Medicaid Business Transformation DC
Prepping for Value

Medicaid Business Transformation DC: Recommendations for Technical Assistance

PREPARED FOR DC DEPARTMENT OF HEALTH CARE FINANCE BY HMA

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Executive Summary

The District of Columbia Department of Health Care Finance (DHCF) created the Medicaid Business Transformation DC Initiative to design and implement an innovative approach for delivering targeted legal and business resources to the healthcare community. The Medicaid Business Transformation DC Initiative builds upon and affirms findings from the Mayor's Commission on Healthcare Systems Transformation to achieve the following goals:[1]

- Facilitate health system integration by providing legal and regulatory technical assistance (TA) to providers who intend to develop clinically integrated networks (CINs), accountable care organizations (ACOs), and independent practice associations (IPAs).
- Make key investments and policy changes to promote system integration for accountable care transformation, invest in practice transformation capabilities, and ensure alignment and integration to enable accountability.

In February 2023, DHCF engaged Health Management Associates (HMA) to assess the technical assistance needs of Medicaid providers and organizations in the areas of legal analysis, budgeting, and business development. HMA partnered with the DC Behavioral Health Association (BHA), Medical Society of the District of Columbia (MSDC), DC Primary Care Association (DCPCA), and DHCF to engage, recruit, and collaborate with organizations and stakeholders across the District. HMA implemented a three-phased, mixed-methods assessment approach that included a literature review, a national scan of exemplar states, and stakeholder engagement to collect quantitative and qualitative data on the healthcare provider network in the District.

This report summarizes grant activities that inform recommendations, including:

- Findings from a literature review of national value-based payment (VBP) best practices, published materials, and a scan of the District's healthcare reform efforts and reports.
- Results from focus groups, interviews, and a technical assistance (TA) survey with District organizations, agencies, and stakeholders to inform the TA needs of providers, and to develop a technical assistance collaborative, for delivery July 2023–September 2023, and recommendations for future learning (pending additional resources).
- Policies and best practices for the District and DHCF are drawn from leading edge states with VBP models designed to facilitate provider readiness that advance value-based care and transform the healthcare delivery system.

[1] Bowser M. Report and Recommendations of the Mayor's Commission on Healthcare Systems Transformation. Office of the Deputy Mayor for Health and Human Services. 2019. Available at: https://dmhhs.dc.gov/sites/default/files/dc/sites/dmhhs/page_content/attachments/Report%20and%20Recommendations%20of%20the%20MCHST_FINAL.pdf. August 2, 2023.

Key Findings

1. District healthcare organizations/providers identified specific technical assistance (TA) needs, and providers exhibit significant variation in their understanding of and readiness for a transition from fee-for-service to value-based payment (VBP) models.

2. Nationally, successful states advance VBP by building on the Health Care Learning and Action Network (HCP-LAN) framework to develop additional guidance for managed care organizations, with criteria, benchmarks, and standards that include both medical and behavioral health expenditures. These states also provide free TA, upfront investments, and resources to prepare healthcare organizations to deliver high-quality value-based care.

3. The transition to VBP for states across the country can take multiple years and significant technical support to prepare healthcare organizations to transform business, legal, and financial operations. This work includes supporting provider readiness for success with advanced payment models (APMs), facilitate provider collaboration and integration through individual and system-level transformation (e.g., mergers, acquisitions, and formation of provider-level entities). Examples include accountable care organizations, clinically integrated networks, and provider-led entities (PLEs).

Medicaid Business Transformation DC Initiative Overview

The Medicaid Business Transformation DC Initiative's long-term goal is to support providers' ability to deliver whole-person, population-based integrated care that is comprehensive, coordinated, high quality, culturally competent, and equitable. The District's ongoing efforts to support change at the Medicaid provider level through technical assistance and practice transformation will ensure providers have the tools they need to successfully move from a fee-for-service (volume-based) business to value-based services that demonstrate improved patient outcomes and satisfaction.

System transformation requires substantial changes in business practice for healthcare providers. Many providers in the District, and across the country, express concern that they do not have the knowledge or resources to make the myriad changes to their practice that are needed to succeed under VBP, which include making fundamental changes in care delivery, finance, and operations. The Medicaid Business Transformation initiative enhances provider capacity to engage in value-based care agreements in the Medicaid managed care program, through which a growing proportion of expenses will be linked to value-based payment VBP structures.

In the District's previous stakeholder engagement with the 2017 Accountable Care Organization (ACO) request for information (RFI) and the 2021 Behavioral Health Transformation RFI, stakeholders largely supported system transformation. This included support for provider-led efforts to manage population health and reimbursement strategies that pay for value rather than volume.[2,3]

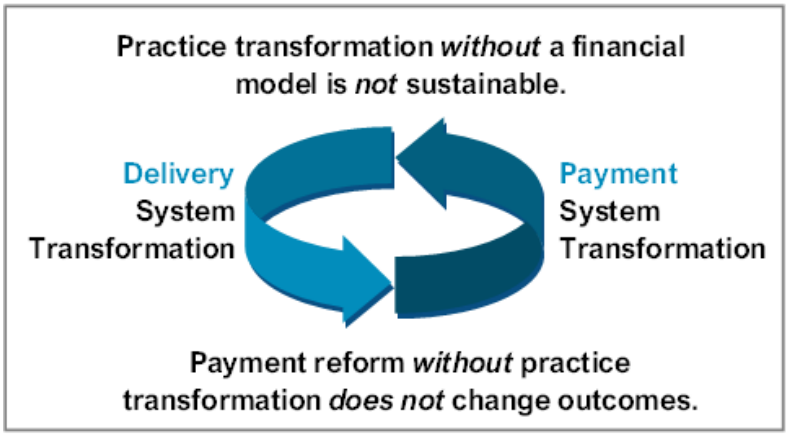
The Medicaid Business Transformation DC technical assistance program aligns with the recommendations from the Mayor's Commission on Healthcare Systems to:[1]

- Facilitate health system integration by providing legal and regulatory technical assistance to providers that want to develop clinically integrated networks (CINs), accountable care organizations (ACOs), and independent physician associations (IPAs)
- Make key investments and policy changes that promote system integration for accountable care transformation, invest in practice transformation capacities, and ensure alignment and integration to enable accountability

Medicaid Business Transformation Goals:

- Provide a brief, stakeholder assessment of Medicaid providers' needs for legal analysis, financial consulting, and business development support.
- Design and deliver appropriate resources to meet these needs.

Together, these activities support Medicaid provider practice transformation and facilitate integrated whole-person care by enhancing providers' ability to collaborate across entities and participate in value-based care arrangements.



The Business Transformation initiative builds on the foundation of earlier successful technical assistance provided by the District to support the transition to population health and whole-person care that leverages digital health tools and the District's designated health information exchange. In 2022, Mayor Bowser expanded ongoing practice transformation support to District providers, new staff resources, and interagency collaboration to facilitate integrated, whole-person care across the health and social service delivery system. The development of targeted technical assistance to support care delivery transformation helps providers develop new capabilities, particularly crucial for historically under-resourced providers and providers disproportionately serving populations experiencing health disparities.

[2] Medicaid Accountable Care Organizations (ACO) in the District of Columbia. Department of Health Care Finance (DHCF). (2017). Available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/release_content/attachments/DHCF%20B24-0092%20Testimony_FINAL_Updated.pdf

[3] Medicaid Behavioral Health Transformation Request for Information Summary. DC Department of Health Care Finance & Department of Behavioral Health. (2021, February). Available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/release_content/attachments/DHCF%20B24-0092%20Testimony_FINAL_Updated.pdf

DHCF's practice transformation initiatives are designed to prepare providers for the transition to VBP in the new managed care contract. The District developed a five-year VBP strategy requiring Medicaid MCOs to contract with District providers to flexibility and progressively incorporate a greater percentage of total medical expenditures into VBP arrangements (see Table 1). This progression, in alignment with the Health Care Payment Learning & Action Network (HCP-LAN) Framework, occurs over five years through partnerships with the District providers.

Table 1. DHCF MCO Contracts Guidance on Five-Year VBP Strategy

BASE YEAR	% OF TOTAL MEDICAL EXPENDITURES IN VBP	ALL QUALIFYING EXPENDITURES			
		CATEGORY 1 FEE FOR SERVICE: NO LINK TO QUALITY and VALUE	CATEGORY 2 FEE FOR SERVICE: LINK TO QUALITY & VALUE	CATEGORY 3 APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION-BASED PAYMENT
1 – 2023	30%		✓	✓	✓
2 – 2024	40%		✓	✓	✓
3 – 2025	50%		✓	✓ At least half of medical expenditures must be in Categories 3 and 4	
4 – 2026	60%		✓		
5 – 2027	70%		✓		

Literature Review, National Scan of Exemplar States, and Local Stakeholder Engagement

HMA implemented a three-phase, mixed-methods approach that involved conducting a literature review, a national scan of exemplar states, and stakeholder engagement to collect quantitative and qualitative data on the DC healthcare provider network.

Phase 1
Literature Review

HMA conducted a comprehensive analysis of published research encompassing national and DC-specific VBP initiatives and healthcare system transformation policies. This review encompassed more than 20 published research reports, resources, and materials focused on VBP models, strategies, and outcomes to identify trends and best practices in VBP across clinical, operational, legal, and financial domains. In July 2023, HMA compiled the insights drawn from this research into a slide deck summarizing key findings, lessons learned, and recommendations for DHCF. Figure 1 summarizes our findings. For a full review, see Appendix 8.

Figure 1. Successful Elements of VBP Models Based on National Research

What is successful?

- Successful Models
  - Adopt consistent standards, clear benchmarks
  - Focus on population health and embed health equity and outcomes
  - Include a framework that is not based on a FFS chassis
  - Alignment of metrics across payers
- Providers and Payers
  - Enhance infrastructure and upfront investments to build APM competencies
  - Develop robust IT investments and models
  - Develop transparent payer-provider partnerships

Why is it successful?

- Develop consistent VBP programs including metrics and performance targets across payers to send an aligned definition of high-value care
- Encourage providers to address community health needs and provide targeted interventions that address social drivers of health
- Allow upfront investments to develop infrastructure and necessary resources for effective participation in VBP
- Incent payer/provider partnership opportunities that align goals, data and resources, and establishes shared accountability
- Identify outcome measures and their definitions at the District level

How can we be successful?

- Identify infrastructure investment needs and mechanisms for addressing them
- Develop processes for outcome measure indicator identification and definition
- Identify VBP strategies and provide technical support to operationalize clinical progression from FFS to more advanced payment models
- Provide technical support that assists providers with understanding contract requirements
- Provide training to enhance understanding of financial implications of contracts, reserves and other aspects

Phase 2

National Scan of Exemplar States with Effective Value-Based Payment Models

HMA studied eight states that serve as national exemplars: California, Massachusetts, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, and Tennessee. These states were identified based on their innovative VBP models and efforts to transition providers from fee-for-services (FFS) to more advanced payment models. Appendix 9 describes our findings for each state. Table 2 highlights key findings from the national scan.

Figure 2. Map of Exemplar States

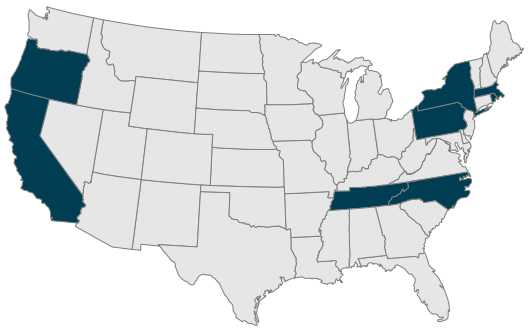


Table 2. Key Findings from Exemplar States

Key Findings from the States	
Design/ Implementation	▪ Readiness assessments are important in understanding the type of arrangement that providers can best negotiate with managed care organizations (MCOs). ▪ Clarity of roles is crucial to determining which party is responsible for administration versus healthcare delivery (e.g., MCO or provider). ▪ Stakeholder engagement is critical. It also is important to include healthcare advocates to reduce concerns regarding access and equity. ▪ It is harder for states to build Alternative Payment Models (APMs) without any upfront provider-level investments or technical assistance.

