New Hampshire Medicaid

Medicaid Symposium
May 31, 2017
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Agenda

- Overview of Medicaid
- Key Populations Served and Key Services Provided
- Delivery Systems
- Building Capacity for Transformation DSRIP Waiver
- Payment Reform

Overview – Office of Medicaid Services

- Publicly funded health insurance program for low-income people.
- New Hampshire Medicaid serves roughly 187,000 residents of the state as of March 31, 2017.
- Offering a Medicaid program is elective for states. All fifty states currently elect to offer a Medicaid program.
- Participating states must cover select groups of people and cover select groups of services that are known as **mandatory**.
- Participating states can elect coverage for additional services and populations that are known as **optional**.
- In return, the federal government pays a fixed percentage of the cost, known as FMAP. In New Hampshire it is always at least 50 percent of cost.

Key Populations Served in Medicaid Managed Care

- Children - approximately 90,000
- Pregnant women – approximately 2,100
- People living with Disabilities – approximately 20,000
- Senior Citizens – 8,600
- Low-income adults – approximately 11,300

Key Medicaid Services

Mandatory Services:

Inpatient Hospital Services
Outpatient Hospital Services
Family Planning Services
Rural Health Clinic Services
Physicians Services
X-Ray Services
Intermediate Care Facility Nursing Home
Dental Service (Children)
Laboratory (Pathology)
Home Health Services
I/P Hospital Swing Beds, SNF
Advanced RN Practitioner
Skilled Nursing Facility Nursing Home
I/P Hospital Swing Beds, ICF
Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Services for Persons < Age 21

Optional Services: Children $156.8M / Adults $417.1M Total Funds

Prescribed Drugs
Optometric Services Eyeglasses
Adult Medical Day Care
Mental Health Center Services
Wheelchair Van Services
Day Habilitation Center
Ambulance Services
Crisis Intervention Services
Physical Therapy
Podiatrist Services
Psychology Services
Audiology Services
Private Duty Nursing
Speech Therapy
Occupational Therapy
Home Based Therapy
Hospice
Personal Care Services
Outpatient Hospital, Mental Health
Inpatient Psychiatric Facility Services Under Age 22
Durable medical equipment and supplies
Nursing Facilities Services for Children w/Severe disabilities

Home & Community Based Care Waivers:

Acquired Brain Disorder
Developmentally Disabled
Choices for Independence
In Home Supports

Medicaid Optional Service Costs

	Child	Adult	Total
HCBS	$20,154,000	$289,886,000	$310,040,000
Prescription Drugs	$53,242,000	$68,501,000	$121,743,000
CMHC	$37,873,000	$39,978,400	$77,851,400
Dental	$23,780,000	$1,443,000	$25,223,000
Adult Day Care	$0	$1,185,000	$1,185,000
PT/OT/ST	$6,233,000	$2,527,000	$8,760,000
IP Psychiatric	$8,516,000	N/A	$8,516,000
Preventive Medicine	$5,842,000	$1,569,000	$7,411,000
Personal Care	$82,000	$6,959,000	$7,041,000
Opiod Treatment	$26,000	$3,790,000	$3,816,000
Prosthetics	$949,000	$806,000	$1,755,000
IP Drug and Alcohol Abuse	$32,000	$304,000	$336,000
Eyeglasses	$153,000	$134,000	$287,000
TOTAL	$156,882,000	$417,082,400	$573,964,400

Medicaid's Mandatory Eligibility Groups

Mandatory Eligibility Group	Income as a Percentage of Poverty	Annual Income Expressed in 2017 Dollars
Parent/caretaker	$670/month; less than 100% FPL	$8,080
Infants and Children	133% FPL	$16,040
Pregnant women	133% FPL	$21,599 (household of 2)
Low-income elders	75% FPL	$9,045
Low-income people with disabilities	75% FPL	$9,045
Extended Medicaid/1619 protection/Refugees	Varies	
Foster children	Varies	
Low-income Medicare beneficiary	100% FPL-135%FPL	$12,060-$16,281

