



**New Hampshire's Building Capacity for Transformation Section 1115(a)  
Medicaid Research and Demonstration Waiver  
DSRIP Alternative Payment Models Roadmap  
For  
Year 2 (CY2017) and Year 3 (CY2018)**

## **INTRODUCTION**

On January 5, 2016, the Centers for Medicare and Medicaid Services (“CMS”) approved New Hampshire’s *Building Capacity for Transformation* Section 1115(a) Medicaid Research & Demonstration Waiver, # 11-W-00301/1, (“the Demonstration”) which allows New Hampshire to access up to \$150 million dollars over the next five years for the purpose of strengthening and expanding capacity for New Hampshire Medicaid’s behavioral health – i.e., mental health and substance misuse - delivery system.

This Demonstration represents an unprecedented and unique opportunity for New Hampshire to strengthen community-based mental health services, combat the opioid crisis, and drive health care delivery system reform. The program is being spearheaded by regionally-based networks of organizations—Integrated Delivery Networks (IDNs)—that are designing and implementing 6 projects over 5 years in a geographic region.

IDNs are made up of multiple community-based social service organizations, hospitals, county correctional and/or nursing facilities, primary care providers, and behavioral health providers – including both mental health and substance use disorder providers - who are partnering to design and implement projects to build behavioral health capacity, promote integration of primary care and behavioral health, facilitate smooth transitions in care, and prepare for the use of alternative payment models (APMs).

The Demonstration enables the achievement of these goals by allowing IDNs to earn performance-based financial incentive payments for achieving specified process milestones and performance based metric targets. The Demonstration operates on a statewide basis, but IDNs are regionally-based. By adopting a regional approach, New Hampshire allows communities to develop strategies and interventions consistent with their own needs and resources. Over the course of 2016, the state approved of seven regional IDNs. They are listed in Table 1.

Under the DSRIP demonstration, the state will make performance-based incentive payments to seven regionally-based IDNs that serve Medicaid beneficiaries’ health needs. IDNs are responsible for project activities that address each of the demonstration goals noted above.

**Table 1: Approved Administrative Leads per IDN Region**

<b>Region Number</b>	<b>Service Region</b>	<b>IDN Administrative Lead</b>	<b>Type of organization</b>
1	Monadnock, Sullivan, Upper Valley	Mary Hitchcock Memorial Hospital & Cheshire Medical Center	Hospital facility
2	Capital	Capital Region Health Care (CRHC)	Hospital facility/Community Mental Health Center /Visiting Nurse Association
3	Nashua	Southern New Hampshire Health	Parent organization for Southern NH Medical Center and Foundation Medical Partners
4	Derry & Manchester	Catholic Medical Center	Hospital facility
5	Central, Winnipesaukee	Partnership for Public Health	Public Health Organization
6	Seacoast & Strafford	Seacoast and Stafford County	County Administrator
7	North Country & Carroll	North Country Health Consortium	Rural Health Network

Throughout the course of the demonstration period, each IDN is required to implement six projects. Each IDN has developed an implementation plan that outlines how each IDN will execute these projects. Three projects are mandatory for all IDNs to conduct; three were selected from a project menu in accordance with each IDN's identified community needs. One of the three had to focus exclusively on those living with substance use disorder issues. The community driven projects that the seven IDNs are responsible for executing against are listed in Table 2.

Performance-based financial awards in years 2-5 will be made to IDNs for achieving specified process milestones and performance metric targets affiliated with the 6 projects each IDN undertakes. IDN performance will be measured based on milestones and metrics that track project planning, implementation progress, clinical quality and utilization indicators, as well as progress toward using APMs. There is significant alignment among the 7 IDNs with respect to their selected community projects, highlighting potential opportunity for an APM reimbursement model specific to the DSRIP initiative.

Table 2: Approved IDN Projects By Region

Region Number	IDN Administrative Lead	Selected Community Projects
1	Mary Hitchcock Memorial Hospital & Cheshire Medical Center	C1- Care Transition Teams D3 - Expansion in Intensive SUD treatment Options E5 – Enhanced Care Coordination for High Need Populations
2	Capital Region Health Care (CRHC)	C2- Community Re-entry for Justice Involved D-1 Medication Assisted Treatment for SUD E5- Enhanced Care Coordination for High Need Population
3	Southern New Hampshire Health	C1- Care Transition Teams D3- Expansion in Intensive SUD Treatment Options E-4 Integrated Treatment for Co-occurring Disorders
4	Catholic Medical Center	C1-Care Transition Teams D3-Expansion in Intensive SUD Treatment Options E4-Integrated Treatment for Co-Occurring Disorders
5	Partnership for Public Health	C2-Community Re-Entry Program for Justice Involved D3-Expansion in Intensive SUD Treatment Options E-5 Enhanced Care Coordination for High Need Populations
6	Seacoast and Stafford County	C1-Care Transition Teams D3- Expansion in Intensive SUD Treatment Options E5-Enhanced Care Coordination for High Need Populations
7	North Country Health Consortium	C1-Care Transition Teams D3-Expansion in Intensive SUD Treatment Options E5-Enhanced Care Coordination for High Need Population

To establish a sustainable approach to financing IDN activities, as a part of the DSRIP demonstration, the state has committed to moving 50 percent of Medicaid provider payments into alternative payment models (APMs) by the end of CY 2020. This CY2017 and CY2018 DSRIP APM Roadmap articulates the process by which the state will work with stakeholders to explore and develop APMs and develop an implementation plan, (“APM Implementation Plan”), to achieve this goal.

New Hampshire Medicaid will lead the system wide transformation to alternative payment model(s) by:

- 1) Convening and leading an APM Workgroup for educating stakeholders about the DSRIP APM goal, viable APM models in this context, and what features and internal capacities providers may need to obtain or possess in order succeed in an APM reimbursement environment;
- 2) Assessing providers’ preparedness for moving to Alternative Payment Models, including, but not limited, to critical data infrastructure and financial resources;
- 3) Using learnings in an APM Workgroup to determine APM strategies, rate-setting approaches, and contracting terms consistent with the Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV. Project Stages, Milestones, and Metrics.

### **Statewide APM Education Groundwork**

The Office of Medicaid Services, together with the UNH School of Law (SL) and the Institute for Health Policy and Practice (IHPP) will be accountable for and take the lead in developing the groundwork needed in order to meet the 50 percent APM use by 2020.

The state intends for all APM implementation plan development participants to be well informed in order to participate fully in this process. Using CMS’ Learning Action Network Health Care Payment framework, the statewide APM Workgroup will review current alternative payment strategies associated with Category 3 - APMs Built on Fee-for-Service Architecture, and Category 4 - Population-Based Payment. Participants will become familiar with risk-based, payment strategies for bundled payments, primary care medical home and centers of excellence, as well as, population-based payment for condition specific, primary care and episode-based care.

In addition to these broad approaches to payment, participants will become familiar with the APM strategies of other payers, including Medicare and NH's commercial payers. As the Medicaid program provides coverage for only 13% of NH's citizens, it will likely be essential to capitalize on payment reform initiatives already underway with Medicare and/or commercial payers to ensure sufficient momentum and incentive to transform and sustain alternative reimbursement approaches.

Office of Medicaid Services, UNH School of Law, and Institute for Health Policy and Practice

In the spring of 2017, the Office of Medicaid together with UNH SL and IHPP began to gather key information and stakeholders necessary in the APM development process. Listed below are steps taken to date in this collaboration. This collaboration will continue throughout CY2017 and CY2018.

*April 2017*

UNH SL and IHPP provided New Hampshire Medicaid with a Payment Reform Survey, offering a summary of various value-based purchasing reform initiatives that impact New Hampshire. This summary can be found in the NH Payment Reform Summary Section beginning on page 22.

*May 31, 2017*

UNH School of Law and IHPP hosted a day-long symposium on Medicaid Payment Reform entitled *NH Medicaid Today and Tomorrow: Focusing on Value*. The agenda and presentations utilized at the Symposium can be found at: <http://chhs.unh.edu/ihpp/nh-medicaid-today-and-tomorrow-focusing-value>. The day-long symposium included an overview of the New Hampshire Medicaid program, analysis of utilization and claims data from New Hampshire Medicaid and comparable commercial populations, as well as keynote presentations and panel discussions of value-based purchasing from national and regional perspectives. The symposium was attended by representatives of provider groups, Medicaid health plans, commercial health insurance carriers, health systems, various state government entities, elected officials, and advocates representing federally qualified health centers, addiction and recovery service providers, consumers and thought leaders in health-care policy.

Medical Care Advisory Committee

*May 15, 2017*

The Medicaid Director introduced to the Medical Care Advisory Committee (MCAC), which is a federally required public advisory group established in accordance with 42 CFR § 431.12 to advise the State Medicaid Director regarding New Hampshire Medicaid policy and planning, the goal and requirements of the APM roadmap that New Hampshire must fulfill. The slide deck distributed and relied on in this session can be found at:

<https://www.dhhs.nh.gov/ombp/documents/apm-mcac-051517.pdf>. The session initiated a broad discussion of the goals of the DSRIP waiver and APMs generally. The Medicaid Director committed to an ongoing standing, monthly discussion with the MCAC on the development of the APMs in the Medicaid program.

June 12, 2017-December 2017

The Medicaid Director will return to MCAC to review CMS' Learning Action Network Health Care Payment framework, in particular alternative payment strategies associated with Category 3 - APMs Built on Fee-for-Service Architecture, and Category 4 - Population-Based Payment. The slide deck that has already been shared with MCAC and will be reviewed can be found at:

<https://www.dhhs.nh.gov/ombp/documents/dsrp-intro-apms-051517.pdf>.

MCAC will also review the value-based payment initiative summary provided by UNH/IHPP in April of 2017, found in the New Hampshire Payment Reform Summary Section beginning on page 22.

## **Alternative Payment Groundwork Activities for IDNs, MCOs and FFS Providers**

As part of a structured, APM Workgroup planning process, IDNs, MCOs and FFS provider organizations will be asked to conduct a groundwork analysis of APM readiness.

### IDN

As a part of DSRIP project planning, each IDN has provided an initial narrative describing at a high-level the current use of APMs among IDN partner organization, delineated by payer type (Medicaid, Medicare, Commercial, Other), including, for example, bundled payments, pay-for-performance, PCMH primary care payments with shared savings, population based payments for condition-specific care (e.g., via an ACO or PCMH), and comprehensive population-based payment models. Additionally each IDN included estimates for the percent of provider payments currently made through APMs to provider organizations within the IDN by payer type. IDN project plans with implementation detail are due to the state by June 30, 2017. Table 1 summarizes the initial findings from the IDNs descriptive project plans (excerpts from IDN Project Plans submitted October 2016, Question #9).

IDN	Current APM Strategies
1. Monadnock, Sullivan, Upper Valley	<ul style="list-style-type: none"> <li>• Dartmouth Hitchcock Medical Center and Clinic have APM arrangements primarily in the commercial market. These models use underlying FFS as the basis to calculate total cost of care, including MH/SUD care, with the opportunity to share in savings generated, or to accept liability for sharing in deficits if the actual claims costs exceed the expected cost of care in any given performance year. Each of these risk models includes both cost and quality components, meaning that eligibility to share in any cost savings generated is dependent upon performance against established patient safety and process/outcomes measures. About 15% of patients fall under this type of APM.</li> <li>• Dartmouth Hitchcock also has small pay for performance arrangements under managed care Medicare and Medicaid.</li> <li>• Region One’s two community mental health centers, West Central Behavioral Health, and Monadnock Family Services, have experience with population-based capitation payments under Medicaid managed care. Up to 75% of Medicaid patients are reported to have been under such an arrangement.</li> <li>• Housing services has a small per diem rate.</li> <li>• All other Region 1 IDN participants reported FFS payment arrangements with a sprinkling of grant funding, county or town funding, and free services.</li> </ul>

