

APMs in New Hampshire Medicaid

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MCAC



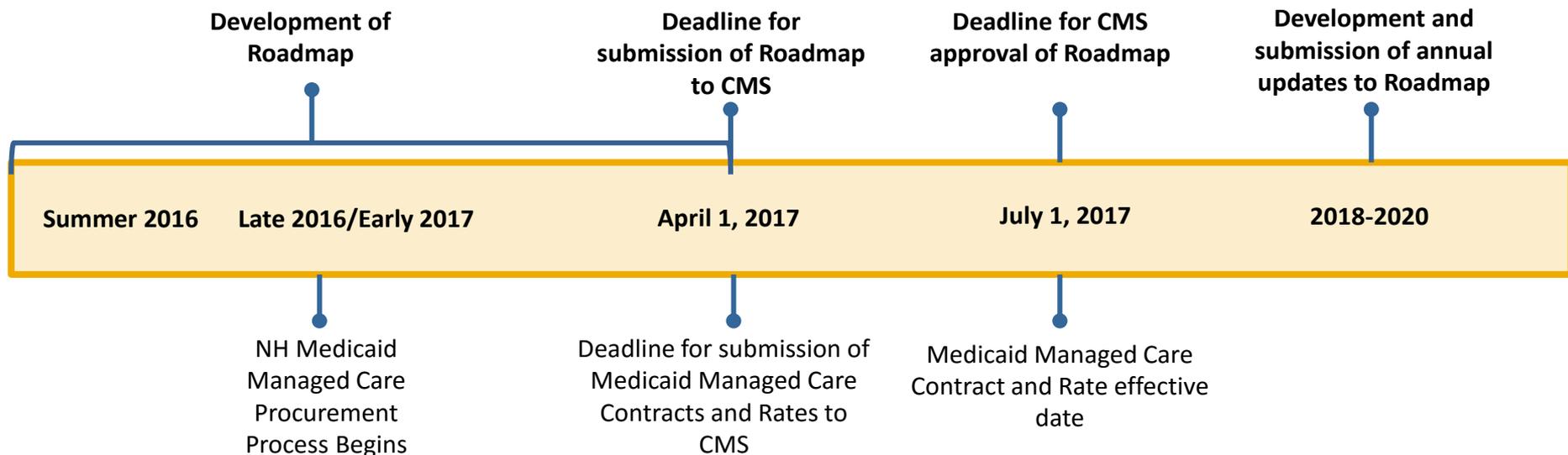
New Hampshire's DSRIP Medicaid Waiver and the Transition to Alternative Payment Models

Goals and Requirements: NH's APM Roadmap



- Under DSRIP, New Hampshire's **funding model** will shift from planning support to performance payments to **long-term sustainability**.
- The Special Terms and Conditions of the waiver require that the state develop a plan, or **Roadmap** for:
 - Sustaining the DSRIP investments beyond the life of the waiver**, including how it will modify its Medicaid managed care contracts to reflect the impact of the waiver and the state's APM goals
 - Moving at least 50 % of payments to Medicaid providers into alternative payment models**

APM Roadmap: Important Dates



New Hampshire Roadmap Requirements

STC Language re: MCO and Medicaid Service Delivery Contracting Plan, aka, the Roadmap

Purpose

In recognition that the **IDN investments** represented in this demonstration must be **recognized and supported by the state's MCO and Medicaid service delivery contracts** as a core component of long term sustainability, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid beneficiaries with diagnosed or emerging behavioral health issues through comprehensive payment reform, strengthened provider networks and care coordination, **the state must take steps to plan for and reflect the impact of IDN in Medicaid provider contracts and rate-setting approaches.**

Process

Recognizing the need to formulate this plan to align with the stages of IDN, this should be a **multi-year plan developed in consultation with managed care plans and other stakeholders, and necessarily be flexible to properly reflect future IDN progress and accomplishments.**

2017 Deadlines

Prior to the state submitting to CMS contracts and rates for approval for any contract period beginning July 1, 2017 [i.e., **prior to April 1, 2017**], **the state must submit a roadmap for how it will amend contract terms and reflect new provider capacities and efficiencies in Medicaid provider rate-setting.**

This plan must be **approved by CMS** before the state may claim FFP for Medicaid provider contracts for the 2018 state fiscal year [i.e., **by July 1, 2017**].

