Medicaid Managed Care Policy Paper

North Carolina's Value-Based Payment Strategy for Standard Plans and Providers in Medicaid Managed Care

North Carolina Department of
Health and Human Services

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Contents

Executive Summary

Purpose: This paper describes the North Carolina Department of Health and Human Services' (the Department's) vision for moving from fee-for-service to value-based payments (VBP) between Prepaid Health Plans (PHPs) offering Standard Plans and providers in NC Medicaid Managed Care. The paper also outlines planned VBP initiatives and proposed targets for the percentage of PHPs' medical payments that should be governed under VBP contracts. The strategy offers guidance for forming VBP arrangements and highlights several possible models, though the Department also encourages PHPs and providers to develop other, innovative VBP models that best suit their needs.

The Department welcomes feedback on all elements of this strategy. We encourage stakeholders to provide any feedback by emailing Medicaid.Transformation@dhhs.nc.gov by **February 19, 2020**.

Background: North Carolina will transition its Medicaid and NC Health Choice programs from a predominantly fee-for-service delivery system to Medicaid Managed Care. To help achieve its goals of improving the health and wellbeing of North Carolinians by "purchasing health," and not just healthcare services, the Department has prepared a strategy for increasing the use of VBP between PHPs and providers in the first five years of Medicaid Managed Care.

Vision: The Department seeks to encourage the use of VBP models that reward providers for delivering high-quality, appropriate care and improved health outcomes. The proposed VBP strategy charts an achievable path towards expanding use of VBP in Medicaid. It accounts for current market readiness for VBP and existing VBP infrastructure in North Carolina. The Department aims to offer guidance for VBP contracting while allowing PHPs and providers flexibility to enter into VBP arrangements tailored to their specific populations and needs.

Overview: Under the proposed strategy, nearly all PHP/provider contracts would include a value-based component by the end of contract year 5 of managed care.[1] To encourage steady progress towards this goal, the strategy includes targets for the percentage of PHPs' medical payments that should be governed under VBP contracts each year. While PHPs may select the specific arrangements they use to meet these targets, the strategy offers several state-led initiatives that PHPs and providers may use to expand their use of VBP, including:

- Advanced Medical Home (AMH) Tier 3 performance incentive payments
- A Medicaid Accountable Care Organization (ACO) program, scheduled to launch as soon as mid-2021
- Adding VBP to existing statewide delivery models, such as the Pregnancy Management Program or local health department (LHD) care management programs

Additionally, the strategy offers PHPs and providers flexibility to pursue VBP arrangements that best align with their own VBP readiness, the populations they serve, and the services they provide.

[1] "Contract year," as used here and throughout this paper, refers solely to PHP contracting years with the Department. Contracts held by providers with PHPs may fall under different timelines.

Section 1. Achieving Value in Prepaid Health Plan (PHP) and Provider Payment

The Department is dedicated to ensuring its comprehensive Medicaid Managed Care program optimizes health and wellbeing for North Carolina's Medicaid members. Central to these efforts are payment models that reward providers for delivering high-quality, appropriate care and improved health outcomes.

The Department is setting forth a comprehensive five-year VBP strategy that will rapidly accelerate the adoption of payment models that reward high-value care. In driving increased use of VBP models, the Department seeks to align incentives for improving health and offer providers greater flexibility to deliver the care that will be best suited to their patients' needs.

PHPs and providers that are ready to enter value-based arrangements now should begin value-based contracting from the outset of Medicaid Managed Care and increase their value-based arrangements and risk-based contracts over time. Providers without VBP experience may experiment with incentive payments and steadily increase their use of value-based arrangements as they gain experience in the managed care environment. By the end of the fifth year of managed care, the Department envisions that nearly all Standard Plan Medicaid payments will be made under VBP arrangements, and that most PHP and provider contracts will incorporate some level of shared savings and shared risk.

Standard Plans (referred in this strategy as Prepaid Health Plans, or PHPs), as payers and administrators of the Medicaid Managed Care program, will play a critical role in this evolution, and this strategy focuses on ensuring their payments to providers drive value. The strategy is intended to define mechanisms to hold PHPs accountable for ensuring their payment contracts reward providers for providing high-value care using a series of targets, which will be enforced using PHP payment withholds.

