

New Hampshire Department of Health and
Human Services
DHHS Medicaid APM Strategy
Guidance No. 1

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**NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CARE MANAGEMENT PROGRAM**

Reference Number	19-0029
Authorized by	Henry Lipman, Medicaid Director
Division/Office/Bureau	Division of Medicaid Services
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Subject	DHHS Medicaid APM Strategy, Guidance Document No. 1
Description	Summary of key guidance for MCOs in meeting requirements for the development, implementation and reporting on Alternative Payment Models consistent with MCM Contract (RFP-2019-OMS-02-MANAG-02) approved by the Governor and Executive Council in March 2019. (Excerpted contract terms included below)

Introduction

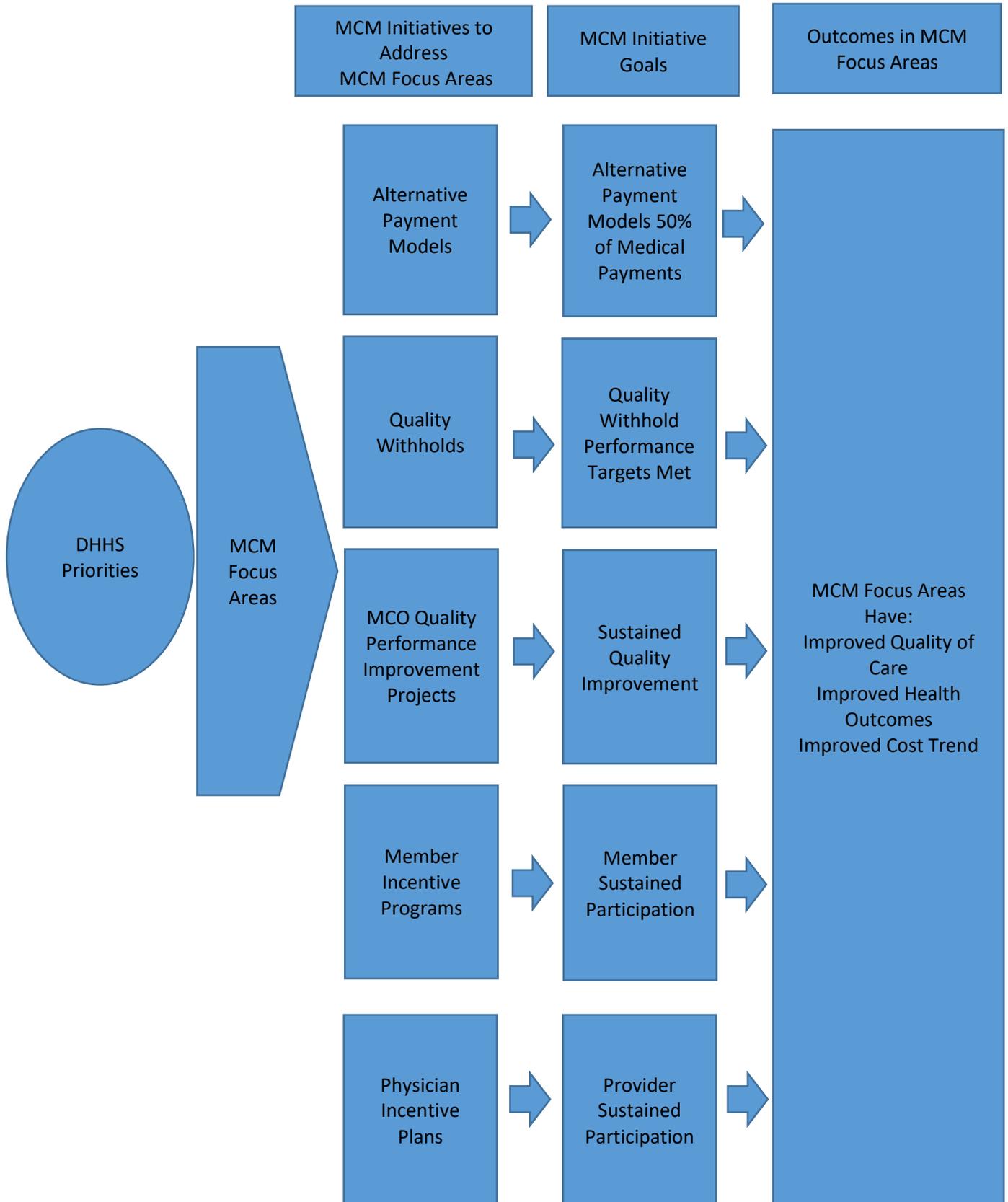
As required by the special terms and conditions of the NH Building Capacity for Transformation waiver, NH is implementing a strategy to expand use of Alternative Payment Models (APM) that promote the goals of the Medicaid program to provide the right care at the right time, and in the right place through the delivery of high-quality, cost-effective care for the whole person, and in a manner that is transparent to the Department of Health and Human Services (DHHS), providers, and the stakeholder community. Including APMs into Medicaid Care Management (MCM) is one of many Medicaid program components that, taken together, will lead to 3 major goals:

- Improved Quality of Care
- Improved Health Outcomes
- Improved Cost Trend

DHHS Priorities and Incentives Alignment

It is DHHS's intent for each MCO to build and implement a Medicaid APM Plan that helps achieve the state's priorities for the health and wellbeing of its beneficiaries and aligns with the MCO's Quality Assessment and Performance Improvement Program, Performance Improvement Projects, Beneficiary Incentives, Provider Incentives, NH Medicaid Quality Strategy and other programs and initiatives. See Graphic below.

DHHS Priority & MCM Initiative Alignment Graphic



This DHHS Medicaid APM Strategy (“DHHS APM Strategy”), Guidance No. 1, is intended to provide MCOs further guidance regarding expectations for the MCOs as they engage in APM planning and implementation pursuant to the terms and conditions of the Medicaid Care Management Services Contracts effective September 1, 2019 (the “MCO Contracts”). The DHHS APM Strategy is not intended to conflict with the terms of the MCO Contracts but to offer further guidance regarding certain terms and conditions as promised therein, including:

1. Guidance for MCOs regarding DHHS’s Medicaid APM Strategy
2. Updated summary of the State’s Priorities in RSA 126-AA
3. Timeline summary of key dates regarding APM implementation
4. Instructions for the MCO APM Implementation Plan contents

The DHHS APM Strategy may be supplemented with additional guidance, templates, worksheets and other materials from time to time.

