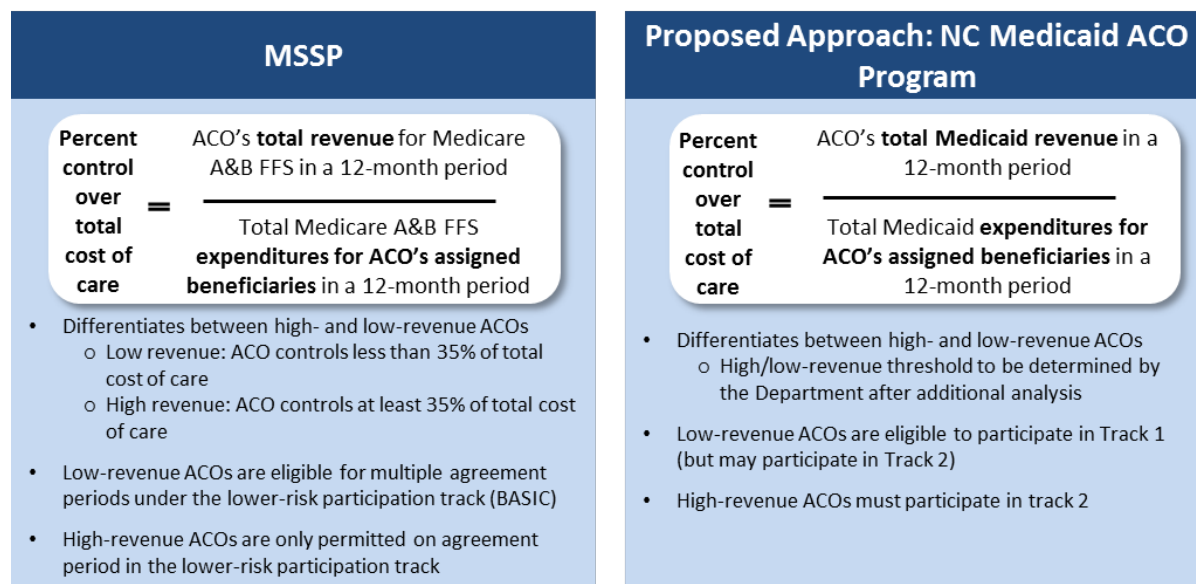
Track Eligibility

The Department proposes to follow a modified version of the “percent control over total cost of care” methodology developed by the Medicare program for determining eligibility for Track 1 and Track 2, with the goal of ensuring that provider-led organizations, independent and rural providers, and FQHCs are able to participate in either track while requiring that more advanced, and often larger hospital-affiliated providers participate in Track 2. The Department’s proposed approach recognizes that ACOs with different characteristics may differ in the degree to which they capture attributed patients’ total cost of care within their network of participating providers and creates different expectations for ACOs that capture a lower percentage of total cost of care compared to those that capture a higher percentage of total cost of care.

Percent control over total cost of care will consist of each ACO’s total Medicaid revenue in the previous year as a percentage of the total Medicaid spending on the ACO’s attributed members (see *Figure 2* below). The Department will then compare this percentage to a threshold predefined by the Department. ACOs with percent control over total cost of care below this threshold will be permitted to participate in Track 1, while those with percent control over total cost of care that exceeds the threshold will be required to enter Track 2.

The Department plans to conduct additional analysis before setting the specific threshold percentage for eligibility for Track 1. The Medicare program currently utilizes 35 percent as the cutoff percentage for eligibility for the low-risk participation tracks, but the Department recognizes that there may be differences in the characteristics of North Carolina’s Medicaid population and the North Carolina provider market which may warrant altering this threshold. The Department’s intention is to establish a threshold that allows independent practices, small or rural hospitals, and other provider groups with less experience in VBP an opportunity to participate in Track 1, while requiring that large health systems participate in Track 2.

Figure 2: Percent Control over Total Cost of Care Calculation - MSSP vs. Proposed Medicaid ACO Program



The Department seeks comment from stakeholders on the appropriate track eligibility threshold as well as the overall proposed track eligibility approach.

Data Strategy

The Department recognizes the need for ACOs to receive timely, actionable data on quality and health outcome measures, service utilization, and total cost of care, and manage data across multiple PHPs. Prior to the launch of the ACO program, the Department will release an ACO data strategy. This data strategy will build upon work currently being done in the AMH context to streamline data flows and identify opportunities to standardize frequency, transmission method, and format of data feeds necessary for PHPs, CINs and providers to successfully enter into ACO contracting arrangements. Please see the [Data Strategy to Support Advanced Medical Homes](#) for additional information about the data strategy work being done in the AMH context.