Providers also have a key role to play in advancing value, and the strategy highlights and proposes several VBP arrangements PHPs and providers can enter into together to meet these targets – many of which build off existing key NC Medicaid initiatives and programs that drive high-value care.

The strategy leaves broad flexibility for PHPs and providers to design their own, innovative VBP arrangements, and to build off and align with VBP models in use today with other payers. It does not require PHPs or providers to enter any specific VBP models. The strategy also builds upon PHP contract year two VBP requirements that are detailed in Section V. Scope of Services of the PHP contract[2] as well as the Department's Initial VBP Guidance.[3] The Department seeks comment from both PHPs and providers on how it can best support the adoption of innovative payment models, including the optional models detailed in the strategy and other models that have been proven successful in improving outcomes and reducing costs.

While the strategy outlined here only applies to Standard Plans, the Department's vision for VBP under Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Plans will be released in future guidance prior to the Behavioral I/DD Tailored Plan launch.

In developing the VBP Strategy, the Department sought to balance the following objectives:

- **Ensure NC Medicaid "purchases health" and is a good steward of state resources** – 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

[2] https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf
[3] https://files.nc.gov/ncdma/documents/Medicaid/Provider/NC-VBP-Initial-Guidance-Final-for-Comms-20190213.pdf

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. Additionally, NC Medicaid aims to be a good steward of State resources and get the full value of the dollars it spends. A critical step to achieving these goals is moving from a fee-for-service payment system, which incentivizes the quantity of care provided, to a system that incentivizes high-quality care and improved whole-person health.

- **Establish ambitious, but achievable, VBP goals** – The Department aims to rapidly accelerate the use of VBP through Medicaid Managed Care. This strategy reflects a strong commitment to measurable and significant progress on VBP adoption. The expectation is that nearly all PHP and provider contracts will contain a VBP component by the end of contract year 5, though the nature of these VBP components may vary based on PHP and provider needs. At the same time, the Department recognizes that PHPs and providers will need time to negotiate and implement value-based arrangements and has considered the provider landscape in North Carolina as well as PHP commitments related to VBP in their contracts with the Department to ensure expectations for VBP adoption are achievable in the defined timeframes.
- **Recognize market readiness for VBP and align across payers when feasible** – The move towards VBP in Medicaid builds upon existing trends in the North Carolina healthcare landscape. Many large health systems in the state participate in Medicare ACOs or have entered into VBP contracts with commercial payers. Within Medicaid, nearly 1,500 practices have attested into AMH Tier 3, which uses a performance-based incentive payment model. All PHPs have begun developing alternative payment models that link provider payments to quality and accountability for total cost of care, and both PHPs and providers have entered into contracts with clinically integrated networks (CINs) or other partners to help their efforts to improve care. In the early years of managed care, the Department hopes to build upon and align with existing VBP infrastructure while encouraging increased adoption in the Medicaid context. This alignment is important to reduce administrative burden for providers who may contract with multiple payers.
- **Allow PHPs and providers flexibility to tailor VBP models to their specific populations and needs**— Recognizing that PHPs and providers will have different needs when developing value-based arrangements, the Department will permit PHPs and providers to develop and enter arrangements that best align with their readiness and infrastructure, and with their specific populations and services. The Department expects larger, more mature health systems with greater VBP experience to move quickly into models that are linked to the total cost of care and quality and incorporate financial risk. However, smaller, independent practices with little VBP experience will have flexibility to build experience in incentive-based or, at their option, lower-risk VBP models. Although the VBP strategy offers guidance for forming VBP arrangements and highlights several VBP initiatives, the Department will not require providers to participate in any specific VBP models, allowing PHPs and providers broad flexibility to develop innovative VBP models that best suit their needs. The Department seeks comment from both PHPs and providers on how it can best support the adoption of innovative VBP models, including the optional models detailed in the strategy and other models that have been proven successful in improving outcomes and reducing costs.
- **Build from and leverage state programs focused on improving high-value care—** Many North Carolina programs focus on delivering high value care to Medicaid members, and these existing programs are foundational to the VBP strategy. The strategy aims to align with and build on these programs and initiatives, which include AMHs, Healthy Opportunities initiatives, the

Medicaid quality strategy, and other efforts that aim to increase provider capacity to deliver high-quality, coordinated, whole-person care.

