APPENDIX N

Health Care Reform Review Committee

NORTH DAKOTANS FOR THE ADVANCEMENT OF CARE UPDATE

September 26, 2018

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The NDAC Vision is…

To create a provider-driven, value-based managed care model that promotes financial stability, improves clinical outcomes, and promotes patient health in the North Dakota Medicaid program by

- **Improving** health care delivery, quality outcomes, & reducing the total cost of care
- **Developing** a value-based model adapted for North Dakota consistent with best practices
- **Minimizing** the administrative burden to the state & disruption to ongoing Medicaid priorities
- **Accommodating** North Dakota's unique provider landscape
- **Rewarding** efficient, patient-centered care delivery & strategic provider-patient engagement
- **Identifying & supporting** investments to enable enhanced care management
- **Promoting** health & wellness in the North Dakota Medicaid population

Core Assumptions

SECTION 2

Key Assumptions

Belief Statements

1. A provider-driven, value-based Medicaid model will put long-term financial sustainability and program outcomes above short-sighted, immediate program savings.

2. NDAC providers can achieve reductions in the growth of Medicaid spending and improve care outcomes through improved care coordination, targeted interventions and decreased utilization of low-value services.

3. Savings will be shared between the state and the provider community to reinvest in the health care and social support infrastructure to result in better cost and quality outcomes.

4. A provider-driven model will support the ND provider community in moving toward value, preserving overall access to care.

The Accountable Care Paradigm: ACOs vs. MCOs

The MCO movement can be characterized by cost containment, while the ACO movement is characterized by health management generating better patient outcomes which *may* result in cost containment

Accountable Care Organization

→ Accept financial responsibility to manage health services of a population with financial rewards for doing so in a less costly manner

→ Partial-Risk: Providers jointly responsible for achieving measured quality improvements **and** reductions in the rate of spending growth

→ Patient-Centered: Embrace more patient-centered health management strategies

→ Payment for care typically **tied to** care outcomes

→ At their core, are a **care model**

Managed Care Organization

→ Accept financial responsibility to manage health services of a population with financial rewards for doing so in a less costly manner

→ Full-Risk: Responsible for managing care and costs within a capitated payment

→ Utilization-Focused: Focus on medical necessity and evidence-based practice. Little or no input in care model or quality

→ Payment for care typically **separated from** the provision of care

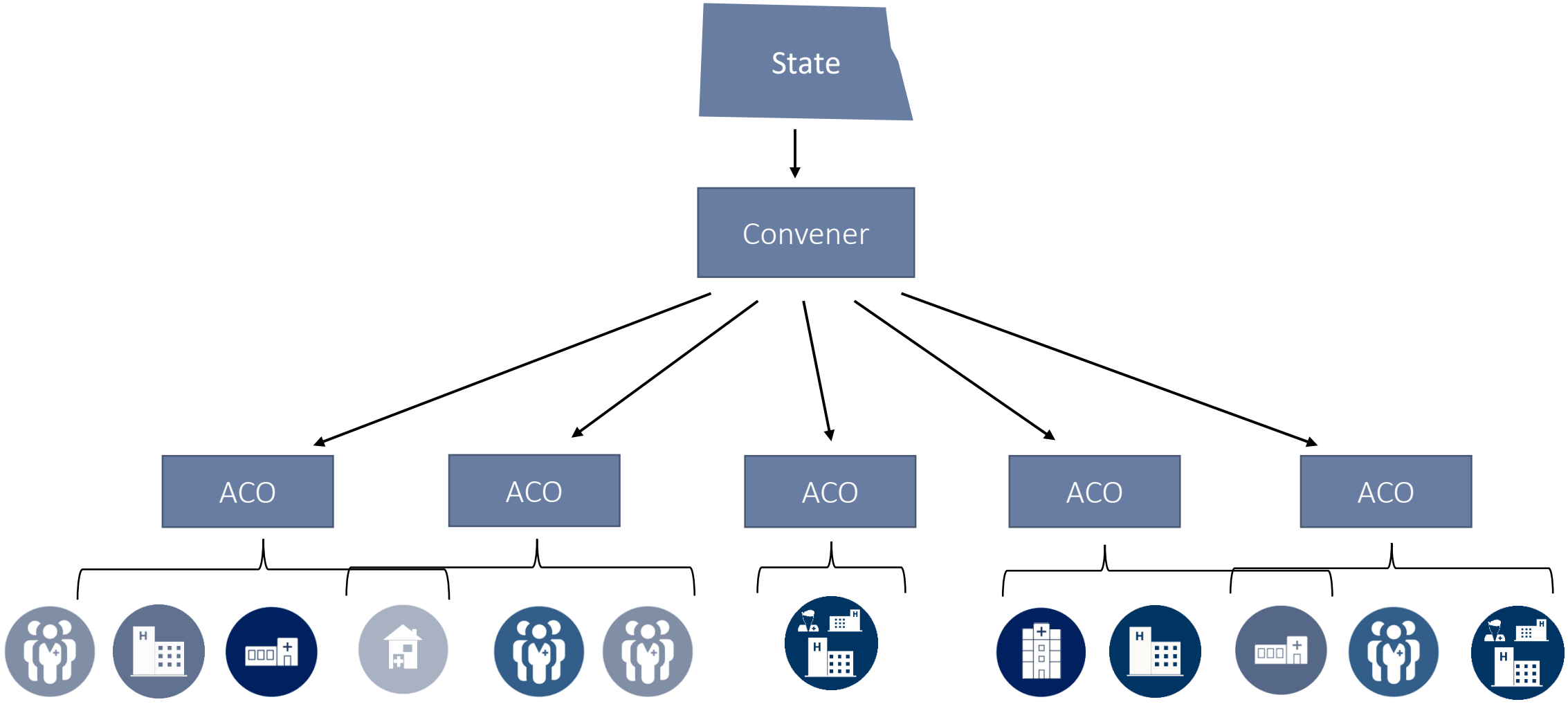
→ At their core, are a **finance model**