The Department seeks feedback on providers’ data, data exchange, and system needs, opportunities, and concerns when assessing their participation in the ACO model.

V. ACO Payment Model

The proposed ACO payment model seeks to clearly link payment to the total cost of care and health outcomes for the ACO's attributed Medicaid members. Actual total Medicaid spending for an ACO's attributed members, adjusted for performance on health outcomes, will be compared to a spending benchmark. All ACOs that achieve total spending that is less than the benchmark (i.e., those that generate savings) while meeting ACO quality and health outcome standards will be eligible to receive payments from PHPs for a share of the difference. Conversely, ACOs in Track 2 are at risk for a share of the losses; when total spending is in excess of the benchmark, these ACOs will be required to make payments back to the PHP for a share of the difference. Further, by linking shared savings and losses to quality and health outcome performance, the payment model would encourage improvements in health and ensure that ACOs do not have incentives to limit the provision of medically necessary care.

Finally, through this payment model, the Department seeks to maximize incentives for ACOs to invest in Healthy Opportunities resources. Because these investments can help PHPs and ACOs improve health, reduce costs, and better serve their members, they should be an important part of the ACO's strategy to earn savings. The Department welcomes comments on how to further ensure Healthy Opportunities efforts are captured and incentivized under the ACO program.

Total Cost of Care and Spending Benchmark

Under both tracks, ACOs will be accountable for total cost of care for all attributed Medicaid members, regardless of which provider delivers the service. To ensure administrative simplicity, comparability across ACOs, and to streamline contract negotiations, the Department proposes to establish and calculate a uniform, risk-adjusted measure of total cost of care to which all ACOs will be held accountable. The Department proposes to include nearly all types of Medicaid spending in the total cost of care calculation, including spending related to physical health, behavioral health, pharmacy, and long-term services and supports.

Savings and losses will be calculated by comparing each ACO's total cost of care against a benchmark representing expected spending for the ACO's attributed members during the contract year. In order to create a level playing field between ACOs and PHPs and ensure that benchmarks are calculated using all available data, including historical fee-for-service data, the Department proposes to establish a uniform methodology and calculate the benchmark for each ACO. The Department seeks comment on whether to make an adjustment to the historical benchmark to consider regional or statewide average spending or other normative standards.

Total Cost of Care Exclusions and Adjustments

The Department is considering several adjustments to the costs included in the measure of ACO total cost of care. NC Medicaid relies on a preferred drug list to ensure value in its pharmacy program and negotiates rebates on certain drugs, which may limit the ability of providers to meaningfully understand and influence pharmacy spending at the point of service. To ensure ACOs maintain an active role in managing pharmacy quality and cost while continuing to prescribe drugs of highest value to the Department, net of rebates, pharmacy claims will be price-adjusted to align with the highest value drugs on the preferred drug list. This proposal is meant to ensure that variations in total cost of care under the program reflect changes in pharmacy utilization, not drug pricing. Furthermore, so as not to limit access to therapies that may increase costs in the short term but drive improvements in quality and patient health in the long term, the Department proposes excluding high cost drugs from the measure of ACO total cost of care. The Department will issue a list of high-cost drugs prior to the launch of the ACO program.

In addition to high cost pharmacy claims, voluntary investments by ACOs in Healthy Opportunities initiatives that are not Medicaid-covered services will also not be included in the total cost of care for ACO-attributed members. The Department intends for ACOs to develop a strategy for addressing Healthy Opportunities and does not want the ACO total cost of care measure to disincentive these investments.

The Department seeks stakeholder feedback on the proposed approach to measuring total cost of care and establishing a benchmark, including which types of spending should be included or excluded from the total cost of care calculation, the approach to risk adjustment, and the methodology for calculating the benchmark.

Linking Payment to Quality and Health Outcomes

In order to ensure that the ACO program drives improvements in care and protects access to medically necessary care, the Department proposes to link the distribution of savings and losses to performance on quality of care and health outcomes. Existing ACO models link payment to quality and outcomes in a variety of ways, using combinations of pay-for-reporting, minimum performance thresholds, and graduated quality scores, depending on the quality measure. The Department intends to adopt a combination of these approaches, described below, and allow PHPs and ACOs flexibility to propose additional links between health outcomes and payment as well.

