NC Medicaid's Value-Based Payment Strategy
and ACO Program for Standard Plans and Providers
January 23, 2020

Dori Reyneri

(Slides 1-2) Welcome, everyone. My name is Dori Reyneri. I'm a senior manager at Manatt. And I've been working with DHHS and the VVP strategy and ACO model work. Thanks so much for joining today's webinar presentation on the North Carolina's Vision for Value-Based Payments and Accountable Care Organizations in Medicaid Managed Care. There are just a few housekeeping notes before we get started. First, all lines will be muted for the duration of this meeting, but you can enter questions at any time during the presentation. So, if you have a question, please submit it using the Q&A text box on your screen. And at the end of the presentation, we will read and respond to questions that we receive. And we'll respond to as many as time permits. Today, we're joined by Mandy Cohen, the Secretary of North Carolina's Department of Health and Human Services. And Amanda Van Vleet, the Senior Program Analyst for Quality and Population Health. I'm going to turn it over now to Secretary Cohen to start the webinar and make opening remarks. Secretary Cohen, over to you.

Secretary Cohen

(Slide 3) Hi, there. Good morning, everyone. This is Mandy Cohen, Secretary of the North Carolina Department of Health and Human Services. Thanks for joining us for this conversation. And some might be saying, Why are we having this conversation? Didn't you suspend your work on implementing Medicaid Managed Care? And that is correct. We are still suspended due to the budget issues that are going on in Raleigh. However, we all knew that as we were making this major change in our Medicaid program and moving to Managed Care, there were going to be many places in which the program needed to mature over a period of time, many skills that we needed to build both here at the Department and with our partners beyond. And so, this is our hope to be able to continue to make progress forward in doing some of the foundational work that I think it will take to move this state forward in terms of building a healthier North Carolina. So, in that vein we are continuing to put out policy papers like the ones we put out just a few days ago, the ones that we're going to be discussing on this webinar, and continue to make progress in building a healthier state. I think that folks who have heard me give speeches before have heard me talk about this vision of us wanting to use all of our tools to buy health for the state of North Carolina. And that has meant a broad thinking about what actually drives health and what actually makes us healthier and, knowing as a physician myself, knowing that the things that make folks healthy are more than what happens inside the four walls in the clinic. We've been thinking very broadly about what drives health. But importantly as part of that is the financing mechanism that goes behind that. How do we think about buying health and creating a financial system that aligns with that vision? I would say that the system that we have right now, one where we pay fee for service and pay in pieces is not one that directly aligns with that vision of buying health, and sometimes in fact inhibits that

vision when you have a financial system where to keep your doors open, to run successful businesses that many of you run every day, the incentives are to move on to the next patient rather than think about holistically in the way that we thought then, those of us who went to medical school and work in this every day want to. So, this is a foundation for, how do we think about the financial incentives within the system? The way in which payments move through the system, that can actually help us align better to that vision for buying health. We're going to dive into a lot of details here, but it's really important to not forget the, Why are we doing this? I think this is fundamental, foundational – I'll keep saying it over and over – to that whole vision of buying health, is getting the financial arrangements aligned so that we can all do the things that we either went to medical school or nursing school or went into this field to do in the first place, which is to keep folks healthy and to build that healthy state that we want to be part of. And so, we're going to dive into a lot of details and you'll see them here. I think some of the principles that will I hope resonate and come through here is that very much try to align what we see as moving the financial alignment and the payment model in Medicaid, to align that with what's going on in the larger system, meaning with our commercial Payers, with Medicare, and to align with those, to make this unified vision of buying health possible across all Payers, to be Payer agnostic, if you will. So, a lot of the details you're going to hear may sound familiar, because that was intentional, to align with where Medicare, where the commercial space is going. But it's important to understand the differences. The Medicaid population is different, particularly more dominant pediatric population, and so it's going to be important for us to understand the nuances and different components of how we're thinking about it. And what I would say is, we are in the design phase of this. And this is your opportunity to tell us yes, we got it right, no, we didn't. Are we doing this at the right scale, scope, speed? What are the details that really matter to making this ultimately successful? So this should be very much an opportunity for you to continue to give us feedback, as we continue to mature and build this program together. So, just at the very high level, what we had built into our Managed Care programs are goals around what we would hope to move from a traditionally pure fee-for-service environment to a value-based payment arrangement environment. And you'll see that here on this first slide, where we had targets within windows where we wanted Managed Care companies to contract with Providers in different and new ways under value-based payment arrangements, and to have those tied to shared savings or risk models by the time we matured the program. We know this is not an overnight kind of activity, but one we would do over time.

