AMERICA'S PHYSICIAN GROUPS

APM Committee

July 13, 2021

Housekeeping

- Type questions in the Q & A box
- This webinar will be recorded
- Links to the recording and slides will be sent to registrations
- Please complete the post-webinar survey that will appear after you close the WebEx window

Welcome and Introduction of APM Committee Chair

Valinda Rutledge
Executive Vice President of Federal Affairs at America's Physician Groups

APM Committee Co-Chair

Steve Neorr
Chief Administrative Officer
from Triad Healthcare Network

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SANOFI PASTEUR

Guest Speakers

Allison Orris
Partner
Manatt, Phelps & Phillips

Seth Morris
RVP Provider Solutions at Healthy Blue North Carolina

David Kibbe
Senior Vice President, Network Development and Contracting
Cone Health

Agenda

- Welcome and Introductions - Valinda Rutledge
- Remarks from APM Committee Chair – Steve Neorr
- A look into the Medicaid National Landscape - Allison Orris

  My Healthy Blue in NC and their Provider Collaboration Model/Strategies for Medicaid - Seth Morris
- Cone's Strategy Perspective on Implementing Medicaid Managed Care with Multiple Payers - David Kibbe

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Current Medicaid Policies and Priorities

Presentation to America's Physician Groups

July 13, 2021

Agenda

- **Background**
- **Biden Administration Medicaid Priorities**
  - Outline of Administration's Key Priorities
- **Administrative Action**
  - Administrative Levers
  - Supplemental Payments
  - New Direction of 1115 Waivers
  - Protecting Coverage at the End of the PHE

Background

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Snapshot of Current Medicaid Enrollment & Delivery System Trends

States are increasingly delivering Medicaid benefits through managed care, both in terms of spending and number of lives

- Today, Medicaid enrolls approximately 80.5 million people
- As of July 2019, 40 states (including DC) contract with comprehensive, risk-based managed care plans to provide care to at least some of their Medicaid beneficiaries
- 69% of Medicaid beneficiaries are enrolled in comprehensive Medicaid managed care plans
- In FY 2019, payments made to MCOs accounted for about 46% of total Medicaid spending
- States are expanding the use of managed care to cover new Medicaid populations *and* new benefits/services

Source: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

Biden Administration Medicaid Priorities

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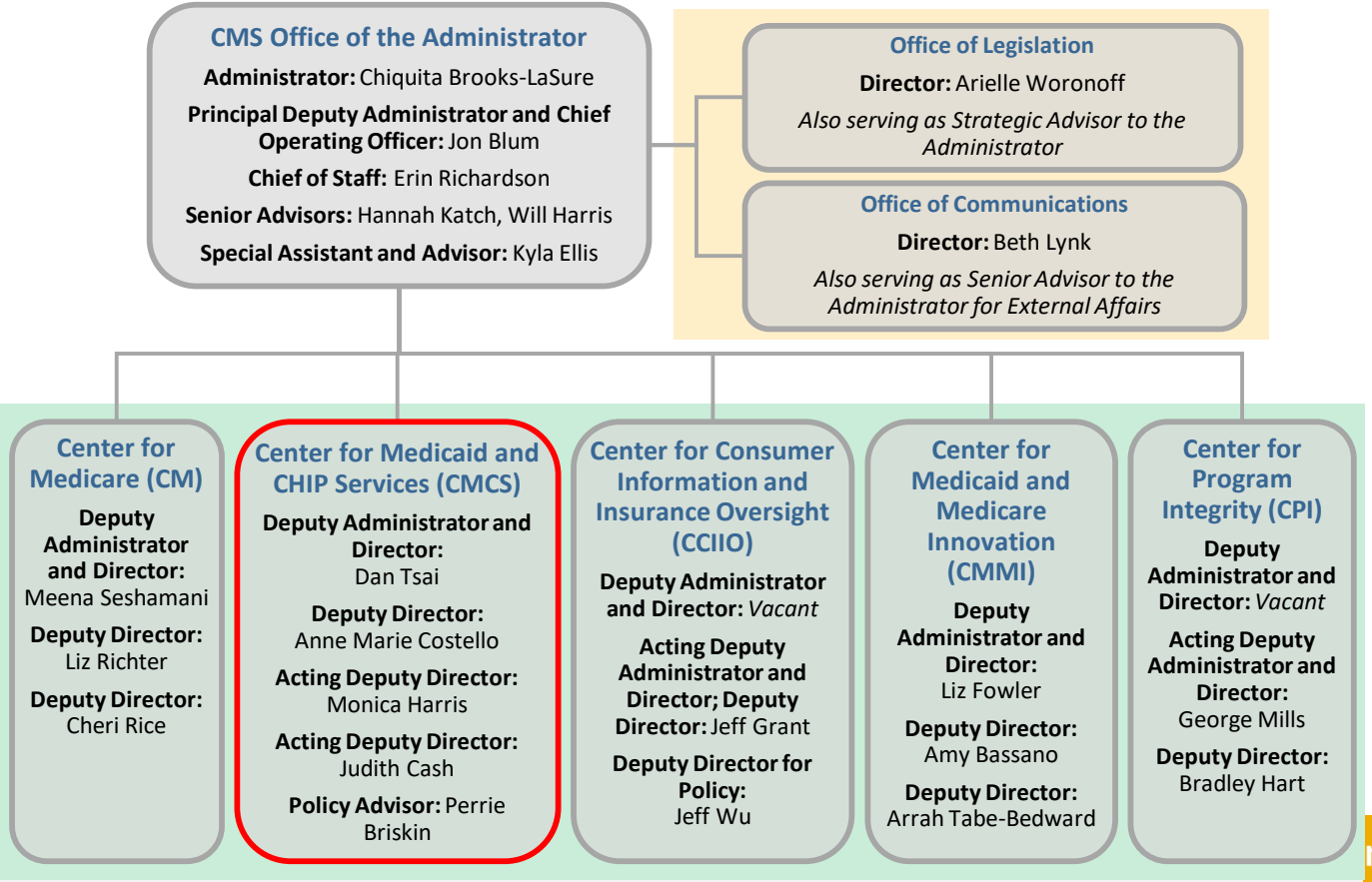
Centers for Medicare & Medicaid Services Leadership