<p>2. Capital</p>	<p>In Region 2, Concord Hospital, Concord Hospital Medical Group, and Dartmouth-Hitchcock (D-H) Concord participate in various alternative payment arrangements with both commercial and governmental players.</p> <ul style="list-style-type: none"> <li>• Concord Hospital, Concord Hospital Medical Group, Riverbend, and CRVNA all participate in the Accountable Care Organization (ACO) known as NH Accountable Care Partners. NH Accountable Care Partners ACO is a joint venture between five hospitals and ACO professionals. It's a not-for-profit organization based in Concord, NH and founded in 2012. The ACO consists of more than 1400+ healthcare providers employed by Catholic Medical Center, Concord Hospital, Mid-State Health Center, Riverbend Community Mental Health, Concord Regional Visiting Nursing Association, Elliot Health System, Southern New Hampshire Health System and Wentworth-Douglass Health System who coordinate the health care of more than 55,000+ Medicare Fee-for-Service beneficiaries in their combined service areas. This ACO has performed extremely well from a quality perspective and has been cost neutral in terms of savings for Concord Hospital and its affiliates.</li> <li>• Commercial Health Plans – Anthem, CIGNA, Harvard Pilgrim: Concord Hospital, Concord Hospital Medical Group, and D-H Concord participate in shared savings programs with all three major payers in NH. The overall payments made to Concord Hospital and its affiliates by one type of alternative payment method (APM) or another is approximately 52% of total revenue. D-H participates as an ACO under a variety of APMs. About 28% of D-H's commercial-related unique patients are managed under such programs, or approximately 15% of underlying FFS-based NPSR.</li> <li>• D-H is a co-founder of One Care Vermont ACO, LLC, along with the University of Vermont Medical Center.</li> <li>• D-H also is a co-founder of Benevera Health, LLC, a population health management company that is an insurance/provider partnership with Harvard Pilgrim Health Plan, Elliot Health System, St. Joseph Hospital, and Frisbie Memorial Hospital.</li> <li>• D-H was one of the original thirty-two Medicare Pioneer ACOs and participated in this shared risk arrangement for the period 2012-2015.</li> </ul>
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<p>3. Nashua</p>	<p>Southern New Hampshire Health (SNHH) has been participating in APMs through Population Health Management for several years. Approximately 70 % of SNHH’s patients belong to an APM, however revenue from APMs account for less than 1% of SNHH’s revenue. Some of the work relative to APMs that SNHH has accomplished includes:</p> <ul style="list-style-type: none"> <li>• All of the SNHH’s primary care practices have achieved Patient Centered Medical Home Designation by NCQA.</li> <li>• SNHH is a member of New Hampshire Accountable Care Partners ACO that participates in the Medicare Shared Savings Program (“MSSP”) phase 1.</li> <li>• SNHH has 24 Care Coordinators focused on managing high-risk chronic disease patients.</li> <li>• SNHH has value-based contracts in place for the majority of our payers; including Medicare (MSSP), Anthem, CIGNA and Harvard Pilgrim.</li> <li>• SNHH performance under these contracts has been favorable.</li> <li>• SNHH value based contracts have been limited to upside shared savings. To date, the Health System has not entered into any “downside” risk agreements.</li> <li>• SNHH is part owner of Tufts Health Freedom Plan.</li> <li>• SNHH works with our Partners at Granite Health (“GH”) to establish broader risk pools, share analytic tools and to promote shared learning.</li> <li>• SNHH has in place the IT infrastructure to comply with the Advancing Care Information requirements.</li> <li>• SNHH has in place advanced analytics both locally and through GH to succeed in quality reporting.</li> <li>• SNHH has in place an operational structure (Leadership, project management, analysts) to advance quality activities and other process related improvements.</li> <li>• SNHH has a highly aligned multi-specialty provider organization, inpatient, outpatient, nursing home, and home care to address all patient needs regardless of location of care.</li> </ul> <p>All other Region 3 providers have minimal APM experience.</p>
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<p>4. Derry and Manchester</p>	<ul style="list-style-type: none"><li>• Network4Health currently has limited participation in APMs. The larger hospital systems participate in APMs as part of their commercial and/or Medicare revenue, but there is limited use of APMs within the Medicaid market, except sub-capitation payments made to community mental health centers. To the extent that providers participate in contracts with Medicare and/or commercial payers where they manage clinical and financial risk, they typically utilize a FFS payment methodology and calculate a total cost of care, allowing providers to share in savings if the actual cost is less than the expected cost and quality performance standards are met, or to share in risk if actual cost is more than expected cost.</li><li>• A number of partners within Network4Health formerly participated as a Pioneer ACO as part of their Medicare line of business. The Pioneer ACO is no longer active.</li></ul>
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<p>5. Central and Winnepesaukee</p>	<p>LRGHealthcare (LRGH)</p> <ul style="list-style-type: none"> <li>• Participates in a shared savings Accountable Care Organization (ACO) with CIGNA through Granite Health; CIGNA is about 8% of Net Revenue</li> <li>• Expects to participate in a shared savings ACO with Harvard Pilgrim through Granite Health starting 1/1/17; Harvard Pilgrim is about 13% of Net Revenue</li> <li>• Owns a 12% stake in Granite Health Holding Company that owns a 49% stake in Tufts Health Freedom Plan; LRGH takes full risk for the premium amount</li> <li>• Participates in a Primary Care Shared Savings Program with Anthem; Anthem is about 21% of Net Revenue</li> </ul> <p>Speare Memorial Hospital (SMH)</p> <ul style="list-style-type: none"> <li>• Has an agreement with Anthem based on incentive payments if SMH scores enough points on their Hospital Improvement Initiative, which essentially measures systems and processes to ensure high quality care, as well as some outcome measures; No risk agreements; Anthem makes up about 20% of payer mix.</li> </ul> <p>Mid-State Health Center Federally Qualified Health Center (FQHC)</p> <ul style="list-style-type: none"> <li>• The State of NH utilizes a bundled payment APM to reimburse federally qualified health centers for all of Medicaid medical and behavioral health encounters; Medicaid represents about 19% of revenue</li> <li>• Mid-State also participates with Anthem Blue Cross on upside shared savings; Amounts to 3% of revenue</li> <li>• Helped form North Country ACO, a first cohort Medicare Advanced Payment / Shared Savings model in 2013</li> <li>• Currently part of the NH Accountable Care Partners ACO</li> <li>• As an FQHC, eligible each year for quality bonuses based on Uniform Data System (UDS) quality performance outcomes; Federal Bureau of Primary Health Care quality bonuses are about 1% of revenue</li> </ul> <p>Health First Family Care Center FQHC</p> <ul style="list-style-type: none"> <li>• Bundled payment rate for all of Medicaid work; Medicaid is about 52% of revenue</li> <li>• Involved in developing a limited liability corporation with BiState Primary Care Association and the other community health centers in southern NH that has contracts for special shared risk fee-for-service alternative payments structured with incentives based on clinical quality outcomes.</li> <li>• Eligible for quality bonuses through federal FQHC program and Also eligible for clinical quality outcome incentive payments through Anthem Blue Cross Blue Shield, Harvard Pilgrim, Cigna, and Martin's Point; Quality incentive payments in total are about 2% of annual revenue</li> </ul> <p>Genesis Behavioral Health and Riverbend Community Health</p> <ul style="list-style-type: none"> <li>• CMHCs are currently in a fee for service payment environment, but are moving to a capitated MCO rate with quality indicators. Payments are still based on fee for service rates with a revenue cap</li> </ul> <p>Franklin VNA &amp; Hospice Home Health Care</p> <ul style="list-style-type: none"> <li>• Currently involved with the Medicare Prospective Payment System (PPS), which reimburses services based on clients' severity of need in 3 domains. Scores are based on the responses to a standardized assessment (OASIS); Approximately 65% of clients are paid via PPS</li> </ul>
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IDN	Current APM Strategies
6. Seacoast and Strafford	<p>The Community Mental Health Centers (CMHC)</p> <ul style="list-style-type: none"> <li>Contracts with the Medicaid Care Management vendors use an alternative payment model, which allows the CMHC to better control service delivery without undue administrative burden. The base model is one of capitation. However, to ensure that the per-member per-month (PMPM) dollars paid to the CMHC are being used for services there is a minimum maintenance of effort threshold in place. In addition, there is the potential to earn additional dollars if specified quality metrics are achieved.</li> </ul> <p>Frisbie Memorial Hospital</p> <ul style="list-style-type: none"> <li>A risk-related program in an arrangement with Harvard Pilgrim in conjunction with the Benevera Program. Benevera is a Population Health Management system to which Frisbie is one of four hospital investors (others being Dartmouth Hitchcock Medical Center, Elliott Hospital, and St. Joseph’s Hospital). The program has an up and downside risk corridor, for both the primary and non-primary members. Frisbie is not participating as yet in any bundled payment plans as of this date.</li> </ul> <p>Wentworth Douglass Hospital (WDH) is engaged in four Alternative Payment Models that serve a significant portion of their patient population.</p> <ul style="list-style-type: none"> <li>Medicare ACO: Through “New Hampshire Accountable Care Partners” relationship; Upside only model with Fee for Service payments as a base and bonuses tied to meeting quality and financial metrics</li> <li>Anthem Shared Savings: Similar to the Medicare NH Accountable Care Partners, involving the Hospital, Wentworth Health Partners (hospital owned medical staff), and independent medical staff through PHO contract – Health Partners of New Hampshire, Inc.</li> <li>Cigna Shared Savings: Very similar to Anthem except it is through Granite Health contract with PHO – Health Partners of New Hampshire, Inc.</li> <li>Medicare Bundled Payment: WDH only arrangement covering Stroke and total joint replacement patients admitted to the hospital and 90 days post discharge; paid FFS with quality and financial budget targets</li> </ul>

IDN	Current APM Strategies
7. North Country and Carroll	<p>Accountable Care Organization Investment Model (AIM ACO)</p> <ul style="list-style-type: none"> <li>An initiative developed by CMMI designed for organizations participating as ACOs in the Shared Savings Program; AIM is a model of pre-paid savings in both upfront and ongoing per beneficiary per month payments to encourage new ACOs to form in rural and underserved area and to transition to arrangements with greater funding risk</li> <li>Participating: Cottage Hospital, Littleton Regional Healthcare, Upper Connecticut Valley Hospital, Androscoggin Valley Hospital, Weeks Medical Center, Coos County Family Health Services, Indian Stream Health Care, Ammonoosuc Community Health Services</li> </ul> <p>Patient Centered Medical Home</p> <ul style="list-style-type: none"> <li>NCQA Level III, identifying practices that promote partnership between individual patients and their clinicians</li> <li>Participating: Ammonoosuc Community Health Services, Indian Stream Health Center, Coos County Family Health Services</li> </ul> <p>Transforming Clinical Practice Initiative</p> <ul style="list-style-type: none"> <li>An initiative supporting practices through sharing, adapting and further developing quality improvement strategies across provider practices through peer-based learning</li> <li>Participating: Northern Human Services, White Mountain Health Center, Huggins Hospital Outpatient Services</li> </ul>

The IDNs have begun to look at their health information infrastructure and work collaboratively on a statewide plan to ensure appropriate health information technology (HIT) to support APMs, consistent with the STC Project Measures and Specifications Guide, A2: Health Information Technology (HIT) Infrastructure to Support Integration. The statewide HIT work plan is due to the state on July 31, 2017. Of necessity, in the absence of a statewide APM, these plans will continue to undergo revisions and will be modified to include process measures and targets toward achieving 50% of Medicaid provider payments by the end of the demonstration period.

MCO

Each Medicaid Managed Care Organization (MCO) health plan will similarly be asked to provide a narrative describing their capacity to incorporate alternative payment models into their current business operations. MCOs will include comment on member and provider attribution into an IDN, provider network management support for IDNs, data analytics and quality oversight with specific comment on an ability for timely and comprehensive quality reporting for clinical management and incentive payments, and other topics as may seem appropriate to

enable the discussion of MCO support for population health improvement and value-based health services reimbursement. This narrative is targeted to be complete and submitted to the state by September 30, 2017.

As early as 2011, New Hampshire began to plan for health care services reform. In its Medicaid managed care Request For Proposals, and subsequently in the Medicaid Managed Care contract, the state required participating health plans to develop and implement payment reform initiatives of their choosing. While basic operations and essential service delivery during the initial transition from a full fee-for-service Medicaid delivery system to a majority Medicaid managed care delivery system delayed the start of payment reform initiatives, each of the two current Medicaid Managed Care Organizations (MCOs) in the state, Well Sense Health Plan and New Hampshire Healthy Families, is currently engaged in quality-related provider payment reform activities.

#### *Well Sense Health Plan*

Well Sense Health Plan operates a provider Quality Incentive Program (QIP) through which it has engaged many providers and provider groups throughout the state to promote and collaborate on quality improvement activities, identified barriers and educated providers on best practices, and expanded its QIP by offering additional funding to providers who achieved metrics in areas like well-child checks, diabetes care, asthma care and preventive screenings. Additionally through the QIP, Well Sense has reviewed individual practice performance and created and supplied performance reports to practices, developed a new provider portal and reports on health plan website, developed a HEDIS Billing & Coding Guide for providers to clarify billing and documentation, and engaged its Provider Advisory Council in quality activities and strategy. Additional information on the Well Sense QIP can be found in Attachment A: Well Sense Health Plan's Annual Payment Reform Plan – Year 3 (Payment Reform.03) (7/1/15 – 6/30/16).

#### *New Hampshire Healthy Families*

The Health Benefit Ratio (HBR) Program is New Hampshire Healthy Families earliest payment reform program. It requires providers to demonstrate improved performance against identified quality performance targets in addition to meeting or exceeding total medical expense targets. As the HBR program is phased out, NHHF is replacing it with a quality and cost driven shared savings program, the Enhanced Primary Care Program (EPCP), for a select number of providers. This program is designed to incentivize appropriate utilization and quality outcomes and eliminate incentives that might serve as an inducement to limit or restrict medically necessary services to our members. The EPCP program requires that provider maintain open panels and reduce preventable events by 5%. Through these incentive programs, NHHF supports the

Primary Care Medical Home model as a mechanism to increase member communication with their PCP and foster the relationship between the PCP and the member. Additional information can be found in Attachment B: Granite State Health Plan New Hampshire Healthy Families Payment Reform Plan.

Well Sense Health Plan and NH Healthy Families activities provide a foundation from which to support and further expand payment reform activities, including migration to APMs.

### State Innovation Model

Through New Hampshire's 2015-2016 State Innovation Model (SIM) development cooperative agreement, the state actively worked with dozens of health and community service providers, payers, local and state government officials, and gathered feedback from over 1,200 citizens, to consider and develop improvements in health care delivery designed to achieve the triple aim: better care for individuals, better health for populations, and lower costs. SIM participants unequivocally recognized that moving from volume to value required a new infrastructure that included the integration of social networks and community into health care delivery, strong health information exchange, and payment reforms. With the additional resources brought into the state through this DSRIP demonstration, the state has an ability to act on its commitment to innovation and is using Medicaid waiver authority to assimilate these changes into regionally integrated physical health, mental health and substance misuse services.

Additionally, in 2016, the State of New Hampshire Department of Health and Human Services (DHHS) became a Committed Partner to the CMS Health Care Payment Learning and Action Network. Small states are uniquely positioned to bring stakeholders together.

### Fee-For-Service

New Hampshire Medicaid will also assess fee-for-service providers for their capacity to incorporate alternative business practices into their current business operations. This assessment is targeted to be completed by September 30, 2017.

## **Statewide APM Workgroup**

Statewide APM Workgroup participants will be identified from among Medicaid Health Plans, IDN governance bodies, MCAC members, and other health care stakeholders including providers, health systems, consumers, and health-policy thought leaders.

The Workgroup members will be identified by September of 2017 and will begin work no later than November 2017. The Workgroup will review the readiness assessments of the IDNs, the

MCOs and the FFS providers. It will also consider APM options, including contribution to health outcomes improvements, beneficiary and provider acceptability, barriers and operational feasibility – such as necessary health information technology infrastructure, economic modeling for health-care resource utilization and cost savings, and sustainability after completion of the DSRIP demonstration.