(Slide 4) I'm going to move to the next slide now, because you're going to hear details here. But we want to make sure that you know, and we recognize, that there are different levels of readiness for different kinds of value-based payment arrangements. Some may just be in the first part of using data, to look at quality metrics and do gap closures on those quality metrics. Others may be in a very different place or there have sophisticated attribution models and data systems that will allow them to really take on more risk as they contract the folks and take on downside risk models and everything in between. And so, we are trying to think about a menu of different arrangements that folks can find themselves in to move forward. And I think for me it is really about the alignment and getting on the path and moving forward. For those who are

going to be mature enough to take on some of those higher risk models, we also want to say well, what's in it for you? In addition to shared savings and financial rewards, but also administrative flexibility and contracting certainty. So I think you'll hear more about some of those things that we've been talking about. But again, this is an opportunity for you to give us feedback. You'll hear the details as we go through the slides here, but you can read even more in the two papers that we put out and that we are asking for your comments back by February 19th, and you can write those to Medicaid.transformation@DHHS.nc.gov. Obviously, we'll answer a lot of your questions here on this webinar. But with that at the high level, I'm going to turn it over to the team here. I want to thank them for the hard work they've been doing to craft where we go next. Again, I think this is so important to ultimately changing the way in which we're able to deliver on that promise of health for North Carolina. So, I appreciate your attention. And with that, I'm going to turn it over to Amanda Van Vleet to go through the next number of slides here.

Amanda Van Vleet

Great. Thank you so much, Secretary Cohen, for joining, and for that introduction. So, I will start, great, on Slide 5.

(Slide 5) This is an image of the Healthcare Payment Learning and Action Network Framework. This is a national framework that was developed by a public/private partnership including CMS as a standard framework for both public and private Payers to have a framework to move towards value. So, you'll see on the left-hand side of the graphic in Category 1, that's basic fee-for-service with no link to quality or value. And as you move to the right on the spectrum, you move in both risk and flexibility. So, in Category 2, you have some of your foundational payments for infrastructure and operations, your paper reporting, your paper performance. As you move on to Category 3, you get into shared savings arrangements both upside and downside. And as you move to Category 4, those are your population-based payments. So, condition-specific payments like bundles, comprehensive, population-based payments, global budget, and that's where integrated delivery systems fall as well. So, for – and I will also preface this by saying that this webinar and both of these two papers are specific to North Carolina Medicaid Standard Plans, Standard Plans and Providers. And so, Tailored Plans – our value-based payment strategy may look different for Tailored Plans, and that guidance will be coming out at a later date, so everything in this webinar today is focused on Standard Plans. So, for Standard Plans, we as a department are defining value-based payment based on this HBP Land framework, to align with a nationally recognized model for both public and private Payers. So, in the first two contract years of managed care, we will define value-based payments as anything in Category 2 and above. So, that's everything in this yellow box that you're seeing here. As we get into Contract Year 3 of Managed Care, we're going to slightly narrow the definition to include anything in Category 2C and above. So, those will be all payments with a direct link to quality or outcome. So, really that just gets rid of the paper performing and some infrastructure payments to really focus on payments that have a direct link to quality.

