

# **New Hampshire's DSRIP Waiver Program, Alternative Payment Models and Safety Net Providers**

**National Academy for State Health Policy's  
Value Based Payment Reform Academy Meeting**

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- ▶ **Overview**
- ▶ **Integrated Delivery Networks**
- ▶ **Pathways and Projects**
- ▶ **Financing**
- ▶ **Planning for Alternative Payment Models**



# Overview of New Hampshire's DSRIP Waiver Program: *Building Capacity For Transformation*

The waiver represents an unprecedented opportunity for New Hampshire to strengthen community-based mental health services, combat the opiate crisis, and drive delivery system reform.

## Key Driver of Transformation



**Integrated Delivery Networks** : Transformation will be driven by regionally-based networks of physical and behavioral health providers as well as social service organizations that can address social determinants of health

## Three Pathways

Improve care transitions

Promote integration of physical and behavioral health

Build mental health and substance use disorder treatment capacity

## Funding Features



Menu of mandatory and optional community-driven projects



Up to \$150 m over 5 years



Support for transition to alternative payment models



Funding for project planning and capacity building



Performance-based funding distribution



# Integrated Delivery Networks (IDNs)

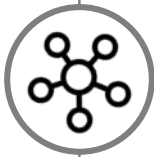


- 7 new, regionally-based networks of providers called Integrated Delivery Networks ('IDNs') will drive system transformation by designing and implementing projects in a geographic region.

## Key Elements



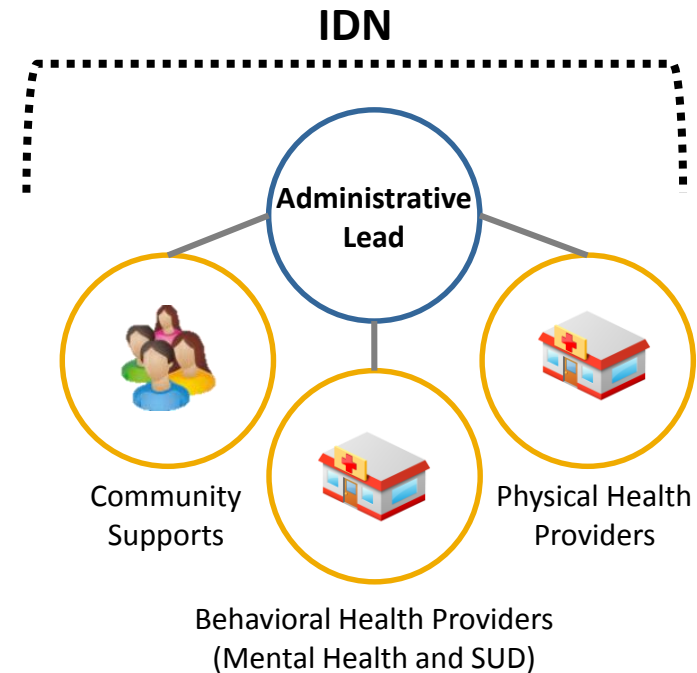
**Participating Partners:** Includes community-based social service organizations, hospitals, county facilities, physical health providers, and behavioral health providers (mental health and substance use).