Guidance Number 1

Timeline

What	First Due Date	Reporting Period (If applicable)	Ongoing Due Date (If applicable)
MCO APM Implementation Plan (APM.01)	October 15, 2019	3/1/2020 – 6/30/2020	May 1
DHHS Review Complete	December 1, 2019	N/A	
APMs Begin	March 1, 2020	N/A	APMs should be in place consistent with MCO APM Implementation Plan
First Partial Quarter Report (APM.02)	7/31/2020	3/1/2020 – 3/31/2020	4 months after the end of the quarter
Second Quarterly Report (APM.02)	10/31/2020	4/1/2020 – 6/30/2020	4 months after the end of the quarter
HCP-LAN Assessment Due ¹ (APM.03)	10/31/2020	3/1/2020 – 6/30/2020	October 31 st
50% Expenditures in Qualifying APMs (4.14.7.1)	6/30/2021 (As reported in APM.03 due on 11/30/2021)	7/1/2020 – 6/30/2021 (WS & NHHF) 1/1/2020 – 6/30/2021 (ACNH)	
Capitated Payment Arrangements with CMHCs (4.11.5.2.2)	No later than 90 days after the effective date		

Fifty Percent Payment Goal (4.14.7.1)

DHHS intends to achieve the goal of moving 50% of provider payments to APMs and expects the MCOs to undertake key activities as set forth in the MCO Contracts towards this goal.

¹ <https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf>

Each MCO shall ensure through its APM Implementation Plan that fifty percent (50%) of all MCO medical expenditures are in Qualifying APMs, as defined by DHHS, within the timeline set forth above.

State Priorities and Evolving Public Health Matters (4.14.12.3)

New Hampshire has identified by statute, RSA 126-AA, key state priorities for its Medicaid program.

The MCO's APM Implementation Plan shall explain how its APM plan will address the following state priorities and any additional evolving public health matters identified by DHHS, and in each quarterly report on the Standard Template for Quarterly Results, the MCO shall update DHHS on how its APMs are impacting the following state priorities:

- Opportunities to decrease unnecessary service utilization, particularly as related to use of the hospital Emergency Department (ED), especially for Members with behavioral health needs and among low-income children;
- Reduce preventable admissions and thirty (30)-day hospital readmissions for all causes;
- Improve the timeliness of prenatal care and other efforts that support the reduction of births of babies affected by prenatal drug or fetal alcohol exposure (including Neonatal Abstinence Syndrome);
- Better integrate physical and behavioral health, particularly efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission; and efforts aligned to support and collaborate with Integrated Delivery Networks (IDNs) to advance the goals of the Building Capacity for Transformation waiver;
- Better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts to promote effective utilization, particularly reducing potential harm from polypharmacy, as described in Section 4.2.5 (Medication Management) of the MCO Contracts;
- Enhance access to and the effectiveness of Substance Use Disorder treatment (further addressed in Section 4.11.6.5 (Payment to Substance Use Disorder Providers) of the MCO Contracts);
- Address social determinants of health;
- Address the needs of patients who are boarded in hospital emergency departments waiting for placements or services and reduce "ED boarding"; and
- Address emerging public health trends identified by DHHS.

Qualifying APMs: Defined

The MCO shall have flexibility to design Qualifying APMs consistent with this DHHS Medicaid APM Strategy and in conformance with CMS guidance.

In developing and refining its APM strategy, DHHS relies on the framework established by the Health Care Payment Learning and Action Network APM framework (or the "HCP-LAN APM framework") in order to develop a common understanding of qualifying categories, encourage

alignment with other payer APMs, and provide a framework for monitoring. DHHS's APM Strategy is also based on Qualifying APMs that promote stakeholder and beneficiary engagement, and result in outcomes that further the state's public health priorities.

Consistent with the MCO contracts, "Qualifying APMs" developed and implemented by MCOs must meet the following standards:

- **HCP-LAN APM Framework:** Meet the requirements of the HCP-LAN APM Framework Category 2C, 3A, 3B, 4A-C, based on the refreshed 2017 framework released on July 11, 2017 and all subsequent revisions (the "Framework");² (*see below*)
- **State Priorities:** Align with state priorities and address the social determinants of health; (*see above*)
- **Community Mental Health:** Include capitated payment arrangements with Community Mental Health Programs to deliver Community Mental Health Services as specified from time to time by DHHS (4.11.5.2.1);
- **Improve Health:** Include outcomes that improve health for Members consistent with state priorities and ensure that delivery of services are provided at the appropriate intensity and duration (4.11.1.12.2);
- **All Payer Alignment:** Align, where practical and possible, with current and emerging APMs being deployed with area providers by other health benefit payers in order to enhance provider engagement and outcomes that improve quality, outcomes and cost-effective care;
- **Transparency:** Meet DHHS's goals for transparency and data sharing with providers as set forth more fully in the MCO Contracts;
- **Provider Engagement:** Meet DHHS's goals for provider engagement as set forth in the MCO Contracts;
- **Quality Measures:** Take quality into account if payment methodology takes cost of care into account, in other words, if payment is related to cost thresholds or benchmarks, payment must also be related to quality thresholds or benchmarks;
- **Compliance:** Comply with 42 CFR 438.6(c)(1)(i) or (ii)(4.14.6); and
- **DHHS Discretion:** Meet any qualifying requirements approved by DHHS and publicized to MCOs consistent with the objectives of this DHHS APM Strategy.

When developing Qualifying APMs with large providers and provider systems, DHHS expects the Qualifying APM to adopt a total cost of care model with shared savings to the maximum extent feasible. As highlighted above, such total cost of care model must include quality thresholds or benchmarks as part of the APM. When developing Qualifying APMs for small providers, DHHS expects the Qualifying APM to take into consideration the capacity of the small provider, and incorporate collaborative care models, pay-for-performance bonus incentives and/or per member per month payments related to a provider's success in meeting actuarially-relevant cost and quality targets.

² <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

The MCO shall ensure that all member incentives adopted pursuant to a Member Incentive Program have a linkage to the APMs (4.9.4). Physician Incentive Plans that have a linkage to APMs shall be included in the MCO's APM Implementation Plan.