Source: Centers for Medicare & Medicaid Services website

Updated July 8, 2021

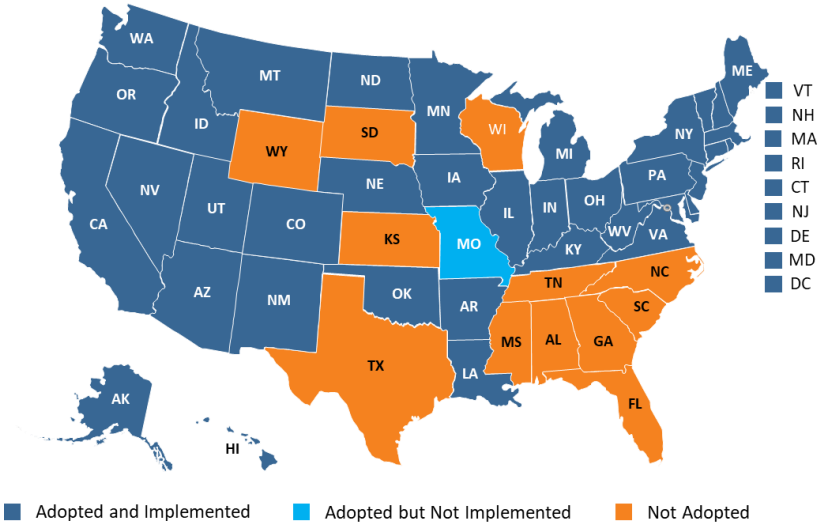
Priority: Commitment to Coverage

The Biden Administration supports efforts in Congress to create a public option, lower the age of Medicare eligibility, and expand benefits (vision, dental, and hearing). Top priorities also include:

- **Medicaid.**
  - Executive Order and early actions to reestablish coverage as the objective of the program; moved to rescind work requirement waivers;
  - Added new expansion incentive in the *American Rescue Plan (ARP)*
  - Seeking federal "fallback" for people that remain in the Medicaid coverage gap
  - Extension of post partum coverage period (state option)
- **Individual Market.**
  - Expanded premium tax credits through ARP, and proposed to make permanent under *American Families Plan*;
  - Healthcare.gov special enrollment period and new navigator funding;
  - Commitment to comprehensive coverage by restricting short-term plans

COVID-19 Relief Bill Prioritizes Medicaid Expansion

Medicaid Expansion Status by State



As of June 2021:

- **Oklahoma** started enrollment with coverage effective 7/1.
- **Missouri's** legislature did not allocate funds for expansion after voters approved expansion last year; litigation pending

Medicaid Expansion Incentive

Two-year, five percentage point increase in the Medicaid matching rate (FMAP) for "traditional" eligibility groups for new expansion states

Source: Status of State Medicaid Expansion Decisions: Interactive Map, 2021.