Source: The Accountable Care Paradigm: More than Just Manage Care 2.0, Leavitt Partners

Strawman Proposal

SECTION 3

Relationships

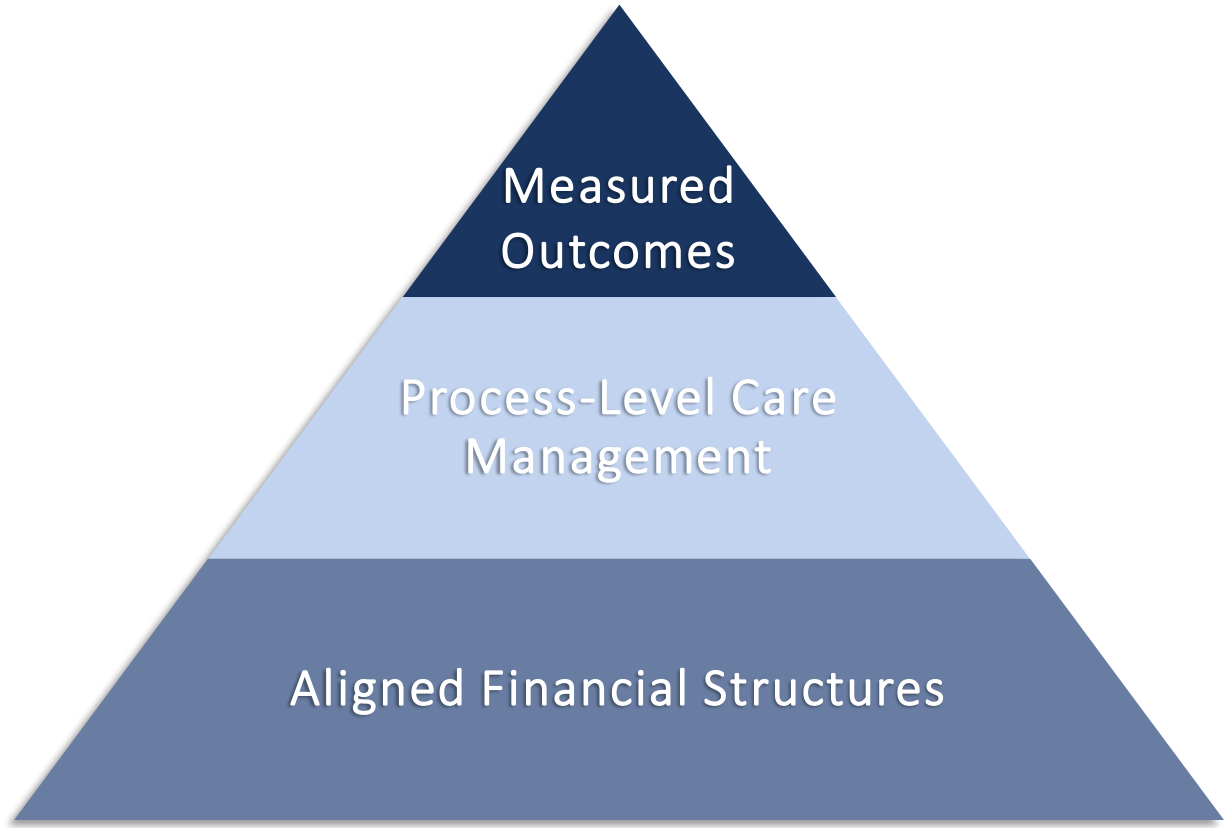


NDAC Strawman – (working model to be refined)