The Department seeks feedback from stakeholders on the proposed approach to expanding VBP in Medicaid, which the Department will use to inform the evolution of the state's VBP policies now and in the future. The Department seeks stakeholder input on whether the considerations noted above were effectively balanced in the VBP strategy and whether other considerations should be factored into future VBP policies.

Section 2. Value-Based Payment Targets and Framework

The VBP strategy includes a range of requirements and incentives to encourage PHPs and providers to enter value-based arrangements. Chief among the requirements are the Department's VBP targets, which establish expectations for the use of VBP arrangements in PHP contracting with providers. The targets included in the VBP strategy indicate the proportion of PHPs' payments to providers that should be governed under VBP arrangements in each of the first five years of Medicaid Managed Care. At the highest level, these targets aim to hold PHPs accountable for VBP adoption.

The Department will define VBP using the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) Framework (see Figure 1).[4] In the first two years of managed care, as described in the Initial VBP Guidance[5] and in Section V. Scope of Services of the PHP contract,[6] the definition of VBP is intentionally broad, and includes any payment arrangements that fall into HCP-LAN Category 2 and above.

By the end of PHP contract year 2, PHPs must increase the percentage of payments in VBP arrangements by 20 percentage points over their year 1 baseline or have VBP arrangements represent at least 50 percent of total medical expenditures.

Beginning in contract year 3, the Department will narrow the definition of VBP to arrangements that fall within HCP-LAN Category 2C and above, and at the same time, will introduce new, higher targets that aim to raise the bar for VBP in Medicaid Managed Care (see Table 1). The Department envisions that nearly all Medicaid payments will be made under VBP contracts by the end of contract year 5. Further, the Department seeks to have all VBP contracts in Categories 2C and above, with a significant portion of payment in Categories 3 and above.

[4] http://hcp-lan.org/workproducts/apm-framework-onepager.pdf
[5] https://files.nc.gov/ncdma/documents/Medicaid/Provider/NC-VBP-Initial-Guidance-Final-for-Comms-20190213.pdf
[6] https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf

Figure 1. HCP-LAN Alternative Payment Model Framework

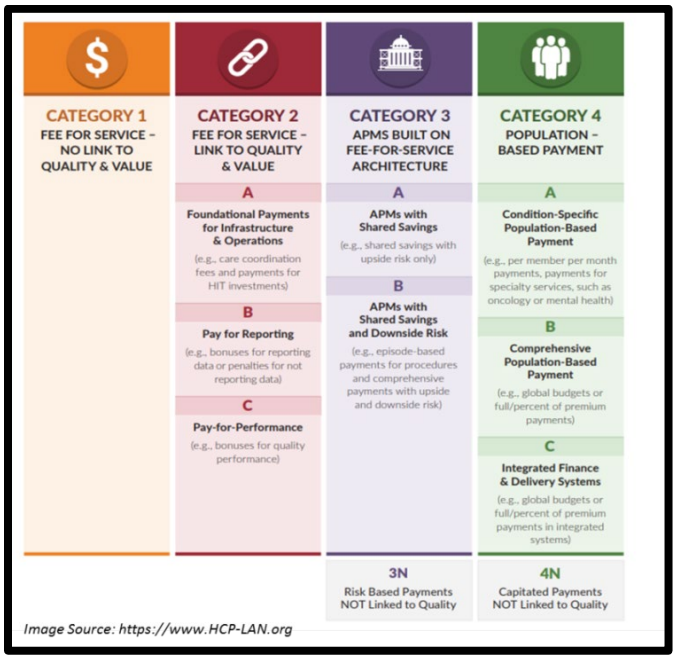

Table 1. VBP Targets for Contract Years 1-5

Year 1	Year 2	Year 3	Year 4	Year 5
PHP submits VBP assessment to establish baseline level of value-based contracting	Percentage of PHP's expenditures in VBP (Category 2A+) must: • Increase by 20 percentage points <u>or</u> • Represent at least 50% of total medical expenditures	**Overall[7] (Category 2C+)** • At least 60% of total medical expenditures **Sub-Target[8] Category 3A+** • At least 15% of total medical expenditures	**Overall (Category 2C+)** • At least 75% of total medical expenditures **Sub-Target Category 3A+** • At least 30% of total medical expenditures	**Overall (Category 2C+)** • At least 90% of total medical expenditures **Sub-Target Category 3A+** • At least 45% of total medical expenditures **Sub-Target Category 3B+** • At least 15% of total medical expenditures