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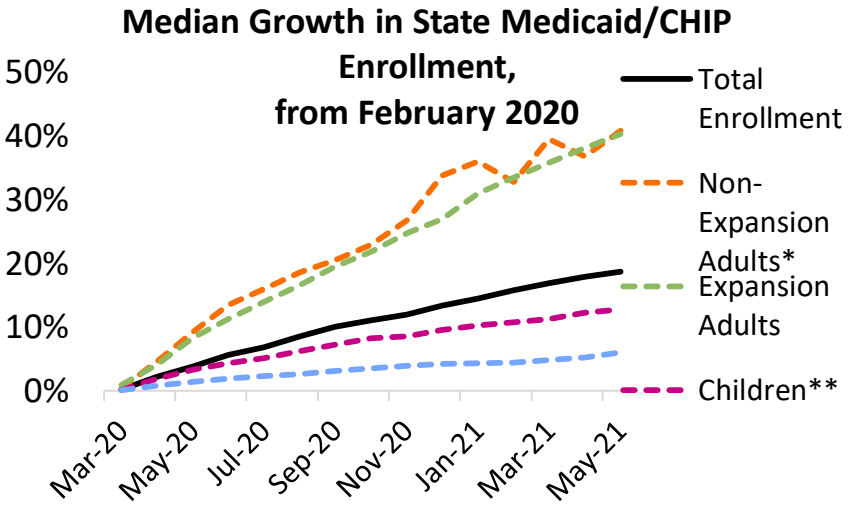
Protecting Coverage at the End of the PHE

Increases in Medicaid enrollment are in part due to a "continuous coverage" requirement in effect during the PHE—without good planning and execution in states when redeterminations resume, substantial coverage losses among eligible people are likely



*E.g., parents and pregnant women
**Includes children enrolled in Medicaid and CHIP
Note: The number of states reporting data varies by month
Source: Manatt analysis of state Medicaid enrollment databases.

- From February 2020 through May 2021, **total Medicaid and CHIP enrollment grew by 18.7%** in the median state
- This suggests that Medicaid and CHIP have **added more than 10 million enrollees** since the beginning of the pandemic
- Some states have seen overall growth **in excess of 30%**

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Priority: Addressing Equity

President Biden issued an executive order pledging to "embed equity across federal policymaking and root out systemic racism." Equity focus reflected in Administration's executive actions, legislative proposals, and proposed budget.

- **COVID-19.** Established a COVID-19 Health Equity Task Force
- **Coverage programs.** Announced support for health coverage outreach and enrollment for Black, Latino, and Asian American and Pacific Islander (AAPI) communities
- **Maternal mortality.** To address the "Black Maternal Health Crisis," announced increased investment in reducing bias and decreasing maternal mortality/morbidity
- **Immigration.** Supported legal and agency actions to overturn the Trump Administration's public charge rule and other restrictive policies
- **Gender Identity.** Reinstated Section 1557 antidiscrimination protections for gender identity
- **Anti-poverty.** Through ARP, enacted healthcare affordability policies, economic stimulus, housing assistance, and child tax credits; *American Families Plan* would make some of these policies permanent
- **Research and data.** Centers for Disease Control (CDC), National Institutes of Health (NIH), and CMS will all be prioritizing data collection and research related to social determinants of health and alleviating health disparities
- **Infrastructural disparities.** Proposed the *American Jobs Plan,* which includes ensuring lead-free drinking water and broadband internet access; the plan calls for 40% of the benefits of infrastructure investments to go to disadvantaged communities

Other Medicaid Priorities

Delivery system reform, Biden style

- New or expanded initiatives to promote value and equity in the delivery of care

Investing in Social Drivers of Health

- Integrating SDOH into health policy priorities and earmarking CDC funding to address social drivers

HCBS

- Proposing $400 billion to create jobs, and raise wages and benefits for essential home care workers

Access to Care

- Strengthening access standards and oversight

Duals

- Improving the integration of care across dual eligible populations

Administrative Action

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Administrative Levers to Advance Medicaid Policies

The federal government has many tools to advance policy priorities, including by defining benefits, reviewing rates from plans, and approving waivers.

Regulations

- Administration can advance priorities through regulations and guidance
- Rules Biden Administration has signaled it plans to or has begun to unwind/modify:
  - Public Charge Rule
  - Section 1557 Healthcare Nondiscrimination Rules
  - Title X rules
  - Access to care
  - Statutory Conscience Objections

Waivers

- Administration may indicate its waiver priorities
- States have their own priorities that address delivery reform, SDOH, and equity.

Center for Medicare and Medicaid Innovation

- Administrative authority to experiment with policy improvements and to reduce costs
- CMMI priorities reinformed by Biden Administration placing Trump-era models on pause
- Significant portion of latest $10 billion appropriation uncommitted, giving Administration a wide berth to act

Inter-agency and inter-department Initiatives (to address issues like homelessness, hunger)

Medicare & Medicaid Coordination Office (Duals Office)