The Workgroup will work through the following threshold questions:

**Which Types of APMs will be Permitted?**

- *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?*
- *Will the state be prescriptive in the type of APMs to be permissibly used?*
- *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)*

**Participation**

- *Should MCOs be required to contract with IDNs?*
- *Could MCOs work with other provider networks or with individual providers within an IDN using a variety of payment arrangements?*
- *Are IDNs required to work with MCOs?*
- *Will the state prescribe a percentage of providers or type of provider that must participate in VBP to the MCOs by a pre-determined date?*

**Model Design**

- *How much flexibility will MCOs have to select VBP models?*
- *Will the state mandate how value-based contractors distribute savings?*
- *MCO discretion: Will they have ability to form other types of ‘off menu’ VBP arrangements?*

### **Additional Threshold Questions**

- *What structures will NH need to help oversee implementation?*
- *How will the state initiatives align with MACRA?*
- *Would the state require EHR based quality reporting?*
- *What data/tools will the state supply in support of value-based payment?*
- *Will NH take steps to review VBP contracts?*
- *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)*
- *Beyond the DSRIP Demo's behavioral health-specific goals, what are the Departments other Medicaid delivery system reform priorities to be supported through payment reform?*
- *Are there some high impact services that the state may want to exclude from value-based payments?*

After addressing the threshold questions, selecting model designs and participation standards, the Workgroup will engage in developing strategies to remove barriers and mitigate risks. More than one model may be selected and/or models may vary across IDNs and/or health plans. However, any model chosen must be operational to apply to the goal of 50 percent of Medicaid provider payments no later than December 31, 2020.

The final APM model and implementation plan will address and include the following:

- Approach to encourage APM participation: Approaches that MCOs will use to reimburse provider and to encourage health services delivery consistent with IDN objectives and metrics, including how the state will plan and implement a goal of 50% of Medicaid provider payments to providers using APM;
- MCO contact strategy: How current MCO contracts will be amended to include the collection and reporting of IDN objectives and measures;
- Administrative activities and burdens: How the IDN objectives and measures will impact the administrative load for Medicaid providers, what MCO technical assistance and other supports to providers will further IDN goals, or if the MCOs will carrying out programs or activities to further the objectives of the waiver, how the state will avoid duplication with IDN funding or other state funding, and how IDN payments differ from any services or administrative functions already accounted for in MCO capitation rates.

- **Systems to Support IDN Objectives and Incentives:** How APM systems deployed by the state, IDNs and MCOs will reward performance consistent with IDN objectives and measures.
- **APM Impact on Provider Network:** How the state will assure that providers participating in and demonstrating successful performance through IDNs will be included in MCO provider networks.
- **Impact on MCO rates:** How MCO 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 matter will be incorporated into timely capitation rate development.
- **Actuarial soundness:** How actuarially-sound rates will be developed, taking into account any specific expectations or task associated with IDNs that the MCOs will undertake.
- **APM integration into MCO Quality Planning:** How plans will be measured based on utilization and quality in a manner consistent with IDN objectives into their Quality Assurance and Performance Improvement plans, and submitted for state review and approval by January 31 of each calendar year.
- **Integration of IDN measures into MCO contracts:** How the state will use IDN measures and objectives in MCO contracting strategies health service delivery.
- **Stakeholder engagement:** How the state has solicited and integrated community and MCO/Medicaid service delivery contact provider organizations' input into the development of the APM implementation plan.

### **Impact on Contracts, Provider Capacities, and Provider Rate-Setting**

In addition to the criteria above, STC 33 requires the Medicaid program health plans to be aligned with or accountable to the DSRIP through the MMC contract. Insofar as new providers, particularly SUD and other mental health providers are hired and incorporated into the IDNs, the Medicaid health plans will work with the IDNs and new providers and integrate these providers into MCO provider network operations, including credentialing, recredentialing, “provider-finder” services, routine provider training and communications, among others.

The state’s Medicaid MCOs will likely play a large role in providing the infrastructure for health services payment and quality oversight under an APM. While each IDN is currently developing project implementation plans to include health information technology infrastructure that will assist in IDN specific monitoring of financial and clinical outcomes, the MCOs will ensure that payments for services – in a model yet to be determined – continues, both during transition to a new payment paradigm and in ongoing payment assurance as well as providing a statewide assessment to the state’s oversight. Additionally, the MCOs will continue to provide quality

data to both the IDNs and the state so that ongoing monitoring of clinical outcomes will be maintained and enhanced.

The Medicaid MCOs currently contracted with NH Medicaid already track 26 of the 41 performance measures that the IDNs will be measured against. As the state moves to re-procure the contracts for the administration of Medicaid benefits, it will work to identify additional data sets that the MCOs will have to capture in order to measure what the IDNs are required to measure. Moreover, New Hampshire Medicaid will work with DSRIP staff to evaluate which initiatives and providers have performed highest in the DSRIP context in order to construct measures and incentives for MCOs to contract with and/or provide financial incentive to those providers. The date by when NH Medicaid will re-procure its contracts for its Medicaid managed care delivery system is not yet determined, although proposed legislation currently contemplates a new program coverage start date in 2019.

It is not possible to specify the rate-setting process at this time as the APMs to be utilized have not yet been determined. Once the Statewide APM Workgroup recommends APMs to be utilized and the state selects them, the state will work with its actuary to ensure appropriate payments to MCOs and ensure appropriate payment to providers.

Additionally, NH has submitted a Letter of Interest for the CMS Innovator Accelerator Program for additional insights and early modeling of the impact of various models on MCO and provider payments; the state has not yet been told if it has been success in its request to participate at this time.

## **Medicaid APM Implementation Plan Measures and Milestones**

### *APM Implementation Measures*

The STCs require specific measures be taken throughout the APM development and implementation time frame. Beginning in 2017 and 2018, the IDN are eligible for “pay for reporting” incentive payments on this set of measures as indicated:

- Conduct IDN Baseline assessment of current use of capacity to use APMs among partners (2017 P4R measure);
- Participate in development of statewide APM roadmap through workgroups and stakeholder meetings (2017 P4R measure);
- Develop an IDN-specific roadmap for using APMs (2018 P4R measure);

- Meet IDN-specific measures identified in the roadmap that measure progress toward meeting APM goals, including financial, legal and clinical preparedness and engagement with MCOs .

#### *Major Statewide APM Workgroup Planning Milestones*

A full, detail APM project plan is an anticipated deliverable at the conclusion of the planning process, in the winter of 2017-2018. The state is committed to the following major milestones as part of the APM Roadmap:

- Statewide APM Education Groundwork: April – August 2017
- IDN, MCO, and FFS APM groundwork activities: June – September 2017
- Statewide APM Workgroup: September 2017-February 2018
- Contracting preparation for implementation of APMs: February 2018-December 2018
- Individual IDN APM Implementation plans: April 2018-December 2018
- State report on using IDNs and MCO as the basis for alternative payment methodologies: December 2018
- Active state, IDN, and MCO APM Implementation: January 2019-Dec 2020

A DSRIP APM Implementation Plan project plan can be found in Attachment C. This project plan will be further developed with the commencement of the statewide APM group.

## NH Payment Reform Summary

### Introduction

This memo offers a summary of various value based payment reform initiatives that impact New Hampshire either because they are happening in NH, or they are part of a more intentional move towards or implementation of value based payment design by health plans, including Medicare. This memo is intended to provide background on what has developed in New Hampshire without clear regulatory direction in order to help inform NH Medicaid as it develops a strategy for directing value based payment reform in the Medicaid program.

Because Medicare impacts all providers and forces delivery system shifts across the providers, it is important to track changes and the current Medicare initiatives reflected in the NH delivery system are outlined below. Commercial payer programs are also summarized, and include general practice transformation efforts as well as managed care plan enhancers. Given the power of the Medicare program to influence change, it is important to recognize the practice transformation efforts that are underway specifically in primary and specialty care practices. Key developments in payment reform in other states' Medicaid programs are summarized in the last section of this memo.

New Hampshire Medicaid must consider the number of providers enrolled in its program that are already engaged in preliminary CMS driven practice transformation. NH Medicaid must also consider that the cost drivers in traditional Medicaid are the patients with the highest need and the most complex care including developmental disabilities, those with serious mental illness and those needing long term care and supports. Commercial insurance coverage and medical providers are not involved in material payment reform efforts that impact the needs of these populations and an investigation into developments in other states is important. See Exhibit E.

Value based payment reform can mean many things. Health plans use a variety of managed care techniques to manage patients and improve cost, quality and patient satisfaction (although few help all three), such as network design, utilization controls (such as medical management, pre-authorizations, formulary design, preferred provider tiers, etc.) and pricing. In addition, often industry refers to practice transformation efforts as "ABP" (or Alternative Benefit Plan) because such efforts can impact the "triple aim" and are an important part of system reform. Finally, ABP can also mean innovative ways of paying for services that go beyond "fee for service" that allow for triple aim outcomes, where a set amount of or fewer dollars are spent for services that maintain or improve quality and outcomes. This memo focuses on VBP payment efforts that serve as true "payment reform" and tracks the Medicare framework.

I. Medicare  
 A. Medicare Goals and Alternative Payment Models

A LAN Guiding Committee was established in May 2015 as the collaborative body charged with advancing the alignment of payment approaches across and within the public and private sectors. This alignment will accelerate the adoption and dissemination of meaningful financial incentives to reward providers that deliver higher quality and more affordable care. In alignment with the goals of the U.S. Department of Health and Human Services (HHS), the LAN aims to have 30% of U.S. health care payments in APMs or population based payments by year 2016, and 50% by year 2018.

When developing the APM Framework, the Work Group began with the payment model classification scheme that CMS recently advanced,<sup>1</sup> and expanded it by introducing refinements that are described in more detail below.

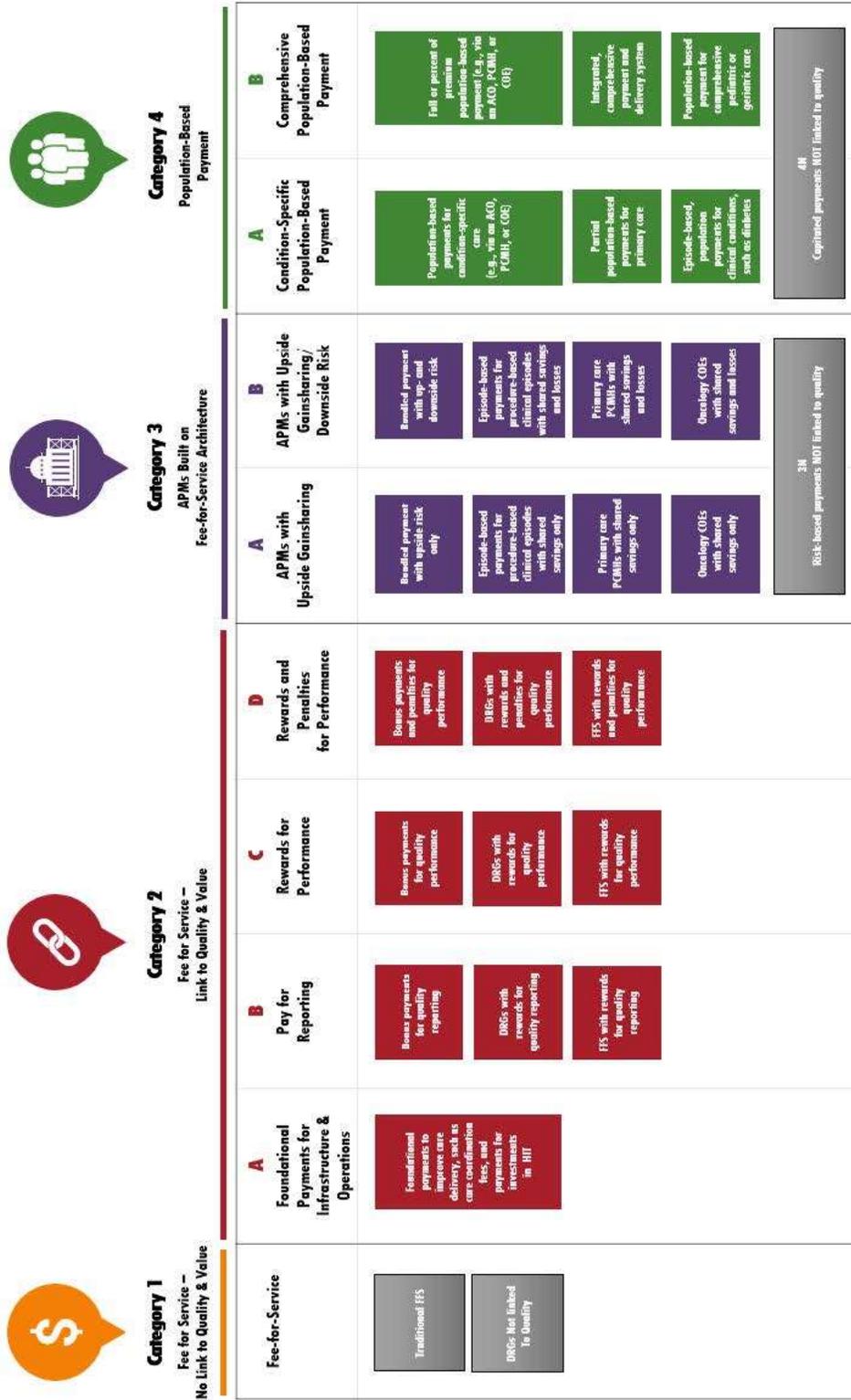
**Figure 1. APM Framework (At-A-Glance)**



<sup>1</sup> <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>

The APM framework is meant to streamline and simplify existing efforts. This framework, displayed in the figure below, provides more detail and focus on rewards and incentives for provider use of EMR and quality reporting, then on episode or population based upside risk models, and finally, episode and population based downside risk models. It's important to note that the regulatory barriers to payment reform are substantial. Accountable Care Organizations (ACOs) could not be formed without government waivers from antitrust law, anti-kickback and staunch physician self-referrals rules and rules governing joint ventures between 501-c (3) s and private interest. Even the ACO "safe harbor" or waivers are extremely limited and strict.