[7] Overall targets represent the total percentage of each PHP's medical expenditures that must be governed under VBP arrangements. The Category listed for each overall target indicates the minimum HPC-LAN Category payment arrangements must meet in order to count towards the overall target.

[8] Sub-targets represent the percentage of each PHP's medical expenditures that must be governed under VBP arrangements in higher HCP-LAN categories. Arrangements that count towards a PHP's sub-target will also count towards its overall target.

VBP Targets and Framework in Contract Years 1-2

Definition of VBP

The Department will define VBP as payment arrangements between PHPs and providers that fall within Categories 2-4 of the HCP-LAN framework.

Target Calculation

PHPs will be required to report the percentage of total medical expenditures (excluding certain directed payments*) that flow through VBP arrangements. The target numerator should include all payments that flow from PHPs to providers under a VBP 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. Payment categories excluded from the denominator should also be excluded from the numerator. If multiple payment arrangements are in use for different populations for a single provider, only the value of the payments made for populations under VBP arrangements should be included in the numerator.

VBP Target

Numerator: All payments that flow from a PHP 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*

Denominator: Total medical expenditures*

* Additional utilization-based payments to certain providers (LHDs, public ambulance providers, faculty physicians associated with University of North Carolina, as described in RFP Scope of Services Section D. Providers, Subsection 4. Provider Payments, will be excluded.

Target Levels

By the end of contract year 2, the Department requires that the percentage of each PHP's medical expenditures governed under VBP arrangements in HCP-LAN Categories 2-4 must either:

- Increase by 20 percentages points over the contract year 1 baseline (as established in the VBP assessment submitted 90 days after at the end of contract year 1)

  or

- Represent at least 50 percent of total medical expenditures

Contract Years 3-5: VBP Targets and Framework

Definition of VBP

Starting in contract year 3, the Department will narrow the definition of VBP to payment arrangements in HCP-LAN Categories 2C and above. This narrower definition of VBP focuses on arrangements that reward providers for delivering high-quality care and positive health outcomes, including performance-based payments, shared savings and risk, or population-based payments; the Department expects PHPs and providers to meet the narrower VBP payment definition.

PHPs and providers are free to develop arrangements that include elements not covered by this definition, but these payment arrangements will not count as VBP for the purposes of the targets unless they also include a component that meets the definition outlined in this strategy. For example, PHPs may use Category 2B arrangements to incentivize reporting of new or challenging quality metrics and allow both providers and PHP staff to develop appropriate processes for documenting and reporting these measures before linking payments to measure performance. However, they should also include separate pay-for-performance measures in the same contract, so that the contract "counts" as VBP for the purposes of the target.

Target Calculation

In general, the calculation for the targets laid out in the initial VBP guidance will remain the same for contract years 3 through 5, and continue to assess proportion of total medical expenditures governed under value-based arrangements.[9]

The majority of PHPs' investments in addressing their enrollees' unmet health-related needs, such as the development of a care management model with this capability, will be included as a part of total medical expenditures in the PHP target calculation. However, PHPs that make voluntary Healthy Opportunities-related investments beyond required spending on care management and Medicaid benefits, such as community investments or coverage of value-added services, do not need to include these investments in the PHP target numerator or denominator, except in the case where these payments are made to Medicaid providers as part of a larger VBP contract.