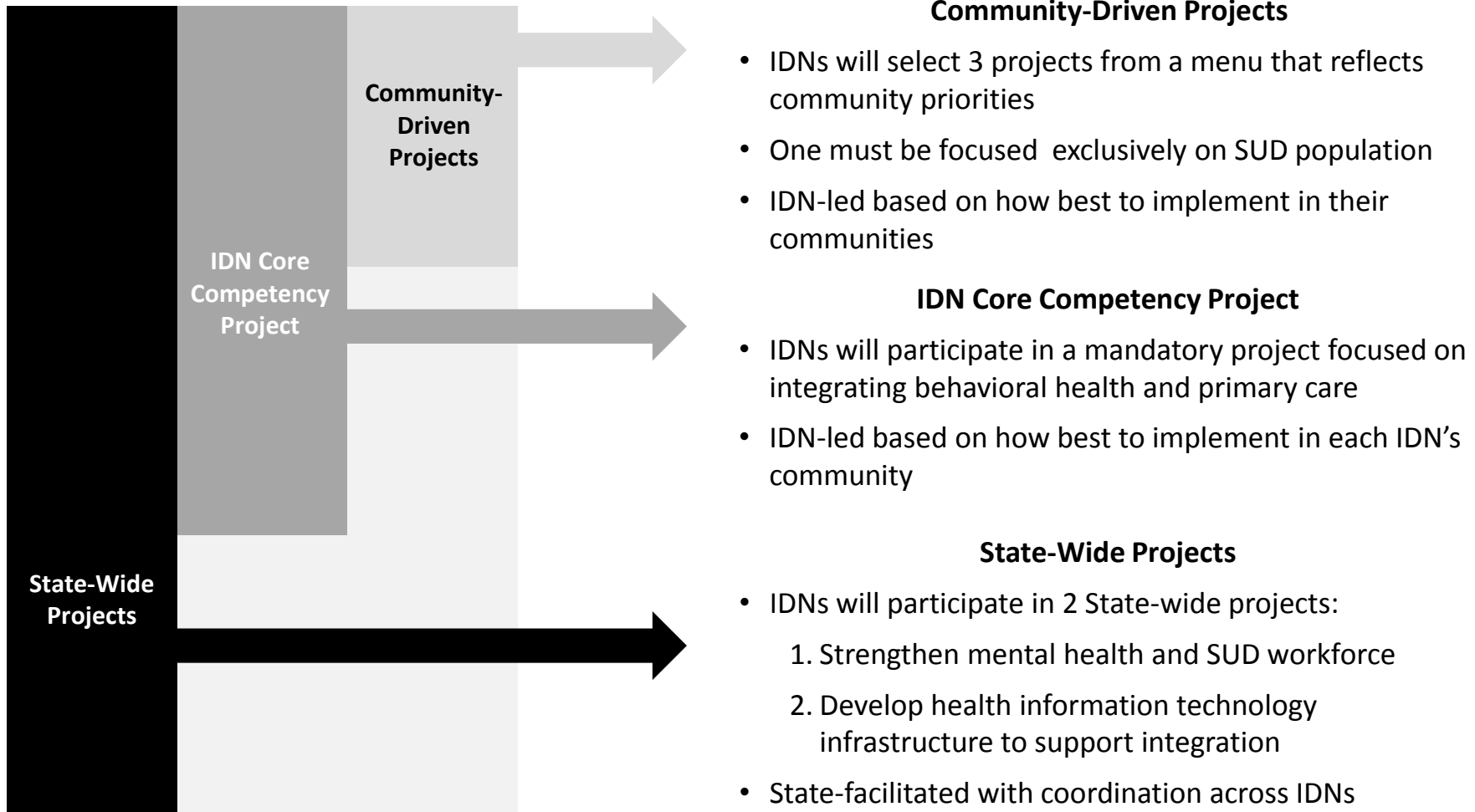
**Structure:** Administrative lead serves as coordinating entity for network of partners in planning and implementing projects.



**Responsibilities:** Design and implement projects to build behavioral health capacity; promote integration; facilitate smooth transitions in care; and prepare for alternative payment models.



# Project Menu Structure



Each IDN will implement the Core Competency Project.



## Integrated Healthcare

- Primary care providers, mental health and SUD providers, and social services organizations will partner to:
  - Prevent, diagnose, treat and follow-up on both behavioral health and physical conditions
  - *Refer patients to community and social support services*
  - Address health behaviors and healthcare utilization
- Standards will include:
  - *Core standardized assessments for depression, substance use, and medical conditions*
  - Integrated electronic medical records and patient tracking tools
  - Health promotion and self-management support
  - Care management services
- NCQA accreditation is not required



# Community-Driven Project Menu

Each IDN will implement three community-driven projects from a DHHS-defined menu.