Mandatory Qualifying APMs To Be Negotiated by MCOs with Certain Providers

MCOs shall include and implement Qualifying APMs in the following provider categories:

- Capitated payment arrangements negotiated with Community Mental Health Programs that support the delivery and coordination of behavioral health services and supports for children, youth and transition-aged youth/young adults and adults, ensure economic sustainability of the Community Mental Health Program, allow for flexibility in the delivery of care, enhance meaningful integrated primary care/behavioral health, reduce ER utilization and provide appropriate incentives to improve the quality of care.³ (4.11.5.2.1);
- APMs negotiated with FQHCs, RHCs and/or other health or family planning clinics or their designated contracting organizations to enhance state priorities, address social determinants of health, and meaningfully integrate behavioral health interventions in clinic settings (4.15.3);
- At least one APM should increase access to MAT for Substance Use Disorder combined with enhanced reimbursement for MAT reflecting the number of MAT patient members on the providers panel and evidence-based outcomes consistent with SAMHSA quality measures approved by DHHS (4.11.6; 4.11.6.5.7; 4.14.12.4.1.2);
- At least one APM should support evidence-based care and treatment of babies born affected by prenatal drug or fetal alcohol exposure, including the eat, sleep and console methods, and support the development of Plans of Safe/Supported Care (4.11.6.5.7; 4.14.12.4.1.1);
- The MCO shall incorporate APM design elements into its Qualifying APMs that permit Participating Providers to attest to participation in an "Other Payer Advanced APM" (including but not limited to a Medicaid Medical Home Model) under the requirements of the Quality Payment Program as set forth by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (4.14.8.10.2)

HCP-LAN Framework and Categories

As set forth above, only APMs that are reported to meet the HCP-LAN Framework and do meet the HCP-LAN Framework according to DHHS are Qualifying APMs. The following descriptions of the HCP-LAN Framework are taken from the MCO Contracts and Framework in order to assist the MCOs in the categorization of APMs. DHHS shall determine whether the MCO's APMs are aligned with an HCP-LAN Category (and which category it aligns with) using the Standardized Assessment of APM Usage (4.14.10.2).

MCOs are permitted to engage providers in payments reflected by Category 2B, providing

³ The timeline for engaging in good faith negotiations between the MCOs and the Community Mental Health Programs regarding the Qualifying APMs for clients in the Medicaid program shall be July 1, 2019, and for Granite Advantage Health Care Program clients on July 1, 2020.

positive or negative incentives for reporting data, however, such APMs are not considered “qualifying” for purposes of meeting the 50% target.

Category 2C is met if the payment arrangement between the MCO and Participating Provider(s) rewards Participating Providers that perform well on quality metrics and/or penalizes Participating Providers that do not perform well on those metrics.

As described in the APM Framework:

Payments are placed into **Category 2C** if they reward providers that perform well on quality metrics and/or penalize providers that do not perform well, thus providing a significant linkage between payment and quality. For example, providers may receive higher or lower updates to their FFS baseline, or they may receive a percent reduction or increase on all claims paid, depending on whether they meet quality goals. In some instances, these programs have an extensive set of performance measures that assess clinical outcomes, such as a reduction in emergency room visits for individuals with chronic illnesses or a reduction in hospital-acquired infections. Payments in this subcategory are not subject to rewards or penalties for provider performance against aggregate cost targets but may account for performance on a more limited set of utilization measures.⁴

HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C shall all also be considered Qualifying APMs, and the MCO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the DHHS Medicaid APM Strategy.

The following explanations from the APM Framework should provide guidance to the MCOs in developing and reporting on their APMs in Category 3.

Payment models classified in Category 3 are based on an FFS architecture, while providing mechanisms for the effective management of a set of procedures, an episode of care, or all health services provided for individuals. To accomplish this, Category 3 payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. Additionally, payments in Category 3 are structured to encourage providers to deliver effective and efficient care. Episode-based and other types of bundled payments encourage care coordination because they cover a complete set of related services for a procedure that may be delivered by multiple providers. Clinical episode payments fall into Category 3 if they are tied to specific procedures.

All Category 3 payments evaluate providers against financial benchmarks and, occasionally, utilization targets. The Category is further subdivided as follows:

- In **Category 3A**, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets

⁴ APM Framework, Refreshed 2017 <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

are met. However, providers do not need to compensate payers for a portion of the losses that result when cost or utilization targets are not met.

- In **Category 3B**, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. Additionally, payers recoup from providers a portion of the losses that result when cost or utilization targets are not met.⁵

The most important distinction between Category 3 and Category 4 payments is that the latter involve a single, predominantly prospective payment that encompasses a broad array of services, whereas providers participating in Category 3 models continue to be paid on an FFS basis with retrospective reconciliation after the period of performance. Additional conditions must be met before a payment model can be placed into Category 4. Specifically, Category 4 payments reflect the TCOC for treating a primary (typically chronic) condition (e.g., diabetes or cancer), a more limited set of specialty services (e.g., primary care or behavioral health), or comprehensive care for an entire population.⁶

Category 4 is subdivided into subcategories A, B, and C, as outlined below:

- **Category 4A** includes bundled payments for the comprehensive treatment of specific conditions. For example, bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering, for example, only chemotherapy payments. Additionally, prospective payments are classified in Category 4A if they are prospective and population-based, and also cover all care delivered by particular types of clinicians (e.g., primary care and orthopedics).

- Payments in **Category 4B** are prospective and population-based, and they cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct.

- Payments in **Category 4C** also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, while in other cases they consist of delivery systems that offer their own insurance products. To be effective, the finance and delivery arms will need to work in tandem to ensure that effective delivery investments are being made and that incentives and strategies within the organization are properly aligned. Additionally, it is important to note that when integrated lines of business comprise a portion of a company's portfolio, only the integrated payments count toward Category 4C.⁷

⁵ Id. at 26-27

⁶ Id. at 27.

⁷ Id. at 28.

Transparency and Data Sharing

In order to engage providers and meet this DHHS APM Strategy, MCOs must provide necessary data and information to providers, including those providers who are not yet engaging, are in negotiations regarding or are participating in Qualifying APMs, to ensure providers' ability to successfully understand, assess, implement and meet the performance, quality and financial expectations included in the APM. MCOs shall make such data and information available to providers on a regular basis, in a consistent format, and as is reasonably requested. All information made available the providers shall be meaningful and actionable.