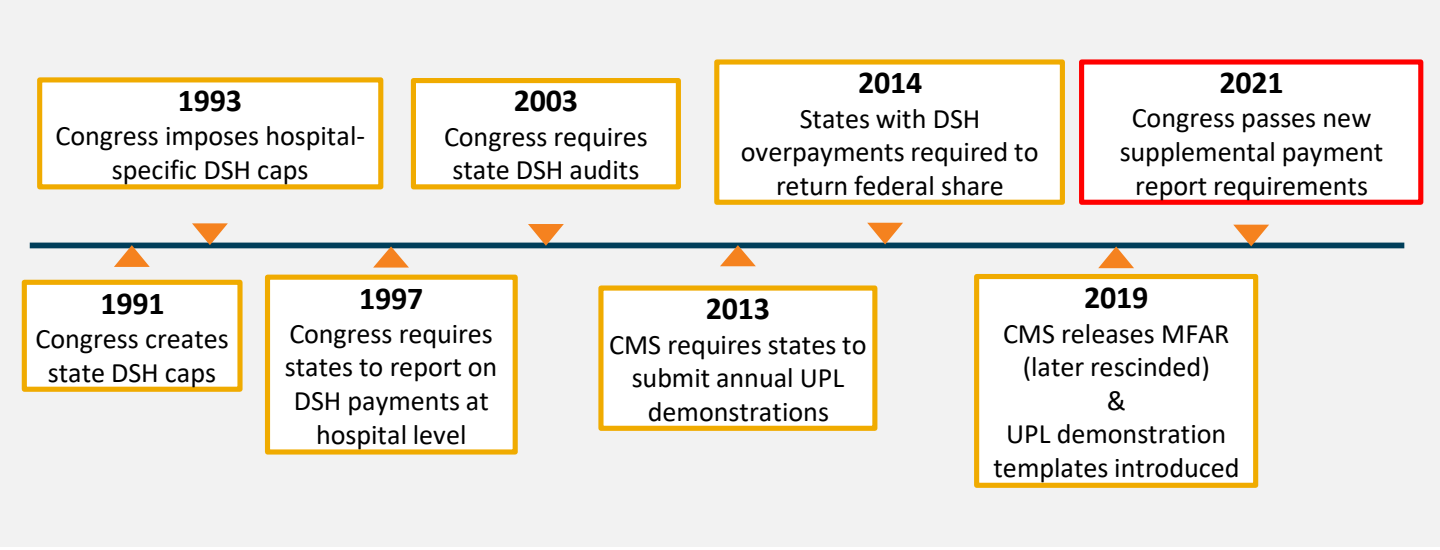
Access to Care: New Medicaid Regulation(s) on Horizon

The Administration's Spring 2021 Unified identifies Medicaid access regulations that CMS plans to pursue over the next year.

- **Access standards.** Medicaid covers more Americans than any other source of health coverage. To ensure that Medicaid enrollees can access needed services, federal regulations requires states to:
  - Conduct regular "access reviews" in their fee-for-service programs
  - Verify that their managed care contractors maintain adequate provider networks
- **Access challenges.** Some enrollees face specialty shortages and wait times in some areas
  - Private litigation is no longer an option for enforcement, due to the Supreme Court's 2015 decision in *Armstrong v. Exceptional Child Center*
  - Without private enforcement, CMS standards and CMS monitoring becomes even more important

New Reporting Requirements on Supplemental Payments

After years of supplemental payment scrutiny, in the Consolidated Appropriations Act (CAA) of 2021 Congress established new federal reporting requirements.



Source: 42 U.S. Code § 1396r–4; President's Budget FY 2019; Bipartisan Budget Act of 2018; 42 CFR Part 447; Information on the DSH Reporting and Audit Requirements (CMS) ; Annual Analysis of DSH Allotments to States (MACPAC 2018); CMS 2017 Proposed Rule: DSH Allotment Reductions