The Department will have a single list of quality and health outcomes measures for which all ACOs are accountable. This list will be drawn from the list of measures that PHPs must report to the Department and which will align with the AMH and priority measure sets.⁸

The Department also proposes the following specific quality and outcome-related payment requirements to ensure ACOs account for and address key Medicaid populations and services appropriately:

- **Pediatric quality and outcomes as a “gateway” to savings:** The Department believes that shared savings alone are not a sufficient incentive to ensure high quality care for children in ACOs; as such, ACOs will need to achieve a minimum level of performance on specified pediatric measures in order to realize any shared savings for their entire attributed population. The Department intends to look at outcome measures when possible. The Department is also considering including additional “gateway” metrics, such as primary care measures and behavioral health measures to ensure ACOs are working successfully for all patients and provider types.

The Department seeks feedback on quality and outcome measures that would be most meaningful for ensuring the ACO program delivers and rewards high quality pediatric care, and alternative cost metrics that may be useful for assessing ACO management of pediatric populations. The Department also seeks comment on whether it should set different cost benchmarks for different age groups or make other modifications to the program to ensure it is responsive to the needs of pediatric populations. PHPs and ACOs are also encouraged to include other pediatric incentive models and initiatives in the design of their ACOs.

- **Required incentives for behavioral health initiatives:** Similarly, PHPs and ACOs must include in their program a payment incentive (in addition to shared savings) for providers focused on

⁸ These are described in [North Carolina’s Medicaid Managed Care Quality Measurement Technical Specifications Manual](#)

behavioral health integration but will have flexibility in the exact design and measures used in these programs. The Department seeks stakeholder feedback on the optimal approach for ensuring a clear link between payment and performance, and on the measures that should be used to ensure physical-behavioral health integration and behavioral health initiatives.

Payment Parameters⁹

The Department seeks to provide opportunity for ACOs and PHPs to negotiate ACO payment terms that are mutually beneficial but proposes establishing a set of parameters to ensure that contracts reflect the Department's policy goals and balance the interests of both PHPs and ACOs (see *Table 3* below).

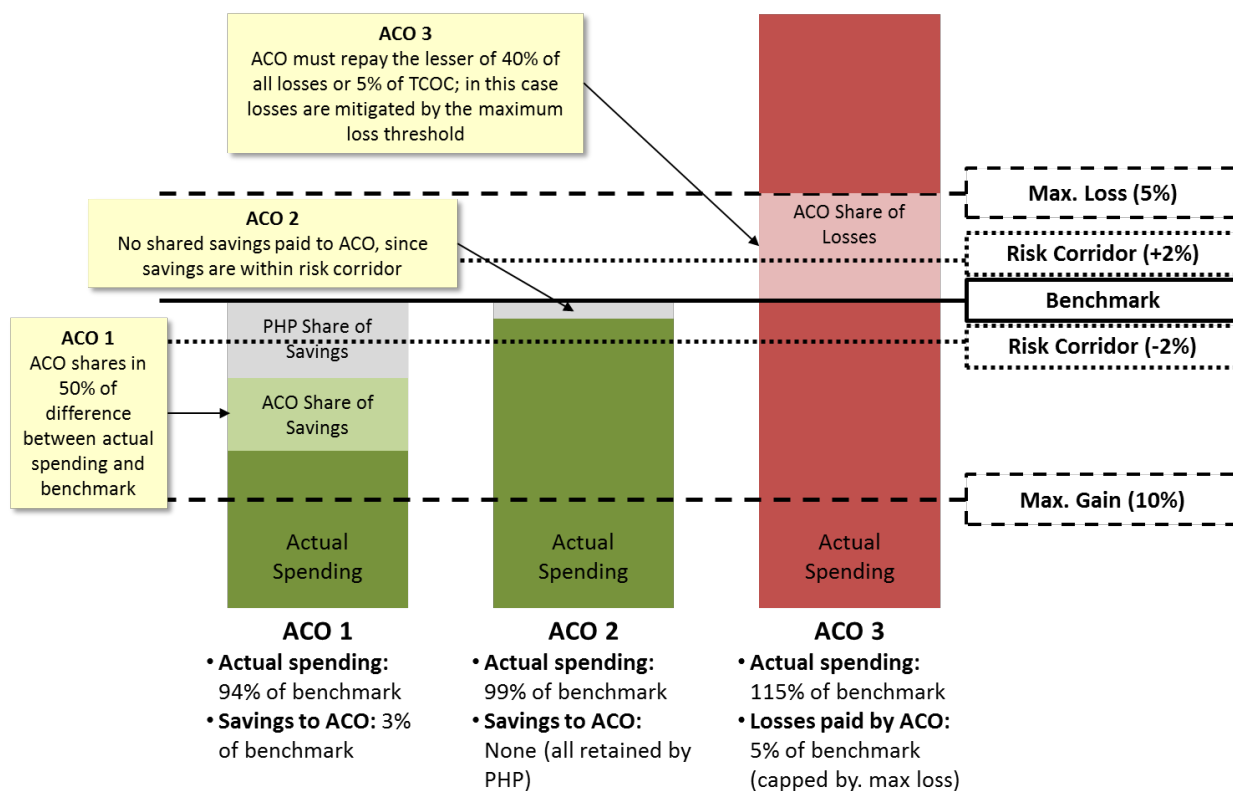
Under the proposed program, ACOs would be protected from excessive risk sharing through maximum gain and maximum loss provisions, which cap savings and losses as a share of the ACO's benchmark. In both tracks, the maximum gain percentage must be at least 10% of the benchmark but may be no higher than 20%. For Track 1 ACOs that decide to take on small amounts of downside risk, the maximum loss percentage must be no higher than 2% of the benchmark. In Track 2, the maximum loss percentage must be at least 2% of the benchmark but no higher than 15%. The precise level of each of these payment parameters could be negotiated between the PHP and the ACO.