The MCO Contracts include detailed expectations to ensure MCOs are transparent with providers around data and information regarding APMs both during negotiations and during implementation. Such transparency includes providing meaningful, actionable and timely information about, but not limited to, the following:

- Member attribution model and methodology, including the process for changing attribution of members during the APM time period. In addition, if retroactive attribution is used, information clarifying how the APM considers the provider's inability to impact members that were not known to the provider until the retroactive attribution occurred;
- Detailed methodology for cost and/or utilization benchmarks or targets;
- Detailed methodology for setting quality measures, targets and/or benchmarks, including the process for changing the same during the agreement;
- Assessment of the potential rewards/penalties/risks associated with the APM;
- Outcomes or results associated with members who are attributed to the provider, including frequent updates to ensure the provider understands who he or she is accountable for and why;
- Risk adjustment methodology of the population as connected to the provider responsibilities in meeting the goals of the APM; and
- Regular, prospective gaps in care reporting to include utilization and triggered risk of members with potential impact to the provider meeting goals of the APM.

DHHS will actively ensure as part of its review of whether MCOs are "qualifying" as well as whether Exhibit O, APM 01, 02 and 03 are successfully complete, whether the MCO has meet its transparency and provider engagement obligations. Such obligations are a mandatory part of the MCO's APM Implementation Plan and implementation. (*see below*)

Reporting Requirements and Templates

APM Quarterly Reporting. MCOs must submit completed and updated APM Quarterly Updates to DHHS on a standard template showing the quarterly results of the APMs four months after the end of each quarter according to the Timeline set forth in this Guidance No. 1, on the MCO APM Quarterly Reporting Template provided by DHHS. DHHS reserves the right to ask questions and be provided timely responses regarding such template detail. (Exhibit O, APM.02)

APM Financial Reporting. MCOs must complete the APM HCP-LAN Assessment consistent with Exhibit O (APM.03). The MCO is responsible for accurately completing and submitting the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable) in a timely manner consistent with the Timeline set forth in this Guidance No. 1.

Penalties

Any penalties, liquidated damages, or other assessment based on the violation or non-compliance with the APM requirements set forth in Exhibit O as described herein shall be consistent with Exhibit N, and their assessment is in the sole discretion of DHHS.

APM Implementation Plan

Each MCO shall submit to DHHS for review and approval an APM Implementation Plan in accordance with Exhibit O. Such APM Implementation Plan shall include all elements identified in, and full and complete responses to, the APM Implementation Plan Template provided by DHHS.. (Exhibit O, APM.01)

DHHS expects that each MCO’s APM Implementation Plan supports and reinforces other key MCO activities, including Quality Performance Targets, Quality Improvement Projects, Member Incentive Programs, and Provider Incentive Programs.

MCOs shall comply with the MCO Contract terms and 42 CFR 438.6(c)(1)(i) or (ii) in its APM strategy and implementation activities.

The APM Implementation Plan shall describe how MCOs expect to advance use of APMs over time (4.14.11) and shall include a plan to advance the capitated payment arrangements with CMHCs to include quality outcomes and flexibility by CMHCs to address social determinants of health.

If DHHS adds or modifies priorities or guidance after the Program Start Date, the MCO shall incorporate plans for addressing the new or modified priorities in the next regularly-scheduled submission of its APM Implementation Plan.

DHHS shall review APM Implementation Plans, respond to MCOs with questions and either approve or request further information.

Revision History

Activity Date	Version	Description of Activity	Author	Approved By
7/3/2019	053119_2	Draft release for comment	H. Lipman	H. Lipman
10/4/2019	20191004vF	Timeline updates; struck references to attachments available separately.	H. Lipman	H. Lipman

Alternative Payment Models (APM)

Compiled key excerpts from the 2019 Medicaid Care Management Services Contract
<https://www.dhhs.nh.gov/business/rfp/documents/rfp-2019-oms-02-manag-exhibits.pdf>
<file:///C:/Users/lfl1008/Downloads/009%20GC%20Agenda%20041719.pdf>

2. DEFINITIONS AND ACRONYMS

2.1 Definitions

2.1.65 MCO Alternative Payment Model (APM) Implementation Plan

2.1.65.1 “MCO Alternative Payment Model (APM) Implementation Plan” means the MCO’s plan for meeting the APM requirements described in this Agreement. The MCO APM Implementation Plan shall be reviewed and approved by DHHS.

2.1.108 Qualifying APM

2.1.108.1 “Qualifying APM” means an APM approved by DHHS as consistent with the standards specified in this Agreement and in any subsequent DHHS guidance, including the DHHS Medicaid APM Strategy.

3. GENERAL TERMS AND CONDITIONS

3.7 CMS Approval of Agreement and Any Amendments

3.7.4 DHHS shall also submit to CMS for review and approval any Alternative Payment arrangements or other Provider payment arrangement initiatives based on DHHS’s description of the initiatives submitted and approved outside of the Agreement. [42 CFR 438.6(c)]

3.15 Staffing

3.15.1 Key Personnel

3.15.1.1.4 Quality Improvement Director: Individual shall be responsible for all QAPI program activities.

3.15.1.1.4.1. Individual shall have relevant experience in quality management for physical and/or behavioral health care and shall participate in regular Quality Improvement meetings with DHHS and the other MCOs to review quality related initiatives and how those initiatives can be coordinated across the MCOs.

3.15.2 Other MCO Required Staff

3.15.2.2 Behavioral Health Clinical Providers to Minimize Psychiatric Boarding: The MCO shall supply a sufficient number of hospital-credentialed Providers in order to provide assessments and treatment for Members who are subject to, or at risk for, Psychiatric Boarding.

3.15.2.2.1 The number of such hospital-credentialed Providers shall be sufficient to provide initial on-site assistance within twelve (12) hours of a Member arriving at an ED and within twenty-four (24) hours of a Member being placed on observation or inpatient status to await an inpatient psychiatric bed.

3.15.2.2.2 The initial on-site assistance provided within these required timelines shall include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or another Designated Receiving Facility.