## Care Transitions:

*Support beneficiaries with transitions from institutional settings to the community*

- Care Transition Teams
- *Community Reentry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues*
- Supportive Housing Projects

## Capacity Building:

*Supplement existing workforce with additional staff and training*

- Medication Assisted Therapy of Substance Use Disorders
- Expansion of Peer Support Access, Capacity, and Utilization
- Expansion in intensive SUD Treatment Options, including partial hospital and residential care
- Multidisciplinary Nursing Home Behavioral Health Service Team

## Integration:

*Promote collaboration between primary care and behavioral health care*

- *Wellness Program to address chronic disease risk factors for SMI/SED population*
- **School-Based Screening and Intervention**
- **Substance Use Treatment and Recovery Program for Adolescents and Young Adults**
- Integrated Treatment for Co-Occurring Disorders
- *Enhanced Care Coordination for High –Need Populations*



# Funding for the Transformation Waiver

## Key Funding Features:

- The transformation waiver provides up to \$150 million over 5 years.
  - State must meet statewide metrics in order to secure full funding beginning in 2018
  - State must keep per capita spending on Medicaid beneficiaries below projected levels over the five-year course of the waiver
- Up to 65% of Year 1 funding will be available for capacity building and planning.
- In Years 2-5, IDNs must earn payments by meeting metrics defined by DHHS and approved by CMS to secure full funding. Under the terms of New Hampshire’s agreement with the federal government, this is not a grant program.
- A share of the \$150 million will be used for administration, learning collaboratives, and other State-wide initiatives.

	2016 (Year 1)	2017 (Year 2)	2018 (Year 3)	2019 (Year 4)	2020 (Year 5)	Total Funding
<b>Capacity Building</b> (Up To 65% of Year 1 Funding)	\$19,500,000	n/a	n/a	n/a	n/a	<b>\$19,500,000</b>
<b>Other Funding</b> (IDN payments, administrative expenses, etc.)	\$10,500,000	\$30,000,000	\$30,000,000	\$30,000,000	\$30,000,000	<b>\$130,500,000</b>
<b>Percent at Risk for Performance</b>	0%	0%	5%	10%	15%	
<b>Dollar Amount at Risk for Performance</b>	(\$0)	(\$0)	(\$1,500,000)	(\$3,000,000)	(\$4,500,000)	