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Supplemental Payments

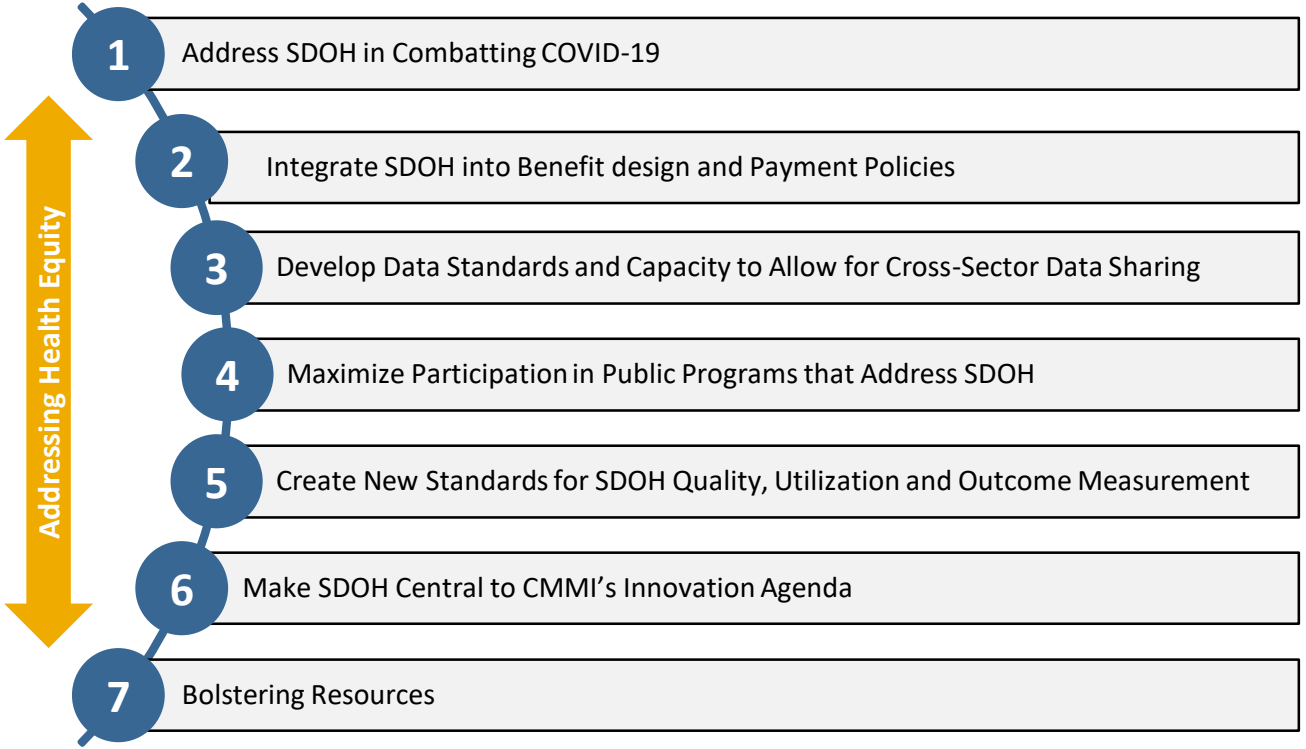
Reporting requirements are focused on UPL payments, but CMS could adopt broader reporting requirements.

Types of Hospital Supplemental Payments	DSH Payments	UPL Payments	GME Payments	1115 Waiver Payments	Directed Payments
	Statutorily **required** Medicaid payments to offset hospital uncompensated care costs	Payments to fill in the gap between Medicaid and Medicare rates (Medicare reimbursement is the "upper payment limit")	Payments for direct and indirect costs of medical education (in some states these are "UPL" payments)	Payments authorized under 1115 waiver to cover uncompensated care costs or support delivery system reform	Payments the State may require MCOs to make to providers to support access and/or quality; unlike other supplemental payments must be made on per-
Size	**$14.9 billion (2019)**	**$16.5 billion* (2019)**	**$5.6 billion** (2018)**	**$14.2 billion (2019)**	**Not available**

Notes:
**Size of UPL payments may be understated due to the different ways states report UPL payments.*
***GME payment methodologies vary by state. Figure includes GME payments made through base payments, supplemental payments andmanaged care plans. A portion of dollars identified as GME may also be included in UPL payment estimates.*

Sources: MACStats Exhibit 24, MACPAC, December 2020; Medicaid Graduate Medical Education Payments: Results From the 2018 50-State Survey, American Association of Medical Colleges, July 2019; Medicaid Base and Supplemental Payments to Hospitals, MACPAC, June 2018.

Many Levers for Addressing SDOH



New Directions for Section 1115 Demonstrations (aka "Waivers")

Federal Administrations often signal their waiver priorities. For example:

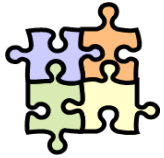
President George W. Bush	→	**Health Insurance Flexibility and Accountability Act** ("HIFA")
President Barack Obama	→	**Delivery System Reform Incentive Payment** ("DSRIP")
President Donald Trump	→	**Work Requirements and Block Grants**

Waivers must:

- ✓ **Be requested by a state**
- ✓ **Approved by the Secretary**
- ✓ **Promote the objectives of the Medicaid program**
- ✓ **Be budget neutral**
- ✓ **Receive stakeholder input during development process**

Medicaid Programs Are Implementing Value-Based Payment

A majority of states are now incorporating or planning to incorporate VBP into their Medicaid programs, sometimes using Medicaid waivers

VBP is about:	
	**Accountability at the site of care.** Providers play a central role in improving patient outcomes and controlling costs.
	**Collaboration across organizations.** Providers adopt a team approach, which requires changes in organizational culture, processes and systems.
	**Whole-person care**. Providers work with other professionals to addresses a broader range of patient needs.

Questions and Discussion

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Thank You!