In excluding Healthy Opportunities investments from VBP target calculations, the Department seeks to encourage PHPs to explore ways in which they can use these investments to improve health and lower medical costs for their patient populations. As North Carolina gains more experience with Healthy Opportunity initiatives, the Department may consider changing these calculations to treat these types of discretionary Healthy Opportunities investments like typical medical expenditures. The Department seeks comment on the decision to exclude these investments from the target calculation in contract years 3 through 5, as well as the possibility of treating these investments like typical medical expenditures in future years.

Figure 2. Target Calculations for Contract Years 3-5

VBP Target

Numerator: All payments that flow from a PHP 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*

Denominator: Total medical expenditures*

Target Levels

Beginning in contract year 3, the Department will transition from increase-over-baseline targets to fixed targets of percentage of total medical expenditures. These targets will encourage more timely adoption of VBP arrangements. The Department will set overall targets for all VBP arrangements (in HCP-LAN Categories 2C and above) and sub-targets for payments in HCP-LAN Categories 3 and above to drive greater adoption of advanced VBP arrangements. The proposed VBP targets for contract years 3-through 5 are summarized in Table 1 above.

The Department believes that the targets shown in Table 1, while ambitious, will be achievable given existing VBP infrastructure, available VBP initiatives and current uptake of these initiatives (such as AMH Tier 3), and the specific commitments PHPs made in their contracts with the Department with respect to VBP contracting.

[9] Total expenditures for calculating VBP targets excludes certain directed payments to providers as defined in RFP Scope of Services Section D. Provider Payments

Participation in the AMH program, the Medicaid ACO program described in Section 3, and PHPs' continued development of their own, innovative VBP arrangements will also contribute to achieving VBP targets. To aid PHPs in meeting these targets, the Department has identified several VBP models in HCP-LAN Categories 2C+ in which PHPs and providers can participate. Please see Sections 3 and 4 for further details on these models.

Enforcement of Targets

At the conclusion of each contract year, PHPs must submit a VBP Assessment documenting VBP contracts in place and payments made under VBP arrangements during the relevant contract year. Annual updates to the VBP Assessment will be due 90 days after the end of the contract year.

The Department will use the results of the VBP Assessment to assess each PHP's progress towards VBP targets. PHPs who fail to meet annual targets will be subject to financial withholds, beginning in contract year 3. While withholds will not be implemented until contract year 3, PHPs are encouraged to begin preparing to meet year 3 withholds in contract years 1 and 2. Additional information on withholds will be available on the Department's website prior to the start of contract year 3.

VBP Targets in Other States

As of 2018, 18 states with Medicaid managed care have set mandatory VBP targets for plans to meet. The Department has used the following example 2021 targets, among others, in setting contract year 3 to 5 targets for NC Medicaid:

- **WA**: 90% of provider payments in HCP-LAN 2C or higher, including 50% in 3A or higher by 2021
- **MA**: 70% of members must receive care in arrangements that are HCP-LAN 3* or higher by 2021
- **NY**: 80% of total expenditures must be in HCP-LAN 3A* or higher, including 35% in 3B or higher by 2021

**State defines its own VBP categories that equate to HCP—LAN levels indicated*

Section 3. Statewide Value-Based Payment Initiatives

To meet the VBP targets detailed in Section 2, the Department encourages PHPs and providers to build off the foundational infrastructure and delivery reform work underway through the state's AMH program and other innovative delivery models, and to participate in a new ACO program described below. While the Department encourages PHPs to engage in these programs, PHPs may develop a wide range of payment models within the VBP framework to meet their annual VBP targets. The Department seeks feedback on the payment models outlined below, as well as other models that should be considered VBP under the Medicaid VBP framework.

Advanced Medical Homes

The Department developed the AMH program to ensure broad access to primary care for Medicaid enrollees and to strengthen the role of primary care in care management, care coordination and quality improvement. This population health management work is foundational to driving value in Medicaid, preparing practices to be successful under VBP models.