3.15.2.2.3 Each such hospital-credentialed Provider shall have the clinical expertise to reduce Psychiatric Boarding and possess or be trained on the resources, including local community resources, that can be deployed to discharge the Member safely to the community or to a step down facility when an inpatient stay is not clinically required.

3.15.2.3 Staff for Members at New Hampshire Hospital: The MCO shall designate an on-site liaison with privileges at New Hampshire Hospital to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process for Members admitted to New Hampshire Hospital.

4. PROGRAM REQUIREMENTS

4.1 Covered Populations and Services

4.1.7 Value-Added Services

4.1.7.1 The MCO may elect to offer Value-Added Services that are not covered in the Medicaid State Plan or under this Agreement in order to improve health outcomes, the quality of care, or reduce costs, in compliance with 42 CFR 438.3(e)(i).

4.1.7.2 Value-Added Services are services that are not currently provided under the Medicaid State Plan. The MCO may elect to add Value-Added Services not specified in the Agreement at the MCO's discretion, but the cost of these Value-Added Services shall not be included in Capitation Payment calculations. The MCO shall submit to DHHS an annual list of the Value-Added Services being provided.

4.9 Member Education and Incentives

4.9.4 Member Incentive Programs

4.9.4.1 The MCO shall develop at least one (1) Member Healthy Behavior Incentive Program and at least one (1) Reference-Based Pricing Incentive Program, as further described within this Section 4.9.4 (Member Incentive Programs) of the Agreement. The MCO shall ensure that all incentives deployed are cost-effective and have a linkage to the APM initiatives of the MCOs and Providers described in Section 4.14 (Alternative Payment Models) of this Agreement as appropriate.

4.9.4.6 Healthy Behavior Incentive Programs

4.9.4.6.1 The MCO shall develop and implement at least one (1) Member

Healthy Behavior Incentive Program designed to:

.....

4.9.4.6.1.2. Increase the timeliness of prenatal care, particularly for Members at risk of having a child with NAS;

4.11 Behavioral Health

4.11.1 General Coordination Requirements

4.11.1.12 Collaboration with DHHS

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4.11.1.12.2 To improve health outcomes for Members and ensure that delivery of services are provided at the appropriate intensity and duration, the MCO shall meet with behavioral health programs and DHHS at least four (4) times per year to discuss quality assurance activities conducted by the MCO, such as PIPs and APMs, and to review quality improvement plans and outstanding needs.

4.11.5 Mental Health

4.11.5.2 Payment to Community Mental Health Programs and Community Mental Health Providers

4.11.5.2.1 The MCO is required to enter into a capitated payment arrangement with CMH Programs to deliver Community Mental Health Services, providing for reimbursement on terms specified by DHHS in guidance.

4.11.5.2.2 The MCO shall reach agreements and enter into contracts with all CMH Programs that meet the terms specified by DHHS no later than ninety (90) calendar days after Agreement execution.

4.11.5.2.2.1. For the purposes of this paragraph, Agreement execution means that the Agreement has been signed by the MCO and the State, and approved by all required State authorities and is generally expected to occur in January 2019.

4.11.5.6 Mental Health Performance Improvement Project

4.11.5.6.1 As outlined in Section 4.12.3.7 (Performance Improvement Projects), the MCO shall engage in at least one (1) mental health PIP. The MCO shall satisfy this requirement by implementing a PIP designed to reduce Psychiatric Boarding in the ED.

4.11.6 Substance Use Disorder

4.11.6.5 Payment to Substance Use Disorder Providers

4.11.6.5.1 The MCO shall reimburse Substance Use Disorder Providers in accordance with rates that are no less than the equivalent DHHS FFS rates.

4.11.6.5.2 The MCO need not pay using DHHS's FFS mechanism where the MCO's contract with the Provider meets the following requirements:

4.11.6.5.2.1. Is subject to enhanced reimbursement for MAT, as described in as outlined in this section; or

4.11.6.5.2.2. Falls under a DHHS-approved APM, the standards and requirements for obtaining DHHS approval are further described in Section 4.14 (Alternative Payment Models).

4.11.6.5.3 DHHS shall provide the MCO with sixty (60) calendar days' advance notice prior to any change to reimbursement.

4.11.6.5.4 In accordance with Exhibit O, the MCO shall develop and submit to DHHS, a payment plan for offering enhanced reimbursement to qualified physicians who are SAMHSA certified to dispense or prescribe MAT.

4.11.6.5.5 The plan shall indicate at least two (2) tiers of enhanced payments that the MCO shall make to qualified Providers based on whether Providers are certified and providing MAT to up to thirty (30) Members per quarter (i.e., tier one (1) Providers) or certified and providing MAT to up to one hundred (100) Members per quarter (i.e., tier two (2) Providers).

4.11.6.5.6 The tier determinations that qualify Providers for the MCO's enhanced reimbursement policy shall reflect the number of Members to whom the Provider is providing MAT treatment services, not the number of patients the Provider is certified to provide MAT treatment to.

4.11.6.5.7 The MCO shall develop at least one (1) APM designed to increase access to MAT for Substance Use Disorder and one (1) APM (such as a bundled payment) for the treatment of babies born with NAS.

4.12 Quality Management

4.12.3 Quality Assessment and Performance Improvement Program

4.12.3.7 Performance Improvement Projects

4.12.3.7.2 Annually, the MCO shall conduct at least three (3) clinical PIPs that meet the following criteria [42 CFR 438.330(d)(1)]:

4.12.3.7.2.1. At least one (1) clinical PIP shall have a focus on reducing Psychiatric Boarding in the ED for Medicaid enrollees (regardless of whether they are Medicaid-Medicare dual individuals), as defined in Section 4.11.5 (Mental Health);

4.12.3.7.2.2. At least one (1) clinical PIP shall have a focus on Substance Use Disorder, as defined in Section 4.11.6 (Substance Use Disorder);

4.12.3.7.2.3. At least (1) clinical PIP shall focus on improving quality performance in an area that the MCO performed lower than the fiftieth

(50th) percentile nationally, as documented in the most recent EQRO technical report or as otherwise indicated by DHHS.

4.12.3.7.3 Annually, the MCO shall conduct at least one (1) nonclinical PIP, which shall be related to one (1) of the following topic areas and approved by DHHS:

4.12.3.7.3.1. Addressing social determinants of health;

4.12.3.7.3.2. Integrating physical and behavioral health.

4.13 Network Management

4.13.5 Provider Contract Requirements

4.13.5.1 General Provisions

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4.13.5.1.10 The MCO shall include in Provider contracts a requirement securing cooperation with the QAPI program, and shall align the QAPI program to other MCO Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.14 (Alternative Payment Models).