Medicaid's Optional Eligibility Groups

Mandatory Eligibility Group	Income as a Percentage of Poverty	Annual income Expressed in 2017 Dollars
Low-income children	134-318% FPL	$16,041-$38,350
Pregnant women	134-196% FPL	$31,830 (household of 2)
Medically Needy	$591/month - less than 100% FPL	$7,092
Katie Beckett Children	300% of SSI	$26,460
Medicaid Employed Adults with Disabilities	450% FPL	$54,270
Breast and Cervical Cancer	250% FPL	$30,150
Family Planning Only	196% FPL	$23,637
NHHPP – expansion adults	138% FPL	$16,642

Medicaid Caseload Report

New Hampshire Medicaid Point in Time Enrollment at End of Month, 9/2013 - 3/2017

Eligibility Group	3/31/16	4/30/16	5/31/16	6/30/16	7/31/16	8/31/16	9/30/16	10/31/16	11/30/16	12/31/16	1/31/17	2/28/17	3/31/17	Current Month vs. 06/30/16	
1a. Low-Income Children - Non-CHIP (Age 0-18)	77,624	77,056	76,756	76,771	76,154	76,076	76,425	76,010	75,647	75,408	75,125	74,910	74,977	-2.3%	-1,794
1b. Low-Income Children - CHIP (Age 0-18)	13,652	13,778	13,788	13,713	13,626	13,618	13,821	13,920	14,159	14,351	14,306	14,350	14,199	3.5%	486
2. Children With Severe Disabilities (Age 0-18)	1,570	1,574	1,579	1,576	1,558	1,559	1,551	1,532	1,523	1,519	1,512	1,509	1,497	-5.0%	-79
3. Foster Care & Adoption Subsidy (Age 0-25)	2,215	2,216	2,231	2,204	2,182	2,174	2,191	2,206	2,213	2,218	2,266	2,283	2,299	4.3%	95
4. Low-Income Non-Disabled Adults (Age 19-64)	13,566	13,511	13,142	13,113	12,505	12,162	12,252	11,863	11,618	11,615	11,322	11,339	11,183	-14.7%	-1,930
5. Low-Income Pregnant Women (Age 19+)	2,284	2,280	2,225	2,173	2,157	2,162	2,124	2,120	2,101	2,064	2,142	2,117	2,169	-0.2%	-4
6. Adults With Disabilities (Age 19-64)	19,388	19,225	19,019	18,997	18,813	18,834	18,816	18,736	18,750	18,651	18,599	18,515	18,624	-2.0%	-373
7. Elderly & Elderly With Disabilities (Age 65+)	8,795	8,736	8,714	8,681	8,661	8,694	8,693	8,728	8,679	8,662	8,632	8,633	8,732	0.6%	51
8. BCCP (Age 19-64)	148	142	147	144	151	150	149	154	150	148	149	152	149	3.5%	5
Standard Medicaid	**139,242**	**138,518**	**137,601**	**137,372**	**135,807**	**135,429**	**136,022**	**135,269**	**134,840**	**134,636**	**134,053**	**133,808**	**133,829**	**-2.6%**	**-3,543**
Month Over Month Change in Standard Medicaid	0.3%	-0.5%	-0.7%	-0.2%	-1.1%	-0.3%	0.4%	-0.6%	-0.3%	-0.2%	-0.4%	-0.2%	0.0%		
NHHPP	**49,203**	**48,817**	**49,137**	**49,522**	**49,911**	**50,315**	**50,911**	**51,269**	**51,543**	**52,474**	**53,169**	**53,179**	**53,099**	**7.2%**	**3,577**
Month Over Month Change for NHHPP	0.1%	-0.8%	0.7%	0.8%	0.8%	0.8%	1.2%	0.7%	0.5%	1.8%	1.3%	0.0%	-0.2%		
Grand Total Full Medicaid	**188,445**	**187,335**	**186,738**	**186,894**	**185,718**	**185,744**	**186,933**	**186,538**	**186,383**	**187,110**	**187,222**	**186,987**	**186,928**	**0.0%**	**34**

Note: Excludes refugees and those who only have Medicare savings plan coverage.