Figure 4. APM Framework



Example payment models will not count toward APM goal. Payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

B. NH's Implementation of Medicare Goals

**CMS Payment Reform Activity, NH; as of 4/3/2017**

Prepared for the NH Purchasers Group on Health<sup>2</sup>

Centers for Medicaid and Medicare Innovation (CMMI) Models in New Hampshire

Source: <https://innovation.cms.gov/initiatives/#views=models>

<u>Innovation Model</u>	<u>Description</u>	<u>Category</u>	<u>Locations Testing Model</u>	<u>Stage</u>
Acute Myocardial Infarction (AMI) Model	Acute care hospitals in certain selected geographic areas will participate in retrospective bundled payments for items and services that are related to AMI treatment and recovery, beginning with a hospitalization for AMI treatment and extending for 90 days following hospital discharge. Under the AMI Model, the hospital is financially accountable for the quality and cost of an AMI episode of care, which incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers.	Episode-based Payment Initiatives	<ul style="list-style-type: none"> <li>• Portsmouth Regional Hospital</li> <li>• Parkland Medical Center</li> <li>• Monadnock Community Hospital</li> <li>• Catholic Medical Center</li> <li>• Elliot Hospital</li> <li>• Southern NH Medical Center</li> <li>• St. Joseph Hospital</li> <li>• Exeter Hospital</li> <li>• Frisbie Memorial Hospital</li> <li>• Wentworth-Douglass Hospital</li> </ul>	<p>Announced:</p> <p>The first performance period will begin on July 1, 2017 and will continue for five performance years, ending on or about December 31, 2021.</p> <p><b>Possibly Delayed</b></p>
Cardiac Rehabilitation (CR) Incentive Payment Model	Under this model, hospitals may use this incentive payment to coordinate cardiac rehabilitation and support beneficiary adherence to the cardiac rehabilitation treatment plan to improve	Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Model	<ul style="list-style-type: none"> <li>• Exeter Hospital</li> <li>• Wentworth-Douglass Hospital</li> <li>• Portsmouth Regional Hospital</li> <li>• Parkland Medical Center</li> <li>• Frisbee Memorial</li> </ul>	<p>Announced:</p> <p>The first performance period will begin on July 1, 2017 and will continue for</p>

<sup>2</sup> Created by the Institute for Health Policy and Practice, Jan 2017

<u>Innovation Model</u>	<u>Description</u>	<u>Category</u>	<u>Locations Testing Model</u>	<u>Stage</u>
	cardiovascular fitness. This test will cover the same five-year period as the cardiac care bundled payment models. Standard Medicare payments for cardiac rehabilitation services to all providers of these services for model beneficiaries would continue to be made directly to those providers throughout the model.		Hospital	five performance years, ending on or about December 31, 2021. <b>Possibly Delayed</b>
Coronary Artery Bypass Graft (CABG) Model	The CABG Model holds participant hospitals financially accountable for the quality and cost of a CABG episode of care and incentivizes increased coordination of care among hospitals, physicians, and post-acute care providers.	Episode-based Payment Initiatives	<ul style="list-style-type: none"> <li>• Elliot</li> <li>• Monadnock</li> <li>• Southern NH</li> <li>• St Joes</li> <li>• Catholic Medical</li> <li>• Exeter</li> <li>• Frisbie Memorial</li> <li>• Wentworth-Douglass</li> <li>• Parkland</li> <li>• Portsmouth</li> </ul>	Announced:  The first performance period will begin on July 1, 2017 and will continue for five performance years, ending on or about December 31, 2021. <b>Possibly Delayed</b>
BPCI Model 2: Retrospective Acute & Post-Acute Care Episode	The Bundled Payments for Care Improvement Initiative bundles payment for an episode of care. In Model 2, retrospective bundled payments are made for acute care hospital stay plus post-acute care.	Episode-based Payment Initiatives	<ul style="list-style-type: none"> <li>• Wentworth-Douglass Hospital</li> </ul>	Ongoing

<u>Innovation Model</u>	<u>Description</u>	<u>Category</u>	<u>Locations Testing Model</u>	<u>Stage</u>
Medicaid Incentives for the Prevention of Chronic Diseases Model	The Medicaid Incentives for the Prevention of Chronic Diseases Model is supporting 10 states providing incentives for Medicaid beneficiaries to participate in prevention programs and demonstrate changes in health risks and outcomes.	Initiatives Focused on the Medicaid and CHIP Population	<ul style="list-style-type: none"> <li>State of New Hampshire</li> </ul>	Ongoing
Health Care Innovation Awards	The Health Care Innovation Awards are funding competitive grants to compelling new ideas that deliver health care at lower costs to people enrolled in Medicare, Medicaid, and CHIP.	Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	<ul style="list-style-type: none"> <li>Feinstein Institute for Medical Research (Care Managers and Technology for care of schizophrenia)</li> <li>Trustees of Dartmouth College (Shared Decision Making Focus)</li> <li>The National Health Care for the Homeless Council (Community Health Workers and HCH)</li> </ul>	Ongoing
Health Care Innovation Awards Round Two	The Health Care Innovation Awards Round Two are funding competitive grants to compelling new ideas that deliver health care at lower costs to people enrolled in Medicare, Medicaid, and CHIP.	Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	<ul style="list-style-type: none"> <li>Association of American Medical Colleges (econsults/ereferrals)</li> </ul>	Ongoing
State Innovation Models Initiative: Model Design Awards Round One	Sixteen States received funding to develop state-based models for multi-payer payment and health care delivery system transformation	Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	<ul style="list-style-type: none"> <li>State of New Hampshire</li> </ul>	No Longer Active

<u>Innovation Model</u>	<u>Description</u>	<u>Category</u>	<u>Locations Testing Model</u>	<u>Stage</u>
Million Hearts®: Cardiovascular Disease Risk Reduction Model	This model provides opportunity for the design of sustainable care approaches to decrease cardiovascular disease risk for Medicare beneficiaries.	Initiatives to Speed the Adoption of Best Practices	<ul style="list-style-type: none"> <li>• Indian Stream Health Center</li> <li>• Weeks Medical Center</li> <li>• Littleton Regional Healthcare</li> <li>• Mid-State Health Center</li> <li>• Pembroke Wellness Center</li> <li>• Dartmouth-Hitchcock Health</li> </ul>	Participants Announced; Beginning in early 2017, end in December 2022
Innovation Advisors Program	The Innovation Advisors Program supported dedicated, skilled individuals in the health care system who can test new models of care delivery in their own organizations and work locally to improve the health of their communities.	Initiatives to Speed the Adoption of Best Practices	<ul style="list-style-type: none"> <li>• Stephen Liu MD, MPH, FACPM</li> <li>• Jeanne McAllister RN, BSN, MS, MHA</li> </ul>	<i>No Longer Active</i>
FQHC Advanced Primary Care Practice Demonstration	The FQHC Advanced Primary Care Practice Demonstration is testing the efficiency of patient-centered medical homes among FQHCs.	Primary Care Transformation	<ul style="list-style-type: none"> <li>• Lamprey Health Care</li> <li>• Manchester Community Health Center</li> <li>• Coos County Family Health</li> <li>• Ammonoosuc Community Health</li> <li>• Mid-State Health Center</li> <li>• Families First of the Greater Seacoast</li> </ul>	<i>No Longer Active</i>
Advance Payment ACO Model	The Advance Payment ACO Model is providing upfront and monthly payments to 35 ACOs participating in the Medicare Shared Savings Program.	Accountable Care	<ul style="list-style-type: none"> <li>• North Country ACO</li> </ul>	<i>No Longer Active</i>

<u>Innovation Model</u>	<u>Description</u>	<u>Category</u>	<u>Locations Testing Model</u>	<u>Stage</u>
Medicare Care Choices Model	Through the Medicare Care Choices Model, the Centers for Medicare & Medicaid Services (CMS) will provide a new option for Medicare beneficiaries to receive hospice-like support services from certain hospice providers while concurrently receiving services provided by their curative care providers.	Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	<ul style="list-style-type: none"> <li>North Country Home Health and Hospice (Littleton)</li> </ul>	Ongoing
Next Generation ACO	A new opportunity in accountable care—one that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care.	Accountable Care	<ul style="list-style-type: none"> <li>Dartmouth Hitchcock Health</li> </ul>	Announced
Transforming Clinical Practices Initiative	...sharing, adapting and further developing their comprehensive quality improvement strategies. The initiative is one part of a strategy advanced by the Affordable Care Act to strengthen the quality of patient care and spend health care dollars more wisely.	Primary Care Transformation	<ul style="list-style-type: none"> <li>Maine Quality Counts is lead, IHPP, Citizens Health Initiative is NH lead (see PPT)</li> </ul>	Ongoing
Transforming Clinical Practices Initiative	...sharing, adapting and further developing their comprehensive quality improvement strategies. The initiative is one part of a strategy advanced by the Affordable Care Act to strengthen the quality of patient care and spend health care dollars more	Primary Care Transformation	<ul style="list-style-type: none"> <li>Community Health Center Association of Connecticut</li> <li>Not sure if NH partner</li> </ul>	Ongoing

<u>Innovation Model</u>	<u>Description</u>	<u>Category</u>	<u>Locations Testing Model</u>	<u>Stage</u>
	wisely.			

Medicare Shared Savings ACO Organizations, NH

Source: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/ACOs-in-Your-State.html>

<b>ACO Name</b>	<b>Service Area</b>	<b>Facilities/Participants</b>	<b>ACO Status</b>
NH Accountable Care Partners	ME MA NH	<ul style="list-style-type: none"> <li>• Catholic Medical Center</li> <li>• Concord Hospital</li> <li>• Mid-State Health Center</li> <li>• Riverbend Community Mental Health</li> <li>• Concord Regional Visiting Nursing Association</li> <li>• Elliot Health System</li> <li>• Southern New Hampshire Health System</li> <li>• Wentworth-Douglass Health System</li> </ul>	Renewal
New Hampshire Rural ACO	NH VT	<ul style="list-style-type: none"> <li>• Androscoggin Valley Hospital</li> <li>• Coos County Family Health Services</li> <li>• Upper Connecticut Valley Hospital Association, Inc.</li> <li>• Indian Stream Health Center</li> <li>• Weeks Medical Center</li> <li>• Littleton Regional Healthcare</li> <li>• Ammonoosuc Community Health Services, Inc. (Littleton Regional Hospital)</li> <li>• Monadnock Community Hospital</li> <li>• Cottage Hospital</li> </ul>	Initial
NEQCA Accountable Care, Inc.	MA NH	<ul style="list-style-type: none"> <li>• No NH partner <ul style="list-style-type: none"> <li>○ <a href="http://neqca.org/ABOUT-NEQCA/NEQCA-Accountable-Care-Inc.aspx">http://neqca.org/ABOUT-NEQCA/NEQCA-Accountable-Care-Inc.aspx</a></li> </ul> </li> </ul>	Initial

ACO Name	Service Area	Facilities/Participants	ACO Status
MaineHealth Accountable Care Organization	ME NH	<ul style="list-style-type: none"> <li>• No NH partner <ul style="list-style-type: none"> <li>○ <a href="http://www.mainehealth.org/workfiles/mh_about/2016%20ACO%20Participant%20List.pdf">http://www.mainehealth.org/workfiles/mh_about/2016%20ACO%20Participant%20List.pdf</a></li> </ul> </li> </ul>	Renewal
Lahey Clinical Performance ACO	MA NH	<ul style="list-style-type: none"> <li>• No NH partner <ul style="list-style-type: none"> <li>○ <a href="http://www.laheyhealth.org/File%20Library/LCP%20ACO/ACO-Participant-List.pdf">http://www.laheyhealth.org/File%20Library/LCP%20ACO/ACO-Participant-List.pdf</a></li> </ul> </li> </ul>	Renewal
Genesis Healthcare ACO, LLC	MA NH	<ul style="list-style-type: none"> <li>• No NH partner <ul style="list-style-type: none"> <li>○ Genesis Eldercare Physician Services, LLC</li> <li>○ GEPS Physician Group of Pennsylvania, P.C.</li> <li>○ GEPS Physician Group of New Jersey, P.C.</li> </ul> </li> </ul>	Initial
Community Health Accountable Care, LLC	NH VT NY	<ul style="list-style-type: none"> <li>• No NH partner <ul style="list-style-type: none"> <li>○ <a href="http://www.communityhealthaccountablecare.com/medicare-shared-savings-program-public-reporting-information.html">http://www.communityhealthaccountablecare.com/medicare-shared-savings-program-public-reporting-information.html</a></li> </ul> </li> </ul>	Initial
Circle Health Alliance, LLC	MA NH	<ul style="list-style-type: none"> <li>• No NH partner <ul style="list-style-type: none"> <li>○ <a href="http://www.lowellgeneralpho.org/files/ACOParticipantList_2016_0101.pdf">http://www.lowellgeneralpho.org/files/ACOParticipantList_2016_0101.pdf</a></li> </ul> </li> </ul>	Renewal

## C. NH Medicare Innovations

### 1. Accountable Care Organizations

ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. An ACO is intended to ensure patients get the right care and avoid unnecessary duplication of services and reduce medical errors. ACOs also have the potential to share in the savings that it achieves for the Medicare program. NH is limited in the number of ACOs that can co-exist because of the minimum number of lives required by Medicare (5,000 attributed lives).

#### i. NH Accountable Partners

Currently in NH there is one active ongoing Medicare ACO, the NH Accountable Care Partners Accountable Care Organization. The ACO, “consists of more than 1400+ healthcare providers employed by Catholic Medical Center, Concord Hospital, Mid-State Health Center, Riverbend Community Mental Health, Concord Regional Visiting Nursing Association, Elliot Health System, Southern New Hampshire Health System and Wentworth-Douglass Health System who coordinate the health care of more than **55,000+** Medicare Fee-for-Service beneficiaries in their combined service areas.”<sup>3</sup>

#### ii. DHMC Next Gen ACO

Building upon experience from the Pioneer ACO Model and the Medicare Shared Savings Program (MSSP), the Next Generation ACO Model (the Model) proposed by DHMC provides “a new opportunity in accountable care—one that sets predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care.” The Model is an initiative for ACOs that are experienced in coordinating care for populations of patients. It will allow these provider groups to assume higher levels of financial risk and reward than are available under the current Pioneer Model and MSSP. The goal of the Model is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Original Medicare fee-for-service (FFS) beneficiaries. Included in the Model are strong patient protections to ensure that patients have access to and receive high-quality care. Like other Medicare ACO initiatives, this Model will be evaluated on its ability to deliver better care for individuals, better health for populations, and lower growth in expenditures. This is in accordance with the Department of Health and Human Services’ “Better, Smarter, Healthier” approach to improving our nation’s health care and

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<sup>3</sup> <http://www.concordhospital.org/about/accountable-care-organization/>

setting clear, measurable goals and a timeline to move the Medicare program -- and the health care system at large -- toward paying providers based on the quality rather than the quantity of care they provide to patients. In addition, CMS will publicly report the performance of the Next Generation Pioneer ACOs on quality metrics, including patient experience ratings, on its website.<sup>4</sup>

In NH, Dartmouth Hitchcock Health/Medical Center (DHMC) was awarded funding from CMS to establish this Pioneer ACO, but abandoned its efforts. DHMC is participating in the Next Gen ACO demonstrations.