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ADVANCED MEDICAL HOMES (AMH) - PROVIDER COLLABORATION & SUPPORT

- **Primary Care Providers (PCPs)** serve as entry point into the health care system and foundation of the AMH.
- The **AMH care model** is designed to strengthen clinician-patient relationships and promote coordinated care over episodic care.
- **Medical homes** improve quality of care and safety, increase focus on preventive services and management of chronic conditions.
- A **dedicated Healthy Blue team** will partner with your practice to develop more efficient, effective care management processes.

PROVIDER COLLABORATION TEAM FUNCTION

Performance Enhancement

- Create collaborative relationships
- Opportunity analysis
- Performance tracking
- Best practice suggestions
- Data, education and clinical interventions
- Structured provider-facing meeting cadence to share performance and drive action planning
- Enhanced data analytics

Improved Provider Performance

Tools & Resources

- Academic detailing and consultative skills
- Action planning
- Comprehensive analysis of timely and accurate data to identify cost/quality opportunities
- Customized collaterals focused on clinical interventions, best practices
- Internal reporting systems for progress monitoring, goal setting, action planning

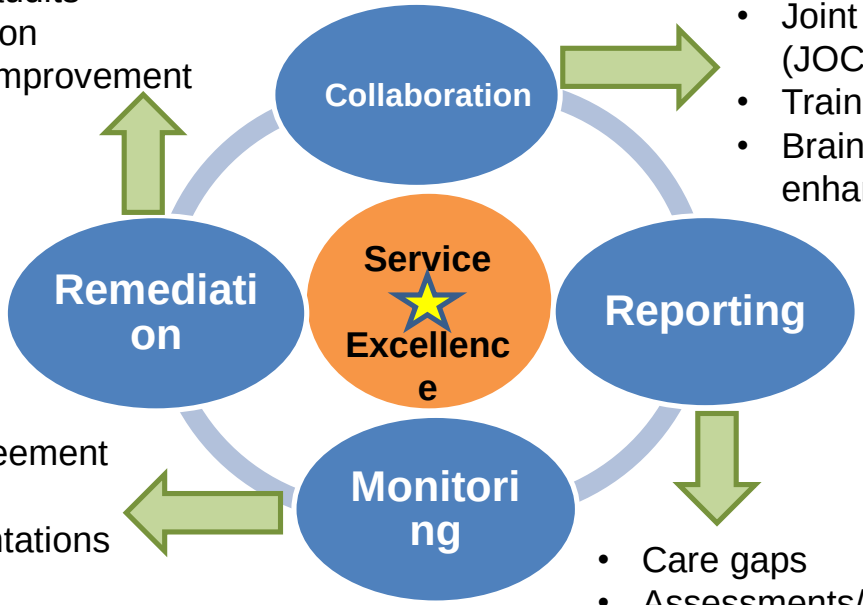
PROVIDER COLLABORATION TEAM ROLES

Title	Functional Role	Example of Responsibilities
Director Provider Collaboration Strategy	Directs/oversees market-wide AMH program initiatives and provider collaboration strategy	Develop strategy to promote AMH progression to higher tiers and deploy value-based payment (VBP) programs to engage multiple provider types: PCPs, OBs, Behavioral Health, etc.
Manager, Community Transformation	Supervise/train/coach Provider Collaboration Managers and data analysts	Hiring, onboarding, AMH program orientation, associate goal setting, performance observation/feedback
Provider Collaboration Managers	Provider-facing VBP program support for tier 3 practices	Prepare AMH for success in VBP arrangements: utilizations analysis, performance improvement strategy development/goal setting/implementation support, progress tracking
Provider Clinical Liaisons	Provider-facing AMH program support for tier 3 practices (clinical strategy)	Delegated care management oversight/support, practice coaching and education, action planning, quality improvement opportunity analysis, goal setting, process implementation and performance tracking
Provider Collaboration Director	Ensure PHP alignment with State's AMH program and payment innovation requirements/expectations	Provider collaboration, AMH subject matter expert, compliance with State regulatory requirements
Business Analysts/Consultants	AMH Data Support Team	Deep dive analytics, data exchange, ensure accuracy of metrics, AMH program performance tracking tool development (eg. dashboards, scorecards)

PROVIDER COLLABORATION TEAM

HEALTHY BLUE PARTNERSHIP WITH AMH

- Root cause analysis
- Performance audits
- Corrective action
- Performance improvement



- Routine check-ins
- Joint Operating Committee (JOC) Meetings
- Training/education
- Brainstorm service enhancement strategies

- Service standards
- Service Level Agreement (SLA) compliance
- Process implementations
- Utilization
- Member outreach
- Quality performance