The Department also proposes to establish a risk corridor in both tracks, which would mitigate the risk that ACOs only share in savings and losses that are driven by actual outcomes, not just random variance. In order to share in savings or losses, actual spending will be required to vary from the benchmark by an actuarially established percentage before savings and losses become "shareable." The Department proposes to prescribe the risk corridor for each ACO depending on the specific number of covered lives (this approach is used in the Medicare program). ACOs with larger attributed populations would be assigned "narrower" risk corridors, meaning savings and losses would be considered statistically detectable at lower levels of variation from the benchmark. Conversely, ACOs with smaller attributed populations would be assigned "wider" risk corridors, meaning savings and losses would need to represent a greater share of the benchmark before any would become shareable.

Finally, risk sharing rates would also vary by track. Track 1 requires PHPs to share in at least 40% of savings with no minimum level of shared losses (i.e., shared savings-only arrangements would be permitted). Track 2 requires PHPs to share in additional savings – at least 50% – but requires that ACOs be accountable for at least 30% of losses. See *Figure 3* for an illustrative example of the proposed payment approach.

⁹ See [Appendix A](#) for a list of key terms used throughout this section

Figure 3: Illustrative Example - Shared Savings and Losses



Note: Example assumes 50% savings rate; 40% loss rate; 2% risk corridor; 10% max gain; 5% max loss

The parameters proposed by the Department were intentionally designed to align with provisions in the Medicare Shared Savings Program (MSSP) Final Rule, which took effect in February, 2019.¹⁰ The rule established two new MSSP Tracks: BASIC and ENHANCED, with the BASIC track containing five levels corresponding to the five-year MSSP agreement period. The payment models established for MSSP BASIC Levels A and B, which are shared savings only, and Level C, which includes minimal downside risk, align with the Track 1 parameters, allowing ACOs in these MSSP Tracks to apply most elements of their MSSP payment models to the Medicaid population with few modifications. Similarly, the payment models for MSSP BASIC Track Levels D and E and ENHANCED Track, which require greater levels of downside risk, broadly align with the payment parameters for Track 2.

The Department seeks feedback on whether this proposed approach provides sufficient structure for developing payment terms, strikes a reasonable balance between driving the Department’s policy goals while providing flexibility to the market, accommodates existing VBP arrangements in North Carolina, accounts for key differences in the Medicare and Medicaid populations, and addresses concerns about administrative burden for both providers and PHPs. The Department is also considering designing ACO contract templates in order to streamline the contracting process and seeks feedback from stakeholders on the utility of this approach.