(Slide 6) So, moving on to Slide 6. These are target levels for value-based payments. So, we will – the Department will be setting targets for our prepaid health plans throughout the Managed Care contract. And they will be progressing. So we will set targets that our prepaid health plans need to meet for the percentage of medical expenditures in value-based arrangements each year. And these targets will increase over time. For the first couple of years of Managed Care, the targets for PHPs, the percentage of their medical expenditures that are in value-based payment arrangements will need to either increase by 20 percentage points, or represent 50% of their total medical expenditures. And then over years 3, 4 and 5 of Managed Care, those targets of the percentage of their medical expenditures that are in value-based arrangements will increase until pretty much all or 90% of total medical expenditures will be expected to be in value-based arrangements. We are also setting sub-targets for value-based arrangements that need to specifically be in shared savings and shared risk arrangements. So starting in Year 3, at least 15% of our PHP's total medical expenditures will need to be in shared saving arrangements. Those are upside savings only arrangements. There's no downside risk. And that's in place for Year 4, as well. And then by the time we get to Year 5, then we're telling our PHPs that at least 15% of their total medical expenditures will need to be in downside risk arrangements. So there is a progression for risk over time, and that will, of course, affect providers, with how their PHPs will be wanting to contract you, with you, in shared savings and shared risk arrangements over time. So, we are looking for you to work with the PHPs in helping to take, take on accountability for both the health of your populations and the total cost of care of your populations. For our PHPs, no withhold will be in place for the first two years, but they will start to take place in Year 3 of Managed Care. So, I know these targets are – seem fairly ambitious. They do align with other states' Medicaid programs in the percentage of medical expenditures tied to value. And we are allowing a lot of flexibility to meet these targets and the arrangements that PHPs and providers come to. So, again, we're defining value-based payments, as I spoke about in the last slide. So anything that falls within those categories, but within those categories, PHPs have flexibility for form any type of payment arrangement that works for them. So, Providers that don't have any experience with value-based payments can start with paper reporting or paper performance and build up their capabilities. Whereas maybe some larger health systems that may already be in the Medicare Shared Savings Program, for example, may be to start taking risks up front. So there's a lot of flexibility within the definition for PHPs and providers to contract directly. We encourage PHPs and Providers to form value-based arrangements that align with some of our existing state models. So, for example, our AMH Tier 3s will need to have some type of incentive payment tied to them. Also linking value-based payments up to some of our local health department care management programs, for example. And then, we are proposing Medicaid ACO programs, but I'll be going into more detail later in the slide. But, if you do look into our value-based payment strategy policy paper, we list a lot of examples of value-based payment arrangements that providers can enter into. Some of these, especially for the Medicaid population, could be maternity or NIC-UACOs, pediatric-related bundles, for example, for asthma, or population-based payments or capitated payment models. And again, those providers with less experience can start with less risk-based payment arrangements, like a paper performance.

(Slide 7) Yes, thank you. One of the payment models that we're proposing to help PHPs and providers meet these targets that we're setting is a Medicaid ACO program. So this will build both on the overall targets to move to value and then also the subtargets for shared savings and shared risk arrangements. So in developing our Medicaid ACO program, we had a few thoughts in mind that we tried to keep in mind for the overall vision. One, as the secretary earlier said, we want to purchase health, so there's a big focus on these ACOs on improving health outcomes and reducing the total cost of care, rather than paying for discrete services. We'd like to build on the advanced medical home delivery model. So our AMHs will still be foundational, especially if they're care management, but we do want to allow some flexibility for providers that take on downside risk, to focus a bit more on outcomes and on total cost of care. We also want to provide flexibility to PHPs and providers to be able to negotiate and innovate while establishing some guardrails to the ACO program, to streamline contract negotiations, and reduce administrative burden. And one of the reasons that we are putting these guardrails besides for ease of contract negotiations, is also really to offer some type of leverage to providers, and coming together and forming these arrangements, and the end contracting that will happen with PHPs. We also wanted to align with some broader market movement in North Carolina towards ACOs. We know that a lot of our larger health systems and some independent primary care providers are in either Medicare or commercial ACOs, and so we're really looking for practices that are already doing this for their other populations, to do this for their Medicaid patients too. And for providers that may not be in these types of arrangements, an opportunity to start getting into some of these type of arrangements or forming your own. And one of the things that I'll get into a bit later, too, is we wanted, we really feel strongly about offering an option for providers that would like to get into these types of arrangements to not – they can join a large health system if they want to, but if they don't want to, we want to allow an option to form their own model. And also, of course, taking into account, the diversity of our providers in North Carolina. So by setting different expectations for smaller, rural independent practices, and those hospital-affiliated providers.