Advancing to APMs	▪ It is important to develop model "on ramps" to advance progress providers from pay-for-reporting and pay-for-performance models to advanced APMs ▪ More advanced total cost of care (TCOC) models have the greatest potential for rewards but are still new and slower to progress because of their complexity. ▪ The more advanced models, like those in New York, Pennsylvania, and Massachusetts, received federal funding/investments. ▪ Many advanced capitated models still reverted back to FFS. ▪ Very few aligned all-payer models have been implemented. ▪ Mandatory models vary from state to state, and while they may be more impactful, may face opposition or force participation prior to readiness. (Only Maryland, New York, and Pennsylvania have some level of participation requirements for MCOs.) ▪ States and the Centers for Medicare & Medicaid Services (CMS) are beginning to invest in payer alignment to reduce provider burden and increase impact of models. ▪ State and federal restrictions may challenge movement toward higher levels of accountability.
Evaluation & Quality	▪ The current evidence is limited. ▪ State initiatives often are implemented alongside other initiatives which impact evaluation. ▪ Vermont, Pennsylvania, and Maryland had federal funding for formal evaluations while other states had limited funds available for formal evaluations. ▪ COVID-19 skewed many findings for states that started VBP models before 2020.

Source: Center for Health Care Strategies. Medicaid Population-Based Payment: The Current Landscape, Early Insights, and Considerations for Policymakers. Available at: https://www.chcs.org/resource/medicaid-population-based-payment-the-current-landscape-early-insights-and-considerations-for-policymakers/.

Phase 3
District Landscape and Stakeholder Engagement

Findings of the District landscape and local stakeholder engagement are summarized here. For an in-depth analysis, see Appendix 8: Literature Review.

The District of Columbia's Medicaid provider landscape includes a wide range of safety-net healthcare providers. Managed care plans under contract with DC Medicaid are required to contract with all District federally qualified health centers (FQHCs), acute care hospitals and their affiliated physician groups.[4] DC has nine community health centers, including eight FQHCs and one FQHC look-alike. Together, they deliver integrated medical, dental, behavioral health, and enabling services at more than 62 sites. Approximately 200,000 people, or one in three DC residents, receive care at a community health center annually.[5]

[4] DHCF Provider Frequently Asked Questions for Managed Care, 2020. Available at: https://dhcf.dc.gov/sites/default/files/u23/Managed%20Care%20Provider%20FAQ.pdf
[5] DC Primary Care Association. Health Center Impact. . Available at:https://www.dcpca.org/health-center-impact#:~:text=Washington%2C%20DC%20has%20nine%20community,and%20one%20FQHC%20Look%2DAlike. August 15,2023.

The District is home to seven general acute care hospitals, two long-term acute care hospitals, one pediatric acute care hospital, two psychiatric hospitals, one rehabilitation hospital, two community hospitals and four Level-1 trauma centers.[6] The District also has a diverse network of health care entities providing long-term services and supports, (LTSS), home and community-based services (HCBS), and community-based organizations serving residents. In addition, DC has a robust behavioral health continuum including a range of community-based providers that provide mental health services and support to children, adolescents, adults, and families. [7]

Recent District reports, including the 2018 Primary Care Needs Assessment,[8] the 2021 Substance Use Disorder Community Need and Service Capacity Assessment,[9] and the 2021 State Health Planning and Development Agency Implementation Plan Final Report,[10] identified the need to improve access to specialized care and address social determinants of health to improve care transitions and coordination of complex care. Outpatient medical specialty care, urgent care and outpatient surgical services, intensive outpatient behavioral health services, and recovery housing lack system capacity to meet the needs of the District residents, particularly in Wards 7 and 8.[11]

The DC Health Matters 2022 Community Health Needs Assessment demonstrated continued interest in revising investment and reimbursement models. Participants in the assessment want to promote quality over quantity of services by moving toward value-based care.[12] The 2019 Community Health Needs Assessment revealed that participants need support to increase the availability of care management services, investments in technology, expansion of integrated care models, advocacy for value-based contracts, and ways to address non-clinical determinants of health.[13] Participants expressed interest in expanding the use of interdisciplinary teams in primary care, along with promising care coordination models like My Health GPS Program in order to improve healthcare services in the District.[14] Participants recommended expanding this model to serve patients with fewer or no chronic illnesses and complex contextual barriers, such as income instability, housing instability, and limited English proficiency.[15]

District providers serving residents living in Wards 7 and 8 report challenges supporting communities that have higher rates of complex health conditions, along with challenges accessing care and social

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[6] District of Columbia Hospital Association. Member Hospitals. Available at: https://dcha.org/our-members/.
[7] Government of the District of Columbia Department of Health. District of Columbia Health Systems Plan 2017. July 2017. Available at: https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC%20Health%20Systems%20Plan%202017.pdf. Accessed August 24, 2023.
[8] our healthydc. District of Columbia Community Health Needs Assessment. Available at: https://ourhealthydc.org/dc-chna/. Accessed August 24, 2023.
[9] JSI. District of Columbia Substance Use Disorder Community Need and Service Capacity Assessment Final Report. Available at: https://dbh.dc.gov/sites/default/files/dc/sites/dhcf/release_content/attachments/DC%20SUD%20NA%20-%20Final%20Report%20for%20Distribution%20Feb%202021.pdf. Accessed August 23, 2023.
[10] District of Columbia State Health Planning and Development Agency. 2021 Annual Implementation Final Report. Available at: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2021-SHPDA-Annual-Implementation-Plan.pdf. Accessed August 24, 2023.
[11] *IBID*
[12] DC Health Matters Collaborative. Community Health Needs Assessment. June 2022. Available at: https://www.dchealthmatters.org/content/sites/washingtondc/2022_CHNA/2022_CHNA_DC_Health_Matters_Collab.pdf. Accessed August 31, 2023.
[13] DC Health Matters Collaborative. Community Health Needs Assessment. June 2019. Available at: https://ourhealthydc.org/dc-chna/. Accessed August 24, 2023.
[14] Health Management Associates. DC My Health GPS Individualized Technical Assistance Program Executive Summary of the Final Report. April 2020. Available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/ITA%20MHGPS%20Summary%20%289.30.
[15] *IBID*

determinants of health, including transportation and food access. Many health care providers and community-based organizations are struggling to recover from the impact of COVID-19, which restricted hours or closed practices because of significant workforce shortages.[16]

Resolving these health disparities and inequities requires an approach that ensures residents have access to high-quality, whole-person care to improve outcomes. Incorporating and addressing health equity throughout as part of a VBP strategy is essential to help the most at-risk individuals and organizations.

A brief stakeholder assessment survey was developed in collaboration with DHCF (See Figure 3). The 30-minute survey was sent to more than 200 healthcare organizations representing behavioral health (BH), long-term services and supports (LTSS), home and community-based services (HCBS), FQHCs, primary care practices, and hospitals. A total of 26 organizations (13%) responded to the survey, nine of which represent Wards 7 and 8. Approximately 46 percent of the respondents were from BH organizations, 7 percent from primary care, 15 percent from home health (HH) organizations, 7 percent from nursing homes, and 4 percent from hospital systems. The remaining 20 percent chose "other" to describe their organization.

Figure 3. Brief Stakeholder Assessment Respondents

26 organizations responded to the brief assessment survey.

Nine organizations represent Wards 7 and 8

Organization Types	
Behavioral Health	12
Primary Care	2
Home Health	4
Nursing Home	2
Hospital	1
Other	5*

Other Includes: Homeless Services; Primary Care and Addiction Medicine; SUD; BH and Primary Care and Housing; Permanent Supportive Housing

Organization Size*	
< 100	2
< 200	4
< 300	6
<500	3
+1000+	11

Organization size is defined as number of unduplicated patients served on an annual basis.

Stakeholder interviews were conducted with 12 key informants representing providers, MCOs, District agencies, and provider associations. HMA conducted 10 focus groups: six sessions for specific provider types (BH, HH, residential treatment providers) and four sessions with a mixed group of providers. For a full list of stakeholder engagement participants, see Appendix 5.

The stakeholder engagement approach was designed in alignment with the initiative requirements to:

- Identify barriers and opportunities for healthcare system practice integration needed to succeed in VBP arrangements in alignment with LAN categories 2-4
- Make recommendations to the Medicaid program on the design and provision of technical assistance and consulting services to address provider needs
- Make recommendations on the scale and scope of legal, financial, and business technical assistance resources needed to support District providers in alignment with managed Medicaid value-based healthcare expenditure targets

[16] Key informant interviews with District providers conducted in spring 2023.

Challenges Facing District Healthcare Providers

HMA's research, interviews, and focus groups with the DC healthcare provider network revealed the following provider-specific challenges and TA needs. For more information on identified barriers, see Appendix 6.

Behavioral Health Providers

The following challenges hamper the capacity of BH providers to participate in VBP risk-sharing arrangements:

- Providers lack financial reserves necessary to launch new population health initiatives and assume risk. Superficial understanding of the foundational concepts and requirements to succeed under VBP.
- Incomplete understanding of their financial picture (e.g., the actual cost of care delivery).
- Ongoing workforce challenges and revenue stressors post-pandemic.
- Infrastructure challenges (e.g., robust electronic health record [EHR] systems).[17]
- Inadequate understanding of the carve in requirements.

Community-Based Organizations and Social Service Providers

Few social service organizations are even in the nascent stages of VBP arrangements because as they have different funding sources, cultures, systems, and processes.[18] Interviews with social service providers revealed the following challenges:

- Community-based organizations (CBOs) that deliver social services often struggle to partner with large health systems because they often lack the staffing, financial solvency, and the IT infrastructure and processes needed to provide the necessary data and evidence that healthcare providers frequently require.
- Ongoing workforce challenges and revenue stressors post-COVID-19 pandemic.
- Insufficient financial reserves coupled with a lack of understanding of how to contract with healthcare providers to achieve sustainable financing.
- Limited capacity to collect, report, and use healthcare quality measures.

Long-Term Services and Supports and Home and Community-Based Services

- Home and community-based providers have limited options to participate in advanced payment models, that may include pay-for-performance. Most of the opportunity exists in arrangements such as incentive-based contracts for specific services with primary care providers or networks.
- LTSS and HCBS providers have few opportunities to enter Medicaid VBP arrangements.
- Providers often lack partnering opportunities with organizations across the District to provide integrated, whole-person care. Providers often lack the ability to share data and monitor patients with external providers.

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[17] https://dhcf.dc.gov/publication/arpa-home-and-community-based-services-hcbs-digital-health-technical-assistance-ta

[18] Tanenbaum SJ. Can Payment Reform Be Social Reform? The Lure and Liabilities of the "Triple Aim." *J Health Polit Policy Law*. 2017;42(1):5371. doi:10.1215/03616878-3702770.

- DHCF has an opportunity to advance value-based payments for HCBS providers through the newly released request for proposal that aims to reassess and redesign a plan for effective oversight of Medicaid-funded LTSS across all services and delivery systems within the Medicaid program. This proposal would allow the District to support and prepare LTSS and HCBS providers for VBP model.

Hospitals

Interviews with providers revealed that though hospitals in the District have existing Medicaid MCO value-based arrangements, they lack more advanced contracts, other than typical pay-for-performance programs.

- Several hospitals have a Medicare ACO affiliation, but formal agreements with Medicaid MCOs are not based on cost of care.
- Community providers have limited opportunities for partnership/collaboration.
- Hospitals expend significant resources on managing transitions of care.
- Workforce shortages continue post-pandemic. Hospitals struggle to get staff to transition back from virtual to provide in-person visits.
- Health information exchange remains a challenge, especially at inpatient behavioral health facilities, which are not all using the relatively new eConsent feature for sharing of protected substance use treatment information.
- The flow of information from hospitals to community providers has been hindered by a lack of adequate IT systems to monitor patients, track alerts, or discharge and transfer feeds in CRISP. The District's recent investments in community provider digital health infrastructure through electronic health record interoperability incentives and technical assistance[19] seek to improve providers' capacity to connect to health information exchanges.
- Consumer use of the emergency department for routine care is an ongoing problem.

FQHCs

FQHCs are ahead of many other ambulatory healthcare providers serving the District in understanding value-based care. The following are several areas of support for DC FQHCs:

- Creating clinically integrated networks such as the DC Connected Care Network (DC CCN).
- DC CCN contracts for a pay-for-performance APM with Medicaid MCOs and is ready to pursue more advanced models that encourage them to manage TCOC.
- Require claims analysis and technical assistance to succeed, including developing actuarial analyses of assigned member claims data to identify opportunities to reduce low-value care. Need support to expand their data collection beyond current focus on just HEDIS quality metrics.