From the onset of Medicaid Managed Care, AMH Tier 3 practices will be eligible to receive performance incentive payments tied to cost and quality performance; all AMH Tier 3 contracts will therefore qualify as VBP arrangements under the state's definition. While contracts for Tier 1 and 2 AMHs are not required to include performance incentive payments, those that do may also count as VBP. For

additional information on AMH payments and their role in VBP target calculations, please refer to the AMH FAQs[10] and Initial VBP Guidance.[11]

The Department intentionally carried the design of the current-state Carolina ACCESS program through to the AMH design to allow a smooth transition for providers into Medicaid Managed Care. Over time, the Department will assess if modifications to the payment and care delivery requirements are warranted. The Department will use the experience and lessons learned in the first two years of Medicaid Managed Care as the basis for any modifications to the program. While AMHs and other primary care providers are free to pursue innovative primary care payment strategies in the meantime, the Department will likely encourage primary care payment reform through modifications to the AMH program beginning in PHP contract year 3.

Accountable Care Organizations

Beginning as soon as mid-2021, the Department will establish a new optional program as a key element of its overarching VBP strategy. The program, while remaining rooted in primary care and tailored to the Medicaid population, would allow providers to leverage experience with Medicare and commercial ACO models that exist today and gain experience in VBP arrangements in the Medicaid context.

The proposed ACO program would build on a foundation established by the AMH program and give AMH practices the opportunity to come together with other providers and earn shared savings for being accountable for the health outcomes and total cost of care of their Medicaid population. The ACO program proposes establishing different expectations for more advanced, large hospital-led ACOs, which would be expected to take on downside risk within two years, and ACOs led by provider-led organizations, FQHCs, or small or rural providers and hospitals, which would be permitted to initially participate through a shared-savings-only model, but eventually take on downside risk over time .

As such, there are two payment tracks within the ACO program for different provider types and readiness for risk (see Table 2 below). Track 1 is a shared savings model that offers smaller, independent, or rural practices, an opportunity to build experience in more advanced VBP arrangements and gain additional resource support through shared savings payments.

Track 2 is a two-sided risk model, which offers larger hospital-affiliated ACOs and providers with more VBP experience a greater opportunity to earn shared savings relative to Track 1. While the Department will determine which ACOs are eligible to participate in Track 1, Track 1-eligible ACOs that believe they are ready and able to participate in higher risk arrangements will be permitted to enter Track 2.

[10] https://files.nc.gov/ncdma/documents/Medicaid/Provider/AMH%20E%2BE%20-%20FAQs%20-%2010.18.18.pdf
[11] https://files.nc.gov/ncdma/documents/Medicaid/Provider/NC-VBP-Initial-Guidance-Final-for-Comms-20190213.pdf

Table 2: Overview - ACO Payment Model

Track 1 *No/minimal risk*	Track 2 *Higher risk*
• 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 small or rural hospitals	• 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

Under the state's definition of VBP for contract years 3 through 5, Track 1 ACOs are designed to count as HCP-LAN Category 3A arrangements, and Track 2 ACOs would count as HCP-LAN Category 3B arrangements. In setting contract year 3 through 5 VBP targets and sub-targets for arrangements in Categories 3 and higher, the Department has assumed widespread participation in the Medicaid ACO program.

The Department envisions that the ACO program will launch as soon as mid-2021. To encourage early adoption, Track 1 ACOs that join at the outset of the program 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, receive technical assistance, access additional data to inform population health management and potentially other benefits.

Track 2 ACOs would also be encouraged to join the program early to qualify for a "glide path" with more favorable payment terms (similar to Track 1) for only 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 at the launch of the ACO program). For more details on the proposed ACO program, please refer to the accompanying paper *North Carolina's Medicaid Accountable Care*

Unique NC 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 down-side 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**

Organizations (ACOs) for Standard Plans and Providers: Building on the Advanced Medical Home Program to Drive Value-Based Payment.

Adding VBP to Other State Delivery Models

There are also several other statewide initiatives to ensure Medicaid enrollees have broad access to high-quality care and local care management, including:

- Pregnancy Management Program[12]
- Care Management for High-Risk Pregnancies (formerly Obstetric Care Management)
- Care Management for At-Risk Children (formerly Care Coordination for Children, or CC4C)

The programs noted above, as outlined in the program guide,[13] are starting efforts to link program performance to quality outcomes. Because payments flowing through these models do not include a clear link to performance against select quality metrics, these payments will not automatically meet the state's definition of VBP. However, the Department encourages PHPs to explore opportunities to establish VBP arrangements that build upon the foundation of these models and the early quality measures for each model noted in the program guide.