(Slide 8) So moving onto the next slide – excuse me. This goes into a bit more detail of what I was thinking about with the different models for providers at different readiness of risk. So our Medicaid ACO – our proposed Medicaid ACO program is a two-track program. Track one will involve no or minimal risk in the early years, they're mostly upside shared savings only. And this track is really, it's open to ACOs that – it's generally meant for ACOs that consist of independent providers that come together, a provider-led organization, FQHCs, independent or rural hospitals. Those types of providers without experience in this area that may be coming together for the first time, to have an opportunity for them to be in upside-only shared savings arrangement. Track two is really meant for groups of providers that are already doing this type of work. So if there is a group of providers, or an IPA or a CIN that is in an existing Medicare – in the Medicare shared savings program or commercial ACO program. This track is open – it'll probably be most attractive to those types of organizations but it is open to any ACO – excuse me – that would like to capture greater per – greater shared savings because with more risk there is a higher opportunity to earned shared savings in this track. But we do expect it to be most appealing to providers with experience in shared savings models. And you'll notice that

these two tracks, as the secretary said to you earlier, they do quickly align to the Medicare shared savings program, and in particular, the basic and enhanced tracks of the, of MSSP. As far as oversight of the ACO program – so for both tracks the state will be outlining ACO program requirements which are detailed in our ACO policy paper that we put out recently and we are seeking feedback and comment on now – and we'll be overseeing ACO entity attestation or certification, so entities that want to be recognized as Medicaid ACO will have an attestation process, especially for those entities that do want to take downside risk, to make sure that they're, that they have the appropriate financial solvency. But our PHPs will be responsible for actually contracting with ACOs and for overseeing ACO compliance with the ACO program on a day-to-day basis.

(Slide 9) We move on to slide 9. This is an example of what an ACO could like. So multiple types of entities can form ACOs. We really want to be open to any type of entity that would like to form one. So they can be composed of CINs, of Independent Practice Associations, of health systems – we're really open to any type of entity that would like to form an ACO as long as they meet the guardrails that we have laid in the program. ACOs that are not taking on downside risk need to be composed of Tier Three AMHs, but for ACOs that are taking on downside risk – for example, we are considering loosening some requirements on some of the Tier Three requirements there in that space. So we will, the state will establish a minimum set of requirements for ACO entities that are outlined in the policy paper that relate to their legal entity status, their governance and leadership structure, and their financial solvency if they are taking on downside risk. We'll also establish requirements for a minimum number of covered lives in each ACO in each of the two tracks. And we're, one important piece of information we are – again, we're really using this model as a lever for providers to form these types of entities, so we are proposing that PHPs must contract with any ACO that meets these state-defined parameters.

(Slide 10) So going on to slide 10. We did include what I think are some unique features into our Medicaid ACO program to meet the needs of North Carolina beneficiaries in particular, especially as compared to some of the Medicare and commercial ACO models. So since, since children are such a large part of the Medicaid population, all of ACOs will need to meet certain pediatric quality measures as a gateway to earn any shared savings. So we want to make sure that all Medicaid ACOs are really focusing on improving care for children, in particular, since they're such an important part of the Medicaid population. Also, to help further drive integration of physical and behavioral care, we do have behavioral health leadership requirements for ACOs. So in addition to having a chief medical officer, they'll also have a chief behavioral health officer to focus on integrating physical and behavioral health. We would also like our ACOs to focus on addressing unmet resource needs, so each Medicaid ACO will need to submit a Healthy Opportunities Strategic Plan to the department to let us know how they plan to work with community-based organizations and social services agencies in their communities to address the unmet resource needs of their Medicaid members.

(Slide 11) Going on to slide 11, we also have some participation incentives for entities that we are referring to as early innovators, so we really want to encourage providers to come together soon to form these models. So any providers that are coming together as a track one ACO – so these are maybe providers that are not in existing ACOs now that are coming together for the first time and form an ACO early at the ACO program launch. They will be able to be early innovators in addition to ACOs that are in track two that take on downside risk early. And I'll go over the timelines in a minute. But basically, again, the two things we would really like to encourage here through the early innovator program are track one ACOs starting soon, and track two ACOs taking on downside risk soon. So for those early innovators, we'll offer some unique incentives. So these can include a variety of incentives, and this is one of the things that we're seeking comment on in the paper, but some of the ones that we've thought about – we have a state-led advisory group that makes policy and implementation recommendations related to care management and the AMH program and will be providing policy and implementation recommendations on the ACO program, so the opportunity to participate in that advisory group – they could be offered technical assistance to help address key implementation issues, you can invite them to participate in department-led learning collaboratives, possible offer enhanced data such as quality data that's aggregated at the ACO level, as well as the ability to bypass some administrative requirements such as prior authorization, for example. But this is an area where we're seeking comment on what would encourage providers to form ACOs quickly and to take on downside risk quickly.