Medicaid Caseload Report

Date	Standard Medicaid	NHHPP	Month Over Month Change in Standard Medicaid
3/31/2016	139,242	49,203	0.3%
4/30/2016	138,518	48,817	-0.5%
5/31/2016	137,601	49,137	-0.7%
6/30/2016	137,372	49,522	-0.2%
7/31/2016	135,807	49,911	-1.1%
8/31/2016	135,429	50,315	-0.3%
9/30/2016	136,022	50,911	0.4%
10/31/2016	135,269	51,269	-0.6%
11/30/2016	134,840	51,543	-0.3%
12/31/2016	134,636	52,474	-0.2%
1/31/2017	134,053	53,169	-0.4%
2/28/2017	133,808	53,179	-0.2%
3/31/2017	133,829	53,099	0.0%

Left axis: 0, 20,000, 40,000, 60,000, 80,000, 100,000, 120,000, 140,000, 160,000
Right axis: -5.0%, -3.0%, -1.0%, 1.0%, 3.0%, 5.0%

Children make up most of the Medicaid (Non-Expansion) participants in Medicaid Managed Care, SFY16

Children Using DCYF Services 2%

Children Using LTSS Services 2%

Elderly & Elderly With Disabilities 6%

Adult Disabled 14%

Low-Income Non-Disabled Adults 12%

Low Income Child 64%

But costs are concentrated among the elderly, disabled

Children Using DCYF Services 3%

Children Using LTSS Services 5%

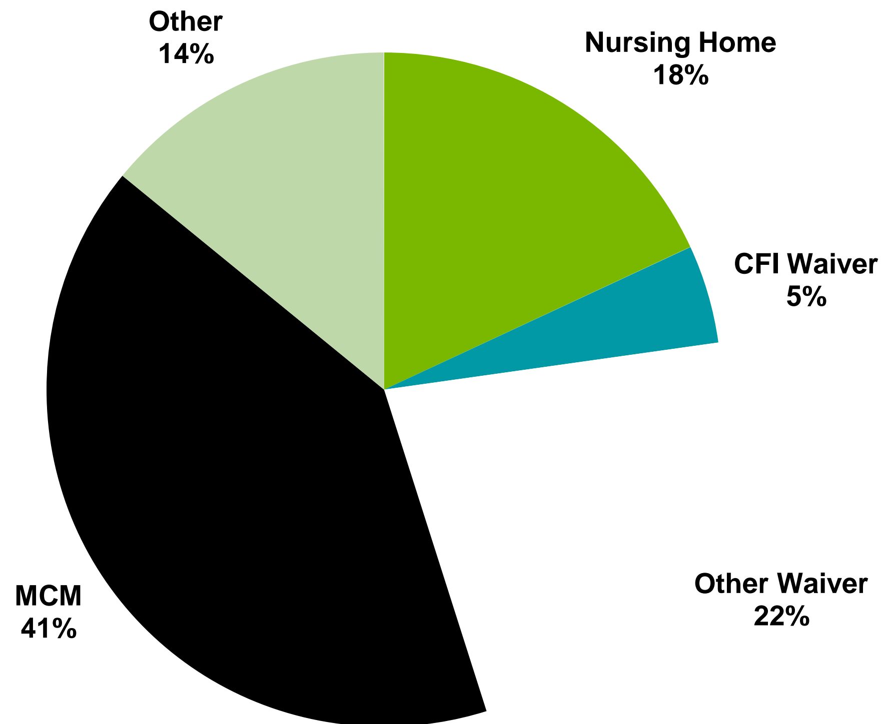
Low Income Child 20%

Elderly & Elderly With Disabilities 23%

Low-Income Non-Disabled Adults 8%

Adult Disabled 41%

In other words, long-term care services are largest single percentage of service costs in Medicaid



Medicaid Delivery Systems

Medicaid has three delivery systems:

- **Medicaid Managed Care**
- **Premium Assistance and NHHPP (Trust Fund)**
- **Fee-for-Service**

NH Medicaid (Non-Expansion) Provider Payments Made by DHHS Directly or by MCOs for Patient Services, SFY2016