Technical Assistance Needs

A mixed-method stakeholder engagement approach was used to assess TA needs across the healthcare delivery system. Through these mechanisms, TA needs were identified in business

[19] https://dhcf.dc.gov/publication/arpa-home-and-community-based-services-hcbs-digital-health-technical-assistance-ta

operations, finance, legal, clinical data management and stakeholder engagement, and provider partnerships (see Table 3).

Table 3. Potential Areas of TA Support

Domain	Potential Areas of TA Support
Business Operations	▪ VBP foundations ▪ Building relationships with MCOs ▪ Evaluating payment models ▪ Change management ▪ Staffing for success ▪ Coaching the workforce to District requirements ▪ Stakeholder engagement and provider partnerships ▪ Developing clinical advisory boards and governance models that advance VBP ▪ Maximizing incentive payments ▪ Development of continuous quality improvement (CQI) ▪ Assessing readiness for participation in VBP
Financial	▪ Cash management ▪ Coding, claims, and reimbursement ▪ Billing and authorizations ▪ Actuarial analysis ▪ Determining and tracking the cost of care ▪ Implement strategies to identify sufficient reserves for risk-bearing arrangements ▪ Implement processes for quality and TCOC/shared-savings payments made six to nine months after the measurement period ends ▪ Maintaining financial sustainability
Legal	▪ Understanding VBP contracts ▪ Negotiating arrangements ▪ Forming independent physician associations (IPAs) and clinically integrated networks (CINs) ▪ Merger and acquisition support
Clinical	▪ Understanding population health ▪ Measurement-based care ▪ Adopting validated screenings for physical and behavioral health conditions and social determinants of health ▪ Standardized clinical workflows ▪ Evidence-based care pathways and workflows ▪ Clinical practice guidelines ▪ Team-based care ▪ Managing complex/high-need individuals ▪ Developing meaningful outcome and process measures that target health disparities and improve health equity
Data	▪ EHR support ▪ Population health management tools ▪ Tools to drive decisions, track quality measures, and monitor outcomes ▪ Best practices for collecting data ▪ Data analytics ▪ Collaboration with MCOs to identify gaps and opportunities ▪ Development of data-sharing agreements ▪ Using CRISP DC and eHealth to support providers

Technical Assistance and Policy Recommendations

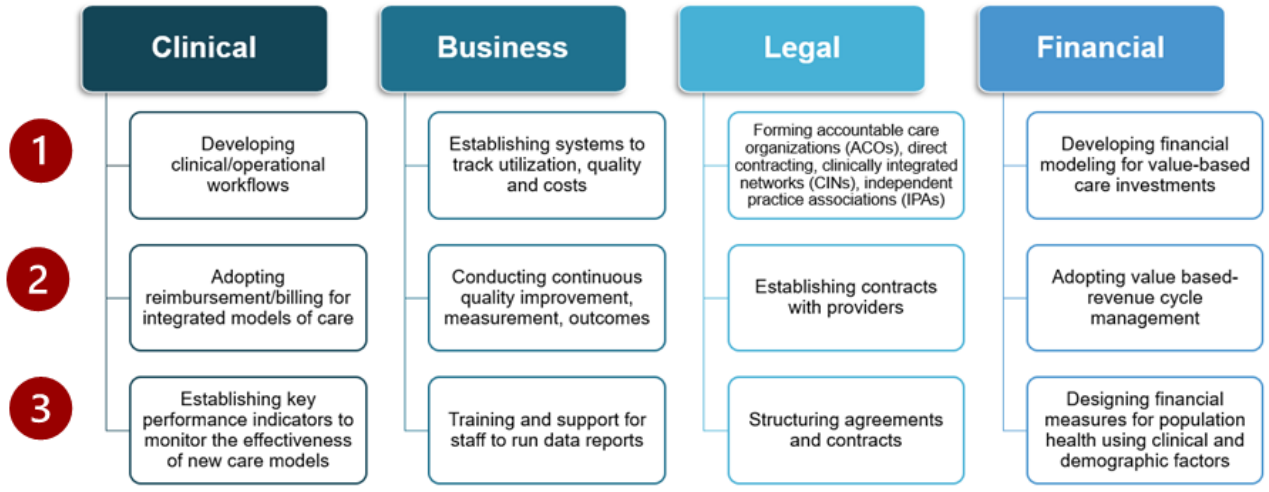
Stakeholder interviews, focus groups, and research uncovered key gaps in provider knowledge, understanding, and capacity necessary to succeed under VBP. Technical assistance should be anchored in the four key Medicaid Business Transformation DC domains: skills in clinical care and integration, business operations, legal, and financial capacity building. Recommendations are organized by: (1) technical assistance delivered during the performance period through September 2023; (2) technical assistance recommendations for the future; and (3) policy recommendations for the District and the Department of Health Care Finance.

Business Transformation Grant Pilot TA during the Performance Period, July 1, 2023–September 30, 2023

At present, behavioral health, LTSS, and CBOs have few opportunities to enter VBP arrangements beyond pay for performance (P4P). Thus, now is an ideal time to develop readiness by addressing gaps in foundational VBP knowledge, understanding, and capacity to operate under an alternative payment arrangement. Through interviews, surveys, and feedback from the spring 2023 MCO behavioral health workshop, District providers identified immediate technical assistance needs, including webinars, tools/ workbooks, and group-learning sessions.

Performance-period TA will be provided in multiple formats to allow participants flexibility and to promote high levels of ongoing participation. Resources needed to succeed in VBP arrangements will be provided, including readiness assessments, tools (workbooks, templates, checklists), group-learning sessions (webinars, workshops, brief videos), individual technical assistance, office hours, and a variety of materials that will be available through the Integrated Care DC website. Training and materials will align with the four key Medicaid Business Transformation DC domains (see Figure 4).

Figure 4. Top Three TA Priorities Across Each Domain Identified in the Brief Assessment



Technical Assistance Recommendations for the Future

To successfully participate in an advanced APM (LAN Categories 3 and 4), providers must have sufficient financial reserves, a prepared workforce that demonstrates consistent and reliable clinical performance, and a robust ability to effectively oversee their revenue cycle, legal contracts, reporting requirements, and the exchange of information.

During the TA needs assessment, organizations identified critical gaps in understanding their operational costs and the implications for risk sharing and when entering VBP arrangements. These gaps must be addressed to ensure Medicaid providers are prepared to transition into risk-based payment arrangements.

Research indicates that states achieving a successful transition incorporate the following best practices into their ongoing technical assistance efforts:

Ongoing support

- Provide two to three years of focused education, technical assistance, resources, and tools for organizations to advance their readiness to succeed in APMs, aligned with the LAN Category Framework (see Appendix 3) and key competencies.
- Establish a forum for engaging providers, MCOs, and key stakeholders in surfacing, addressing, and resolving challenges, implementation barriers, and opportunities to advance capacity to operate under VBP arrangements across the District.
- Use a variety of channels to address new developments in the District's VBP plan and frequently asked questions, such as listening sessions, town halls, provider meetings, emails, podcasts, newsletters, and web-based resources.

Key topics

- Legal, contracting, and financial operations, including use of term sheets, as well as understanding operational costs and ensuring sufficient financial reserves.
- Incorporating and monitoring key performance indicators (KPIs) and metrics used in VBP contracts.
- Implementing care models and evidence-based guidelines that improve clinical outcomes.
- Using a health equity lens to analyze data and identify gaps in population health outcomes.
- Developing governance models to create and operate clinically integrated networks (CIN, IPA, ACO) in the District.
- Developing accountable partnerships that achieve clinical outcomes and cost savings.
- Evaluating organizations that lack alignment in terms of value and quality, and implementing strategies for improving, monitoring, and tracking metrics of significance to external stakeholders.

Policy Recommendations for the District and DHCF

HMA developed the following recommendations. Appendix 10 details our full assessment, detailed recommendations, and questions/considerations.

1. Develop clear definitions and a common methodology for measuring revenue growth tied to value-based care delivered to individuals covered by Medicaid-managed care in the District

2. Identify measurable goals (milestones) for the MCOs that participate with DHCF to achieve its strategic plan goals

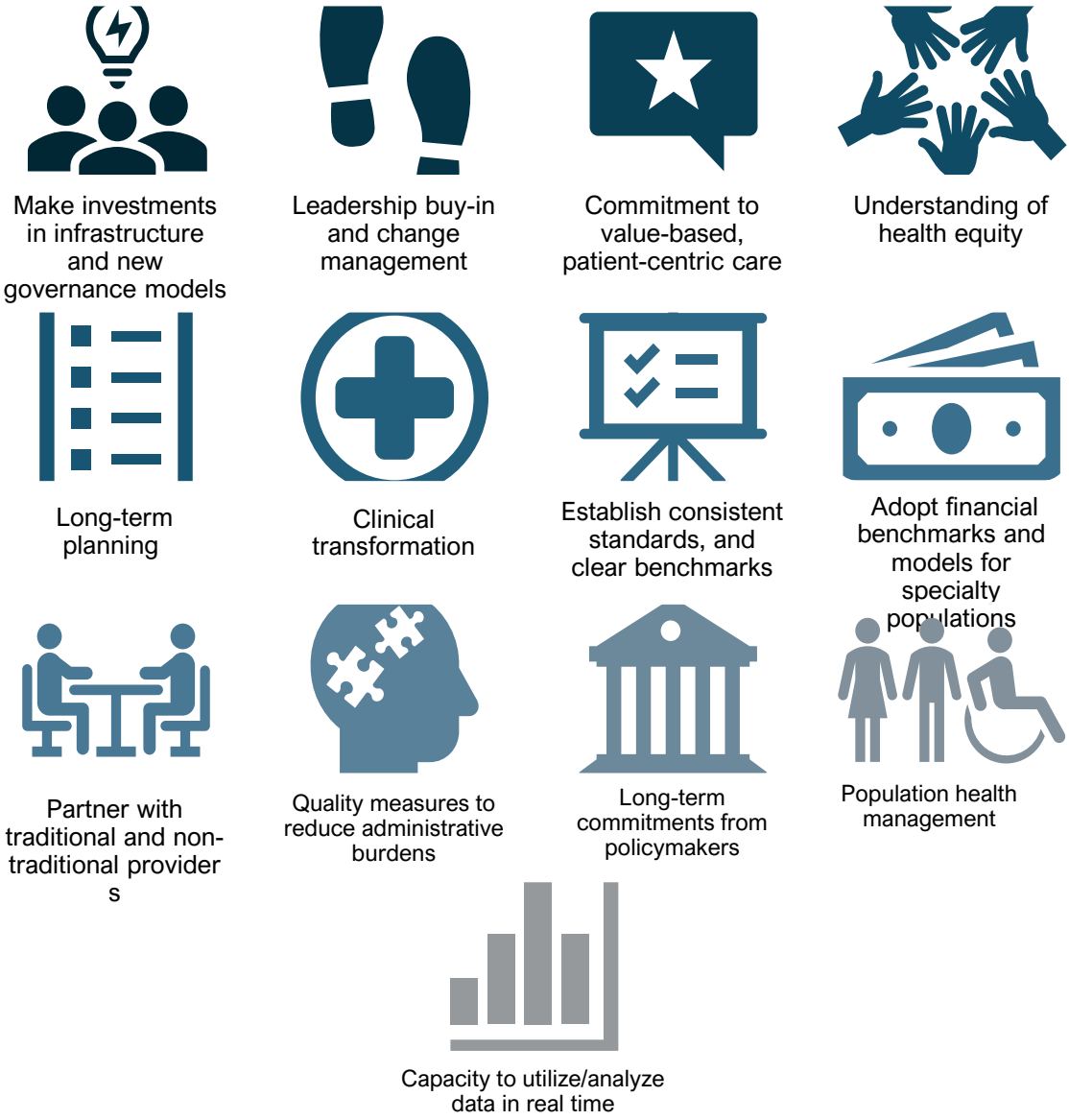
3. Assign accountability for reaching the goal in the described timeline with financial implications for performance

4. Develop attribution assignment and reassignment policies to assure members are appropriately assigned to their treating clinician
5. Make upfront population health investments available to providers who agree to value-based payment arrangements with an MCO
6. Align quality measures and incentive across MCOs
7. Limit quality metrics to a manageable number of measures across payers so providers can focus their quality improvement work
8. To transition providers from LAN Category 2 to LAN Category 3, focus on reducing potentially avoidable emergency department visits, hospitalizations, and rehospitalizations
9. Develop processes that ensure timely and accurate exchange of information between payers and providers
10. Ensure that the financial incentives for achieving success under an APM yield a positive return on investment
11. Encourage the creation of CINs, ACOs, and IPAs
12. Consider leveraging the previous My Health GPS initiative as a valuable tool for providers to succeed in LAN 3 or 4 APM

Appendices

Appendix 1. Learning from National VBP Models

The following elements are key to successful VBP based on national research.