## 2. North Country Hospital Coalition

The New Hampshire Rural ACO is currently in development. The prior ACO dissolved when the North Country hospitals formally affiliated in 2016. A new ACO is in progress.

### D. Dual Eligible Innovation Models

A number of states and organizations are starting to focus on payment from models that address the needs of dual eligible populations in Medicare and Medicaid. The goal of these models is to coordinate care for its members via an individualized healthcare plan that encompasses the benefits of Medicare and Medicaid, and via coordination of communication between the member's providers. Of the current Medicaid population in NH, 1.9% are dually eligible Medicare/Medicaid beneficiaries.

Meridian Care and Oak Street Health in Chicago are examples of organizations who are focusing on models specifically designed for members who are Medicare and Medicaid dual eligible. Meridian Care is a health insurer that provides health insurance plans to people located in Illinois, Michigan, and Ohio.<sup>5</sup> Oak Street Health is comprised of clinics located throughout Illinois, Michigan, and Indiana, that provides healthcare services tailored specifically to meet the needs of older adult patients with Medicare.<sup>6</sup> In 2016, Meridian Care and Oak Street Health partnered to allow Meridian Care patients to seek in-network care from Oak Street's clinics. Oak Street will be held financially accountable for the primary care of Medicare Advantage and dual-eligible patients enrolled in Meridian Care plans.<sup>7</sup> The goal of the partnership is to give dual eligible a higher quality of care at a more affordable price.<sup>8</sup>

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<sup>4</sup> Centers for Medicare and Medicaid Services. Next Generation ACO Model. 2017.

<https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>

<sup>5</sup> <https://www.mymeridiancare.com/>

<sup>6</sup> <http://www.oakstreethhealth.com/>

<sup>7</sup> Shelby Livingston, *Meridian Care signs value-based care deal with Chicago primary-care chain Oak Street Care*, Modern Healthcare, February 6, 2017, <http://www.modernhealthcare.com/article/20170206/NEWS/170209943>

<sup>8</sup> *Id.*

The Center for Medicare and Medicaid Services (CMS) has been working with various states to approve state-run demonstrations which implement programs that will integrate Medicare and Medicaid services in order to better serve dual-eligible patients. As of January 2017, thirteen states have signed Memorandum of Understanding with CMS for their specific models.<sup>9</sup>

The following States have implemented programs that provide dual eligible patients with one health plan that covers their Medicaid and Medicare Services and also provides them with a care coordinator, like a case manager, that will develop an individual healthcare plan for each patient based on their needs, including coordination of doctors' appointment, the delivery of health information between doctors, specialists, and family members, transportation to health facilities, etc.:

- California: <http://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareInitiative.aspx>
- Colorado: <https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-acc-medicare-medicaid-program>
- Illinois: <https://www.illinois.gov/hfs/MedicalProviders/cc/mmai/Pages/default.aspx>
- Michigan: [http://www.michigan.gov/mdhhs/0,5885,7-339-71551\\_2945\\_64077---\\_00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_64077---_00.html)
- Minnesota: [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id\\_006271](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006271)
- Massachusetts: <http://www.mass.gov/masshealth/duals>
- New York: [https://www.health.ny.gov/health\\_care/medicaid/redesign/fida/](https://www.health.ny.gov/health_care/medicaid/redesign/fida/)
- Ohio: <http://medicaid.ohio.gov/PROVIDERS/ManagedCare/IntegratingMedicareandMedicaidBenefits.aspx>
- Rhode Island: <https://www.nhpri.org/Medicare-Medicaid.aspx>
- South Carolina: <https://msp.scdhhs.gov/SCDue2/>
- Texas: <http://legacy-hhsc.hhsc.state.tx.us/medicaid/managed-care/dual-eligible/>
- Virginia: [http://www.dmas.virginia.gov/content\\_pgs/altc-enrl.aspx](http://www.dmas.virginia.gov/content_pgs/altc-enrl.aspx)
- Washington: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Washington.html>

#### E. Practice Transformation Networks

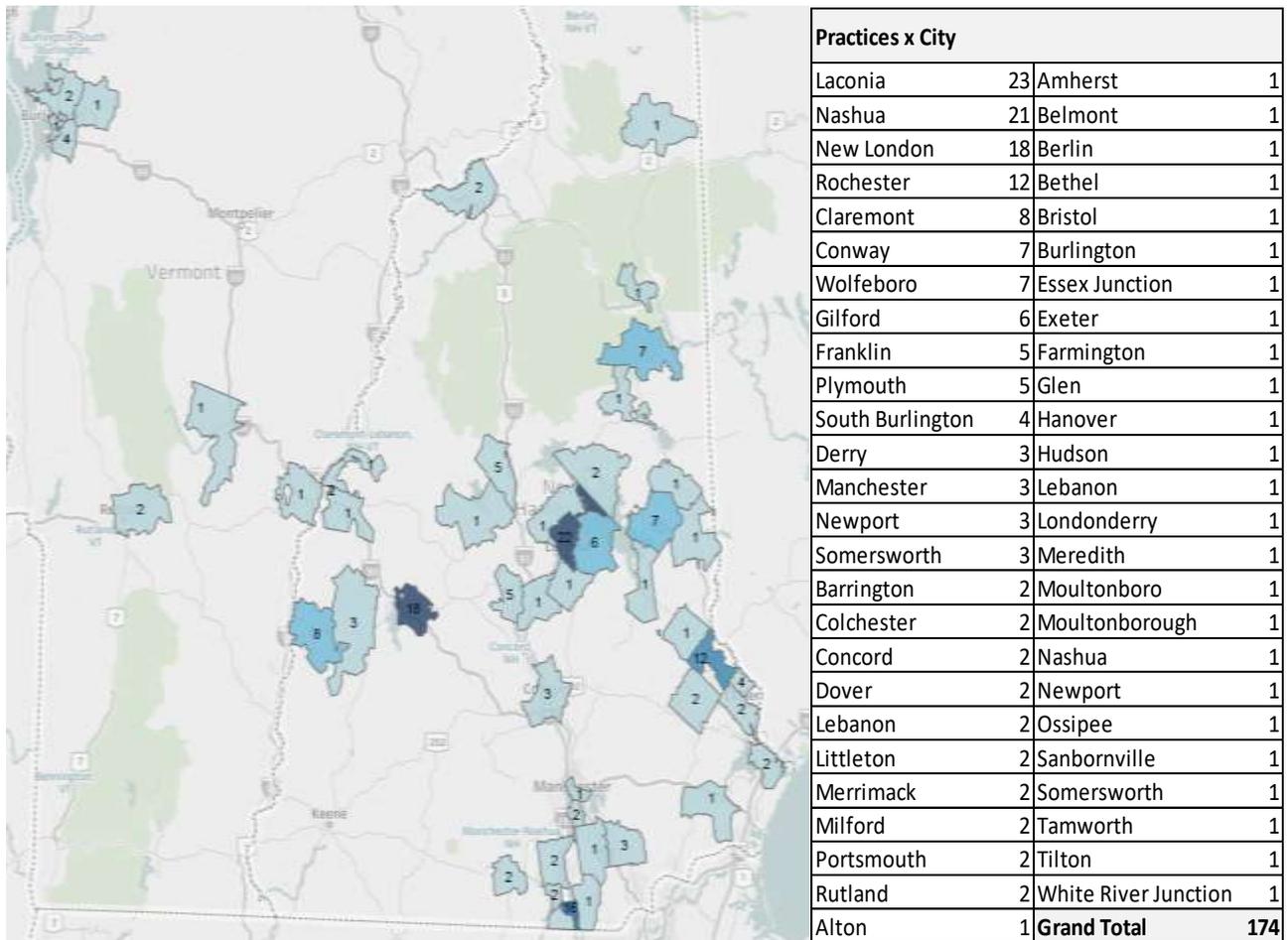
In preparation for payment incentives and penalties codified in federal statute and now regulation as MACRA/MIPS, Practice Transformation Networks (PTN) are peer-based learning networks designed to coach, mentor and assist providers in developing core competencies

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<sup>9</sup> Approved Demonstrations – Signed MOUs, CMS.gov, (Mar. 6, 2017 8:31 am), <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html>

specific to practice transformation. This approach allows provider practices to become actively engaged in the transformation and ensures collaboration among a broad community of practices that creates, promotes, and sustains learning and improvement across the health care system.<sup>10</sup> In New Hampshire, there are a total of 174 PTN enrolled practices (10% behavioral health, 34% primary care, and 56% specialty practices) and 849 PTN providers (25% behavioral health, 33% PCPs, and 42% specialists). Current PTN practice locations are detailed in the figure below.

Figure 3. PTN Practice Locations



1. Medicare Access and CHIP Reauthorization Act (MACRA) of 2015

“The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 made significant changes to Medicare payment including:

<sup>10</sup> Centers for Medicare and Medicaid Services. Transforming Clinical Practice Initiative. 2017. <https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/>

- Repealing the Medicare sustainable growth rate (SGR) formula
- Creating a new framework for quality care with two payment tracks:
  - Merit-based Incentive Payment System (MIPS)
  - Alternative Payment Models (APMs)
- Consolidating three existing quality reporting programs.<sup>11</sup>

Through this legislation, there are two tracks for payment that create predictable pay increases that focus on either improvement in outcome measures or adopting payment models that move away from fee for service.<sup>12</sup> While the program is slated to start in 2019, clinicians must submit data for 2017 and clinicians participating in the Merit-based Incentive Program System (MIPS) are able to choose from three options to satisfy the MIPS requirements.”<sup>13</sup>

## F. Other Models

### 1. Accountable Health Communities

The Accountable Health Communities (AHC) model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of beneficiaries’ impacts total health care costs, improves health, and quality of care. The AHC Model is based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs. Unmet health-related social needs, such as food insecurity and inadequate or unstable housing, may increase the risk of developing chronic conditions, reduce an individual’s ability to manage these conditions, increase health care costs, and lead to avoidable health care utilization.

This model will promote clinical-community collaboration through:

- Screening of community-dwelling beneficiaries to identify certain unmet health-related social needs;
- Referral of community-dwelling beneficiaries to increase awareness of community services;
- Provision of navigation services to assist high-risk community-dwelling beneficiaries with accessing community services; and

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<sup>11</sup> AAFP. FAQ on MACRA and Medicare Payment Reform. September 2016. <http://www.aafp.org/practice-management/payment/Medicare-payment/faq.html#macraimpact>

<sup>12</sup> American Hospital Association. MACRA: Implementing the Physician Quality Payment Program. 2016. <http://www.aha.org/advocacy-issues/physician/index.shtml>

<sup>13</sup> American Hospital Association. CMS to give clinicians more options to comply with MACRA quality program in 2017. September 2016. <http://news.aha.org/article/160908-cms-to-give-clinicians-more-options-to-comply-with-macra-quality-program-in-2017>

- Encouragement of alignment between clinical and community services to ensure that community services are available and responsive to the needs of community-dwelling beneficiaries.<sup>14</sup>

No Accountable Health Communities exist in New Hampshire.

## 2. Behavioral Health Homes

The ACA created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 of the Social Security Act. Health Home providers are to integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.<sup>15</sup> New Hampshire did not participate in this model. Massachusetts is developing its own variation on the Behavioral Health Home through its DSRIP waiver for the seriously mentally ill.

## 3. Behavioral Health Integration

In 2015, the New Hampshire Citizen's Health Initiative (NHCHI) launched the Behavioral Health Integration Learning Collaborative<sup>16</sup> in an effort to teach primary care practices, health systems, behavioral health providers, health care payers, and other stakeholders how to integrate behavioral health care into primary care to improve patient health and improve health outcomes using evidence-based practice.

The University of New Hampshire's Institute for Health Policy and Practice (IHPP) and NHCHI are helping providers integrate behavioral health into primary care. The learning collaborative is identifying and exploring challenges in payment for substance use disorder screening and treatment. The research, conducted in partnership with 60 organizations, is based on a philosophy of shared data and shared learning that emphasizes the importance of transparency across all stakeholder groups. Collaborative care models for integrated care are being explored and tested. Twenty-five to 30 percent of visits for primary medical care either originate from or have a significant related behavioral health component. Research also found that depression and anxiety with a co-occurring chronic medical condition increase costs dramatically

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<sup>14</sup> Centers for Medicare and Medicaid Services. Accountable Health Communities Model. 2017. <https://innovation.cms.gov/initiatives/ahcm/>

<sup>15</sup> Centers for Medicare and Medicaid Services. Medicaid Health Homes. 2017. <https://www.medicaid.gov/medicaid/ltss/health-homes/index.html>

<sup>16</sup> <https://www.citizenshealthinitiative.org/behavioral-health-integration-learning-collaborative>

## II. NH Commercial Alternative Payment Model and Plan Enhancement Examples

Below is a summary of information available regarding the payment reform or care management efforts of New Hampshire's commercial payers both in the fully-insured and self-funded markets. The Exhibits also include excerpts from the materials developed as part of the State's SIM 2 process (Exhibits A and B) and from the NHID's annual hearing on cost-drivers (Exhibits C and D).