4.13.5.12 Payment Models

4.13.5.12.1 The MCO shall negotiate rates with Providers in accordance with Section 4.14 (Alternative Payment Models) and Section 4.15 (Provider Payments) of this Agreement, unless otherwise specified by DHHS (e.g., for Substance Use Disorder Provider rates).

4.14 Alternative Payment Models

4.14.1 As required by the special terms and conditions of The NH Building Capacity for Transformation waiver, NH is implementing a strategy to expand use of APMs that promote the goals of the Medicaid program to provide the right care at the right time, and in the right place through the delivery of high-quality, cost-effective care for the whole person, and in a manner that is transparent to DHHS, Providers, and the stakeholder community.

4.14.2 In developing and refining its APM strategy, DHHS relies on the framework established by the Health Care Payment Learning and Action Network APM framework (or the “HCP-LAN APM framework”) in order to:

4.14.2.1 Clearly and effectively communicate DHHS requirements through use of the defined categories established by HCP-LAN;

4.14.2.2 Encourage the MCO to align MCM APM offerings to other payers’ APM initiatives to minimize Provider burden; and

4.14.2.3 Provide an established framework for monitoring MCO performance on APMs.

4.14.3 Prior to and/or over the course of the Term of this Agreement, DHHS shall develop the

DHHS Medicaid APM Strategy, which may result in additional guidance, templates, worksheets and other materials that elucidate the requirements to which the MCO is subject under this Agreement.

4.14.4 Within the guidance parameters established and issued by DHHS and subject to DHHS approval, the MCO shall have flexibility to design Qualifying APMs (as defined in Section 4.14 of this Agreement) consistent with the DHHS Medicaid APM strategy and in conformance with CMS guidance.

4.14.5 The MCO shall support DHHS in developing the DHHS Medicaid APM Strategy through participation in stakeholder meetings and planning efforts, providing all required and otherwise requested information related to APMs, sharing data and analysis, and other activities as specified by DHHS.

4.14.6 For any APMs that direct the MCO's expenditures under 42 CFR 438.6(c)(1)(i) or (ii), the MCO and DHHS shall ensure that it:

4.14.6.1 Makes participation in the APM available, using the same terms of performance, to a class of Providers providing services under the contract related to the reform or improvement initiative;

4.14.6.2 Uses a common set of performance measures across all the Providers;

4.14.6.3 Does not set the amount or frequency of the expenditures; and

4.14.6.4 Does not permit DHHS to recoup any unspent funds allocated for these arrangements from the MCO. [42 CFR 438.6(c)]

4.14.7 Required Use of Alternative Payment Models Consistent with the New Hampshire Building Capacity for Transformation Waiver

4.14.7.1 Consistent with the requirements set forth in the special terms and conditions of NH's Building Capacity for Transformation waiver, the MCO shall ensure through its APM Implementation Plan (as described in Section 4.14) that fifty percent (50%) of all MCO medical expenditures are in Qualifying APMs, as defined by DHHS, within the first twelve (12) months of this Agreement, subject to the following exceptions:

4.14.7.1.1 If the MCO is newly participating in the MCM program as of the Program Start Date, the MCO shall have eighteen (18) months to meet this requirement; and

4.14.7.1.2 If the MCO determines that circumstances materially inhibit its ability to meet the APM implementation requirement, the MCO shall detail to DHHS in its proposed APM Implementation Plan an extension request: the reasons for its inability to meet the requirements of this section and any additional information required by DHHS.

4.14.7.1.2.1. If approved by DHHS, the MCO may use its alternative approach, but only for the period of time requested and approved by DHHS, which is not to exceed an additional six (6) months after the initial 18 month period.

4.14.7.1.2.2. For failure to meet this requirement, DHHS reserves to right to issue remedies as described in Section 5.5.2 (Liquidated Damages) and Exhibit N, Section 3.2 (Liquidated Damages Matrix).

4.14.7.2 MCO Incentives and Penalties for APM Implementation

4.14.7.2.1 Consistent with RSA 126-AA, the MCO shall include, through APMs and other means, Provider alignment incentives to leverage the combined DHHS, MCO, and providers to achieve the purpose of the incentives.

4.14.7.2.2 MCOs shall be subject to incentives, at DHHS' sole discretion, and/or penalties to achieve improved performance, including preferential auto-assignment of new members, use of the MCM Withhold and Incentive Program (including the shared incentive pool), and other incentives.

4.14.8 Qualifying Alternative Payment Models

4.14.8.1 A Qualifying APM is a payment approach approved by DHHS as consistent with the standards specified in this Section (Qualifying Alternative Payment Models) and the DHHS Medicaid APM Strategy.

4.14.8.2 At minimum, a Qualifying APM shall meet the requirements of the HCP-LAN APM framework Category 2C, based on the refreshed 2017 framework released on July 11, 2017 and all subsequent revisions.

4.14.8.3 As indicated in the HCP-LAN APM framework white paper, Category 2C is met if the payment arrangement between the MCO and Participating Provider(s) rewards Participating Providers that perform well on quality metrics and/or penalizes Participating Providers that do not perform well on those metrics.

4.14.8.4 HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C shall all also be considered Qualifying APMs, and the MCO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the DHHS Medicaid APM Strategy.

4.14.8.5 DHHS shall determine, on the basis of the Standardized Assessment of APM Usage described in Section 4.14.10.2 (Standardized Assessment of Alternative Payment Model Usage) below and the additional information available to DHHS, the HCP-LAN Category to which the MCO's APM(s) is/are aligned.

4.14.8.6 Under no circumstances shall DHHS consider a payment methodology that takes cost of care into account without also considering quality a Qualifying APM.

4.14.8.7 Standards for Large Providers and Provider Systems

4.14.8.7.1 The MCO shall predominantly adopt a total cost of care model with shared savings for large Provider systems to the maximum extent feasible, and as further defined by the DHHS Medicaid APM Strategy.