Service Group	Millions
LTSS Waiver - DD	$233.6M
Nursing Facility - ICF	$196.9M
Prescription Drugs Pharmacy	$120.3M
Hospital Outpatient	$94.1M
Mental Health Center	$90.6M
Hospital Inpatient	$65.4M
LTSS Waiver - CFI	$55.3M
Physician, APRN, Clinic, Midwife, Ambulatory Surgical Center	$54.4M
Other	$29.1M
Medicaid to Schools	$28.9M
Dental	$26.2M
LTSS Waiver - ABD	$22.5M
Home Health and Private Duty Nursing	$18.0M
Durable Medical Equipment and Medical Supplies	$17.7M
DCYF - PNMI	$16.1M
Nursing Facility - SNF	$16.1M
Non-Emergency Transportation	$14.8M
Radiology and Pathology (Non-Hospital Billed)	$9.2M
DCYF - Other	$8.7M
Personal Care	$7.4M
Psychology and Substance Abuse	$6.7M
LTSS Waiver - IHS	$5.5M
Opioid Treatment Program	$4.1M
PT, OT, ST	$3.9M
Nursing Facility - IID ICF	$3.9M

Notes:
Contains MCO fee for service equivalent payment where MCO has a subcapitated arrangement for the service
Bulk financial transactions and one time payments excluded (e.g., MQIP, primary care rate increase, EHR incentive program) except for Hepatitis drug treatment paid to MCOs through a reimbursement mechanism when it was not in MCO rates, but paid by the MCO

Medicaid Managed Care

New Hampshire has a full-risk, capitated style of managed care

- 2 Managed Care Organizations (MCOS) WellSense and NH Healthy Families
- The state pays a per-member, per month rate to the vendors for each participant
- Approximately 133,200 Medicaid members receive short-term medical services through these two vendors

Premium Assistance & NHHPP – private public partnership

- Medicaid funds are used to purchase commercial insurance policies known as Qualified Health Plans (QHPs) certified for sale on the individual market.
- The commercial carriers in 2017 are Anthem, Harvard Pilgrim, Minuteman and Ambetter.
- Approximately 42,000 participants receive short-term medical services through these four carriers. The state, through fee-for-service, covers Medicaid required benefits not offered by the commercial plans, known as wrap benefits, such as limited dental and vision and transportation services.
- Another 6,000 members are medically frail and are excluded from the Premium Assistance Demonstration. They are served through the Medicaid managed care system. 3,000 more are in fee-for-service while they select.

NHHPP - April 21, 2017 Enrollment

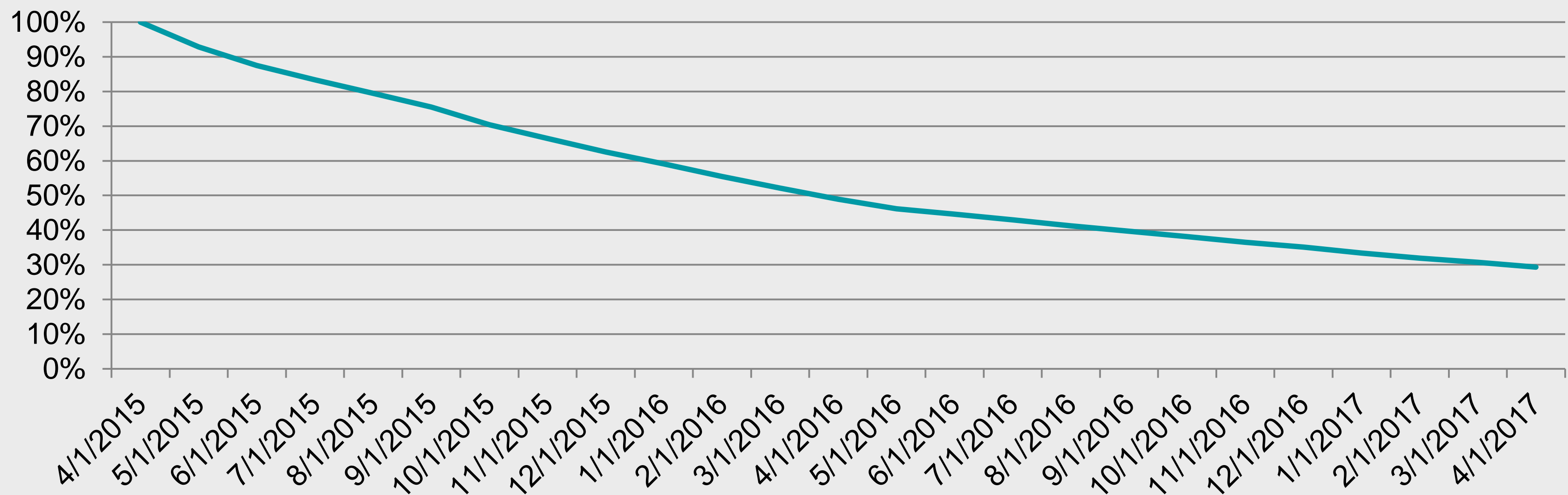
Health Plan Enrollment: February 2017	
QHP Enrollment	
• Ambetter	17,302
• Anthem	10,350
• Harvard Pilgrim	11,732
• Minuteman Health	3,453
MCO Enrollment	
• Well Sense	3,883
• NHHF	2,800
Health Insurance Premium Program HIPP	130
Fee For Service	2,455
Total	**52,105**