### A. Anthem

#### 1. Anthem Enhanced Personal Care Program Model (EPMC)

Anthem's Enhanced Personal Care Program Model is a value-based, patient-centered care program and part of Anthem Togetherworks, their name for their provider collaboration work. The EPMC Model was designed based on pilot programs Anthem sponsored which focused on patient-centered care. The EPMC Model includes financial incentives and value-based compensation, but also provides support for making changes to the delivery system that drive better care. The payment, information and support Anthem offers a support changes for participating practices. Each program element supports these key elements of patient-centered care: expanded access, shared decision making, proactive health management, coordinated care delivery, adherence to evidence based guidelines and care planning built around the needs of the individual patient.<sup>17</sup>

#### 2. Bundled Payments: Specialty Care

Bundled payments, sometimes referred to as episodes of care payments, is a singled payment for all the services associated with a particular health episode. For example, a bundled payment could pay for the different components of a knee replacement from the replacement, operating room costs, etc. Bundled payments provide incentives to keep costs down through various addressing potential complication, encouraging collaboration, increasing efficiency and using the best evidence-based practices. Anthem has collaborated with outpatient specialty care and surgical care providers to develop a bundled payment for certain ambulatory surgical procedures. The program has been difficult to implement due to the underlying fee for service/claims based framework of Anthem's claims adjudication system.

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[https://www.anthem.com/wps/portal/ca/provider?content\\_path=provider/fo/so/to/pw\\_e191020.htm&label=Enhanced%20Personal%20Health%20Care%20Program](https://www.anthem.com/wps/portal/ca/provider?content_path=provider/fo/so/to/pw_e191020.htm&label=Enhanced%20Personal%20Health%20Care%20Program)

### 3. Live Health Online Summary

Live Health Online is an online program introduced by Anthem Blue Cross Blue Shield (Anthem). The program is a telehealth solution for Anthem members and non-members who need non-emergency medical care when their own primary care physician is not available. It is a solution for anyone who cannot get to a doctor's office when the need arises.<sup>18</sup>

Live Health Online is basically a virtual doctor's office where a user can talk to a doctor 24 hours, 7 days a week, depending on which state you are located in, from any location where you have access to an internet connection. The system uses two-way video chat communication between you and a U.S. board-certified doctor via your computer or mobile device. Your computer or mobile device must have camera attached, or built into the device in order to communicate via video chat. During your virtual visit, a doctor may assess your condition, answer your questions, and even provide you with a prescription if needed.<sup>19</sup>

Typically, the doctors on Live Health Online are there to help with issues such as cold, flu, allergies, sinus infections, bronchitis, diarrhea, pinkeye, urinary tract infections, and rashes.<sup>20</sup> However there is also a Psychology Health Online that will put you in contact with a licensed therapist or psychologist. While, you can see a doctor immediately for help with an illness such as one listed above, a psychology or therapy visit requires an appointment first. You can make the appointment online with a particular therapist or psychologist of your choice.<sup>21</sup>

The costs of a Live Health Online service is typically \$49.00 and may be covered by a copay, depending on your insurance coverage.<sup>22</sup> The typical cost of a Psychology Health Online service is \$95.00 for a psychologist and \$80.00 for a therapist.<sup>23</sup> Before any virtual visit with a doctor, you will be notified of what the service will cost. You do not need Anthem insurance coverage to use this service, however if you do not have Anthem, you will need to pay for your visit via a credit card and then submit your claim to your health insurance plan to determine whether you will be reimbursed for your visit.<sup>24</sup>

Signing up for this service is free. Live Health Online uses a simple sign-up questionnaire which includes, your name, email address, and creating a login password. You must then provide your location, age, gender, and health insurance information, if applicable. Once you are signed-up

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<sup>18</sup> Business Wire, *Cleveland Clinic Doctors and Practitioners Now Available via Live Health Online*, Business Wire, June 14, 2016, <http://www.businesswire.com/news/home/20160614006073/en/Cleveland-Clinic-Doctors-Practitioners-LiveHealth-Online>

<sup>19</sup> *About*, Live Health Online, (Mar. 4, 2017 3:38pm), <https://www.livehealthonline.com/about>

<sup>20</sup> *Id.*

<sup>21</sup> *Live Health Online Psychology*, Live Health Online, (Mar. 4, 2017 3:40pm), <https://www.livehealthonline.com/psychology>

<sup>22</sup> *How It Works*, Live Health Online, (Mar. 4, 2017 3:41pm), <https://www.livehealthonline.com/how-it-works>

<sup>23</sup> *Supra* note 4

<sup>24</sup> *Supra* note 5

you will be able to find doctors in your area and in some cases, connect right away. As noted above, you will be able to find a psychologist or therapist as well, but must schedule an appointment first.<sup>25</sup>

## B. CIGNA

### 1. CIGNA Collaborative Care (previously called CIGNA Accountable Care)

Cigna Collaborative Care is Cigna's approach to achieving the same population health goals as ACOs: better health, affordability and experience. A Cigna Collaborative Care arrangement with a large physician group is a collaboration between Cigna and a physician practice that's responsible and accountable for the population it serves. The physician group must have a substantial primary care component, which can take any of the following forms:

- A large primary care practice (examples: ProHealth Physicians in Connecticut, Medical Clinic of North Texas in the Dallas/Ft. Worth Metroplex)
- A multi-specialty group (example: Holston Medical Group in northeastern Tennessee)
- A fully integrated delivery system, including doctors and facilities (example: Piedmont Physicians Group in Atlanta)
- A Physician Hospital Organization (example: Health Choice in Memphis)
- An Independent Physician Association/Independent Practice Association (example: Renaissance Physician Organization in Houston)

Regardless of practice type, the medical group must be willing to accept responsibility and accountability for achieving improved health, affordability and patient experience. The medical group is rewarded through a pay for value structure if it meets targets for improving quality and lowering medical costs.

A key component to these programs is the care coordinator – typically a registered nurse employed by the medical group who works with individuals, especially people with chronic conditions, to ensure they get the screenings and follow-up care they need and have access to educational materials that can help them manage their health. Care coordinators work closely with Cigna's case managers and help their patients access Cigna's clinical support programs, such as chronic condition management (diabetes, heart disease) and lifestyle management programs (weight, stress, tobacco).<sup>26</sup>

Cigna has arrangements with the following large physician groups in NH:

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<sup>25</sup> [Sign-up](https://startlivehealthonline.com/landing.htm?_ga=1.173043755.965221327.1487876783), Live Health Online, (Mar. 4, 2017 3:45pm), [https://startlivehealthonline.com/landing.htm?\\_ga=1.173043755.965221327.1487876783](https://startlivehealthonline.com/landing.htm?_ga=1.173043755.965221327.1487876783)

<sup>26</sup> <https://www.cigna.com/newsroom/knowledge-center/aco/>

- Core Physicians<sup>27</sup>
- Dartmouth-Hitchcock Clinic<sup>28</sup>
- Derry Medical Center<sup>29</sup>
- Elliot Phrygian Network<sup>30</sup>
- Granite Healthcare Network<sup>31</sup>

### C. Harvard Pilgrim Health Care

#### 1. Benevera Health (35,000 lives attributed to hospital partners)

Benevera Health is a partnership between Harvard Pilgrim Health Care and four hospital systems in NH - Dartmouth-Hitchcock, Elliot Health System, Frisbie Memorial Hospital, and St. Joseph Hospital. The partnership was created to break down legacy barriers between insurers, hospitals and caregivers in an effort to enhance the health and health care of NH residents. Through the partnership, the health care insurer, hospitals, and providers work together to reduce costs. In particular, Benevera Health uses data, advanced health management techniques, proactive interventions, and professional guidance to improve patient care and attempt to slow the rising costs of health care. There is also a greater focus on population health where the partnership seeks to use the data from the community to help clinicians improve population health. With this design and focus, the company refers to itself as a “population health improvement company.”<sup>32</sup>

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<sup>27</sup> [https://www.cigna.com/newsroom/news-releases/2014/core-physicians-and-cigna-start-accountable-care-program-to-improve-health-and-lower-costs-in-southeastern-new-hampshire?WT.z\\_nav=newsroom%252Fknowledge-center%252Faco%252Fcigna-cac-partnerships%253Baccordion%253BNew%2520Hampshire%253BPress%2520release](https://www.cigna.com/newsroom/news-releases/2014/core-physicians-and-cigna-start-accountable-care-program-to-improve-health-and-lower-costs-in-southeastern-new-hampshire?WT.z_nav=newsroom%252Fknowledge-center%252Faco%252Fcigna-cac-partnerships%253Baccordion%253BNew%2520Hampshire%253BPress%2520release)

<sup>28</sup> [https://www.cigna.com/newsroom/news-releases/2008/cigna-and-dartmouth-hitchcock-launch-patient-centered-medical-home-program-to-provide-better-care-coordination?WT.z\\_nav=newsroom%252Fknowledge-center%252Faco%252Fcigna-cac-partnerships%253Baccordion%253BNew%2520Hampshire%253BPress%2520release](https://www.cigna.com/newsroom/news-releases/2008/cigna-and-dartmouth-hitchcock-launch-patient-centered-medical-home-program-to-provide-better-care-coordination?WT.z_nav=newsroom%252Fknowledge-center%252Faco%252Fcigna-cac-partnerships%253Baccordion%253BNew%2520Hampshire%253BPress%2520release)

<sup>29</sup> [https://www.cigna.com/newsroom/news-releases/2013/cigna-continues-expansion-of-collaborative-accountable-care-to-improve-health-outcomes-and-lower-costs?WT.z\\_nav=newsroom%252Fknowledge-center%252Faco%252Fcigna-cac-partnerships%253Baccordion%253BNew%2520Hampshire%253BPress%2520release](https://www.cigna.com/newsroom/news-releases/2013/cigna-continues-expansion-of-collaborative-accountable-care-to-improve-health-outcomes-and-lower-costs?WT.z_nav=newsroom%252Fknowledge-center%252Faco%252Fcigna-cac-partnerships%253Baccordion%253BNew%2520Hampshire%253BPress%2520release)

<sup>30</sup> [https://www.cigna.com/newsroom/news-releases/2015/elliott-physician-network-collaborates-with-cigna-to-improve-health-and-lower-costs-in-southern-new-hampshire?WT.z\\_nav=newsroom%252Fknowledge-center%252Faco%252Fcigna-cac-partnerships%253Baccordion%253BNew%2520Hampshire%253BPress%2520release](https://www.cigna.com/newsroom/news-releases/2015/elliott-physician-network-collaborates-with-cigna-to-improve-health-and-lower-costs-in-southern-new-hampshire?WT.z_nav=newsroom%252Fknowledge-center%252Faco%252Fcigna-cac-partnerships%253Baccordion%253BNew%2520Hampshire%253BPress%2520release)

<sup>31</sup> [https://www.cigna.com/newsroom/news-releases/2012/granite-healthcare-network-and-cigna-launch-largest-accountable-care-program-in-new-hampshire-linking-doctors-hospitals-and-health-plan?WT.z\\_nav=newsroom%252Fknowledge-center%252Faco%252Fcigna-cac-partnerships%253Baccordion%253BNew%2520Hampshire%253BPress%2520release](https://www.cigna.com/newsroom/news-releases/2012/granite-healthcare-network-and-cigna-launch-largest-accountable-care-program-in-new-hampshire-linking-doctors-hospitals-and-health-plan?WT.z_nav=newsroom%252Fknowledge-center%252Faco%252Fcigna-cac-partnerships%253Baccordion%253BNew%2520Hampshire%253BPress%2520release)

<sup>32</sup> <http://www.beneverahealth.com/about>

#### D. Aetna Accountable Care Solutions

Although Aetna does provide Accountable Care Solutions (ACS) to neighboring states such as Maine and Connecticut, no partnerships exist in New Hampshire with Aetna.<sup>33</sup>

#### E. Tufts Freedom Plan

“The Tufts Freedom Plan is a joint venture between Granite Health (comprised of Catholic Medical Center, Concord Hospital, LRG Healthcare, Southern New Hampshire Health and Wentworth Douglass Hospital) and Tufts Health Plan to jointly own an insurance company. Through the joint ownership the provider groups take on risk and potentially share in the cost savings of caring for patients in the network. The plan also seeks to provide the highest quality care at an affordable costs will sustaining a locally managed health system. With this mission in mind, the joint venture will use NH’s creativity to enhance value-based health care in the state. These initiatives further seek to provide, “comprehensive products...designed to drive economic incentives that change behavior while providing exceptional care management and an outstanding member experience.”<sup>34</sup>

#### F. Self-Insured Employer Efforts

##### 1. Wellness

##### i. Fitness Reimbursements

Fitness reimbursements are typically reimbursements for expenses related to gym, fitness/studio, health club memberships and fees. Employers determine which expenses are eligible for *reimbursement* under the outlined benefits of the employers’ insurance benefits.

##### ii. Health Risk Assessments

A Health Risk Assessment (HRA) is a health questionnaire used to assess a person’s health status. The information obtained in an HRA is used to provide individuals with feedback and, oftentimes, recommendations for behavior change to decrease health risk and increase quality of life.

##### iii. Flexible Spending Account

A Flexible Spending Account (FSA) also known as a flexible spending arrangement, is one of a number of tax-advantaged financial accounts that can be set up through a cafeteria plan of an employer in the United States. This plan lets you use pre-tax dollars to pay for eligible health care expenses for you, your spouse, and your eligible dependents.

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<sup>33</sup> <http://www.aetnaacs.com/>

<sup>34</sup> <https://thfp.com/about-us>

#### iv. Health Spending Account

A Health Spending Account (HSA) is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan (HDHP). The funds contributed to an account are not subject to federal income tax at the time of deposit.

#### v. Community Health Education Reimbursement Program

A Community Health Education Reimbursement Program (CHERP) reimburses expenses to an individual for specific community health education classes, as outlined in their employer sponsored insurance. Currently in New Hampshire, Anthem HMO and POS plans include CHERP and allow up to \$150 per calendar year per family the opportunity to get reimbursed for community health education classes, including:

- Smoking Cessation
- Nutrition Education
- Weight Management
- Stress Management
- Physical Activity
- Childbirth Education
- Parenting Education
- CPR/First Aid<sup>35</sup>

#### 2. Incentives for Savings and Payment related to Consumer Driven Health Plans (CDHPs)/High Deductible Plans (HDPs)

A high deductible plan (HDP) is a health insurance plan that has lower monthly premiums, but a larger amount that an individual has to pay out of pocket before the health insurance company starts to pay its share through co-pays and co-insurance. These HDPs are often connected to a health savings account, which is a tax-advantaged medical savings account that can be contributed to and withdrawn from for certain medical expenses. HDPs are intended to make health care consumers more sensitive to cost, which is intended to reduce the amount of health services an individual uses. While HDPs are not always suitable for all individuals, some populations can see larger cost savings from having a high deductible plan over a traditional health insurance premium. In NH there are HDPs available to residents through Anthem and Minute Man Health. Consumers with HDPs purchase health services and pay for them “out of pocket”.