4.14.8.8 Treatment of Payments to Community Mental Health Programs

4.14.8.8.1 The CMH Program payment model prescribed by DHHS in Section

4.11.5.1 (Contracting for Community Mental Health Services) shall be deemed to meet the definition of a Qualifying APM under this Agreement.

4.14.8.8.2 At the sole discretion of DHHS, additional payment models specifically required by and defined as an APM by DHHS shall also be deemed to meet the definition of a Qualifying APM under this Agreement.

4.14.8.9 Accommodations for Small Providers

4.14.8.9.1 The MCO shall develop Qualifying APM models appropriate for small Providers, as further defined by the DHHS Medicaid APM Strategy.

4.14.8.9.2 For example, the MCO may propose to DHHS models that incorporate pay-for-performance bonus incentives and/or per Member per month payments related to Providers' success in meeting actuarially-relevant cost and quality targets.

4.14.8.10 Alignment with Existing Alternative Payment Models and Promotion of Integration with Behavioral Health

4.14.8.10.1 The MCO shall align APM offerings to current and emerging APMs in NH, both within Medicaid and across other payers (e.g., Medicare and commercial shared savings arrangements) to reduce Provider burden and promote the integration of Behavioral Health.

4.14.8.10.2 The MCO shall incorporate APM design elements into its Qualifying APMs that permit Participating Providers to attest to participation in an "Other Payer Advanced APM" (including but not limited to a Medicaid Medical Home Model) under the requirements of the Quality Payment Program as set forth by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

4.14.9 MCO Alternative Payment Model Implementation Plan

4.14.9.1 The MCO shall submit to DHHS for review and approval an APM Implementation Plan in accordance with Exhibit O.

4.14.9.2 The APM Implementation Plan shall meet the requirements of this section and of any subsequent guidance issued as part of the DHHS Medicaid APM Strategy.

4.14.9.3 Additional details on the timing, format, and required contents of the MCO APM Implementation Plan shall be specified by DHHS in Exhibit O and/or through additional guidance.

4.14.9.4 Alternative Payment Model Transparency

4.14.9.4.1 The MCO shall describe in its APM Implementation Plan, for each APM offering and as is applicable, the actuarial and public health basis for the MCO's methodology, as well as the basis for developing and assessing Participating Provider performance in the APM, as described in Section 4.14.10 (Alternative Payment Model Transparency and Reporting Requirements). The APM Implementation Plan shall also outline how integration is promoted by the

model among the MCO, Providers, and Members.

4.14.9.5 Provider Engagement and Support

4.14.9.5.1 The APM Implementation Plan shall describe a logical and reasonably achievable approach to implementing APMs, supported by an understanding of NH Medicaid Providers' readiness for participation in APMs, and the strategies the MCO shall use to assess and advance such readiness over time.

4.14.9.5.2 The APM Implementation Plan shall outline in detail what strategies the MCO plans to use, such as, meetings with Providers and IDNs, as appropriate, and the frequency of such meetings, the provision of technical support, and a data sharing strategy for Providers reflecting the transparency, reporting and data sharing obligations herein and in the DHHS Medicaid APM Strategy.

4.14.9.5.3 The MCO APM Implementation Plan shall ensure Providers and IDNs, as appropriate, are supported by data sharing and performance analytic feedback systems and tools that make actuarially sound and actionable provider level and system level clinical, cost, and performance data available to Providers in a timely manner for purposes of developing APMs and analyzing performance and payments pursuant to APMs.

4.14.9.5.4 MCO shall provide the financial support for the Provider infrastructure necessary to develop and implement APM arrangements that increase in sophistication over time.

4.14.9.6 Implementation Approach

4.14.9.6.1 The MCO shall include in the APM Implementation Plan a detailed description of the steps the MCO shall take to advance its APM Implementation Plan:

4.14.9.6.1.1. In advance of the Program Start Date;

4.14.9.6.1.2. During the first year of this Agreement; and

4.14.9.6.1.3. Into the second year and beyond, clearly articulating its long-term vision and goals for the advancement of APMs over time.

4.14.9.6.2 The APM Implementation Plan shall include the MCO's plan for providing the necessary data and information to participating APM Providers to ensure Providers' ability to successfully implement and meet the performance expectations included in the APM, including how the MCO shall ensure that the information received by Participating Providers is meaningful and actionable.

4.14.9.6.3 The MCO shall provide data to Providers and IDNs, as appropriate, that describe the retrospective cost and utilization patterns for Members, which shall inform the strategy and design of APMs.

4.14.9.6.4 For each APM entered into, the MCO shall provide timely and

actionable cost, quality and utilization information to Providers participating in the APM that enables and tracks performance under the APM.

4.14.9.6.5 In addition, the MCO shall provide Member and Provider level data (e.g., encounter and claims information) for concurrent real time utilization and care management interventions.

4.14.9.6.6 The APM Implementation Plan shall describe in example form to DHHS the level of information that shall be given to Providers that enter into APM Agreements with the MCO, including if the level of information shall vary based on the Category and/or type of APM the Provider enters.

4.14.9.6.7 The information provided shall be consistent with the requirements outlined under Section 4.14.10 (Alternative Payment Model Transparency and Reporting Requirements). The MCOs shall utilize all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information.

4.14.10 Alternative Payment Model Transparency and Reporting Requirements

4.14.10.1 Transparency

4.14.10.1.1 In the MCO APM Implementation Plan, the MCO shall provide to DHHS for each APM, as applicable, the following information at a minimum:

4.14.10.1.1.1. The methodology for determining Member attribution, and sharing information on Member attribution with Providers participating in the corresponding APM;

4.14.10.1.1.2. The mechanisms used to determine cost benchmarks and Provider performance, including cost target calculations, the attachment points for cost targets, and risk adjustment methodology;

4.14.10.1.1.3. The approach to determining quality benchmarks and evaluating Provider performance, including advance communication of the specific measures that shall be used to determine quality performance, the methodology for calculating and assessing Provider performance, and any quality gating criteria that may be included in the APM design; and

4.14.10.1.1.4. The frequency at which the MCO shall regularly report cost and quality data related to APM performance to Providers, and the information that shall be included in each report.

4.14.10.1.2 Additional information may be required by DHHS in supplemental guidance. All information provided to DHHS shall be made available to Providers eligible to participate in or already participating in the APM unless the MCO requests and receives DHHS approval for specified information not to be made available.