Sources

Value-based Payments and Behavioral Health: Results of a Nationwide Environmental Scan. National Council. (2019, September 11). Available at: https://www.thenationalcouncil.org/wp-content/uploads/2022/01/Value-based-Payments-and-Behavioral-Health-slides.pdf. August 22, 2023.

Bailey M, Matulis, R, Brykman K, Center for Health Care Strategies *(2019, September).* Behavioral Health Provider Participation in Medicaid Value-Based Payment Models: An Environmental Scan and Policy Considerations. Center for Health Care Strategies. Available at: https://www.chcs.org/resource/behavioral-health-provider-participation-in-medicaid-value-based-payment-models-an-environmental-scan-and-policy/. August 22, 2023. Bailit Health. State Strategies to Promote Value-Based Payment Through Medicaid Managed Care Final Report. March 13, 2022. Available at: https://www.macpac.gov/wp-content/uploads/2020/03/Final-Report-on-State-Strategies-to-Promote-Value-Based-Payment-through-Medicaid-Mananged-Care-Final-Report.pdf. August 21, 2023.

Crook HL, Saunders RS, Roiland R, Higgins A, McClellan MB. A Decade of Value-Based Payment: Lessons Learned and Implications for The Center For Medicare And Medicaid Innovation: Part 1. *Health Affairs* Forefront. June 9, 2021. doi: 10.1377/hblog20210607.656313.

Appendix 2. Mayor's Commission on Healthcare Systems Transformation Areas of Focus

The Mayor's Commission on Healthcare Systems Transformation[1] sought to develop a set of recommendations—outlining the strategies and investments necessary to transform healthcare delivery in the District of Columbia—with the overall goal of creating a more equitable, robust, and integrated system of care for all the District residents. Six committees were charged with developing these recommendations, focused on a key challenge facing the healthcare system:

Overcrowding in emergency rooms and general reliance on inpatient hospital care

Discharge planning and transitions of care

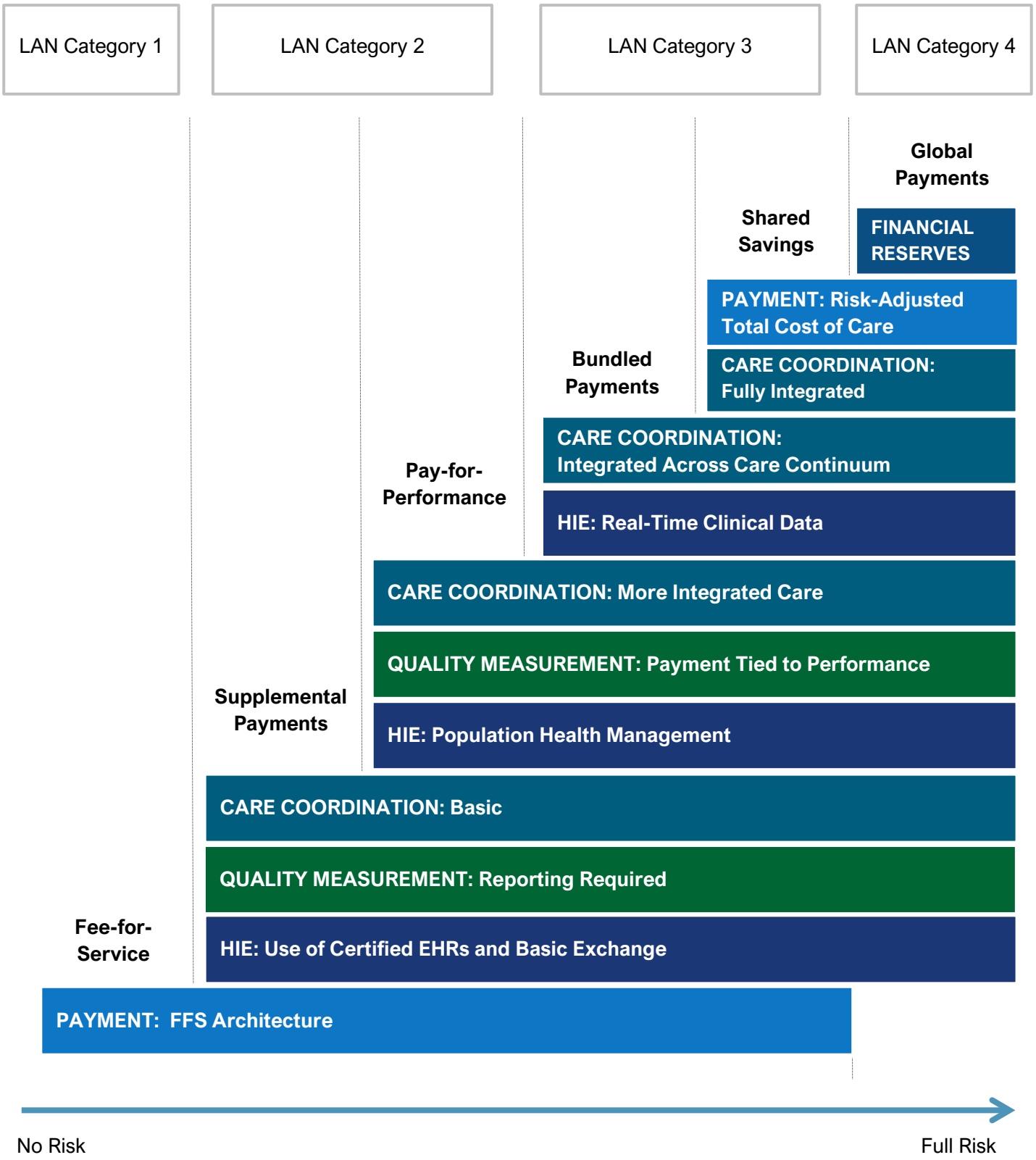
Access to critical and urgent care services, specifically maternal, behavioral, and emergency care

Allied healthcare professionals and workforce development

Value-based payment

Equitable Geographic Distribution of Acute, Urgent, and Specialty Care

Appendix 3. Health Care Payment Learning and Action Network (HCP-LAN)Framework and Key Core Competencies



VBP Elements	Essential Steps
Leadership and Board Engagement	▪ Establish a VBP Leadership Team with representation from finance, clinical, operations, and data analytics. ▪ Engage in a comprehensive strategic planning process that prepares for the transition to VBP. ▪ Develop an overall value proposition for your organization. ▪ Create a performance management dashboard that includes trends in membership by plan, quality outcomes for metrics with financial implications, utilization, and cost with benchmarking. ▪ Determine organizational risk tolerance. ▪ Consider tying quality and performance metrics to performance reviews, employee incentives, or contractual expectations of employment.
Health Information Exchange (HIE)	▪ Consider embedding evidenced-based clinical protocols and decision support tools electronically in your EHR to aid in point-of-service decision-making. ▪ Develop a system for direct service staff/care team members to receive alerts (e.g., via Regional Health Information Organizations) regarding real-time admission, discharge, and transfer (ADT) alerts.
Quality Measurement	▪ Establish the technology needed to support storing, retrieving, calculating, and reporting out on clinical-quality population health metrics management. ▪ Identify which metrics have direct and which have indirect financial implications in the VBP contracts. ▪ Estimate the financial implications of meeting or missing performance targets. ▪ Establish a CQI plan for each key metric including a financial ROI analysis for making additional investments. ▪ Develop a strategy for using the data collected to improve clinical care and outcomes. ▪ Create a system to collect data on the social determinants of health outcomes.
Care Coordination	▪ Assess your current care management capabilities. For example, if you were given a list of your most complex, high-risk clients, do you feel your organization would have a model in place to manage that list including staffing, competency, capacity, and guidelines? ▪ Develop an actionable registry to monitor high-risk individuals. ▪ Assess required functionalities of your care management platform (intake of external data sources, integration with the EHR, assessment tools, risk stratification algorithms, care planning templates, task prioritization, transition of care workflows, ability to share care plans with the full interdisciplinary care team). ▪ Develop a process to stratify and re-stratify your client population. ▪ Establish formal written arrangements through an MOU, care compact, or contract with social services, behavioral health, and physical health. Create plans to formally engage and communicate about mutual clients. ▪ Ensure that every direct service and other staff within the care team can collaborate on the development of a common care plan. ▪ Develop a strategy to outreach to and engage any managed care members who are assigned to you but have never been seen in your organization.
Clinical	▪ Implement a system for administering, tracking, and reporting on industry-recognized measures (e.g., PHQ-9, GAD7, AUDIT-C). ▪ Train staff in evidence-based practices and measurement-based care.

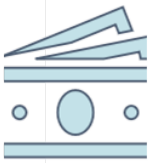
	▪ Collect client satisfaction data through a survey tool.
Financial Strength	▪ Develop a financial plan that estimates cost of new investment in staff and infrastructure needed to pursue VBP and plan for securing those resources. ▪ Determine the adequacy of financial reserves required to assume that level of risk. ▪ Establish your cost per visit including non-CPT codable services (e.g., enabling services, social determinants of health) and analyze cost per visit on a regular basis to identify cost efficiencies. ▪ Calculate/monitor the total annual cost per client for in-house services. ▪ Consider using business intelligence (BI) software to assimilate and report on data from internal systems (EHRs, billing systems, accounting systems), assimilate external claims data with internal data, manipulate third party claims data. ▪ Develop a revenue model to budget the amount and timing of revenue and cash flow of potential VBP arrangements. ▪ Evaluate the upfront costs of participating in the VBP arrangement and new skill sets/core competencies. ▪ Monitor direct service staff productivity including visits and relative value units (RUVs). ▪ Train direct service staff on proper coding and documentation practices on a regular basis, at least annually, and review the coding of direct service staff regularly. ▪ Develop an incentive compensation program for direct and non-direct service staff including a provision for direct service staff productivity. Align the incentive program with existing quality incentive programs in payer contracts. ▪ Review productivity reports with clinical leadership and direct service staff. Monitor the productivity (panel size) of non-direct service staff. Monitor the use of specific in-house services by individual. ▪ Meet with health plan representatives regularly to review your performance on VBP arrangements. ▪ Establish more than 90 days of working capital. Definition: Days in working capital = (current assets - current liabilities)/ (total annual operating expenses/365 days). ▪ Evaluate reserve requirements and/or the opportunities to partner with other providers and/or assume a risk VBP contract. ▪ Maintain positive net assets for operations of at least 30 days. ▪ Prepare monthly financial statements and make the financials available within 15 business days of month end. ▪ Develop a service volume, profit, and loss statement for each product with each health plan as well as a roll-up of all management care contracts. ▪ Present financials monthly for the board's/finance committee's approval. ▪ Develop a system where financials include a comparison to budget with a written explanation of variances and are prepared in accordance with generally accepted accounting principles (GAAP). ▪ Complete agency independent audit within six months of year's end. ▪ Complete an independent audit for the past three years. ▪ Budget the amount and timing of revenue and cash flow of potential VBP arrangements. ▪ Evaluate reserve requirements and/or the opportunities to partner with other providers. ▪ Offer financial assistance to clients by subsidizing services based on client need as applicable. ▪ If applicable, review financial performance of any clinically integrated network that you participate in.