- Care gaps
- Assessments/screenings
- Specialty referrals
- Patient risk list

THREE-YEAR APM STRATEGY

	Year 1	Year 2	Year 3
Type of VBP Model	Primarily Blue Premier: Upside Only Negotiated Shared Savings • Blue Premier: Medicaid Enhanced CIN Agreement • Pregnancy Medical Home incentives	In addition to Year 1 VBP models, Healthy Blue will offer: • Blue Premier: OBQIP • Blue Premier: BHQIP • Blue Premier: PQIP-E By the end of year 2, portion of medical expense in VBP will (a) increase by 20% or (b) be 60% of total.	Models that are included in HCPLAN Categories 3 and 4, including those that incorporate total accountability risk (both delegated and non-delegated). Percent of increase in portion of medical expense in VBP by year 3 TBD
Risk Type	Primarily Upside Only	• Primarily Upside Only, some targeted Total Liability	Upside and Full Accountability
Why Is This Model Optimal for Healthy Blue?	Focuses on providers in existing VBP arrangements for Medicare or Commercial programs, as well as large health systems that specifically request VBP models. While Healthy Blue typically only offers upside risk models during year 1, several large provider organization have accepted total liability risk in Year 1.	• Use claims data collected during Year 1 of the Contract to drive entry into additional VBP arrangements. • Begin to roll out specialist programs. • Providers will likely indicate intent to move into fully accountable risk models during Year 2.	• Continued launch of total accountability risk models. • Healthy Blue will target additional providers for inclusion in fully accountable risk models — delegated and non-delegated.
Type of Providers Targeted for inclusion in VBP	Blue Premier: Medicaid Enhanced CIN Agreement - Upside Only Negotiated Shared Savings — Large groups, IPA groups, and CINs	• Blue Premier: OBQIP: Available for OB groups with >10 Members • Blue Premier: BHQIP: Available for BH groups with >100 Members • Blue Premier: PQIP Essentials will incent smaller PCPs with 250-999 attributed Members.	• Blue Premier: Total Accountability Risk Models — available for additional large groups (>500 Member panel

HEALTHY BLUE VALUE BASED INCENTIVES

VBP	HCP-LAN Category	Provider Types
Blue Premier: PQIP Essentials	3A	PCPs
Blue Premier: BH Provider Quality Incentive Program (Blue Premier: BHQIP)	2C	BH Professionals, LMHAs
Blue Premier: Obstetrical Quality Incentive Program (Blue Premier: OBQIP)	2C	OB Providers
Blue Premier: Negotiated Risk/Shared Savings (Blue Premier: NR/SS)	3A, 3B	PCPs, IPAs, Hospitals with Affiliated PCPs, ACO
Blue Premier: Delegated Risk/Capitation (DR/C)	4B	Hospitals with Affiliated PCPs, ACOs, IPAs
Blue Premier: Personal Attendant Care Quality Incentive Program (PACQIP)	2C	Personal Attendant Care Agencies
Blue Premier: Integrated Care for Kids (InCK)	2C – 3B	PCPs

QUESTIONS?

BlueCross BlueShield of North Carolina | HealthyBlue

CONE HEALTH

Cone Health: A Provider Perspective on Medicaid Transformation in NC

CONE HEALTH

Cone Health Overview Relative to Value-based Care

- 10+ Year History of Value-based Care and Contracts.
- Largely in partnership with Triad Healthcare Network (THN) our physician partnered ACO
- $1.2 B + of claims in Full Risk or Shared Risk contracts. $600 M more in claims responsibility in Shared Savings. 12 ACO Agreements. 225,000 lives
- Cone Health Medical Group (CHMG) 600 + providers including 140 primary care physicians. Sees approximately 24,000 Medicaid patients in their primary care practices.
- Cone Health also owns a Medicare Advantage Health Plan, Health Team Advantage with 16,000 members.
- Cone Health also is a partial owner of My Health (along with 10 other NC health systems) which unsuccessfully sought to be a Medicaid Provider-Led Entity (PLE).

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Cone Health Medicaid Contracting Strategy

- Contracted on behalf of Cone Health facilities and Cone Health Medical Group.
- THN as an ACO did not contract for value-based care with the PHP's (Prepaid Health Plans).
- Recognized inevitable revenue leakage, demand destruction, and channeling that would erode FFS yields.
- Required strong value-based arrangements in the PHP and PLE contracts, without exception.
- Concept that Cone Health share of savings as the population matures, would increase and offset the loss of FFS revenue.
- Contracting for the right, NC-directed payment for the Advanced Medical Home (Tier 3) was also essential for our embedded care management approach in key practices.
- Movement in Years 3 & 4 to Shared Risk with 3 PHP's.

