Alternative Payment Model Plan

Reporting Details

Reference ID: APM.01

Description

Each MCO must describe its plan to achieve the goal of moving 50% of provider payments to qualifying APMs consistent with the DHHS Medicaid APM Strategy and guidance.

For each of planned APM, each MCO must provide the information requested below at the level of detail that would allow DHHS to recreate the attribution, risk adjustment methodology, budget development, incentive/at-risk calculations, and provider performance metrics.

At a minimum, it is expected that an APM Implementation Plan Template will be completed for each required provider category

Specification Details

At a minimum, the plan shall include in the following order:

1. Title Page:
    a. MCO Name;
    b. MCO Email and Phone Number;
    c. Authorized Representative(s) Completing this Plan;
    d. Performance Period (Agreement Year);
    e. Submission Date
    f. Exhibit O Report Name; and
    g. Exhibit O Report Reference ID.

2. Table of Contents.

3. General Questions:
    a. Describe generally the MCO's APM Implementation plan identifying what type of APM and anticipated time-line for implementation over the anticipated duration of the contract.
    b. How will the MCO advance the use of APMs over time?
    c. How will the APM plan advance state priorities?

4. Questions Specific to **each** APM (please complete all Qs for each APM):
    a. APM Name and number. (See APM.02 and APM.03 for more details on numbering APMs)
    b. Identify what HCP-LAN Framework Category type of APM is this by including and completing the checklist below? (Note only HCP-LAN categories 2C and higher are "qualifying APMs")
        ☐ HCP-LAN 2B: Pay-for-Reporting
        ☐ HCP-LAN 2C: Pay-for-Performance
        ☐ HCP-LAN 3A: APMs with Shared Savings

- ☐ HCP-LAN 3B: APMs with Shared Savings and Downside Risk
- ☐ HCP-LAN 4A: Conditions-Specific Population Based Payment
- ☐ HCP-LAN 4B: Comprehensive Population-Based Payment
- ☐ HCP-LAN 4C: Integrated Finance and Delivery System
- ☐ Other APM (specify):

c. Identify What Type of Provider (by size and specialty) is included in this APM by including and completing the check list below (Note: select one):
   - ☐ Large Provider or Provider System
   - ☐ Community Mental Health Programs
   - ☐ Federally Qualified Health Center/Rural Health Center
   - ☐ Other Health or Family Planning Clinic (specify):
   - ☐ Small Provider:
   - ☐ Other:

d. What percentage of the provider cohort in your network do you anticipate will participate in or is participating in this APM?

e. Identify if the APM focus on a Mandatory Service Type by including and completing the checklist below? (select one):
   - ☐ Increasing Medically Assisted Treatment (MAT) for Substance Use Disorder
   - ☐ Supporting integrated behavioral health (either BH in primary care, or primary care in BH)
   - ☐ Supporting evidenced based care and treatment of babies born affected by prenatal drug or fetal alcohol exposure?
   - ☐ Other

f. Briefly describe the APM (e.g., total cost-of-care with quality goals, withhold arrangement, bundled payment for condition, PMPM or collaborative care payment for intervention, etc.) (500 words or less)

g. Provide a timeline for APM Implementation over the next twelve months, including milestone dates for APM negotiations, contracting, APM payments to begin, and data sharing.

h. What proportion of total provider payments does the MCO estimate will be paid through this APM? Please explain your calculation.

i. Per provider, what amount could each provider earn or forfeit under this APM? Please explain in detail so it is clear what the provider has at risk and what the provider might be able to earn if provider meetings cost targets, quality targets or both.

j. Does this APM build off a currently implemented APM used in New Hampshire? If yes, how specifically will the current APM be revised to align with the MCM Contract starting on 9/1/19 and the DHHS APM Strategy and Guidance?

k. Describe the clinical outcomes that the MCO seeks to improve through this APM. If applicable, specify how this APM supports one of the three priority areas for which the MCO is required to have supporting APMs: the integration of behavioral health, babies born affected by prenatal drug or fetal alcohol exposure, or increasing access to MAT.

l. How does the APM support improvement in a state priority area? Which ones? State priority areas are:
    i. Decrease unnecessary service utilization, particularly as related to use of the ED, especially for Members with behavioral health needs and among low-income children;
    ii. Reduce preventable admissions and thirty (30)-day hospital readmission for all causes;
    iii. Improve the timeliness of prenatal care other efforts to reduce the number of babies born affected by prenatal drug or fetal alcohol exposure;
    iv. Better manage of pharmacy utilization;
    v. Enhance access to and the effectiveness of SUD treatment
    vi. Address social determinants of health
    vii. Address the needs of patients who are boarded in hospital emergency rooms waiting placements or services and reduce "ED boarding"
    viii. Address emerging public health trends identified by DHHS;
    ix. Priorities in the DHHS MCM Quality Strategy.

m. Describe the strategies that the MCO will use to **assess** provider readiness for implementation of APM, which should include how these strategies will be tailored to the specific providers likely to be included in this APM model.

n. Strategies MCO will use to advance provider readiness for implementation of APM, which should include how these strategies will be tailored to the specific providers likely to be included in this APM model.

o. Describe in meaningful detail the methodology for initial and ongoing Member Attribution, which should include the process for changing the attribution of members during the agreement. If retroactive attribution is used, how will the overall APM consider the provider's inability to impact members that were not known to the provider until the retroactive attribution occurred? Provide information at the level of detail that would allow DHHS to recreate the attribution.

p. Describe in detail the methodology for developing budgets and financial incentives associated with this APM, including how the APM payments are calculated. For example, how will the total cost of care amounts, pmpm budgets, utilization targets, incentive

payments or at-risk amounts be calculated. What is the dollar amount the participating providers are eligible to earn in a bonus or incentive in any specific term and/or what amount do the providers have at risk in any given term? Provide information at the level of detail that would allow DHHS to recreate the budget amounts.

q. Describe the planned strategy for assuring transparency to providers regarding the APM. What meaningful and actionable information will the MCO share with providers during negotiations? How will providers be informed about the methodology for member attribution, utilization targets, quality goals, performance assessment, and awards/penalties/risk? The MCO should describe how the planned strategy will be tailored to the specific providers likely to be included in this APM model.

r. Please share a template (as an appendix) of the information that will be shared with each provider operating under this APM and the timeline for sharing such information.

s. Describe the planned strategy for provider engagement which should include the process for providing technical assistance and/or meeting with providers. The MCO should describe how the planned strategy will be tailored to the specific providers likely to be included in this APM model.

t. Describe the planned strategy for sharing with providers data that is timely and actionable, including provider-level and system-level clinical, cost, and performance measures. Include the type of data to be shared, frequency of data sharing, and mechanism to share data (e.g., email, provider portal). Include sample or template standard reports, if available. At a minimum, data sharing is expected to include:
    i. Results of members who are attributed to the provider, including frequency of updates to attributed members.
    ii. Risk profile of the attributed population, particularly those risks related to the cost and quality targets for providers in the APM.
    iii. Reporting of gaps in care reporting to include utilization, care management interventions, and triggered risk of members with potential impact to the provider meeting goals of the APM.

u. Describe the methodology for measuring progress to the cost targets for the APM, if applicable.
v. Describe the methodology for measuring and reporting quality targets for the APM, if applicable.

w. Describe the methodology for measuring and reporting any other performance targets for the APM, if applicable.

x. Are there any member incentives that complement this APM? If so, please identify.

5. Anticipated Challenges and Recommendations (Including where more DHHS support could be provided.)

6. Changes to Prior Year Plan (If applicable):