Appendix 4. Key TA Areas Identified from the Managed Care Readiness Workshop

The following are key areas of technical assistance identified by providers at the May 2023 Integrated Care DC Managed Care Readiness BH Workshop. For more information on the workshop, visit: https://www.integratedcaredc.com/resource/integrated-care-dc-managed-care-readiness-workshop/

Business/Operational

- Mergers & Acquisitions
- Step by step guides/codes
- MCO Integration & Transition Steps
- VBP 101
- Leadership during times of transition
- Foundational elements of managed care



Financial

- Billing & Reimbursement
- More trainings on fiscal implications of VBP
- Billing, payment authorizations, and reimbursements

Legal

- Negotiating contracts with MCOs
- How to start an organization

Clinical

- How to for SUD providers
- Emphasis on treating the whole person
- Level of care training

Data

- CRISP training
- How to use HIE
- Compliance based trainings (e.g., Quality)

Other

- Recognizing stakeholders and being aligned to community needs
- More trainings for nursing homes
- Connecting to resources in DC
- Grants and financial resources

Appendix 5. Stakeholder Engagement Participants

Interviewees

1. Robert Hay (Medical Society of DC)
2. Michael Neff (DC Department of Behavioral Health)
3. Yavar Moghimi (AmeriHealth)
4. Mark LeVota (DCBHA)
5. Khalil Hassam, Dr. Asad Bandealy (DC Department of Health)
6. Tippi Hampton (DHCF)
7. Nathaniel Beers (EVP Population Health, formerly HSCSN)
8. Dr. Bernard Arons (Amerigroup)
9. Gayle Hurt, Eden Cunningham (DCHA)
10. Tamara Smith, Allyson Smith, Patricia Quinn (DCPCA)
11. Donna Ramos-Johnson (DCPCA)
12. Don Blanchon (Wasque Advisors, formerly with Whitman Walker)

Focus Group Participants

Focus Group	Providers
Session 1: Behavioral Health Providers	Catholic Charities, Community Connections, Integrated Community Services, McClendon Center, The Family Wellness Center, Gaudenzia
Session 2: FQHCs	Community of Hope DC, DCPCA, Family Medical Counseling Services, La Clinica del Pueblo, Unity Health Care, Whitman Walker Health
Session 3: Behavioral Health Providers	Restoration Community Alliance, FixPat, Inc., Kahak Health Care Services
Session 4: Behavioral Health Providers	Umbrella Therapeutic Services, Wellness Health Services, La Clinica del Pueblo, Quality Healthcare Services, Inspire Consulting
Session 5: Home Health	Maxim Healthcare Services
Session 6: Residential Treatment Providers	Prestige Health Resources, RAP, Inc.
Session 7: General (All Providers)	Forest Hills of DC, Verigreen, Maryland Family Resource, Family and Medical Counseling Services, Volunteers of America, Total Family Care Coalition, Innovative Life Solutions, DC Home Health Holdings, Hillcrest, Aglow, Abundant Grace, Mary's Center, Unite Planning Organization, Open Systems
Session 8: General (All Providers)	Open Systems
Session 9: General (All Providers)	Howard University Hospital, Open Arms Housing, Volunteers of America
Session 10: General (All Providers)	P&G Behavioral Health, Community Wellness Ventures, Jaydot, Capital Clubhouse, Whitman Walker, United Medical Center, Life Enhancement Services, Wholistic Services, Behavioral Health Group, Children's National, Open Systems

Survey Respondents

1. Anchor Mental Health
2. Autumn Lake Healthcare at Oakview
3. Community Action Group
4. DC Home Health Holdings
5. Elaine Ellis Center of Health
6. Everyone Home DC
7. Forest Hills of DC
8. Friendship Place
9. Howard University
10. Inner City Family Services
11. Integrated Community Services
12. Latin American Youth Center
13. Life Enhancement Services LLC
14. Maryland Family Resource, Inc.
15. Medical Home Development Group
16. Meiger Health
17. Pathways to Housing DC
18. RAP-Gaudenzia
19. So Others Might Eat
20. St. Elizabeths Hospital
21. T&N Reliable Nursing Care
22. Total Family Care Coalition
23. VOA DC
24. Volunteers of America Chesapeake & Carolinas
25. Wellness Health Services LLC d/b/a The ARK of DC
26. Woodley House

Appendix 6. Stakeholder Engagement Reported Barriers

Domain	Reported Barriers	Potential Areas of TA Support
Business/ Operational	▪ Lack of knowledge about VBP (e.g., contracts, negotiation) ▪ Untimely MCO payment ▪ Silos within District (e.g., lack of natural incentives to work together) ▪ Resistance to change/culture shift (particularly in independent practices) ▪ Staffing (e.g., limited resources, workforce shortages) ▪ Technology ▪ Corporate/government distrust	▪ Contracting support (negotiating VBP arrangements) ▪ Help with staffing plans (teams needed, how to build them out) ▪ Individual coaching ▪ Building relationships with MCOs
Financial	▪ Variation in rates ▪ Lack of standardization in payment methodology ▪ Cash management	▪ Evaluating payment models ▪ Billing and authorizations ▪ Actuarial analysis
Legal	▪ Lack of understanding with contracts and negotiating better arrangements ▪ Concerns with workforce and managing DC requirements	▪ MCO agreements ▪ IPA/CIN agreements ▪ Mergers and acquisitions support
Clinical	▪ Improved access to care ▪ Standardized workflows ▪ Sufficient staffing	▪ Follow clinical practice guidelines ▪ Ongoing training to support care teams (e.g., helping them be more effective, maximizing capacity to deliver care)
Data	▪ Lack of actionable, user-friendly information ▪ Better data needed on claims/payments; current systems inadequately setup ▪ Limited data systems	▪ EHR support ▪ Data analytics ▪ Best practices for collecting data ▪ Reviewing scorecards to identify opportunities

Appendix 7. Technical Assistance Webinars
August 2023-September 2023

Medicaid Business Transformation DC
Prepping for Value

Value-Based Payment Cohort-Based Training

Medicaid Business Transformation DC is a DC Department of Health Care Finance technical assistance initiative for District health care providers who serve Medicaid members. Technical assistance content is driven by results from a market analysis and stakeholder engagement process. Health Management Associates' subject matter experts will be delivering virtual, interactive group learning events, outlined in the calendar below. All events will be recorded and posted here: www.integratedcaredc.com/learning-library.

To sign up for upcoming events, visit: www.integratedcaredc.com/events

Value-Based Payment Foundations (All Providers)	Session Date
VBP 101 (The "Basics")	Wed., Aug. 9, 12 - 1 p.m.
Data-Driven Insights to Advance Behavioral Health Quality	Thurs., Aug 31, 12 - 1 p.m.
Allocation of Value-based Payment Incentive Payments to Optimize Performance	Fri., Sept. 8, 12 - 1 p.m.
Clinical and Programmatic Implications of VBP	Tues., Sept. 12, 3 - 4 p.m.
VBP 101- Teaching to the Tools	Mon., Sept. 18, 12 - 1 p.m.
Behavioral Health	**Session Date**
Promise and Perils of VBP	Wed., Aug. 16, 1 - 2 p.m.
Measurement Based Care for VBP	Mon., Aug. 28, 12 - 1 p.m.
Getting to an Advanced Alternative Payment Model as a Behavioral Health Provider	Wed., Sept. 6, 1 - 2 p.m.
Managing High Cost High Need Individuals	Thurs., Sept. 14, 1 - 2 p.m.
Federally Qualified Health Centers	**Session Date**
Clinically Integrated Networks: Build, Buy or Stay on the Sidelines	Tues., Aug. 15, 11-12 p.m.
Value-based Payment: Is it Disrupting Health Care for the Better? Role of a Capitated Alternative Payment Model	Wed., Aug. 23, 12 - 1 p.m.
Value-based Payment: Is it Disrupting Health Care for the Better? Role of a Clinically Integrated Network	Wed., Sept. 13, 12 - 1 p.m.
Legal	**Session Date**
Strategies for Negotiating Managed Care Contracts	Fri., Aug. 11, 12 - 1 p.m.
Understanding Key Terms in Managed Care Contracts	Thurs., Aug. 17, 12 - 1 p.m.
Where Quality Meets Legal	Wed., Aug. 30, 1 - 2 p.m.
Key Considerations for Value Based Payment Arrangements	Tues., Sept. 19, 12 - 1 p.m.

Contact us!

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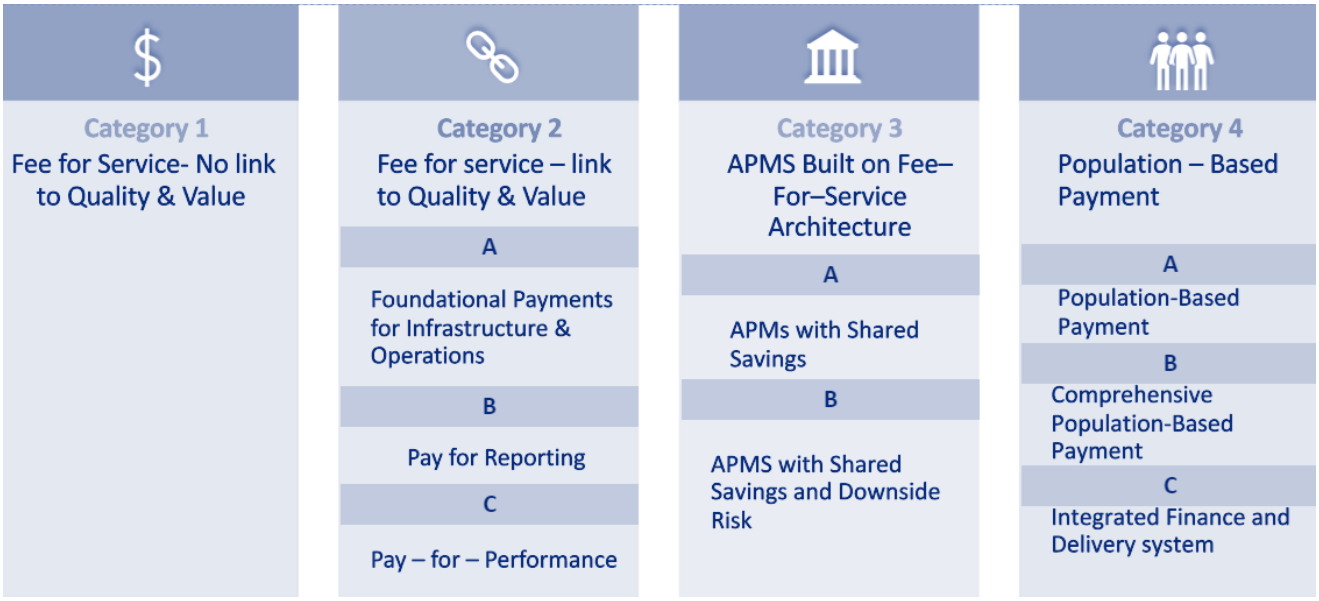
The source of funding for this grant award is District appropriated funds earned based on the American Rescue Plan Act (ARPA) of 2021.The obligated amount funded by Grantor shall not exceed $999,000 in the first year per year, and one option year of up to $500,000 unless changes in the obligated amount are executed in accordance with ARTICLE XV of this agreement.

Appendix 8. Literature Review

Since the passage of the Affordable Care Act in 2010, healthcare payers and policymakers have made a series of advances in the transformational shift to paying for value. The CMS has led these efforts, with a growing share of payers transitioning from outmoded FFS payment models.

In 2015, the US Department of Health and Human Services (HHS) increased efforts to advance VBP, with a goal of tying 50 percent of healthcare expenditures to APMs by 2018. To measure progress toward these goals, the Health Care Payment Learning and Action Network (HCP-LAN) developed an APM framework to classify VBP payment models. The framework places payment models in four categories based on where they fall on the continuum of clinical and financial risk for providers as illustrated below.

HCP-LAN Framework[20]



Data from HCP-LAN showed that 90 percent of traditional Medicare payments were made through value-based payment arrangements, but only 34 percent of Medicaid payments were made under such arrangements.[20] Though Medicare has paved the way in advancing VBP, only half of the 21 MCO states identified a specific target in their contracts for the percentage of provider payments or plan members that MCOs must cover via alternative payment models in FY 2019.[21] State Medicaid agencies are increasing efforts to develop VBP arrangements that advance population-based payment and significant practice transformation.

States may use waivers or mandate MCO or provider/organization participation in VBP to enhance access, improve patient experience, and reduce utilization and costs. In light of recovery from the

[20] These rates are calculated by summing HCP-LAN categories 2, 3, and 4 from the CY 2018 payment results tables (p.18 and 20) in the HCP-LAN 2019 Methodology and Results Report available at http://hcplan.org/workproducts/apm-methodology-201.