¹⁰ <https://www.federalregister.gov/documents/2018/12/31/2018-27981/medicare-program-medicare-shared-savings-program-accountable-care-organizations-pathways-to-success>

Table 3: Payment Parameters

Guardrail	Parameters	
	Track 1	Track 2
Maximum gain/loss	<ul style="list-style-type: none"> • Max. gain: must be at least 10% of benchmark; no higher than 20% of benchmark • Max. loss (if applicable): No higher than 2% of benchmark 	<ul style="list-style-type: none"> • Max. gain: must be at least 10% of benchmark; no higher than 20% of benchmark • Max. loss: at least 2% of benchmark; no higher than 15% of benchmark
Risk corridor	<ul style="list-style-type: none"> • To be actuarially determined by State based on number of lives • Size of risk corridor will be inversely proportionate to number of covered lives 	<ul style="list-style-type: none"> • To be actuarially determined by State based on number of lives • Size of risk corridor will be inversely proportionate to number of covered lives
Shared risk	<ul style="list-style-type: none"> • Savings: At least 40% of savings • Losses: None required but ACOs may agree to take on downside risk by mutual agreement 	<ul style="list-style-type: none"> • Savings: At least 50% of savings • Losses: At least 30% of losses • ACOs may agree to greater risk sharing by mutual agreement
Total Cost of Care Benchmark	<ul style="list-style-type: none"> • DHHS will prescribe benchmark methodology, as described above 	<ul style="list-style-type: none"> • DHHS will prescribe benchmark methodology, as described above
Calculation of Total Cost of Care	<ul style="list-style-type: none"> • DHHS will calculate total cost of care for all members in the program as described above 	<ul style="list-style-type: none"> • DHHS will calculate total cost of care for all members in the program as described above
AMH Payments	<ul style="list-style-type: none"> • Medical Home Fees and AMH Tier 3 Care Management Fees would continue unchanged 	<ul style="list-style-type: none"> • Medical Home Fees and AMH Tier 3 Care Management Fees would continue, but ACOs taking on downside risk could receive greater flexibility in how to use these payments

Distribution of Savings and Losses

The Department is not proposing to regulate the distribution of savings and losses within ACOs to participating providers at this time. However, the Department expects that ACOs, through their internal governing bodies, will develop mutually agreeable arrangements that govern these payment flows, including to any partnered specialists or other non-AMH providers. Further, the Department expects ACOs to distribute savings to PCPs, pediatricians, FQHCs, LHDs, school-based clinics and behavioral health providers commensurate with their important role in the ACO and seeks comment on whether it should require ACOs to distribute a certain percentage of savings to these types of providers or increase rates to these types of providers that participate in ACOs.

VI. Incentives/Requirements for Participation in the ACO Program

While participation in the ACO program will be optional for providers, the Department is considering options to create additional incentives for providers and requirements of PHPs to drive program adoption.

Provider Incentives

Perhaps the most important incentives for providers to participate in the program are greater flexibility to provide high-quality, whole-person care and the opportunity to earn shared savings. However, the Department recognizes that it may need to create additional incentives to spur provider participation.

As such, the Department plans to establish an “Early Innovators” program, which will provide a range of benefits to ACOs that join the program upon launch. All Track 1 ACOs that enter the program in the first year after launch and Track 2 ACOs that opt to forgo the Track 2 “glide path” and take on minimum levels of downside risk at program launch will be eligible to participate in the “Early Innovators” program.

Benefits the Department has contemplated as part of this initiative include the following:

- **Advisory group membership.** Early Innovators would be made standing members of a State-led advisory group tasked with making policy and implementation recommendations related to the ACO program leading up to and immediately following program launch.
- **Technical assistance.** The State plans to offer ACO-level practice training and technical assistance to Early Innovator ACOs to support practice transformation and help address key implementation issues. In addition, the State may offer targeted technical assistance to small and rural providers who wish to participate in ACOs but need support in training, data analysis, organizational change, and other key ACO competencies.
- **Learning collaboratives.** Early Innovators would be able to participate in Department-facilitated learning collaboratives with other ACOs to come together and share best practices.
- **Enhanced data.** Early Innovators may also gain access to enhanced data, such as quality data aggregated at the ACO level. The Department seeks comment from stakeholders on what types of data would be most desirable.
- **Streamlining administrative requirements.** ACOs that take on full, Track 2 downside risk at program launch may be eligible to bypass certain additional administrative requirements, such as prior authorization.