Initial Program Recommendations	
Model Vision	• Population-based alternative payment model in which one or more ACOs contract with the state to take responsibility for delivering cost-effective care to a defined panel of Medicaid enrollees
Covered Population	• All traditional and expansion Medicaid enrollees, excluding the developmentally disabled population (Approx. 80k mandatory enrollees)
Services Included	• Required: Physical health, behavioral health, LTSS, Rx services; Optional: Oral Health (to be phased in over time), Non-emergency transportation • LTSS & Rx services included in total cost of care calculations beginning PY3; Non-emergency transportation not included in total cost of care calculations
Provider Configuration	• Program to include multiple ACOs, comprising all of the state's eligible providers who will work collaboratively toward shared goals • Participation will be mandatory for all eligible Medicaid providers, though approaches to participation may vary
Governance Model	• State → Convener → ACOs
Geographic Coverage	• Initially piloted in select region(s), then expanded statewide after initial phase-in period
Financial Risk	• ACOs will eventually share downside risk for actual expenditures exceeding a predetermined target, with increasing levels of risk/reward over time.

What will change?

- Incentives
  - Providers are held accountable for measured outcomes
  - Providers are paid differently
- Care
  - Incentives and payment flexibility will reward providers for delivering more efficient, coordinate care across a continuum of health care services
- Costs
  - ND Medicaid enrollees experience improved health care outcomes
  - ND Medicaid experiences a lower total cost of care per enrollee



Source: The Accountable Care Paradigm: More than Just Manage Care 2.0, Leavitt Partners

What will change?

When asked to identify their top three priorities, the ten most common priorities were…

1. Reduce avoidable emergency department visits and avoidable inpatient admissions
2. Prevent readmissions through better care transitions
3. Active management of high-need, high-cost patients
4. Manage/reduce post-acute-care spending and quality
5. Reduce avoidable/unnecessary care
6. Increase referrals to ACO-based providers/reduce network leakage
7. Integrate behavioral health care into primary care settings
8. Palliative care/hospice
9. Patient engagements (i.e., patient activation)
10. Manager pharmacy use/increase medication adherence

Next Steps

Pursue Authorizing Legislation

VBP Environmental Scan & Alignment

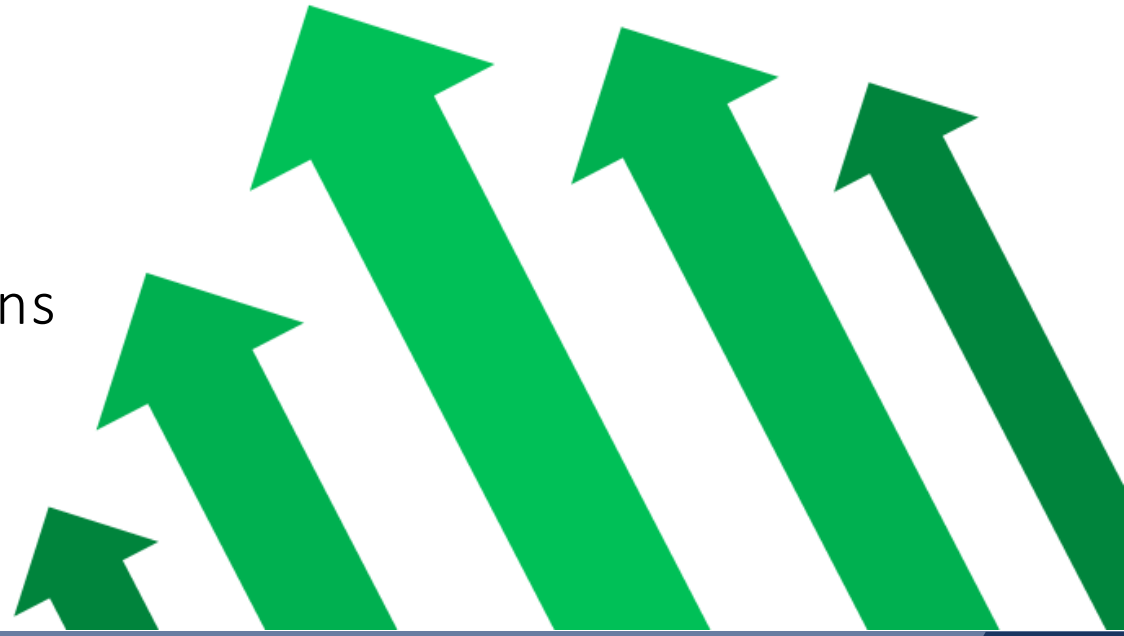
Data Assessment & Analysis Plan

Refine Model Framework

Create Bridge Strategy

Conduct Data Analysis & Validate Assumptions

Develop Program Roadmap and Timelines



Smart on Value

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DRAFT

NDAC Medicaid ACO: Model Legislation

A BILL for an Act to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to Medicaid accountable care organizations, and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Medicaid Accountable Care Organizations.