NHHPP - Length of Enrollment

Examined Most Recent 24 month period

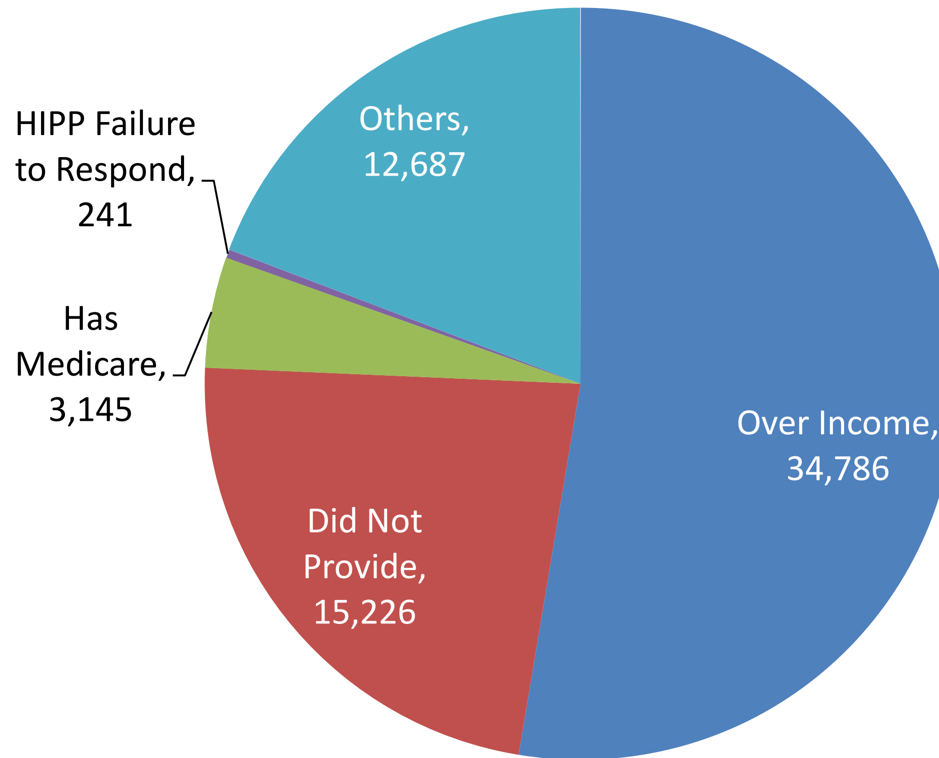
38,625 enrollees as of 4/1/15

29% (11,315) were covered by NHHPP for all 24 months



Source: Data based on 4/1/15-4/1/17 data extracted from the NH MMIS

Income being too High is Top Documented Reason Clients Disenrolled from NHHPP in November, 2016



Source: New Heights data as of 11/18/2016

Working Draft

Unique NHHPP Members Using Any SUD Service

Quarter	Unique Members
2014Q3	584
2014Q4	1,314
2015Q1	2,025
2015Q2	2,663
2015Q3	2,929
2015Q4	3,190
2016Q1	3,221
2016Q2	3,580
2016Q3	3,965

Data as of January 2017;
Data subject to change

NHHPP Month-Over-Month Enrollment Change in 2017

January to April 2017 Average:

- Lost NHHPP Coverage: 6.7% per month
  (3,600 average January - March 2017)
  - Average of 440 (12%) of those left NHHPP to other Medicaid coverage category
- Gained NHHPP Coverage: 6.9% per month
  (3,700 average January - March 2017)
  - Average of 670 (18%) of those came from other Medicaid coverage category to NHHPP

Source: Data based on 1/1/17, 2/1/17, 3/1/17, and 4/1/17 data extracted from the NH MMIS

Fee-for-Service

- Medicaid's legacy reimbursement system. For every Medicaid covered service, Medicaid pays a fee.
- Provides dental services to children in Medicaid.
- Provides wrap benefits for Premium Assistance enrollees and all Medicaid services to members during their selection windows.
- Provides Long-term services and supports to roughly 10,000 participants in 4 waivers.
- Provides short-term medical service coverage to roughly 1,000 participants excluded from the other delivery systems, who are:
  - Family Planning Only participants;
  - Spend Down participants
  - Participants who receive Veterans Benefits

New Hampshire Medicaid Has Seven Medicaid Waivers

- **1 waiver provides legal authority to mandate enrollment for managed care waiver under the 1915(b) authority**
  - Two-year (or five-year, if serving dual eligibles), renewable waiver authority for mandatory enrollment in managed care on a statewide basis or in limited geographic areas.
- **4 waivers are Home and Community Based Care waivers under the 1915(c) authority**
  - Renewable waiver authority that allows states to provide long-term care services delivered in community settings as an alternative to institutional settings. The state must select the specific target population and/or sub-population the waiver will serve.

Developmentally Disabled Waiver

In-Home Supports Waiver,

Acquired Brain Disorder Waiver

Choices for Independence Waiver

Medicaid Waivers (cont.)

- **2 waivers are Research and Demonstration waivers under the Section 1115(a) authority**
  - Broad waiver authority at the discretion of the Secretary to approve projects that test policy innovations likely to further the objectives of the Medicaid program. Permits states to provide the demonstration population(s) with different health benefits, or have different service limitations than are specified in the state plan. Granted for up to 5 years, and then must be renewed.
  - **Premium Assistance Demonstration Waiver**
  - **Building Capacity for Transformation DSRIP Waiver**

Implementation of Integrated Delivery Networks

- IDN applications were due May 31, 2016
- Detailed DSRIP project plans were due by October 31, 2016
- Distribution of project funds was targeted for December 31, 2016

Implementation Timeline

Date	Event
Jan-April 2016	State establishes IDN guidelines and a menu of IDN project options
April 4, 2016	Potential IDNs submit non-binding letters of Intent
May 31, 2016	IDNs submit Applications to State
June 30, 2016	State issued decisions on approved IDNs
Oct 31, 2016	IDNs submit Project Plan Applications to State
Dec 31, 2016	State issues decisions on IDN Project Plans
2017-2020	State awards ongoing fiscal incentives to IDNs based on achievement of pre-determined metrics

Note: pending final approval by CMS and subject to change

DSRIP Progress To Date - 2016

DSRIP Implementation Has Required Months of Ongoing Preparation

January 5:	**Waiver Approval Issued**
March 1:	**NH Submits Draft Protocols to CMS**
April 4:	**14 Letters of Interest Received**
May 31:	**IDN Applications Submitted to the State**
June 30:	**7 IDN Applications Approved by DHHS**
July 20:	**CMS issues Approval of Last Protocol**
August 24:	**G&C Approves 7 contracts between DHHS and IDNs to permit disbursement of capacity building funds**
Sept. 20:	**Initial $19.5M DSRIP funds are received by IDNs**
October 31:	**Project Plans Submitted to DHHS**
December 21:	**Project Plans Approved**

Note: pending final approval by CMS and subject to change

DSRIP Progress To Date - 2017

DSRIP Implementation Has Required Months of Ongoing Preparation

January 18: **Project Plan Funds Awarded**

January to March:

Workforce Taskforces

- Taskforce has been developing statewide workforce capacity strategic plan. This includes identification of policy, education and licensing strategies that will enhance the workforce capacity pipeline.
- Each IDN is also building their local staffing plan to meet IDN goals and objectives.