The Department is eager to understand what would make an ACO program most attractive to providers and seeks feedback on what incentives would be most likely to spur robust participation. The Department is particularly interested in feedback on incentives that would spur participation of physician-led, rural, and FQHC-led models, and incentives that foster inclusion of FQHCs, LHDs, and other safety-net providers in ACOs.

PHP Contracting Requirements

In order to drive maximum participation in the ACO program, the Department proposes requiring PHPs to execute contracts with all certified ACOs with attributed members who are enrolled in the PHP (see below for more information on the certification process). To ensure this process is equitable to PHPs, the State will require that ACOs have the organizational capacity to perform critical ACO functions before they are “certified” (see [ACO Entity Requirements](#)) and will establish payment parameters that ensure opportunity for reasonable payment agreements for both parties. In situations where the PHP determines that an ACO is not in compliance with all program requirements, PHPs will have the ability to decline contracts. However, the Department anticipates that such occurrences will be rare.

VII. Oversight of the ACO Program

The Department will exercise oversight over programmatic elements of the ACO program and manage the ACO certification process. However, the State will rely on PHPs to oversee the day-to-day operations of the program and ensure ACO compliance with program requirements.

State Oversight

The Department will maintain programmatic oversight over the ACO program and will continuously monitor the program's progress in order to ensure that it is advancing the State's policy goals. The Department reserves the right to access all ACO contracts at any time and may exercise additional oversight, as necessary, in order to ensure the financial stability of NC Medicaid providers and PHPs. To ensure prospective ACOs are qualified, the Department also proposes to establish a certification process under which prospective ACOs must demonstrate that they can meet all ACO entity requirements (i.e., related to entity status, governance, leadership and management, financial solvency, and number of covered lives) and submit the Healthy Opportunities Strategic Plan for State review and approval. ACOs that complete the process would be "certified" as ACOs, and PHPs would be required to contract with them.

PHP Oversight

Primary day-to-day oversight of the ACO program will fall to PHPs. PHPs should work with providers who are ready to form ACOs to encourage and facilitate adoption of the program. PHPs will also be responsible for validating that certified ACOs are in compliance with program requirements on an ongoing basis. In instances where ACOs fall out of compliance with program requirements during the contract year, PHPs would be permitted to take corrective action in these situations. However, the Department plans to closely monitor ACO contracting and expects PHPs to enter into contracts with all certified ACOs that have members assigned to that PHP and take all reasonable steps to ensure the ongoing success of the program. The Department will provide more detail related to ongoing oversight in future guidance. PHPs may also provide supports to ACOs in the form of data, trainings, or other investments as appropriate.

VIII. Conclusion

The Department encourages stakeholder comment on all aspects of this proposed ACO program and on the broader context informing the program described in the accompanying [*North Carolina's Value-Based Payment Strategy for Standard Plans and Providers in Medicaid Managed Care*](#). In particular, the Department requests comment from PHPs, AMHs, and other providers who are already pursuing ACO-like value-based payment models in Medicaid on how this program aligns with current efforts and can support this important work to drive value in North Carolina's Medicaid program. The Department also seeks more input on innovative ways to tailor the proposed ACO program to the unique needs of North Carolina's Medicaid Managed Care members and the providers and PHPs serving those members. Finally, the Department is eager to understand what would make an ACO program most attractive to providers and PHPs and seeks feedback on what incentives or design features would be most likely to spur robust participation.

Appendix A. Key Terms

- **Total Cost of Care.** Total Medicaid spending on an ACO's attributed members, regardless of whether services were provided by providers who are not affiliated with the ACO.
- **Benchmark.** Expected spending for the ACO's attributed members during the contract year, typically set using historical claims data. Each ACO's total cost of care is compared against its benchmark in order to calculate shared savings or losses.
- **Maximum Savings/Loss Rate.** Cap on the total amount of shared savings or losses in relation to the benchmark. These provisions are meant to protect PHPs or ACOs from having to share in excessive savings or losses.
- **Risk Corridor.** The minimum level of savings or losses that must be achieved or incurred before risk sharing begins. The risk corridor is intended to ensure ACOs do not share in savings or losses due to random variation.
- **Shared Risk Level.** The amount of savings or losses that PHPs share with the ACO, after the risk corridor is met. Shared savings mean that a PHP must make payments to an ACO for a share of the difference between the ACO's actual total cost of care and the benchmark. Shared losses mean that an ACO must make payments back to the PHP for a percentage of the share of total cost of care that exceeds the benchmark, up to a cap (established by the maximum loss rate).