Consumer Driven Health Plans (CDHPs) are insurance plans that allow members to use Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), or similar medical payment products to pay routine healthcare expenses directly, but a high-deductible health plan protects

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<sup>35</sup> [https://das.nh.gov/hr/health\\_benefits.html](https://das.nh.gov/hr/health_benefits.html)

them from catastrophic medical expenses. High-deductible policies cost less, but the user pays medical claims using a prefunded spending account, often with a debit card provided by a bank or insurance plan. If the balance on the account runs out, the member pays healthcare claims just like under a regular deductible. Members keep any unused balance or "rollover" at the end of the year to increase future balances or to invest for future expenses. CDHPs are subject to the provisions of the Affordable Care Act, which mandates that routine or health maintenance claims must be covered, with no cost-sharing (copays, co-insurance, or deductibles) to the patient.

i. Anthem Lumenos Consumer Driven Health Plan

Anthem offers high deductible CHDPs called Lumenos plans. Plan options include utilization of Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), and Health Incentive Accounts (HIAs).<sup>36</sup>

ii. Vitals SmartShopper

Vitals is technology company that built Vitals SmartShopper, an incentives and engagement program which provides cost, quality and healthcare access information on the web to its members. Members include consumers, health insurance plans and health system clients. Benefits of SmartShopper include:

- Toll-free call center concierge agent shopping
- 24x7 web self-service with quick and easy registration
- Mobile-enabled shopping
- Accurate, personalized search results for cost and quality
- Total cost for services as well as full member-out-of-pocket costs
- Helpful online member alerts and messaging
- Fully-customized, co-branded and powerful engagement campaigns
- Full incentive administration and member-level tax reporting<sup>37</sup>

iii. Cigna Choice Fund

Cigna offers a \$1,000-2,000 Choice Fund and HSA contribution plan.<sup>38</sup>

iv. Vivarae

Vivarae is a workplace wellness technology company that offers employers a web-based platform to develop, manage and analyze their workplace wellness solutions.<sup>39</sup>

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[https://www.anthem.com/wps/portal/ahpprovider?content\\_path=provider/mo/f3/s10/t0/pw\\_ad083996.htm&rotLevel=2&state=mo&label=Lumenos%20CDHP](https://www.anthem.com/wps/portal/ahpprovider?content_path=provider/mo/f3/s10/t0/pw_ad083996.htm&rotLevel=2&state=mo&label=Lumenos%20CDHP)

<sup>3737</sup> <https://www.vitalssmartshopper.com/About>

<sup>3838</sup> <https://www.cigna.com/iwov-resources/national-second-sale/docs/inventiv/combined-open-enrollment-customer-presentation.pdf>

### 3. Telehealth Options

#### i. LiveHealth Online

LiveHealth Online is administered by Anthem as part of its Third Party Administration series. A visit on-line costs \$49 or, if covered by plan, a co-pay.<sup>40</sup>

### III. New Hampshire Health Insurance Marketplace

Five insurance companies participated in the New Hampshire marketplace in 2016. These included:

- Ambetter from NH Health Families, offered by Celtic Insurance
- Anthem Blue Cross Blue Shield of New Hampshire
- Community Health Options (MCHO)
- Harvard Pilgrim Health Care of New England
- Minuteman Health

Through these five companies, a total of 62 plans (32 individual and 30 small group) were offered in the state.<sup>41</sup>

### IV. Medicaid Other States

#### A. Maine Medicaid Payment Reform

In 2011, Maine announced its intention to pursue a Value-Based Purchasing (VBP) strategy in order to improve the quality and cost of care for its MaineCare (Medicaid) members. In 2013, Maine received a three year \$33 Million grant from the Centers for Medicare and Medicaid Services to help achieve its goal to improve population health, patient experience, and lower the cost of care by 2016. As of 2017, Maine has four VBPs: Health Homes, Behavioral Health Homes, MaineCare Accountable Communities Initiative, and State Innovations Model Initiative.<sup>42</sup>

#### 1. Health Homes - Maine

Health Homes are a partnership between an enhanced Health Home primary care practice (HHP) and one of ten Community Care Teams (CCTs) around the state. Both partners receive a per member, per patient, payment for Health Homes services they provide to MaineCare members who have chronic conditions or one chronic condition and are at a risk for another.

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<sup>39</sup><http://viverae.com/>

<sup>40</sup><https://www.livehealthonline.com/>

<sup>41</sup><https://www.nh.gov/insurance/consumers/documents/2017-marketplace-health-insurance-networks-ppt.pdf>

<sup>42</sup> Valued-Based Purchasing (VBP) Strategy, MaineCare Services, (Mar. 2, 2017 1:46 pm), <http://www.maine.gov/dhhs/oms/vbp/>

Services include care coordination, case management, individual and family support, and health promotion/education. Enrollment in Health Homes is optional.<sup>43</sup>

For more information on Health Homes, including provider requirements, member eligibility, covered and non-covered services, reporting requirements, and reimbursements, see Section 91 of the MaineCare Benefits Manual: <http://www.maine.gov/dhhs/oms/vbp/health-homes/index.html>.

It is important to note that in 2014, the University of Southern Maine, Muskie School of Public service, issued a report commissioned by MaineCare, to evaluate their Health Homes initiative. This report notes that MaineCare members enrolled in Health Homes reported receiving a higher quality of care than those not enrolled, however, they also reported higher costs for services expected to be lowered by Health Homes initiative, despite receiving lower overall costs. The entire report may be accessed below:

[http://www.maine.gov/dhhs/oms/pdfs\\_doc/vbp/HH/Stage%20A/HHReport\\_Yr1\\_Stage%20A\\_FINAL%20\(2\).pdf](http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/HH/Stage%20A/HHReport_Yr1_Stage%20A_FINAL%20(2).pdf)

## 2. Behavioral Health Homes

Behavioral Health Homes are a partnership between a licensed community mental health provider and one or more Health Home practices to manage the physical and behavioral health needs of eligible adults and children. Each partner receives a per member, per month, payment for Health Home services they provide to MaineCare members. Behavioral Health Homes build on existing care coordination and behavioral health expertise of community mental health providers. Enrollment in Behavioral Health Homes is optional.<sup>44</sup>

For more information on Behavioral Health Homes, including provider requirements, member eligibility, policies and procedures for member identification and enrollment, covered and non-covered services, reporting requirements, documentation and confidentiality, and reimbursement, see Section 92 of the MaineCare Benefits Manual:

<http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s092.docx>

## 3. Accountable Communities Initiative - Maine

Accountable Communities Initiative is MaineCare's version of an ACO which is comprised of a group of providers who share in savings of an assigned population, with the amount of shared savings tied to the ACO's score on a range of quality measures. Quality measures include

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<sup>43</sup> [Health Homes for Members with Chronic Conditions \(Stage A\)](http://www.maine.gov/dhhs/oms/vbp/health-homes/index.html), MaineCare Services, (Mar. 2, 2017 1:56 pm), <http://www.maine.gov/dhhs/oms/vbp/health-homes/index.html>

<sup>44</sup> [Behavioral Health Homes \(Stage B\)](http://www.maine.gov/dhhs/oms/vbp/health-homes/stageb.html), MaineCare Services, (Mar. 2, 2017 2:16 pm), <http://www.maine.gov/dhhs/oms/vbp/health-homes/stageb.html>

patient experience (10%), preventative health (30%), care coordination/patient safety (30%), and at-risk populations (30%). Under this initiative, a lead entity representing a group of providers enters into a 3 year contract with Maine's Department of Health and Human Services to act as an ACO and provide services to MaineCare members.<sup>45</sup>

As of 2017, there are four ACOs under the Accountable Communities Initiative: Beacon Health, LLC, Community Care Partnership of Maine, LLC, Kennebec Region Health Alliance, and Maine Health ACO.

Each ACO must meet the following requirements:

- Representation by a Lead Entity,
- Inclusion of providers that directly deliver primary care services and Maine's Primary Care Case Management requirements,
- Inclusion of at least one provider of services under chronic conditions, developmental disabilities, and behavioral health,
- Have a relationship or policies to ensure coordination with all hospitals in the ACO's service area and with at least one Public Health Entity, and
- Inclusion of two MaineCare members in its Governance.<sup>46</sup>

There are two shared models for ACOs to choose from. The first model requires a minimum of 1,000 members. A maximum of 50% of the savings is shared based on quality performance, with a cap of 10% of benchmark Total Cost of Care. There is no downside risk in any of the three performance years. The second model requires a minimum of 2,000 members. A maximum of 60% of savings is shared based on quality performance, with a cap of 15% of benchmark Total Cost of Care. There is no downside risk in the first performance year, however, the ACO is liable for 40-60% of losses in years two and three, with a cap of 5% of benchmark Total Cost of Care in year two and 10% in year 3.<sup>47</sup>

#### 4. State Innovations Model (SIM) Initiative - Maine

SIM is the \$33 million grant from CMS in 2013. Over the past three years, SIM has facilitated partnerships among physical and behavioral health providers, public and private insurers, data and system analysts, purchasers, workforce developers, and Maine consumers. Due to SIM's

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<sup>45</sup> Accountable Communities Initiative, MaineCare Services, (Mar. 2, 2017 2:30 pm), <http://www.maine.gov/dhhs/oms/vbp/accountable.html>

<sup>46</sup> MaineCare Services, *MaineCare's Accountable Communities Initiative*, 6-8 (June 2015), available at [http://www.maine.gov/dhhs/oms/pdfs\\_doc/vbp/AC/2015%20AC%20Pres%20for%20VBP%20Site.pdf](http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/AC/2015%20AC%20Pres%20for%20VBP%20Site.pdf)

<sup>47</sup> *Id.* at 4.

work, Maine has received a No-Cost Extension to continue the work, with a narrower focus on preventing diabetes and avoidable hospital readmissions, for an additional year.<sup>48</sup>

The main activities for the remaining year of SIM are:

- Behavioral Health and Health Information Technology: Providing for the alignment of practice workflow discussions with real use of data, and assuring that the behavioral health community continues prioritizing coordination of care for the high-cost, high-need patients they serve.
- Predictive Analytics: Providing DHHS with awareness of the MaineCare members who are likely to become the highest service utilizers and those with increasing risk scores, as well as enabling proactive care management and resulting in cost avoidance for these members.
- Workforce Development: Maintaining specialized curriculums and informational resources for Health Home coordinators, peers, and families as well as a targeted effort to highlight preventative diabetes care, identifying pain in individuals with diabetes and an intellectual or developmental disability, and strategies to manage diabetes in patients with intellectual or developmental disabilities.
- Diabetes Prevention: Expansion of the National Diabetes Prevention Program dashboard.
- Data Focused Learning Collaborative: Continuation of training to Health Homes and Behavioral Health Homes to improve case based on effective data and the implementation of a continuous improvement process.
- Accountable Communities: Continued provision of services requiring ongoing support for the analytics necessary to calculate shared savings.<sup>49</sup>

## B. Massachusetts Payment Reform

In 2016, the MassHealth program was awarded \$1.8 billion dollars over five years by the Center for Medicare and Medicaid Services. This grant is an extension of the MassHealth program which was set to end on June 30, 2017. Terms of the grant include the requirement that the State use the funds to implement three types of healthcare reform initiatives that support value-based care delivery, including enhanced care coordination, inclusion of behavioral health and long-term services and supports in delivery, and ACO development.<sup>50</sup> In = 2017, the ACO

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<sup>48</sup> SIM – Year Four – 2017, Maine State Innovation Model, (Mar. 2, 2017 3:30 pm), <http://www.maine.gov/dhhs/sim/>

<sup>49</sup> *Id.*

<sup>50</sup> Jacqueline Belliveau ED., *CMS Grants 1.8B to MA Value-Based ACO Implementation Program*, Value-Based Care News, November 9, 2016, <http://revcycleintelligence.com/news/cms-grants-1.8b-to-ma-value-based-aco-implementation-program>

pilot program launched, transiting MassHealth from the current fee-for-service care model toward accountable care and population-based payments.<sup>51</sup>

There are three models of ACOs that providers may choose to form: Accountable Care Partnership Plans, Primary Care ACOs, and MCO-Administered ACOs.<sup>52</sup>

#### 1. Accountable Care Partnership Plan – MA

An Accountable Care Partnership Plan is an ACO that partners with a single managed care organization (MCO). The ACO is comprised of an exclusive group of primary care physicians (PCPs), from whom all members receive their primary care. The ACO communicates the services it offers directly to its members as well as the ways in which the members may access those services. There is no specified geographic region for this ACO, as it has the ability to define its own services areas, provided that these service areas receive MassHealth approval and the service areas meet network adequacy.<sup>53</sup>

Accountable Care Partnership Plans are financially accountable under a prospective payment and is responsible for negotiating rates with providers and paying providers' claims for services. Therefore, it is accountable for both unit cost/provider rates as well as utilization.<sup>54</sup>

#### 1. Primary Care ACOs - MA

Primary Care ACOs contract directly with MassHealth and are comprised of an exclusive group of participating primary care clinicians (PCCs) from whom all members of the ACO will receive their primary care. Members are also automatically enrolled in MassHealth's behavioral health plan.<sup>55</sup>

Primary Care ACOs are financially accountable to a price-normalized Total Cost of Care (TCOC) Benchmark compared to the Primary Care ACO's price-normalized TCOC Performance. Therefore it is primarily accountable for utilization, not differences in provider fee schedules.<sup>56</sup>

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<sup>51</sup> Mass Gov., *Baker-Polito Administration, Centers for Medicare and Medicaid Services Announce Five Year, \$52.4 Billion Deal for MassHealth Restructuring*, Mass Gov. Press Releases, November 4, 2016, <http://www.mass.gov/governor/press-office/press-releases/fy2017/five-year-deal-for-masshealth-restructuring-announced.html>

<sup>52</sup> *Id.*

<sup>53</sup> *MassHealth Accountable Care Organization (ACO) Models: Questions and Answers*, 3, (September 2016), available at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/aco-models-questions-and-answers.pdf>