Annual Updates

The state shall **update and submit** the MCO and Medicaid service delivery contracting plan **annually** on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the MCO and Medicaid service delivery contracting plan will also be included in the **quarterly demonstration report.**

New Hampshire Roadmap Requirements

Per the STCs, the state's Roadmap must address the following areas:

1. **Payment Approaches:** What approaches service delivery providers will use to reimburse providers to encourage practices consistent with IDN objectives and metrics, including
2. **Path to 50% APM Goal:** How the state will plan and implement a goal of 50 percent of Medicaid provider payments to providers using Alternative Payment Methodologies.
3. **Impact on Providers and Alignment with IDN objectives/measures:**
 - a. How alternative payment systems deployed by the state and MCO/Medicaid service delivery contracts will reward performance consistent with IDN objectives and measures.
 - b. How the IDN objectives and measures will impact the administrative load for Medicaid providers, particularly insofar as plans are providing additional technical assistance and support to providers in support of IDN goals, or themselves carrying out programs or activities to further the objectives of the waiver. The state should also discuss how these efforts, to the extent carried out by plans, avoid duplication with IDN funding or other state funding; and how they differ from any services or administrative functions already accounted for in capitation rates.
4. **Stakeholder Engagement:** How the state has solicited and integrated community and MCO/Medicaid service delivery contract provider organization input into the development of the plan.

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New Hampshire APM Roadmap Requirements

Per the STCs, the state's APM Roadmap must address the following areas (cont'd):

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5. Managed Care Rates:

- a. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by IDNs, including how up-to-date data on these matters will be incorporated into capitation rate development.
- b. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with IDNs that the plans will undertake. How plans will be measured based on utilization and quality in a manner consistent with IDN objectives and measures, including incorporating IDN objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.

6. Contracting Approach:

- a. How the state will use IDN measures and objectives in their contracting strategy approach for MCO/Medicaid service delivery contract plans, including reform.
- b. If and when plans' current contracts will be amended to include the collection and reporting of IDN objectives and measures.

Threshold Decisions for Discussion

The following questions must be addressed as New Hampshire prepares its Roadmap:

- 1) What is the purpose of the Roadmap?**
- 2) How prescriptive does New Hampshire want to be?**
- 3) What counts as a value-based payment?**

Discussion Point 1: What is the Purpose of the Roadmap?

...Beyond Satisfying CMS Requirements

- *What are NH's goals? What is the state aiming for with value-based payment?*
- *To what extent will the Roadmap address Medicaid services NOT affected by DSRIP (i.e., beyond behavioral health and integration services)?*
- *How does the Roadmap intersect with other payment initiatives?*
- *What is the Roadmap's relationship to Medicaid managed care procurement and rate setting?*

Discussion Point 2: What Counts As a Value-Based Payment?

- *What types of VBP will be allowed?*
 - *Alternative payment models for integrated care practices (NH-specific definition)*
 - *Bundles*
 - *Acute*
 - *Chronic*
 - *Global capitation*
 - *For an entire population (total costs for total attributed population)*
 - *For a special needs subpopulation*
- *What are the risk sharing arrangements associated with each model?*

Combinations (e.g., plan could contract with an ACO and still also provide enhanced reimbursement for integrated care practices)

Discussion Point 2: What Counts As a Value-Based Payment? (cont.)

New York Approach

Does not count as VBP

Options	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP
Total Care for General Population	FFS with bonus and/or withhold based on quality scores	FFS with upside only shared savings when quality scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	Global capitation (with quality-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside only shared savings based on total cost of care (savings available when quality scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	PMPM capitated payment for primary care services (with quality-based component)
Bundles	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when quality scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	Prospective bundled payment (with quality-based component)
Total Care for Subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when quality scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	PMPM capitated payment for Total Care for Subpopulation (with quality-based component)

Revised Roadmap specifies new criteria for Level 1 and Level 2 Arrangements:

- To count as Level 1, MCOs must allocate at minimum 40% of potential savings to high-scoring providers.
- To count as Level 2, MCOs must allocate at least 20% of losses (3-5% of the target budget) to low-scoring providers.

Other Key Decisions

Additional threshold decisions include:

1. What structures will NH need to help oversee implementation?
2. How will the state initiatives align with MACRA?
3. How will the state engage stakeholders, including providers?
4. What data/tools will the state supply in support of value-based payment?
5. Will NH take steps to review VBP contracts?
6. Which of the IDN investments being made under DSRIP will require additional long-term funding to be sustainable? (e.g., Core Competencies, services addressing social determinants of health)
7. Beyond the DSRIP waiver 's behavioral health-specific goals, what are the Departments other Medicaid delivery system reform priorities to be supported through payment reform?
8. Are there some high impact services that the state may want to exclude from value-based payments?