(Slide 12) You'll see a timeline of the proposed Medicaid ACO program. So right now, they are scheduled to launch in mid-2021. This may depend on the budget in Managed Care launch, but as of now, we are planning to launch them in mid-2021. And while this will be the start date of the program, ACOs can form at launch at any time, so on a rolling basis – they don't have to start on a specific schedule. For track one ACOs, they will be, again, in minimal or no downside risk during the initial years, but we do expect them to move to downside risk in later years. And for track two ACOs, we'll allow a two-year glide path at the beginning of the program where they can take on lower risk arrangements or upside risk only arrangements that are similar to track one for the first two years before needing to take on some minimal levels of downside risk. We are proposing that this initial two-year glide path only be available in the first two years of the program, so another incentive for ACOs to join early so that you'll have access to this initial glide path before taking on minimum levels of downside risk as a track two ACO.

(Slide 13) So again, we have our two policy papers out now – one is our overarching value-based payment strategy for Managed Care and out standard plan, and the other is a policy paper on our proposed ACO program. So please we welcome and encourage your feedback. Now is your time to please give us input on these models, in particular – particular we'd really welcome your feedback on a few areas. One is that the appropriate timeline for track one ACOs to again taking on downside risk. The second really how to encourage providers like SUHDs, local health departments, rural health providers, and other Medicaid partners into ACOs – how to incorporate them as best as possible. What participation incentives would be attractive for ACOs to take on early downside risk? The eligibility thresholds and minimum covered lives for

track one and in track two ACOs, the approach for setting benchmarks and measuring total cost of care, which we are working through now and will relay – we'll release some future guidance. The proposed payment parameters that are outlined in our ACO policy paper, and what quality and outcome measures would be most meaningful for ensuring high quality pediatric care again as that kind of threshold to earn shared savings for the pediatric population.

(Slide 14) So we'll open it up to questions now. Dori, would you like to facilitate questions?

Dori Reyneri

Sure. Sounds good. So we have a few questions here to address. I think one that you've heard before and one that's a TF whether the AMH program is going to continue after launch of the ACO model, and how the ACO model relates to the Advanced Medical Home Program. So Amanda, did you want to take that one?

Amanda Van Vleet

Yeah, sure. Yes. AMH program will very much still be in place and track three AMHs are still very important to us. I think that we view the ACOs as an evolution in the AMH process so a process that practices can take to become an AMH tier three and then an ACO when they're ready.

Dori Reyneri

Thank you. Another question we've gotten is whether providers who are interested in the ACO model but don't think they will be ready to start right at program will be permitted to join or form ACOs at a later date?

Amanda Van Vleet

Yeah. Yes, definitely. The program, again, is slated to launch in mid-2021 but ACOs can join the program at any time.

Dori Reyneri

Thank you. Another question we've received is how long ACOs will be allowed to remain in track one, the lower risk track? I think this is one where we solicit comment in the paper, if you wanted to speak to that.

Amanda Van Vleet

Yeah. I think this is something that we're thinking through, too, and would really like public comments on when, yeah, on what the appropriate timing would look like there.

Dori Reyneri

Great. Another question we've gotten is how does the ACO program relate to the CIN, this Clinically Integrated Network, we've had a question about what a CIN is, and whether you can be part of the ACO and also part of the CIN.

Amanda Van Vleet

Yeah. So CINs are one type of entity that I think would be prime candidates to become ACOs, so a CIN can certainly become an ACO. The CIN could still continue to serve practices that are not in the ACO, as well. Though, excuse me, if that makes sense. They could be one and the same but they don't necessarily have to be, if that makes sense.

Dori Reyneri

And could you just say a word or two about what a CIN is, Amanda?

Amanda Van Vleet

Yes. A clinically integrated network. So a clinically integrated network of providers– so, for example, CCPN or UNC.