1. For purposes of this section:
   a. "Accountable Care Organization" means a health care delivery model in which a hospital or group of hospitals, doctors, and other health care providers work together to coordinate care for a defined set of Medicaid recipients and share accountability for the overall quality and cost of care rendered and which provides support for care coordination, quality improvement, cost savings, and the distribution of any overall cost savings.
   b. "Department" means the department of human services.
   c. "Medical Loss Ratio" means the ratio of payments made for health care costs and quality improvement activities to Medicaid premiums paid to an accountable care organization, as determined under title 42, Code of Federal Regulations, part 438, Subpart A, section 438.8.
   d. "Provider" means any individual or entity furnishing Medicaid services under a provider agreement with the department.
   e. "Risk Adjustment" means the methodology the department may use to modify payments and financial targets for an accountable care organization to account for variations in the health status or burden of disease among attributed patients.
   f. "Risk Sharing" means the department financially sharing in an accountable care organization's financial risk associated with providing care to the defined Medicaid population.
2. The department, in conjunction with providers, shall develop and implement reforms to the Medicaid delivery system utilizing one or more accountable care organizations and develop a actuarially sound value-based payment system that supports the new care delivery model. The department's reforms shall:
   a. Utilize one or more accountable care organizations to manage the care of a defined set of Medicaid recipients;
   b. Restructure provider payment provisions to reward accountable care organizations for delivering the most appropriate services at the lowest cost and in ways that maintain or improve the health status of Medicaid recipients;
   c. Identify the evidence-based practices and measures, risk adjustment methodologies, payment systems, and other mechanisms necessary to reward an accountable care organization for delivering the most appropriate services at the lowest cost, including mechanisms that reward the delivery of services that make the most positive contribution to a Medicaid recipient's health status;

d. Identify how it will inform the public of its enrollment attribution policies; rate setting methodologies, including risk sharing policies; risk adjustment methodologies, medical loss ratio limits, and quality indicators and quality outcomes.
e. Require an accountable care organization to establish an adequate medical service delivery network as determined by the department and provide services to Medicaid recipients directly or by contract with other providers;
f. Identify which Medicaid populations should be required to receive services through an accountable care organization and how different populations should be phased into the new delivery system;
g. Identify which Medicaid services should be provided through an accountable care organization and which services should remain under fee for service.
h. Identify the level of risk assumption under the model and how it will be phased in over time based on prospective Medicaid enrollment numbers and the financial capacity and management experience of an accountable care organization to assume risk at the time of program implementation.
i. The department may enter into a contract pursuant to this section only if, in the judgment of the department, the program would meet federal budget neutrality requirements and the care of Medicaid beneficiaries will likely result in better, more efficient care.
j. By June 30, 2019, the department shall establish a steering committee consisting of providers and department representatives. The steering committee, with input from a broad group of program stakeholders identified by the department, shall guide the development of the Medicaid delivery system reforms;
k. Beginning in September 2019 through December 31, 2022, the department and the steering committee shall report no less than once every three months on development activities and the status of implementing the reforms described in this section to the legislative management. The department shall report its final recommendations to the legislative management no later than August 31, 2020. The final recommendations shall include the basic approach under consideration to implement the requirements of this section including an estimate of the cost to convert to a value-based payment system, administrative costs and cost savings; and the process and time within which the conversion will take place.
l. The department shall submit all required State Plan Amendments and waiver applications to the centers for Medicare and Medicaid Services no later than July 1, 2021;
m. The department shall begin implementation of Medicaid managed care described in this section no later than October 1, 2021, with all targeted populations enrolled no later than October 1, 2022.[1]
n. In order to demonstrate the feasibility of a managed Medicaid program prior to the final report date, the Dept. of Human Services is hereby authorized to pursue a waiver allowing them to implement either a pilot project or a full-scale managed Medicaid program

SECTION 2. EMERGENCY. This Act is declared to be an emergency measure.

[1] Consider the dates to be place holders at this point.