4.14.10.2 Standardized Assessment of Alternative Payment Model Usage

4.14.11 Development Period for MCO Implementation

4.14.11.1 Consistent with the requirements for new MCOs, outlined in Section 4.14.8 (Qualifying Alternative Payment Models) above, DHHS acknowledges that MCOs may require time to advance their MCO Implementation Plan. DHHS shall provide additional detail, in its Medicaid APM Strategy, that describes how MCOs should expect to advance use of ADPMs over time.

4.14.12 Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters

4.14.12.1 The MCO's APM Implementation Plan shall indicate the quantitative, measurable clinical outcomes the MCO seeks to improve through its APM initiative(s).

4.14.12.2 At a minimum, the MCO shall address the priorities identified in this Section 4.14.12 (Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters) and all additional priorities identified by DHHS in the DHHS Medicaid APM Strategy.

4.14.12.3 State Priorities in RSA 126-AA

4.14.12.3.1 The MCO's APM Implementation Plan shall address the following priorities:

4.14.12.3.1.1. Opportunities to decrease unnecessary service utilization, particularly as related to use of the ED, especially for Members with behavioral health needs and among low-income children;

4.14.12.3.1.2. Opportunities to reduce preventable admissions and thirty (30)-day hospital readmission for all causes;

4.14.12.3.1.3. Opportunities to improve the timeliness of prenatal care and other efforts that support the reduction of NAS births;

4.14.12.3.1.4. Opportunities to better integrate physical and behavioral health, particularly efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission; and efforts aligned to support and collaborate with IDNs to advance the goals of the Building Capacity for Transformation waiver;

4.14.12.3.1.5. Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing generic prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing polypharmacy, as described in Section 4.2.5 (Medication Management);

4.14.12.3.1.6. Opportunities to enhance access to and the effectiveness of Substance Use Disorder treatment (further addressed in Section 4.11.6.5 (Payment to Substance Use Disorder Providers) of this Agreement); and

4.14.12.3.1.7. Opportunities to address social determinants of health (further addressed in Section 4.10.10 (Coordination and Integration with Social Services and Community Care) of this Agreement), and in particular to address “ED boarding,” in which Members that would be best treated in the community remain in the ED.

4.14.12.4 Alternative Payment Models for Substance Use Disorder Treatment

4.14.12.4.1 As is further described in Section 4.11.6.5 (Payment to Substance Use Disorder Providers), the MCO shall include in its APM Implementation Plan:

4.14.12.4.1.1. At least one (1) APM that promotes the coordinated and cost-effective delivery of high-quality care to infants born with NAS; and

4.14.12.4.1.2. At least one (1) APM that promotes greater use of Medication-Assisted Treatment.

4.14.12.5 Emerging State Medicaid and Public Health Priorities

4.14.12.5.1 The MCO shall address any additional priorities identified by DHHS in the Medicaid APM Plan or related guidance.

4.14.12.5.2 If DHHS adds or modifies priorities after the Program Start Date, the MCO shall incorporate plans for addressing the new or modified priorities in the next regularly-scheduled submission of its APM Implementation Plan.

4.14.13 Physician Incentive Plans

4.14.13.1 The MCO shall submit all Physician Incentive Plans to DHHS for review as part of its APM Implementation Plan or upon development of Physician Incentive Plans that are separate from the MCO’s APM Implementation Plan.

4.14.13.2 The MCO shall not implement Physician Incentive Plans until they have been reviewed and approved by DHHS.

4.14.13.3 Any Physician Incentive Plan, including those detailed within the MCO’s APM Implementation Plan, shall be in compliance with the requirements set forth in 42 CFR 422.208 and 42 CFR 422.210, in which references to “MA organization,” “CMS,” and “Medicare beneficiaries” should be read as references to “MCO,” “DHHS,” and “Members,” respectively. These include that:

4.14.13.3.1 The MCO may only operate a Physician Incentive Plan if no specific payment can be made directly or indirectly under a Physician Incentive Plan to a physician or Physician Group as an incentive to reduce or limit Medically Necessary Services to a Member [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(1)-(2); 42 CFR 438.3(i)]; and

4.14.13.3.2 If the MCO puts a physician or Physician Group at substantial financial risk for services not provided by the physician or Physician Group, the MCO shall ensure that the physician or Physician Group has adequate stop-loss protection. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR

422.208(c)(2); 42 CFR 438.3(i)]

4.14.13.4 The MCO shall submit to DHHS annually, at the time of its annual HCP-LAN assessment, a detailed written report of any implemented (and previously reviewed) Physician Incentive Plans, as described in Exhibit O.

4.14.13.5 Annual Physician Incentive Plan reports shall provide assurance satisfactory to DHHS that the requirements of 42 CFR 438.208 are met. The MCO shall, upon request, provide additional detail in response to any DHHS request to understand the terms of Provider payment arrangements.

4.14.13.6 The MCO shall provide to Members upon request the following information:

4.14.13.6.1 Whether the MCO uses a Physician Incentive Plan that affects the use of referral services;

4.14.13.6.2 The type of incentive arrangement; and

4.14.13.6.3 Whether stop-loss protection is provided. [42 CFR 438.3(i)]

4.15 Provider Payments

4.15.3 Federally Qualified Health Centers and Rural Health Clinics

4.15.3.1 FQHCs and RHCs shall be paid at minimum the encounter rate paid by DHHS at the time of service, and shall also be paid for DHHS-specified CPT codes outside of the encounter rates.

4.15.3.2 The MCO shall not provide payment to an FQHC or RHC that is less than the level and amount of payment which the MCO would make for the services if the services were furnished by a Provider which is not an FQHC or RHC. [Section 1903(m)(2)(A)(ix) of the Social Security Act]

4.15.3.3 The MCO shall enter into Alternative Payment Models with FQHCs, RHCs, and/or other health or family planning clinics or their designated contracting organizations as negotiated and agreed upon with DHHS in the MCO's APM Implementation Plan and as described by DHHS in the Medicaid APM Strategy.

EXHIBIT N – Liquidated Damages Matrix

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
3. LEVEL 3 MCO action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program.	3.2 Failure to submit to DHHS within the specified timeframes all required plans, documentation, and reporting related to the implementation of Alternative Payment Model requirements	\$10,000 per week of violation