Secretary Cohen

So, sorry, this is Mandy, why don't I just jump in here? So what I think is the important decision is there are many competencies the CIN may be engaging in – whether it's looking at data, understanding who their patients are, looking at quality metrics – that are all foundational to then taking on the next step, which is when we're talking about taking on some financial accountability for total cost of care, as well. I think that the distinction, at least in my mind, is that CINs generally stay in the quality space and looking at data, which is all great, and I think foundational important – the next step here is to then think about the financial models that go along with that that I think facilitate doing better work on the quality side and the patient care side, and allow for that flexibility and additional investment for the integrated networks, and I think we are trying to layer in incentives for folks to say well why would I take the step from clinically integrated network to ACOs and I think there's a number of reasons to do that. One, I think the financial incentives align better with the ability to invest to meeting those quality metrics. We're also – you heard about some administrative flexibility. I think all of us who have ticked off quality measures and are always interested in thinking about well what are the administrative flexibilities that we can get if we are all aligned in a model that looks at both quality and total cost of care. And so I think there are a lot of really important reasons why some organizations will take the step from becoming just a clinically integrated network to an ACO. But I do think that that is, that takes more sophistication with understanding exactly who your patients are how you're tracking them over time, so there are additional competencies as you mature those organizations.

Dori Reyneri

Thank you. We've gotten a few questions on the timeline. So how does the timeline relate to the launch of Managed Care and what does it mean to say year one, or year two of the program now that Managed Care has been delayed? I don't know, Amanda or Jay, if you'd like to take that one.

Jay Ludlam

Yes, good morning, everybody. This is Jay Ludlam. So contract – year one, year two refer to contract years. So once we have clarity of the budget and we launch, that would begin contract year one. I think that clearly this timeline will have to adjust to the, you know, to the new contract – the start of the new contract year – when we have greater clarity about the budget. But for the time being, this is our, this timeline that Amanda spoke to earlier, does reflect where we want it to be and I think that, you know, there have been events that have taken place since the ACO paper was released that indicate that time timeline may need to be adjusted. But rather than adjust that timeline now, I think what we are waiting for is greater clarity about the budget.

Dori Reyneri

Thank you. Another question we've gotten if you're an individual provider, how would you begin to think about joining an ACO? What are the pathways available to you to understand more about what the ACO options are if you would like to join? Amanda, is that one you can take?

Amanda Van Vleet

Yeah, that's a great question. There are some organizations out there, some in North Carolina already, that help with this type of work. I would certainly - I think that that's a really good place to start. A lot of these organizations offer technical assistance, IT assistance, some will even take on downside financial risk for providers that join, so certainly getting in touch with some of these organizations, and then, I think. I mean--

Secretary Cohen

Yeah, I think doing some market research in your own community, I'm sure, there, we have a number of ACOs that already exist on the Medicare, and the commercial side, as we've mentioned, and so you may – either you may be part of those already, or thinking about whether or not joining us. And joining those networks does not, that does not mean you need to be bought by them, or have official merger agreements – they can be partnerships that allow you to stay financially independent but then partner in ways that allow you to share data and join together from a governance perspective to allow you to participate in these models. So I'd do a little bit of asking around of like who are the ACOs in our net--- in your geographic area, as

well as in the total state. I'd get in touch with our professional societies, whether that's a medical society or family physicians, pediatricians – all of those, I think, can be important gateways. And then there are a ton of vendors in this space can help as Amanda mentioned in different ways to actually get you started and give you the tools. And I think we are agnostic to whom and how you partner, but rather, at the core of it, getting to these aligned incentives, so that we could sort of all be rowing in the same direction.

Dori Reyneri

Thank you. We've had a number of questions from pediatric providers and those interested in how the ACO model for a pediatric population. And I know this is an area we're definitely interested in stakeholder feedback, as well, but Amanda, maybe you could speak a little bit to the thinking about pediatric ACOs and how that might work.

Amanda Van Vleet

Yeah. I think that's a really good question that we're also trying to think through and would love public comment on. Yeah. We certainly want these ACOs to work for children, and I think that there could be pediatric-specific ACOs, there could be ACOs that include both children and adult, you know.

Secretary Cohen

And I think the kind of, and this is Mandy again, the kinds of information that would be helpful for feedback are what are the quality metrics like, right, because we keep focusing on that we have to have accountability for quality as we think about these financial models. What are the quality metrics that are right for pediatricians. What is the attribution model? What size do these organizations need to be? I think we have benchmarks for the Medicare population – is that right? How many lives are we talking about? And then what are the specific special needs of children as we think about these models that we should be aware of. Obviously, we want, Medicaid is such a large payer for care for kids that we want to be sensitive to making sure this works for our pediatric colleagues who are doing the hard work every day. So, I know, we've appreciated your feedback in the past about what are the concerns of pediatric practices and what do we need to be thinking about. But think about those quality metrics, attribution, size, governance and—

Jay Ludlam

Risk tolerance.