HIT Taskforce Continues Work

- Taskforce has been working on identifying minimal, desired, and optional HIT/HIE standards for all IDN partners. Partners convene for weekly statewide calls and monthly face to face meetings.
- The group has come to consensus on recommendations for the statewide standards which will become the foundation for shared care plans and secure message exchange.
- Features include real time information such as ED or hospital visits.
- Each IDN is building their local IDN specific HIT/HIE implementation plan customized to the current level of readiness for each IDN partner.

DSRIP Progress To Date - 2017

DSRIP Implementation Has Required Months of Ongoing Preparation

January to March:

Implementation Plans for All 6 Projects

- IDNs have been developing their 6 implementation plans for their projects.
- Budgets, staffing, goals/objectives, outcome measures, timelines, and identification of necessary protocols for each project will be included.

Outcomes measures

- All IDNs have been meeting w DHHS to finalize and understand documentation and reporting protocols for required outcome measures. T
- The group is in agreement that pursuing a shared data and reporting system would be transformative and sustainable in a changing environment while positioning the IDN 's towards APMs.

Network growth and management

- IDNs have met and assessed their local partners and beyond (non partners with whom they still interface) for opportunities in collaboration.
- IDNs have engaged supportive housing providers, Public Health Networks, managed care organizations and many more.
- IDNs are looking at data that identifies high utilization and high cost patients to inform their ability to make meaningful impacts on people's lives, which reduce overall cost while increasing quality and outcomes.
- Network partners have completed HIT gaps analysis and assessment of Core Standardized Assessment domains.

State-wide and IDN-level Metrics

- **Performance metrics at the state- and IDN-levels will be used to monitor progress toward achieving the overall waiver vision. Payments from CMS to the state and from the state to IDNs will be contingent on meeting these performance metrics.**
- **Accountability shifts from process metrics to performance metrics over the course of the 5-year program.**

	Process Metrics	Performance Metrics
State-wide performance metrics	Steps taken by the State to establish and manage the waiver program	Select quality and utilization indicators that measure state-wide impact
IDN-level performance metrics	Steps required to be taken by an IDN to organize its network and implement its projects	Quality, access, and utilization measures tied to one or more projects

Relative dependence of IDN performance payments	**2016**	**2017**	**2018**	**2019**	**2020**
			5%	10%	15%

State-wide funding at risk for State-wide outcome measures

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

Goals and Requirements: NH's APM Roadmap

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

APM Roadmap: Important Dates

Date	Milestone (above timeline)	Milestone (below timeline)
Summer 2016 – Late 2016/Early 2017	**Development of Roadmap**	NH Medicaid Managed Care Procurement Process Begins
April 1, 2017	**Deadline for submission of Roadmap to CMS**	Deadline for submission of Medicaid Managed Care Contracts and Rates to CMS
July 1, 2017	**Deadline for CMS approval of Roadmap**	Medicaid Managed Care Contract and Rate effective date
2018-2020	**Development and submission of annual updates to Roadmap**	

New Hampshire Roadmap Requirements

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

Purpose

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

Process

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

2017 Deadlines

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

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

Annual Updates

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

New Hampshire Roadmap Requirements

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

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

Continued on following page

New Hampshire APM Roadmap Requirements

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

Continued from prior page

5. **Managed Care Rates:**
   a. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by IDNs, including how up-to-date data on these matters will be incorporated into capitation rate development.
   b. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with IDNs that the plans will undertake. How plans will be measured based on utilization and quality in a manner consistent with IDN objectives and measures, including incorporating IDN objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.
6. **Contracting Approach:**
   a. How the state will use IDN measures and objectives in their contracting strategy approach for MCO/Medicaid service delivery contract plans, including reform.
   b. If and when plans' currents contracts will be amended to include the collection and reporting of IDN objectives and measures.

Threshold Decisions for Discussion

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

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

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

…Beyond Satisfying CMS Requirements

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

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

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

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

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

New York Approach

Does not count as VBP

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

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

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

Discussion Point 3: How Prescriptive Does NH Want to Be?

Participation

- *Should MCOs be required to contract with IDNs?*
- *Can they instead 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?*

Model Design

- *How much flexibility will MCOs have to select VBP models?*
- *Does the state want to mandate how value-based contractors distribute savings?*
- *MCO discretion: Ability of stakeholders to form other types of 'off menu' VBP arrangements?*

Other Key Decisions

Additional threshold decisions include:

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