[21] Gifford K, Ellis E, Lashbrook A, et al. A View from the States: Key Medicaid Policy Changes—Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020. Kaiser Family Foundation. October 18, 2019. Available at: https://www.kff.org/medicaid/report/a-view-from-the-states-key-medicaid-policy-changes-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2019-and-2020/. Accessed August 25, 2023.

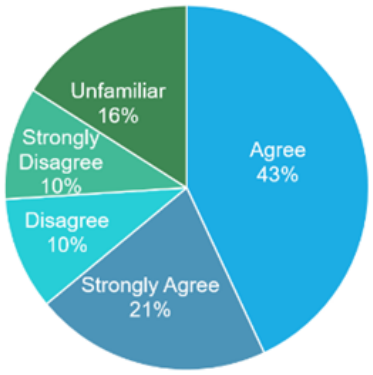
COVID-19 pandemic, ongoing budget challenges, and unsustainable cost growth trends, VBP models continue to expand in Medicaid. As these changes take hold, healthcare organizations are expected to make fundamental changes to their care delivery, financing, and operations. The move to VBP is a long-term goal, with analyses of ACOs showing that organizations often need at least three years to generate consistent savings.[22]

This finding aligns with feedback from organizations, where many providers reported that the first year is often spent trying to design and assess reforms based on program rules and data, and the second year is when they refine and scale promising care initiatives. That process requires upfront investments, skills and trust among providers, government, and payers to succeed.

"Our organization has the necessary information to understand outcomes and related measures that MCOs use to define success."

- **36%** are unfamiliar, disagree or strongly disagree with the above statement

Source: DBH Readiness Survey High-Level Overview (March 2022)



Results from the 2019 Department of Behavioral Health BH MCO readiness survey revealed that providers were largely unfamiliar with MCO contracts, outcomes, and ways to succeed.

Though VBP models have the potential to provide additional revenue for nonprofit community behavioral health providers through shared savings, incentives tied to quality, capitated, case, or bundled rates paid on a per member per month basis, providers may be unable to take advantage of these opportunities if they have insufficient financial reserves. Behavioral health providers should consider and ensure they fully understand and can succeed under VBP requirements such as quality measure attainment, attribution methodology, and reporting requirements when entering arrangements.

Nonprofits must reinvest the savings into the mission and infrastructure of the organization, which can further enhance innovation, workforce capacity, evidence-based strategies/interventions, and flexible care models. It is critical that organizations have a complete understanding of their financial picture, the funding needed to accept additional risk, and risk corridors to prevent financial overexposure and instability.

Through our research, interviews, and focus groups with a variety of providers, several common themes and TA needs emerged. In addition, we identified the following provider-specific learnings and TA needs:

Behavioral Health Providers

Though VBP models could provide additional revenue for nonprofit community behavioral health providers through shared savings, incentives tied to quality, capitated, case, or bundled rates paid on a per member per month basis, providers may be unable to take advantage without sufficient financial reserves. Behavioral health providers should consider and ensure they fully understand and can

[22] Bleser WK, Saunders RS, Muhlestein DB, McClellan M. Why Do Accountable Care Organizations Leave the Medicare Shared Savings Program? *Health Affairs*. 2019;38(5):794-803.

succeed under VBP requirements such as the quality measure attainment, attribution methodology, and reporting requirements when entering arrangements.

Nonprofits must reinvest the savings into the mission and infrastructure of the organization, which can further enhance innovation, workforce capacity, evidence-based strategies/interventions, and flexible care models. It is critical that organizations have a complete understanding of their financial picture, funding necessary to accept additional risk, and risk corridors to prevent financial overexposure and instability.

> A challenge is when a consumer is discharged from a hospital setting, the practice is not made aware, and they may not have a direct contact for the individual.
>
> *Stakeholder engagement feedback from Behavioral Health Provider*

Behavioral health providers experienced significant changes because of COVID-19, forcing organizations to rapidly shift from providing primarily in-person services to telehealth. This change, coupled with workforce challenges, revenue stressors, the upcoming behavioral health carve-in, and EHR requirements have affected the behavioral health community. Providers are focused on understanding the carve-in requirements, building relationships with MCOs, and preparing for VBP.

Community-Based Organizations and Social Service Providers

> A challenge is being successful in the transition with current staff. Try to have blended funds to stay afloat. Have a long way to go for VBP.
>
> *Stakeholder engagement feedback from Social Services and Supports Provider Organization*

Unstable housing, food insecurity, and employment instability drive poor health outcomes. VBP models offer an opportunity to include the full array of health-related social needs to encourage providers to integrate healthcare delivery with social services that address needs such as housing, food, and transportation. To provide these incentives, organizations need the ability to hold providers accountable for reducing health disparities and implementing interventions to advance health equity.[23]

For example, some VBP models encourage the use of non-traditional providers such as community health workers[24] to provide community-based care and address health-related social needs.

Nonetheless, few social service organizations are in even the nascent stages of VBP arrangements because they have different funding sources, cultures, systems,[25] and processes. Social service CBOs often struggle to partner with large health systems as they often lack sufficient staffing, financial solvency, IT infrastructure, and processes to provide the necessary data and evidence that healthcare

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[23] The Center for Health Equity Action for System Transformation. Accelerating health equity by measuring and paying for results. Families USA. March 2019. Available at: https://www.familiesusa.org/wp-content/uploads/2019/03/HEV_Data-Stratification_-Issue-Brief.pdf. Accessed 31, 2023.

[24] Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment: A Return on Investment Analysis of a Randomized Controlled Trial of a Standardized Community Health Worker Program that Addresses Unmet Social Needs for Disadvantaged Individuals. *Health Affairs*. 2020;39(2):207-213.

[25] Tanenbaum SJ. Can Payment Reform Be Social Reform? The Lure and Liabilities of the "Triple Aim." *J Health Polit Policy Law*. 2017;42(1):53–71. doi:10.1215/03616878-3702770.

providers often require. Interviews with social service providers revealed challenges with staffing, entering contracts with healthcare providers, and sustainable financing.

Long-Term Services and Supports, Home and Community-Based Services (Nursing Home, Home Health)

Long-term care settings have long been the subjects of care continuum partnerships as value-based payment models have grown. ACOs have engaged skilled nursing homes and home health providers in preferred networks to help better manage cost, quality, and experience. Additionally, with the onset of Medicare and then commercial payer bundles, health systems and hospitals have partnered with nursing homes and home health providers to shift care appropriately to the lowest acuity, yet safe and effective, setting.

It may seem that nursing homes and home health providers are well-positioned within the VBP landscape, but they have limited options to participate directly in value-based payment models, such as pay-for-performance. Most of the opportunity exists in downstream partnerships or incentive contracts with primary care providers or networks that are in value-based contracts where they are responsible for the total cost of care of their populations.

> Not seeing a lot of VBP in LTSS right now, but there is starting to be a shift. Feel as though MCOs have not been rewarding providers that are going above and beyond, so no incentive to take on additional consumers. Care delivery model is labor-heavy compared to a traditional home health model, so it becomes risky for the provider.
>
> *Stakeholder engagement feedback from LTSS Provider*

Nursing homes and home health providers encounter many of the same challenges as other providers in their readiness to adopt value-based models of care and payment. The nursing homes that responded to the brief assessment survey indicated a need for technical assistance on the high end of the spectrum.

Unless the MCOs in the District move toward more TCOC accountability models with providers, nursing homes and home health providers will continue to have limited opportunity to apply value-based payment models and the incentives to move toward a more value-centric care model. DHCF could advance value-based payments for HCBS providers through the newly released RFP that aims to reassess and redesign a plan for effective oversight of Medicaid-funded LTSS across all services and delivery systems within the Medicaid program, which would allow the District to support and prepare providers for VBP models.

Hospitals

Hospitals have played a significant role in the shift to value. Across the country, hospitals have had to adopt Medicare's hospital value-based purchasing program, which focuses on a host of performance metrics. They also have been subject to public transparency through Medicare's hospital comparison site.

That said, many hospital-centric health systems have adopted value-based payment models across lines of business and have led or participated in ACOs; however, community hospitals that have limited primary care bases have had a different experience. This landscape is similar to what is occurring in the District. Hospitals with greater resources and primary care bases have had more opportunities to adopt value-based payment models than community hospitals, which have struggled to navigate the shift.

Provider interviews revealed that while hospitals in the District have existing Medicaid MCO value-based arrangements, they do not have more advanced contracts in place, other than typical pay-for-performance programs. Several hospitals have an ACO affiliation, but other than what they have in the Medicaid contract, it does not exist. A few challenges that were identified include the disconnect between hospitals and hours of availability for community providers to perform hand-offs and the significant resources hospitals spend on managing transitions of care.

> Would be difficult to transition into VBP but are striving for it. Trying to lower readmission rate. Transitional clinic would really help the readmission rate.
>
> *Stakeholder engagement feedback from Hospital Provider*

Workforce shortages after the pandemic have had a significant effect on District hospitals, and they are struggling to get staff to transition back to in-person visits. Health information exchange remains a challenge, especially at inpatient behavioral health facilities, which are not all using the relatively new eConsent feature for sharing of protected substance use treatment information. Acute care hospitals send information through CRISP, and the flow of information from hospitals to community providers has been hindered by a lack of adequate IT systems to monitor patients, track alerts, or discharge and transfer feeds in CRISP. The District's recent investments in community provider digital health infrastructure through electronic health record interoperability incentives and technical assistance[26] seek to improve providers' capacity to connect to health information exchanges.

In addition, a remaining challenge in the District includes individual use of the emergency department for routine care. It is still necessary to ensure people have access to the most appropriate level of care and use population health approaches to address their needs. As the District works to move providers to more advanced Medicaid LAN-category VBP models, hospitals will be critical stakeholders and partners for the efforts to be successful.

FQHCs identify ways to monitor the impacts of the VBP

FQHCs have been relatively late to join the pursuit of value-based care (VBC), in part because of federal regulations that have precluded their participation in some Medicare demonstration programs and policies that have discouraged FQHCs from assuming financial risk. CMS strategy has changed in the past year with the introduction of Medicare APMs designed for FQHCs and other physician practices with limited experience in VBC such as Advanced Investment Payments for Track A and the Making Care Primary Model.

> Metrics are not representing the quality of care being provided—feels like they don't have much say in how the contracts are being developed. Contracting feels one-sided.
>
> *Stakeholder engagement feedback from FQHC Provider.*

FQHCs are increasingly creating clinically integrated networks (CINs) that allow them to make joint investments and gain leverage during contract negotiations with payers. FQHCs are ahead of many other ambulatory healthcare providers that serve the District of Columbia in terms of understanding VBC. They created DC Connected Care Network (DC CCN) shortly before the COVID-19 pandemic to allow them to contract with payers and make investments together. The public health emergency diverted attention to more pressing matters, as was appropriate.

[26] https://dhcf.dc.gov/publication/arpa-home-and-community-based-services-hcbs-digital-health-technical-assistance-ta

Appendix 9. Example State VBP Models

California

California implemented a voluntary FQHC APM for FQHCs per federal regulations, and FQHCs with multiple sites having different prospective payment system (PPS) rates can choose which sites are included if all sites with the same PPS rate are included or excluded.[27] This program requires FQHCs to apply and be accepted to participate in the APM. FQHCs may withdraw from the program both before and after contract start, subject to providing sufficient notice to the Department of Health Care Services.

To support this effort, Kaiser is providing approximately $35 million to help California FQHCs improve population health and VBP performance. HMA is supporting and staffing the design of a population health management solution set for implementation at the health centers under the direction of Kaiser Foundation Health Plan and Permanente Medical Group leadership. These solutions include:

- Enhancing HIT capabilities for data capture, as well as monitoring and improving population health, clinical models, and pathways that advance population health activities at the health centers.
- Improving social health screening and practices and enhancing access to specialty services.
- Improving HIT capability includes developing business requirements, overseeing design, and subsequent testing of requirements in a population health management platform.

The solution focus areas have been developed from a co-design process between Kaiser Permanente and health centers, with the goal of identifying the needs and priorities of health centers to guide solution development.

Massachusetts

Massachusetts' Delivery System Reform Incentive Payment (DSRIP) was authorized through an 1115 waiver that supported MassHealth's transition to ACOs, including funding to establish community partners (CPs) to integrate behavioral health, LTSS, and health related social needs (HRSNs).[28] DSRIP also included funding to support statewide investments to scale statewide infrastructure and workforce capacity in support of MassHealth restructuring. The MA DSRIP program funds three major initiatives central to transforming MassHealth: ACOs, CPs/community service agencies (CSA), and statewide investments.