Secretary Cohen

Yeah, fair enough, risk tolerance, pace of change. All those things will be useful for us to hear about.

Dori Reyneri

Thank you. So another question we've gotten is about attribution to the ACOs and how the attribution logic will work for the ACOs? Amanda, did you want to take that one?

Amanda Van Vleet

Yeah. So we're proposing that attribution flow through the beneficiary's PCP so through a normal standard plan PCP attribution process so a beneficiary will either be able to – well they'll be able to choose a PCP or if they do not choose a PCP, then the PHPs have an algorithm to assign a beneficiary to a PCP. But if the beneficiary's PCP is in an ACO, then the member would be with that ACO and the member's PCP is not in an ACO, then the member would not be in an ACO.

Mandy Cohen

I think this is an important point to note if – the attribution – yes, we're thinking about through primary care practices, but this does not mean that specialty practices don't have a role here and, in fact, even though the attribution is linked, having specialty practices be involved in thinking about total cost of care, I think is really important. And so this, I think, we're, think is an opportunity for different entities and different kinds of practices to come together, even though the attribution is through primary care, we are looking for models that can be larger partnerships beyond just primary care.

Dori Reyneri

Thank you. And I think we have a couple of more questions here. One question is on the necessary number of minimum lives that will be required to form an ACO. And Amanda, I know we did put some proposals there in the paper for stakeholder input, but if you'd like to speak to that a little bit.

Amanda Van Vleet

Yes, I believe that we – please correct me if I'm wrong, Dori – I believe we said 5,000 minimum covered lives for track two and we're considering one to two thousand minimum covered lives for track one. Although or, we also realized that – especially with the one with 2,000 is fairly low – so this is also an area where we could really use stakeholder feedback. We're aligning the 5,000 with MSSP but the track one and track two we're real, I believe, we're really looking to allow smaller groups of providers to come together but we realize that there still needs to be a minimum number to spread the risk. So yes, we'd love feedback.

Jay Ludlam

And when you say align with MSSP – what is MSSP?

Amanda Van Vleet

Yes, sorry. The Medicare Shared Savings Program, which is a Medicare ACO model that we are aligning this to, to try to ease provider burden.

Dori Reyneri

Great. Thank you. OK. I think we had one question back at the beginning of the presentation, Amanda, about the HCP land categories and what counts as VBPs, so pivoting away from the ACO model briefly. There was a question about whether the 3N and 4N categories – those are the ones that don't have a link to quality but are risk-based would count as VBP. And I think the answer is no but Amanda, I thought you might like to elaborate on why quality link is so important.

Amanda Van Vleet

Yeah, that's correct. No, they would not be counted as value based payments with the department or in our targets or in the ACO program. I think that what we're really trying to do with value based payments is link payment to quality and to outcome, and so that's the whole goal of what we're trying to do with paying for value so that quality or outcome link is really important.

Dori Reyneri

Great. OK, and last question, I think, is on – we've gotten a few questions about the vision for involving maternity care and OB/GYN providers – whether they would be considered primary care or specialty.

Amanda Van Vleet

We would love feedback on that. I don't know if you have other thoughts on that, Dori, but I think it's a really good question that we could use feedback.

Dori Reyneri

Yeah, I would say we definitely welcome feedback on that and, you know, to the extent that a maternity care provider can already participate in the AMH program, that's certainly one way to get attribution, but we definitely want to think about maternity care and how that fits into the ACOs – what the appropriate quality measures are there to get those services.

OK. So I think that's all the questions we got. We'll wrap up a little bit early but Amanda, would you like to close us out?

Amanda Van Vleet

Thank you everyone for joining. Please continue to send feedback. The email address is listed on the slides. We're collecting feedback through February 19th so please send it soon and we'll consider it as we build out this program.

Dori Reyneri

Also note that the presentation from today will be available on the Medicaid Transformation website in the coming days. So you can download it there. Thank you.

Amanda Van Vleet

Thanks everyone.

END WEBINAR