If PHPs elect to introduce quality-based performance incentives or other value-based elements into their payments under these programs, those modified contracts could count towards the VBP requirements defined in the Department contracts with the PHPs. The Department seeks comment on whether it should issue guidance for incorporating value-based components into these modified contracts.

Section 4. Aligning VBP Arrangements to Key Medicaid Populations and Services

Pediatrics

The Department encourages PHPs to explore VBP arrangements for pediatric care and notes that these arrangements should consider the unique needs, costs and outcomes specific to the pediatric population. Several options for such arrangements include:

- **Pay for performance programs.** While the Department seeks to increase the use of payment arrangements in HCP-LAN Category 3 in contract years 3 through 5 of Medicaid Managed Care, it recognizes that for pediatric populations, Category 2C (pay-for-performance) arrangements may be most appropriate for certain quality measures. PHPs should identify quality metrics most relevant to pediatric care goals, such as increasing well-child visit or immunization rates, and establish meaningful incentive programs to reward providers for high-quality performance on these measures.
- **Building on the AMH program to promote advanced primary care for children.** The current AMH program incorporates a payment model that applies to all primary care practices, including pediatrics. The program provides minimum payment arrangements in each AMH Tier but allows and encourages innovation by PHPs and practices above those minimums. The Department encourages PHPs and pediatric practices to work together to develop payment models that

[12] Per the initial VBP guidance, these payments will count as VBP in years 1-2. However, in year 3 and onward, these payments will only qualify as VBP if they also include a clear link to performance or quality metrics.
[13] https://files.nc.gov/ncdma/documents/Providers/Programs_Services/care_management/Program-Guide-High-Risk-Pregnancy-and-At-Risk-Children-11072018.pdf

meet minimum AMH requirements but may better promote population health at the level of a pediatric practice.

- **Modifying the NC Medicaid ACO Program for Pediatric Populations.** Pediatric providers are encouraged to participate in the Medicaid ACO program described above. However, because pediatric populations typically have low medical costs, the Department recognizes that shared savings based on the total cost of care may not be an appropriate incentive for improving pediatric care. To ensure that the Medicaid ACO program will drive meaningful improvements in pediatric care and appropriately reward pediatric providers for delivering high quality care, the Department will use several pediatric-focused measures in assessing quality for all ACOs.

  Further, all ACOs will be required to meet a certain benchmark on pediatric health outcome performance indicators in order to be eligible to receive shared savings payments. For further information on the ACO program and pediatric-focused model elements, please refer to the accompanying 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.*

  Partners for Kids

  Partners for Kids is a pediatric ACO formed through a partnership between Nationwide Children's Hospital and more than 1,000 doctors. Since its founding, Partners for Kids has made a number of improvements in the cost and quality of care for the pediatric population it serves, including:

  - Lower per member, per month costs than fee for service or managed care
  - Fewer asthma-related emergency department visits
  - Increased rate of appropriate treatment for upper respiratory infection

  The Department is also considering how this proposed ACO program might be further modified for providers who wish to form a pediatric ACO. For example, variations on the payment model, ACO entity requirements, quality and health outcome measures, or other parameters might better focus the program on improving care for children. The Department welcomes stakeholder feedback on such modifications and plans to directly engage pediatric-focused stakeholders in this discussion in the coming weeks.

- **Maternity/Neonatal Intensive Care Unit (NICU) ACOs**. Shared savings based on total cost of care may drive meaningful improvements for certain pediatric subpopulations, such as preterm or low birthweight infants. ACOs focused on improving maternal health and reducing NICU admissions may offer providers a greater opportunity to manage costs and earn shared savings. The Department encourages PHPs and providers to explore opportunities to form ACOs around these or other high-cost pediatric subpopulations.

- **Pediatric-related bundles**. Bundled payments for care episodes relevant to pediatric populations may help improve pediatric care quality and help contain the cost of care. Other states have used bundles to encourage improvements for both children and the larger Medicaid population. For example, Arkansas offers an asthma exacerbation bundle for all care delivered within 30 days of exacerbation of asthma.[14] The Department encourages PHPs to identify pediatric conditions or episodes of care that may be appropriate for bundled payments and explore opportunities for developing bundled payment arrangements with pediatric providers.