<sup>54</sup> *EOHHS ACO Rate and Benchmark Setting Methodology for The Request for Responses for Accountable Care Organizations*, 1, (December 2016), available at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/170208-summary-pricing-methodology-aco-and-mco.pdf>

<sup>55</sup> *Supra* note 4, at 3-4

<sup>56</sup> *Supra* note 5

## 2. MCO-Administered ACOs - MA

MCO-Administered ACOs are part of the primary care provider network(s) for one or more MassHealth MCO(s). It may contract with multiple MCOs, or contract with multiple MCO-Administered ACOs as part of its network. Each ACO has an exclusive group of participating PCPs from whom members receive their care.<sup>57</sup>

MCO-Administered ACOs are financially accountable to a priced-normalized TCOC Benchmark. The actual costs incurred by the MCO-Administered ACO's Contracting MCO may vary based on the rates that MCO negotiates with individual providers. These costs will be price-normalized, so that the MCO-Administered ACO's TCOC Benchmark and TCOC Performance are compared on a price-normalized basis. Therefore it is primarily accountable for utilization, not differences in provider fee schedules.<sup>58</sup>

Each kind of ACO will also work with Community Partners (CPs) to meet the unique needs of members with complex behavioral health needs, and/or complex long-term services and supports needs.<sup>59</sup> ACOs will also offer members Flexible Services such as community transition services, home and community-based services to divert individuals from institutional placement, services to maintain a safe and healthy living environment, physical activity and nutrition, experience of violence support, or other goods and services.<sup>60</sup>

As of December 2016, there are six ACO pilot organizations:

- Boston Accountable Care Organization
- Children's Hospital Integrated Care Organization
- Community Care Cooperative
- Partners Care Connect
- Steward Medicaid Care Network Inc.
- UMass Memorial Healthcare Inc.<sup>61</sup>

MassHealth recipients are not required to enroll in an ACO. However, if they do, they will enjoy numerous benefits. Members will receive better integration and coordination of care as providers will be measured on their quality of care, including prevention and wellness,

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<sup>57</sup> *Supra* note 4, at 4

<sup>58</sup> *Supra*, note 5 at 1-2

<sup>59</sup> Jim Lloyd and Katherine Heflin, *Massachusetts' Medicaid ACO Makes a Unique Commitment to Addressing Social Determinants of Health*, CHCS Center for Health Care Strategies, Inc., December 19, 2016, <http://www.chcs.org/massachusetts-medicare-aco-makes-unique-commitment-addressing-social-determinants-health/>

<sup>60</sup> *Id.*

<sup>61</sup> Health and Human Services, *MassHealth Partners with Six Health Care Organizations to Improve Member Care*, Health and Human Services Newsroom, November 29, 2016, <http://www.mass.gov/eohhs/gov/newsroom/press-releases/eohhs/masshealth-partners-with-six-health-care-organizations.html>

managing chronic disease and avoidable utilization, and behavioral health and substance abuse treatment. Members will also have easier access to specialty care, and enjoy the benefit of lower copayments, and the ability for their ACO to waive requirements for special referrals.<sup>62</sup>

### C. Vermont Payment Reform

In October 2016, the Centers for Medicare and Medicaid Services (CMS) announced that beginning in January 2017, it would grant \$9.5 million in a start-up investment to assist Vermont providers with care coordination and bolster their collaboration with community-based providers. CMS also approved a five-year expansion of Vermont's Medicaid demonstration, which enabled Medicaid to be a full partner in Vermont's All-Payer ACO Models.<sup>63</sup>

The \$9.5 million start-up investment will be specifically used as a based to fund care coordination, connections to community-based providers, and practice transformation in order to help Vermont achieve the statewide health outcomes, financial, and ACO scale targets during 2018-2022. During 2018-2022 the Vermont Medicare ACO Initiative will become available for eligible ACOs in Vermont. Additionally, Vermont will be accountable to statewide health outcomes, financial, and ACO scale targets.<sup>64</sup>

The focus of the ACO model will be to achieve Health Outcomes and Quality of Care targets in four areas: substance use disorder, suicides, chronic conditions, and access to care. There are three categories of measure for the four priority areas:

- Population-level Health Outcomes Measures and Targets: Statewide measures and targets related to the health of the population consistent with the priority areas, regardless of whether the population seeks care at the providers in the ACO.
- Health Care Delivery System Measures and Target: Measures and targets primarily related to the performance of care delivered by the ACO.
- Process Milestones: Milestones measurable during the early years of the Model that would support achievement on the population-level and health care delivery system measures and targets.<sup>65</sup>

A major goal of Vermont's ACO model is for ACOs to eventually encompass all of Vermont's 16 hospitals, 1,933 doctors and at least 70% of the population, including workers insured through

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<sup>62</sup> *Id.*

<sup>63</sup> CMS Press, *Vermont All-Payer ACO Model*, CMS Media Release Database, October 26, 2016, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-26.html>

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

their jobs and people covered under Medicare and Medicaid.<sup>66</sup> Other goals include limiting health care cost growth to no more than 3.5 percent in aggregate across all payers, increase access to primary care, and improve health outcomes for Vermonters.<sup>67</sup>

As of 2017, there are three ACOs in Vermont: OneCare Vermont, Community Health Accountable Care, and Accountable Care Coalition of the Green Mountains. The most notable ACO is OneCare Vermont because of the support it will begin to receive from the state government in 2017.

In February 2017, Al Gobeille, Vermont's secretary of Human Services, and Governor Phil Scott announced the formal launch of the ACO pilot phase. 30,000 of the state's Medicaid patients will get care, under a set budget, through OneCare Vermont.<sup>68</sup> OneCare Vermont is a state-wide ACO working with Medicare, Vermont Medicaid and the Commercial Exchange Shared Saving Programs. It comprises an extensive network of providers, including several of Vermont's hospitals, 2 New Hampshire hospitals, hundreds of primary and specialty care physicians and Advance Practice Providers, federally qualified health centers, and several rural health clinics, to coordinate the health care of approximately 95,000 combined Medicare, Medicaid and Commercial Exchange Vermont beneficiaries.<sup>69</sup>

In 2017, the State will give OneCare \$93 million, in monthly payments, for the care of the 30,000 Medicaid patients. This is \$3,100 per person. If OneCare spends more than \$93 million, the company will absorb the loss. If OneCare spends less than that amount, the company and the state share the savings. If the program is successful, OneCare will be expanded in 2018 to encompass the rest of the Medicaid population, Medicare beneficiaries and people who have insurance through private employers and on their own.<sup>70</sup>

#### 1. Vermont All Payer ACO Model<sup>71</sup>

The Vermont All-Payer Accountable Care Organization (ACO) Model is the Centers for Medicare and Medicaid Services' (CMS) new test of an alternative payment model in which the most significant payers throughout the entire state – Medicare, Medicaid, and commercial health care payers – incentivize health care value and quality, with a focus on health outcomes, under

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<sup>66</sup> Steven Findlay, *Liberal Vermont Tests the Waters on GOP Health Care Overhaul*, Kaiser Health News, February 27, 2017, [http://khn.org/news/liberal-vermont-tests-the-waters-on-gop-health-care-overhaul/?utm\\_campaign=KHN%3A+First+Edition&utm\\_source=hs\\_email&utm\\_medium=email&utm\\_content=43414641&hsenc=p2ANqtz-9OJnYQkZBWNBftgLFYHykzDpNOQSM-EILGh9efMGNTux\\_YsjyEXF-hwyqmiFKQSOLUieUYCKo6KuvoZ5CzSMfm\\_fNwyA&hsmi=43414641](http://khn.org/news/liberal-vermont-tests-the-waters-on-gop-health-care-overhaul/?utm_campaign=KHN%3A+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=43414641&hsenc=p2ANqtz-9OJnYQkZBWNBftgLFYHykzDpNOQSM-EILGh9efMGNTux_YsjyEXF-hwyqmiFKQSOLUieUYCKo6KuvoZ5CzSMfm_fNwyA&hsmi=43414641)

<sup>67</sup> Vermont All-Payer Accountable Care Organization Model Agreement Draft, 1, [http://gmcbboard.vermont.gov/sites/gmcb/files/documents/payment-reform/APM\\_Draft\\_Agreement\\_One\\_Page.pdf](http://gmcbboard.vermont.gov/sites/gmcb/files/documents/payment-reform/APM_Draft_Agreement_One_Page.pdf)

<sup>68</sup> *Supra* note 4

<sup>69</sup> OneCare Vermont, OneCare Vermont, (March 4, 2017 1:51pm), <https://onecarevt.org/>

<sup>70</sup> *Supra* note 4

<sup>71</sup> <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model/>

the same payment structure for the majority of providers throughout the state's care delivery system and transform health care for the entire state and its population.

The Green Mountain Care Board will be a key partner in administering the Vermont All-Payer ACO Model and provides additional information on the Model at its website: <http://gmcboard.vermont.gov/payment-reform/APM>.

The Vermont All-Payer ACO Model offers ACOs in Vermont the opportunity to participate in a Medicare ACO initiative tailored to the state, and will provide Vermont a funding opportunity announcement for \$9.5M in start-up investment to assist Vermont providers with care coordination and bolster their collaboration with community-based providers. Additionally, CMS also approved a five-year extension of Vermont's section 1115(a) Medicaid demonstration, which enables Medicaid to be a full partner in the Vermont All-Payer ACO Model. Under the Vermont All-Payer ACO Model, the state commits to achieving statewide health outcomes, financial, and ACO scale targets across all significant health care payers. CMS and Vermont expect to work closely together to achieve success.

CMS will make available to Vermont start-up funding of \$9.5M in 2017 to support care coordination and bolster collaboration between practices and community-based providers. Vermont is expected to direct at least a portion of any such funding towards its existing Blueprint for Health and Supports and Services at Home programs that perform such activities.

Participation by providers and other payers in the Vermont All-payer ACO Model will be voluntary, and CMS and Vermont expect to work closely together to achieve success. In particular, this Model and the section 1115(a) Medicaid demonstration extension will make a Vermont Medicare ACO Initiative and Medicaid ACO initiatives tailored to the state available to physicians and other clinicians in Vermont. The Vermont Medicare ACO Initiative is considered an Advanced Alternative Payment Model for the providers in the two-sided risk Medicare ACO portion of the model within CMS' Quality Payment Program, and physicians and other clinicians participating in the Vermont Medicare ACO Initiative may potentially qualify for the Advanced Alternative Payment Model bonus payments starting in performance year 2018. More information is available on the Quality Payment Program website.

#### D. Texas Managed Care: Developmentally Disabled

In September of 2014, the State of Texas started an initiative to expand one of their Medicaid programs. More specifically, as of September 2014, people over the age of 21 with intellectual and developmental disabilities began to receive acute care medical services through Texas' STAR+PLUS managed care program.<sup>72</sup> STAR+PLUS is designed to give its members health-care

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<sup>72</sup> Update: Transition to Managed Care, Texas Council for Developmental Disabilities, (Mar. 2, 2016 12:16pm), <http://tcdd.texas.gov/transition-managed-care-mar16-update/>

and long-term services and support through a medical plan of their choice, while also providing service coordination via a personalized health-care plan tailored to the patient's medical needs which is administered by a STAR+PLUS staff member to ensure communication between the member's doctors, specialists, and family.<sup>73</sup>

The expansion of STAR+PLUS to include people with developmental and intellectual disabilities requires a person who is covered by Medicaid and over the age of 21 to join STAR+PLUS if the person:

- Has an intellectual or developmental disability,
- Lives in a community-based intermediate care facility for individuals with an intellectual disability or related conditions, and
- Gets services through any of the following Department of Aging and Disability Services Intellectual and Developmental Disabilities waiver program:
  - Community Living Assistance and Support Services
  - Deaf Blind with Multiple Disabilities
  - Home and Community-based Services
  - Texas Home Living<sup>74</sup>

In contrast, the expansion of STAR+PLUS excludes persons who:

- Live in state supported living centers and receive both Medicaid and Medicare benefits,
- Are enrolled in the Program of All-Inclusive Care for the Elderly, or
- Are not covered by the full package of Medicaid benefits.<sup>75</sup>

While the expansion of STAR+PLUS requires people to be over the age of 21, there is a provision of the expansion that gives children and youth age 20 and younger, who do not have Medicare Part B, a choice to enroll in STAR+PLUS or get their basic medical services through traditional fee-for-service Medicaid.<sup>76</sup>

Since September 2014, it appears that the expansion of STAR+PLUS has been a success in providing quality managed care services to its members.<sup>77</sup>

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<sup>73</sup> STAR+PLUS Client Information, Texas Health and Human Services, (Mar. 2, 2016 12:14 pm), <https://hhs.texas.gov/services/health/medicaid-chip/programs/childrens-health-insurance-program-chip/chip-comparison-charts/star/report-cards/starplus>

<sup>74</sup> Answers to Common Questions, (May 2015), available at <http://legacy-hhsc.hhsc.state.tx.us/medicaid/managed-care/mmc/common-questions/idd-faq.pdf>

<sup>75</sup> *Id.*

<sup>76</sup> STAR+PLUS Expansion, Texas Health and Human Services, (Mar. 2, 2017 12:50 pm), <http://legacy-hhsc.hhsc.state.tx.us/medicaid/managed-care/mmc/starplus-expansion/adding-basic-health-services.shtml>

<sup>77</sup> Chapter 7: Medicaid Managed Care, 25-27, available at <https://hhs.texas.gov/sites/hhs/files/documents/services/health/medicaid-chip/book/chapter7.pdf>; Dennis Borel, Executive Director of Coalition of Texans with Disabilities, (December 2015), available at <https://www.legis.iowa.gov/docs/publications/IH/711167.pdf>

**Attachment A: Well Sense Health Plan's Annual Payment Reform Plan – Year 3 (Payment Reform.03) (7/1/15 – 6/30/16)**



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**Attachment B: Granite State Health Plan, New Hampshire Healthy Families, Payment Reform Plan, Version 3.3, May 1, 2016**



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## Attachment C: DSRIP Statewide APM Implementation Plan



DSRIP APM Roadmap  
Timeline Draft 2017-0