The TA Program is one component of DSRIP statewide investments designed to strengthen the healthcare workforce and infrastructure across the Commonwealth of Massachusetts. This effort is intended to enhance the MassHealth ACO, CP, and CSA capacity to improve health outcomes and experiences and lower the total cost of care for MassHealth members.

The Learning Collaborative that supported care teams at ACOs and CPs engaged in shared care planning to improve care for eligible MassHealth members included: 28 change teams across ACOs and CPs, seven webinars, ongoing coaching calls, pop-up events focused on emerging topics for ACOs

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[27] Howe G, Silverman K, Houston R. California Federally Qualified Health Center Alternative Payment Model: Implementation Guide. March 2023. Available at: https://www.chcf.org/wp-content/uploads/2023/03/CAFQHCAPMImplementationGuide.pdf. Accessed August 31, 2023.

[28] MassHealth. Massachusetts Delivery System Reform Incentive Payment Program. Mass.gov. Available at: https://www.mass.gov/info-details/massachusetts-delivery-system-reform-incentive-payment-program. Accessed August 31, 2023.

and CPs, including two in-person events, two virtual events, and a virtual shared-learning event for MassHealth ACOs and CPs.

New York

New York State (NYS) submitted its first VBP roadmap in July 2015 and one every year thereafter under the 1115 waiver demonstration to implement DSRIP to ensure its efforts were aligned with the goals of the US Department of Health and Human Services (HHS) on value-based purchasing and APMs.[29] The roadmap was designed to move at least 80 percent of all Medicaid managed care payments, which were traditionally reimbursed through fee-for-service arrangements, into VBP arrangements. VBP contractors and MCOs were subject to the following minimum VBP goals: Eighty percent of total MCO expenditure (in terms of total dollars) will have to be captured in at least Level 1 VBP arrangements; 35 percent of total payments are contracted through Level 2 VBP arrangements or higher; and MCOs that do not meet the minimum VBP goals or certain other regulatory requirements will be subject to penalties outlined in the Medicaid Managed Care Model Contract.[30]

NYS also provided on-menu and off-menu VBP arrangements from which providers may select to achieve state approval. The state also developed a governance model inclusive of provider participation to oversee the VBP model, which included clinical advisory groups (CAGs) to review bundled payment design and subpopulation definitions most relevant to NYS Medicaid. The CAG made recommendations to the state on the quality measures, data, and support that providers needed to be successful and addressed other implementation details related to specific VBP arrangements, including bundles and subpopulations.

New York provided ongoing technical assistance through a contractor to its performing provider systems (PPS) in the development of their DSRIP project plans. The state allocated a portion of the DSRIP project design grants to assist PPS with their DSRIP project plan development. Awards were made on August 6, 2014, to 42 of the emerging PPS. Some PPS merged; ultimately, 25 PPS submitted Project Plan applications on December 22, 2014. As part of this work, HMA assisted behavioral health providers with the following efforts:

- Administering HMA's VBP readiness assessment tool to a cohort of behavioral health providers (examples: a trade association's members, members of an IPA, performing provider system)
- Benchmarking providers in each cohort against each other
- Helping each build out a workplan for their agency to address the gaps identified

North Carolina

The North Carolina Department of Health and Human Services (DHHS) developed the advanced medical home (AMH) program as the primary vehicle for delivering care management as the state transitioned to managed care. An AMH is a primary care practice that agrees to:

- Accept a patient panel
- Provide primary and preventive care according to program guidelines
- Have a certain amount of access and availability for Medicaid/CHIP members

[29] New York State Department of Health. Value-Based Payment: Update. New York State Department of Health. May 2022). Available at: https://www.health.ny.gov/health_care/medicaid/redesign/vbp/roadmaps/final_exec_summary.htm. Accessed August 31, 2023.

[30] New York State Roadmap for Medicaid Payment Reform May 2022 Available at: https://www.health.ny.gov/health_care/medicaid/redesign/vbp/roadmaps/docs/final_updated_roadmap.pdf

- Coordinate primary and specialty care for the patient panel
- Provide age- and condition-appropriate screenings, immunizations, and interventions
- For Tier 3s only, provide team-based care management

Medicaid MCOs must delegate certain care management functions to AMHs. HHS developed standards for AMHs and was responsible for initially certifying that practices meet AMH criteria as the state transitioned to Medicaid managed care. In exchange for taking on additional care management functions, Tier 3 AMHs receive an additional negotiated care management fee from health plans. Health plans are required to offer negotiated performance incentive payments to Tier 3 AMHs. Advanced medical homes can receive $5 per member per month (PMPM) add-on payment for each assigned Medicaid member. If the medical home receives readiness review from the state Medicaid agency and the health plan, it also receives an average $8.51 PMPM to complete delegated care management services.

Oregon

The Oregon Health Authority (OHA) Medicaid program enacted an aggressive push to get more payments tied to value-based arrangements. OHA developed a VBP Roadmap for Coordinated Care Organizations[31] (CCOs) to ensure at least 70 percent of their provider payments are in the form of a VBP by 2024. The VBP roadmap also includes VBP models in key care delivery areas[32] (CDAs), infrastructure payments for Patient-Centered Primary Care Homes[33] (PCPCHs), and strategies to promote equity in VBP design.

In 2021, the Oregon Health Authority primary care, behavioral health, and maternity care providers were invited to participate in a five-part webinar series[34] focused on increasing readiness for VBP and taking advantage of the additional flexibility VBPs offer for innovatively redesigned care models.

The webinars were intended to support providers engaging with CCOs to:

- Work with their own networks of providers
- Annually increase the level of payments that are in the form of a VBP and fall within LAN Category 2C (Pay-for-Performance) or higher
- Develop VBPs in the following CDAs: hospital care, maternity care, behavioral health care, children's health care and oral health care. Required VBPs in CDAs must fall within LAN Category 2C (Pay-for-Performance) or higher.
- In addition, the Oregon Primary Care Association and the Association of Oregon Mental Health Programs have invested grant dollars to hire HMA to develop a small pilot of sites on VBP readiness that included the HMA VBP readiness tool. Providers reported that they would have benefited from ongoing assistance.

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[31] Oregon Health Authority. Value-Based Payment Roadmap. September 2019. Available at: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx. Accessed August 31, 2023.

[32] Oregon Health Authority. Value-Based Payment Care Delivery Areas. https://www.oregon.gov/oha/HPA/dsi-tc/Pages/VBP-Care-Delivery-Areas.aspx. Accessed August 31, 2023.

[33] Oregon Health Authority. Patient-Centered Primary Care Home Program. Available at: https://www.oregon.gov/oha/HPA/dsi-pcpch/Pages/index.aspx. Accessed August 31, 2023.

[34] Oregon Health Authority. Spring 2021: OHA's Value-based Payment Webinar Series. Oregon Health Authority. https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx. Accessed August 31, 2023.

Pennsylvania

In 2017, DHS began holding Physical HealthChoices Managed Care Organizations (PH-MCOs) accountable for using value-based contracting for a steadily increasing percentage of their provider payments.[35] In 2020, this percentage was 50 percent, with at least half of this portion coming in the form of medium- or high-risk arrangements. A medium- or high-risk arrangement means that providers are incentivized both to improve quality and reduce costs.

In Pennsylvania, these arrangements include shared savings, shared risk, bundled payments, and global payments. In 2018, DHS expanded its VBP requirements to include the Behavioral HealthChoices system. In Behavioral HealthChoices, the primary contractor is often county-based, and this entity, in turn, usually holds the contract with a Behavioral Health MCO.

The Rehabilitation and Community Provider Association (RCPA) of Pennsylvania contracted with HMA to provide its members with a variety of VBP learning opportunities over a one-year period. RCPA members offer mental health, drug and alcohol, intellectual and developmental disabilities, brain injury, medical rehabilitation, and aging services. VBP education focused on building intermediate and advanced understanding of VBP through webinars and workshop presentations at four RCPA regional meetings across the state. All RCPA members were offered HMA's VBP Readiness Assessment and, for those members who completed the tool, we facilitated group meetings to promote collaborative problem solving and coaching.

Community Behavioral Health, Philadelphia's BH-MCO, hired HMA to conduct a VBP assessment of BH providers' readiness and facilitate a series of workshops, webinars, and office hours focused on increasing capacity to succeed under PA's five-year VBP roadmap. HMA's VBP Assessment tool was used to benchmark providers and determine areas of training and TA at the individual level. HMA then supported 75 behavioral health organizations including small to large integrated systems in advancing VBP capacity around PA's BH VBP roadmap.

Rhode Island Medicaid Accountable Entities and TA

Under an 1115 waiver, Rhode Island implemented accountable entities (AEs), which are similar in structure to accountable care organizations (ACOs) and are responsible for the total cost of care and healthcare quality and outcomes, for their attributed populations by providing integrated, whole-person care. AEs had availability of health system transformation incentive funds through the full AE Program. These funds were used to allow for investments in AE infrastructure and are integral to the program's success.

Rhode Island Executive Office of Health and Human Services (EOHHS) hired a consultant to provide a 12-month training and technical assistance program to AEs that aligned with the following program goals:

- Transition away from fee-for-service models
- Define Medicaid-wide population health targets, and, where possible, tie them to payments
- Maintain and expand on Rhode Island Medicaid's record of excellence in delivering high-quality care
- Deliver coordinated, accountable care for high-cost, high-need populations

[35] Pennsylvania Department of Human Services. Roadmap to Whole Person Health. 2021. Available at: https://www.dhs.pa.gov/HealthInnovation/Documents/WholePersonCareReport_Final.pdf. Accessed August 29, 2023.

- Ensure access to high-quality primary care
- Shift Medicaid expenditures from high-cost institutional settings to community-based settings

The TA included monthly webinars, annual in-person meetings, and presentations from external subject matter experts designed to create cross-learning opportunities across Medicaid AEs and to increase the capacity of providers.

Tennessee

The patient-centered medical home (PCMH) is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities and practice standards of primary care providers, and the overall value of healthcare delivered to the TennCare population.[36] PCMH providers commit to member-centered access, team-based care, population health management, care management support, care coordination, performance measurement, and quality improvement. Participating providers receive training and technical assistance, quarterly reports with actionable data, and access to a care coordination tool. These providers are compensated with ongoing financial support and an opportunity for an annual outcome payment based on performance quality and efficiency. The three Medicaid managed care plans are required to offer this standard alternative payment model to qualifying primary care providers.

Tennessee provides free access to MCO transformation coaches who deliver provider training and technical assistance services to PCMH providers across the state. The MCO transformation coaches help providers make the needed investments in practice transformation across all of their sites. This in-kind training investment is intended as a co-investment with PCMH organizations and not as full coverage for the time, infrastructure, and other investments that practices will need to make.

[36] TennCare. TennCare Delivery System Transformation: Patient Centered Medical Home Analytics Report. October 2019. Available at: https://www.tn.gov/content/dam/tn/tenncare/documents2/PatientCenteredMedicalHomeAnalyticsReport.pdf. Accessed August 31, 2023.