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Cone Health Medicaid PHP/PLE Contracts

- Healthy Blue
- UHC Community Care
- WellCare
- Carolina Complete Health (PLE J-V between Centene and NC Medical Society) is near completion

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Cone Health Managed Medicaid Implementation

Attest, Attribute, Align

- PCPs enrolled NC Tracks
- Population risk defined
- Provider assignment made
- Internal/external communication provided
- Training completed
- Care Management sub-delegation model formed
- Accountabilities defined

Model & Processes

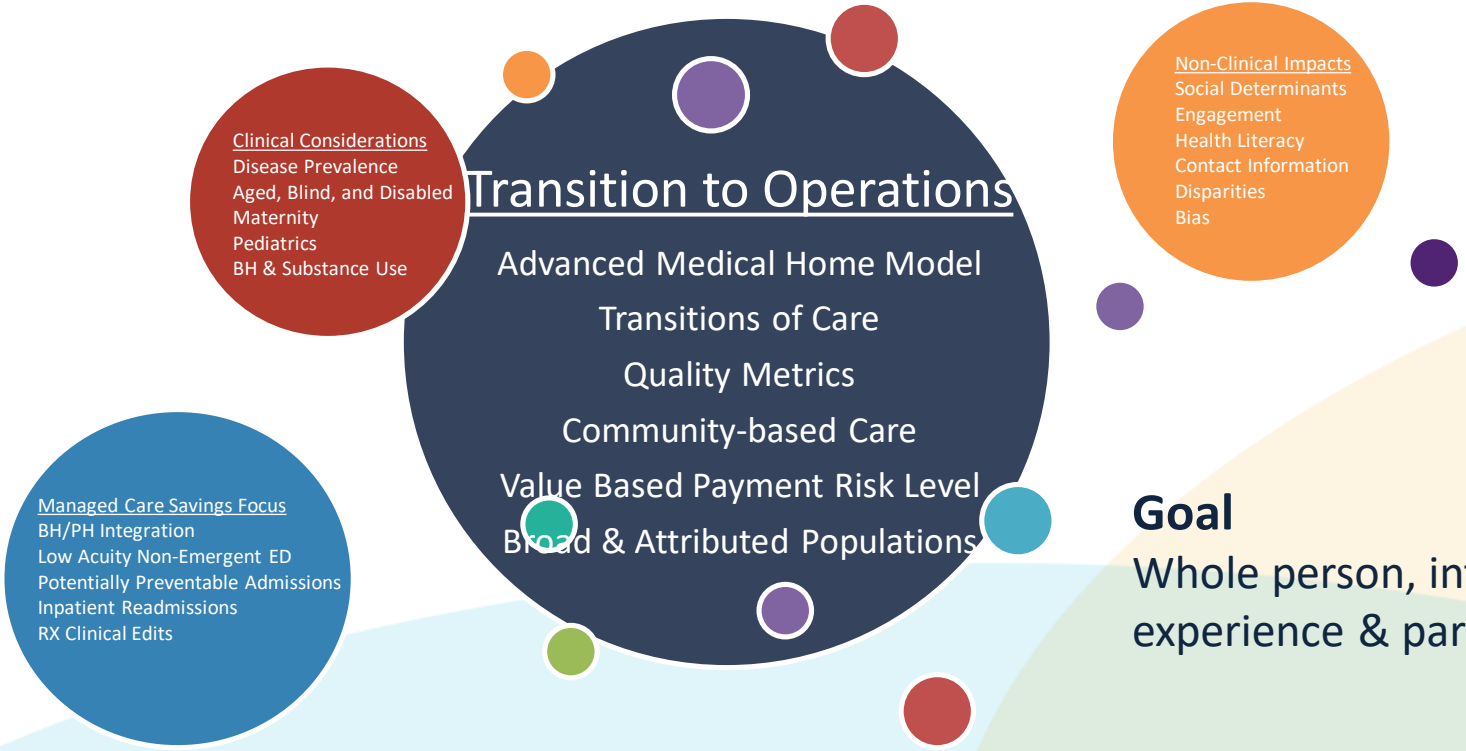
- Point of care design; top of license strategy
- Processes updated
- Transitions of care support
- Care management in place
- Compliance, billing, claims
- EMR updates
- Data flow with payors

Measure & Correct

- Baselines established
- Quality benchmarks set
- Data sharing process defined
- Reporting in place
- Payor Collaboration: Bi-weekly operations & quarterly JOC meetings

CONE HEALTH

Cone Health Managed Medicaid Post Implementation



Goal

Whole person, integrated experience & partnership

Cone Health & Medicaid Transformation Thoughts

- Anxious
- Hopeful
- Opportunities
- Time to Mature
- We will see!

Save the Date for the Next APM Committee Meeting

Tuesday, September 21, 2021 – 1pm ET

AMERICA'S PHYSICIAN GROUPS

Questions?

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APG's Value-Based Contracting Manual

An Essential Guide for Physician Organizations

Announcing an exclusive ***online*** resource for APG members that includes invaluable information regarding planning, business relationships, financial operations and administrative operations that goes far beyond payor agreement negotiations

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EMERGING FROM THE PANDEMIC: THE PATH FORWARD