[14] For further information on Arkansas' asthma exacerbation bundle, please see https://medicaid.mmis.arkansas.gov/Download/provider/provdocs/Manuals/EPISODE/EPISODE_II.doc

- **Population-Based Payment Models.** Population-based, or capitated models focused on care for children reimburse providers for the total cost of care for a defined patient population. Models such as these, when designed with close attention to quality and access protections for patients, can give providers more flexibility to provide both medical and non-medical care that is appropriate for their population.

  These models are a promising way to provide payment for services that address unmet resource needs and for coordination with social service organizations, schools, and other partners that serve children and can help assure their physical and emotional well-being. One example of such a model is Partners for Kids, a pediatric ACO at Ohio's Nationwide Children's Hospital, which works with Medicaid Managed Care Organizations in Ohio, receives age-and-sex adjusted capitated payments for the population it serves and has seen promising results.

Maternity Care

The Department encourages PHPs and providers to explore options for developing bundled payments for maternity care. Medicaid currently makes a single payment for each maternity episode, covering prenatal care, delivery and postpartum care. If PHPs implement additional requirements to link these payments to quality metrics related to maternity care or the total cost of care, these payments can be considered a maternity bundle, which is classified as an HCP-LAN Category 3B arrangement. Please refer to the HCP-LAN framework[15] for further information on characteristics of bundled payments that qualify as Category 3B VBP. The Department also welcomes stakeholder feedback on how other VBP models might best serve pregnant women, new mothers and their infants.

Pharmacy

The Department has established a number of state-wide policies, including its Preferred Drug List (PDL),[16] to manage Medicaid prescribing patterns and pharmacy costs. The PDL aligns prescribing patterns around drugs that yield the greatest benefit at the best value for the State, saving $58 million in state funds in SFY 2017. While these policies promote high-value pharmacy care for the Medicaid population, they limit PHP and provider control over prescribing patterns and pharmacy spending. In light of this, the Department is proposing to price-adjust pharmacy costs to align with the highest value drugs on the PDL when calculating the total cost of care for its ACO program. This proposal is meant to ensure that variations in total cost of care under the program reflect changes in pharmacy utilization, not drug pricing.

Additionally, the Department encourages PHPs and providers to develop incentive-based initiatives around medication adherence and quality measures associated with medication adherence, which would count as VBP under the state's definition in HCP-LAN Category 2C. The Department welcomes stakeholder feedback on other ways to ensure VBP arrangements can capture pharmacy spending.

Healthy Opportunities

Investments in Healthy Opportunities resources have strong potential to reduce costs and improve the quality of care, and as such are an important way for PHPs and providers to ensure success under VBP arrangements. VBP arrangements can also offer flexibility to pay for these resources that may not exist as readily in the fee-for-service context. For providers pursuing ACO arrangements, the Department will require the ACO to submit a Healthy Opportunities Strategic Plan, outlining the ACO's approach to ensuring members' health-related resource needs are met and outlining roles and responsibilities for

[15] http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf
[16] https://medicaid.ncdhhs.gov/documents/preferred-drug-list

entities involved in addressing these needs. For further information on ACO Healthy Opportunities Strategic Plans, please see the accompanying white paper on the proposed ACO program. The Department also encourages PHPs and providers to explore opportunities to leverage other types of VBP arrangements to address patients' unmet health-related resource needs.

Section 5. Conclusion

At the conclusion of the public comment period, the Department will incorporate feedback it receives on the feasibility of targets, design of VBP, appropriateness of VBP goals and initiatives for the North Carolina Medicaid market, and other aspects of the above strategy as appropriate before releasing the final VBP Strategy on its website.

In the early years of Medicaid Managed Care, the Department will continue to monitor VBP adoption through reviews of PHP VBP strategies and assessments and outreach to stakeholders across the state. As the Department gains further insight into VBP activities, it will refresh the VBP Strategy as needed to ensure it remains achievable while continuing to raise the bar for value-based care in Medicaid.