Appendix 10. Policy Recommendations for the District and DHCF

HMA Assessment and Recommendations on DHCF's Strategy for Increasing Value-Based Care

1. **Develop clear definitions and a common methodology for measuring revenue growth tied to value-based care delivered to District resident individuals who have Medicaid managed care coverage.**

   i. *Assessment:* DHCF has set a goal of progressively increasing the percentage of total medical expenditures through VBP arrangements including a goal for the inclusion of LAN category 3 and 4 APMs beginning in year three. The goal as articulated appears reasonable. Work needs to be done to develop clear definitions and a common methodology for attribution assignment and for capturing how revenue is calculated. Defining what "counts" as attribution and how revenue is calculated per attributed life will be key in accurately capturing year-over-year revenue growth in a value-based care contract.

   ii. *Recommendation(s)*: DHCF could create the definitions and methodology in advance with input from the MCOs. Actual reporting by the MCO should be completed at least annually. DHCF could audit and monitor all reports for compliance. Examples for defining patient attribution and calculating revenue include:

      - Attribution can be the starting point for the calculation. For example, DHCF could use an attribution-based methodology that includes primary or specialty models if the patient has seen the provider in the last 12-24 months. Attribution also needs to be defined as prospective, continuous, or retrospective. The attribution methodology should remain stable throughout the measurement period.
      - Revenue could be measured by calculating only those medical services for the attributed members that are linked to the value-based incentive program (e.g., primary care codes only) or for total medical expenditures for the attributed member if the health system is taking on TCOC accountability.

   iii. Questions*: Are there attribution definitions in place that MCOs could leverage and easily operationalized? Will it be tracked by primary care provider (PCP) attribution or is attribution to specialists allowed? How will revenue be calculated (i.e., total medical expenditures of managed care members assigned to a PCP who is in a LAN category 2, 3, or 4 arrangements with the managed care organization (MCO) for that member)?*

2. **Measurable goals (milestones) should be set for the MCOs that participate with DHCF to achieve its strategic plan goals. Identify measurable goals (milestones) for the MCOs that participate with DHCF to achieve its strategic plan goals.**

   i. *Assessment*: As previously mentioned, DHCF has set a goal of progressively increasing the percentage of total medical expenditures through VBP arrangements, which seems reasonable. It appears as though some goals need to be set at the MCO level as well, so that DHCF can meet its goals.

   ii. *Recommendation(s):* Goals at the MCO level should be determined. Additionally, outstanding questions around how the goals will be evaluated and tracked should be addressed. DHCF could create a standardized tool and methodology to calculate baseline and year-over-year changes with value-based care goal achievement (growth). Actual reporting by the MCO could be

completed annually at minimum, along with a plan on how the organization intends to grow over the next year. All reports could be audited and monitored by DHCF for compliance.

- Additionally, from learnings in other states, when VBP targets such as those the DHCF has put in its strategic plan are set, MCOs will try and meet these goals, in the early years, by engaging with their largest network providers (typically health systems) to get the largest percentage of members and expenditures into a few value-based arrangements. This approach tends to leave safety-net providers and critical specialties, who tend to have less capital and resources for transformational change, lagging in terms of value advancement. DHCF could consider setting specific VBP adoption goals for provider populations (e.g., FQHCs, behavioral health, maternity) to mitigate unintended consequences of the overall strategy.

iii. *Question(s):* All the questions in #1 also apply. Furthermore, DHCF leaders should ask themselves if they will change behavior if all providers stay in a shared savings-only program (under category 3A) or if they will ask MCOs to push for some risk or fixed, prospective-based payments.

3. Assign accountability for reaching the goal in the described timeline with financial implications for performance.

i. *Assessment*: Based on currently available information, an assignment mechanism does not appear to be in place. A few years ago, the District put a withhold in place for MCOs regarding unnecessary hospital utilization using these parameters:

- Low-acuity non-emergent (LANE) visits to a hospital emergency department
- Potentially preventable hospitalizations ambulatory sensitive conditions
- All-cause hospital readmissions for patients ages 18-64

These restrictions are no longer enforced as of August 2023.

ii. *Recommendation(s):* DHCF could define what steps will be taken for MCOs that do not meet the year-over-year goals. Reversely, there could be documentation of the benefits/incentives (or not) for those MCO that are exceeding expectations after year one. MCOs could report on progress annually and any additional expectations would become part of the annual contract negotiations.

iii. *Question(s):* Are there any plans to hold MCOs accountable for reaching the performance targets outlined in the strategy? If so, how will performance be measured and reported? What will be the financial implications for performance on these metrics? Is there a "carrot and stick" component to the program?

4. Develop attribution assignment and reassignment policies to ensure members are appropriately assigned to their treating clinician.

i. *Assessment*: Based on currently available information, DHCF does not have assignment and reassignment policies in place.

ii. *Recommendation(s):* Although some Medicaid managed care members may not receive any primary care services in the performance year, they still should be assigned to a PCP using an attribution methodology (12–24-month lookback). Attribution assignment is important to ensure that a primary care practice is seeing patients routinely. If patients are not being seen, the MCO should actively engage the members and connect them to services. If a member is receiving care from a specialist and/or another primary care provider for most of their

services, reassignment could be considered based on policies that are in place. The MCO policies could address both assignment and reassignment.

iii. *Questions:* Have any of the MCOs implemented this reassignment practice? Does DHCF have any policies in place that would preclude implementing this reassignment without member consent?

5. Make upfront population health investments available to providers who agree to VBP arrangements with an MCO.

i. *Assessment:* DHCF made investments in its My Health GPS, Health Home program, but that initiative is currently paused because of COVID-19. DHCF has invested in CRISP and TA for providers but not in direct funding for providers to build capacity and succeed in value-based care. MCOs do not appear to be making that investment either.

ii. *Recommendation(s)*: Value-based payments are typically made five to eight months after the conclusion of the performance year (17–20-month lag). Healthcare providers must invest significant upfront resources if they are to improve performance in their APMs. Given the financial reality of most safety-net providers, DHCF or the MCOs should make an upfront investment in providers who meet their readiness criteria for contracting under an APM. An additional or alternative approach would be that when incentives are used, the MCO could agree to make incentive payments to providers periodically (quarterly/every six months) throughout the year instead of waiting until the end of the performance year. Incentive payment could be reconciled to actuals when the performance year closes so that bonus/incentive payments are more directly linked to performance and work performed.

iii. *Question(s):* Is either DHCF or the MCOs making any LAN Category 2A infrastructure payments to healthcare providers contracted under APMs? Can DHCF or the MCOs operationalize incentive payments more frequently than annually?

6. Align quality measures and incentive across MCOs.

i. *Assessment*: The three Medicaid MCOs serving the DC Medicaid managed care population vary significantly in what they are offering in terms of types of APMs, metrics, performance targets, and financial opportunities. The approach varies among Medicaid agencies nationally, but states that are more advanced in this effort have tended to be more prescriptive with MCOs and providers.

ii. *Recommendation(s):* Measures should be the same (or similar) across all MCOs that contract with DHCF. Any exceptions, additions, variance from the agreed upon measure set should be pre-approved by DHCF. Measures should always be agreed upon before the performance year begins and held stable for at least 2 years (unless a measure is being retired by the measure steward or no longer clinically relevant). AmeriHealth's current value-based care program and scorecard could be looked at as a starting point.

iii. *Question(s):* Has DHCF considered becoming more prescriptive of the APM metrics and opportunities being offered to healthcare providers? What would be the cons of being more prescriptive?

7. Limit quality metrics to a manageable number of measures across payers so providers can focus their quality improvement work.

i. *Assessment:* In the past, DHCF has focused on the three hospital utilization metrics that could help them to meet cost/utilization goals.

ii. *Recommendation(s):* DHCF should consider adding two to three ambulatory care metrics that directly evaluate delivery of preventive services and/or management of common chronic conditions. Prevention and chronic disease management measures, along with the monitoring of attribution visits, can also indirectly evaluate assigned member engagement in primary care or behavioral health services.

iii. *Questions:* Will DHCF take the lead in defining the metrics and performance targets that MCOs will use in APMs? How will DHCF evaluate which measures clinicians think should be added because of their impact on quality improvement activities.

8. **To transition providers from LAN Category 2 to LAN category 3, focus on reducing potentially avoidable emergency department visits, hospitalizations, and rehospitalizations.**

    i. *Assessment:* DCHF has already recognized this objective by incorporating these metrics into VBP arrangements in the past. AmeriHealth has several P4P programs for primary care, perinatal, behavioral health, dental and community partner programs. These programs use a PMPM funding pool generated based on the number of members in the panel, with HEDIS and other quality measures. Currently no withholds are in place for these incentive programs.

    ii. *Recommendation(s):* DHCF should think about adding these metrics to the MCO contracts. DCHF could also assess if (and eventually require) that hospitals have systems in place to track avoidable admissions and have a care coordination protocol in place to connect with the member's primary care provider to avoid such visits in the future.

    iii. *Question(s):* Does DCHF have plans to reintroduce these metrics into contractual arrangements with the MCOs and expectations MCOs will do the same with healthcare providers? Can DHCF influence the hospitals to put into place care coordination protocols for members that come through the ER or readmitted?

9. **Develop processes that ensure timely and accurate exchange of information between payers and providers.**

    i. *Assessment:* DHCF invested in CRISP as a data warehouse and a health insurance exchange. Currently inpatient psychiatric hospitals are not required to participate in CRISP, which creates significant issues to coordinate transitions of care for people with behavioral health admissions. In addition, providers generally lack a financial incentive to use that data to improve member outcomes.

    ii. R*ecommendation(s):* Defining the quality and utilization metrics that will be central to the value-based program's success will help DHCF better understand where investments in the health insurance exchange could be made or perhaps supplemented in the interim. DHCF could require the hospitals provide ADT feeds (including ER discharges) and encourage the MCOs to engage with IT vendors that can support better care coordination, such as same-day "pinging" for primary care when patients enter an emergency room or are readmitted to the hospital.

    iii. *Questions*: Can DHCF identify the most important measures and then identify if there is a gap with the current HIE? Does DHCF know what tools the MCOs have in place?

10. **Ensure that the financial incentives for achieving success under an APM yield a positive return on investment.**

i. *Assessment:* Although a few healthcare providers serving Medicaid members in DC have LAN category two pay-for-performance programs, even they are challenged to negotiate those arrangements with all three Medicaid MCOs and are unable to progress to more advanced APMs.

ii. *Recommendation(s):* DHCF could ask MCOs to share with them their strategies for expanding value-based care contracts, including what initial incentives they will offer that will be attractive to providers that serve people with complex/high-acuity needs. Care coordination will be a cornerstone of any value-based care strategy.

iii. *Questions:* Does DHCF plan to take more initiative in how it expects Medicaid MCOs to pursue its value-based care strategy?

11. Encourage the creation of CINs, ACOs, IPAs.

i. *Assessment*: At present, District providers have few opportunities to engage in clinically integrated networks, and they take time to implement. In addition, the absence of licensing or regulatory approvals supports healthcare providers seeking to establish a CIN, IPA, or ACO by removing potential legal barriers that can arise if the entity fails to comply with applicable legal standards and the administrative delays that can result from gaining regulatory approval.

ii. *Recommendation:* This is a key difference from other states that have established formal regulatory procedures for creating a CIN, IPA, or ACO. For example, New York State requires an IPA to receive a consent, waiver, or approval from the Department of Health, Department of Financial Services, and State Education Department prior to filing a certificate of incorporation (or articles of organization in the case of LLCs) with the Secretary of State. The requirement to seek regulatory approval from these three separate state agencies delays the establishment of an IPA by approximately four to six months. New York State also has established a process for ACOs to submit applications to receive approval as an ACO from the Department of Health. Anecdotally, the Department of Health can take as long as 12 months to issue a certificate of authority to the ACO.

iii. *Questions: A*re there any providers who would pursue a CIN and if so, what would they need to be successful? What supports could DHCF provide? Does DHCF plan to be more proactive in how it expects Medicaid MCOs to build robust care coordination programs that are provider led (not telephonic or insurance based)?

12. **Consider leveraging the previous My Health GPS initiative, as a valuable tool for providers to succeed in LAN 3 or 4 APM**

i. *Assessment*: Complex care management programs offer a significant opportunity to provide comprehensive, integrated care for people with complex medical, behavioral health, and social needs. My Health GPS participants recommended that this model be expanded to serve patients with fewer or no chronic illnesses and complex contextual barriers (i.e., income instability, housing insecurity, limited English proficiency). The District has existing federal authority and previous experience operating the program with providers.

ii. *Recommendation*: Enhance the My Health GPS program to update the eligibility criteria, simplify quality metrics, risk assessments, offer incentive payments. The program could be further enhanced by:
   - Requiring the MCOs to share care plans for these high-risk members with their medical and, as applicable, behavioral health home
   - Removing barriers to enroll members into the program such as simple assessment tools

- Streamlining information sharing among My Health GPS providers and other organizations
- Simplifying quality measures to include metrics that address preventative screening and outcomes
- Allowing providers or care managers to get reimbursed for the time it takes to establish relationships with community-based organizations and social service agencies, (i.e., reimburse them for participating in care team conferences)
- Providing upfront and incentive payments for completion of risk assessments, transitions of care, outreach, and engagement activities

iii. *Questions:* Does DHCF need to seek additional waiver authority from CMCS to adapt the My Health GPS program? If so, what is the anticipated timeline for approvals?