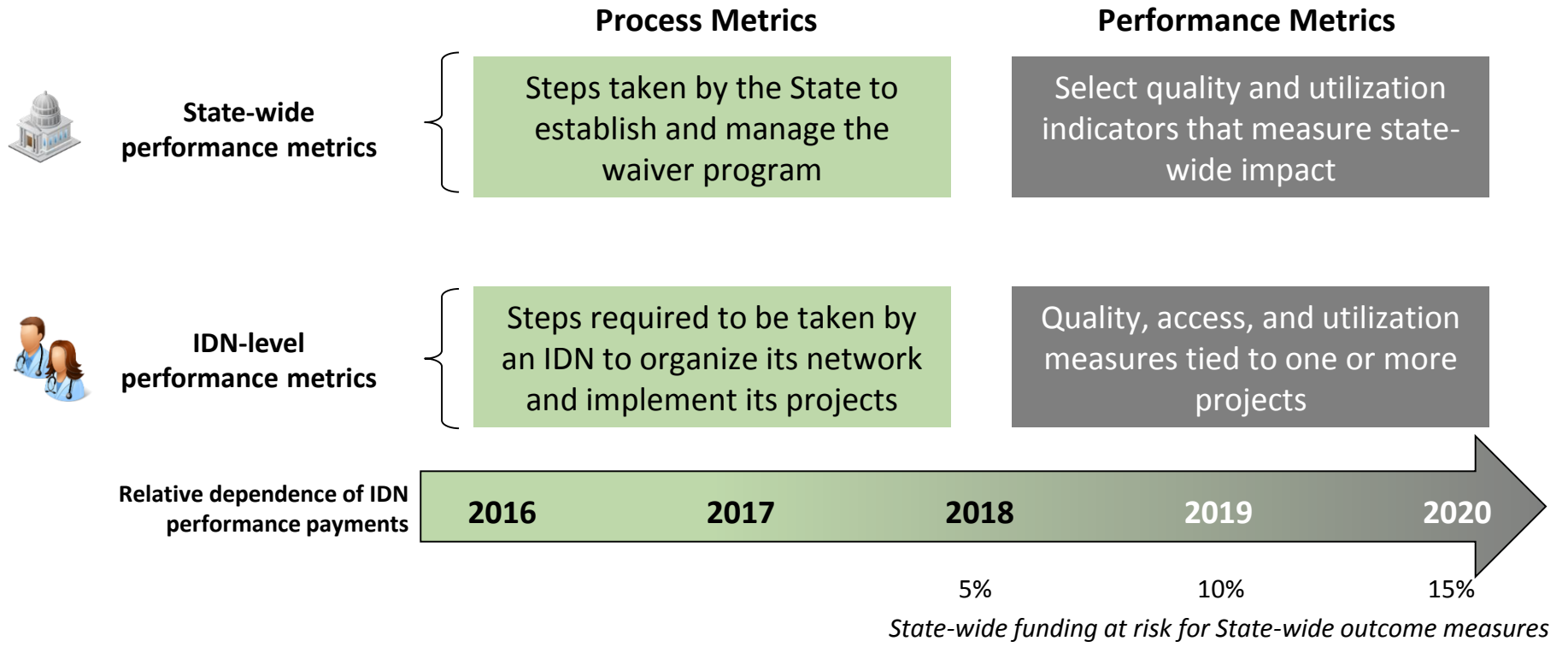
**TOTAL \$150,000,000**





# 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.



Note: pending final approval by CMS and subject to change



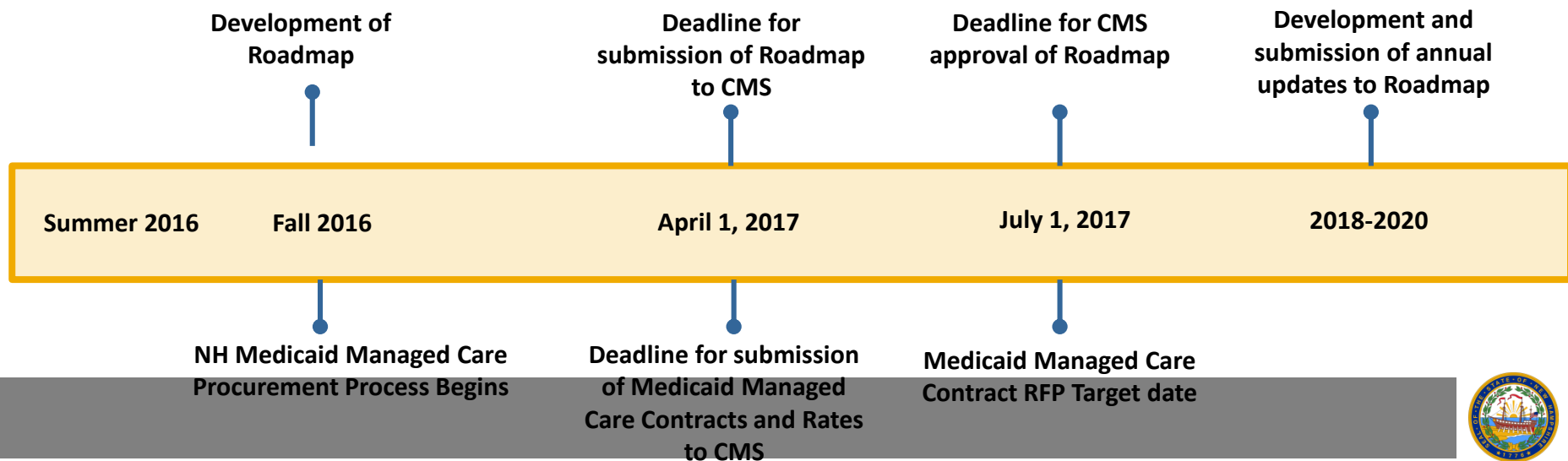
# New Hampshire's DSRIP Medicaid Waiver and the Transition to Alternative Payment Models

## 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 percent of Medicaid provider payments into alternative payment models**

## APM Roadmap: Important Dates



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

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# STC Spotlight: APM Roadmap Requirements

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

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## 5. Managed Care Rates:

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

## 6. Contracting Approach:

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



# Discussion Point 1: What is the Purpose?

## ...Beyond Satisfying CMS Requirements

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



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

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- *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

Options	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP
<b>Total Care for General Population</b>	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)
<b>Integrated Primary Care</b>	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)
<b>Bundles</b>	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)
<b>Total Care for Subpopulation</b>	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)

Does not count as VBP

### 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 2: What Counts As a Value-Based Payment?

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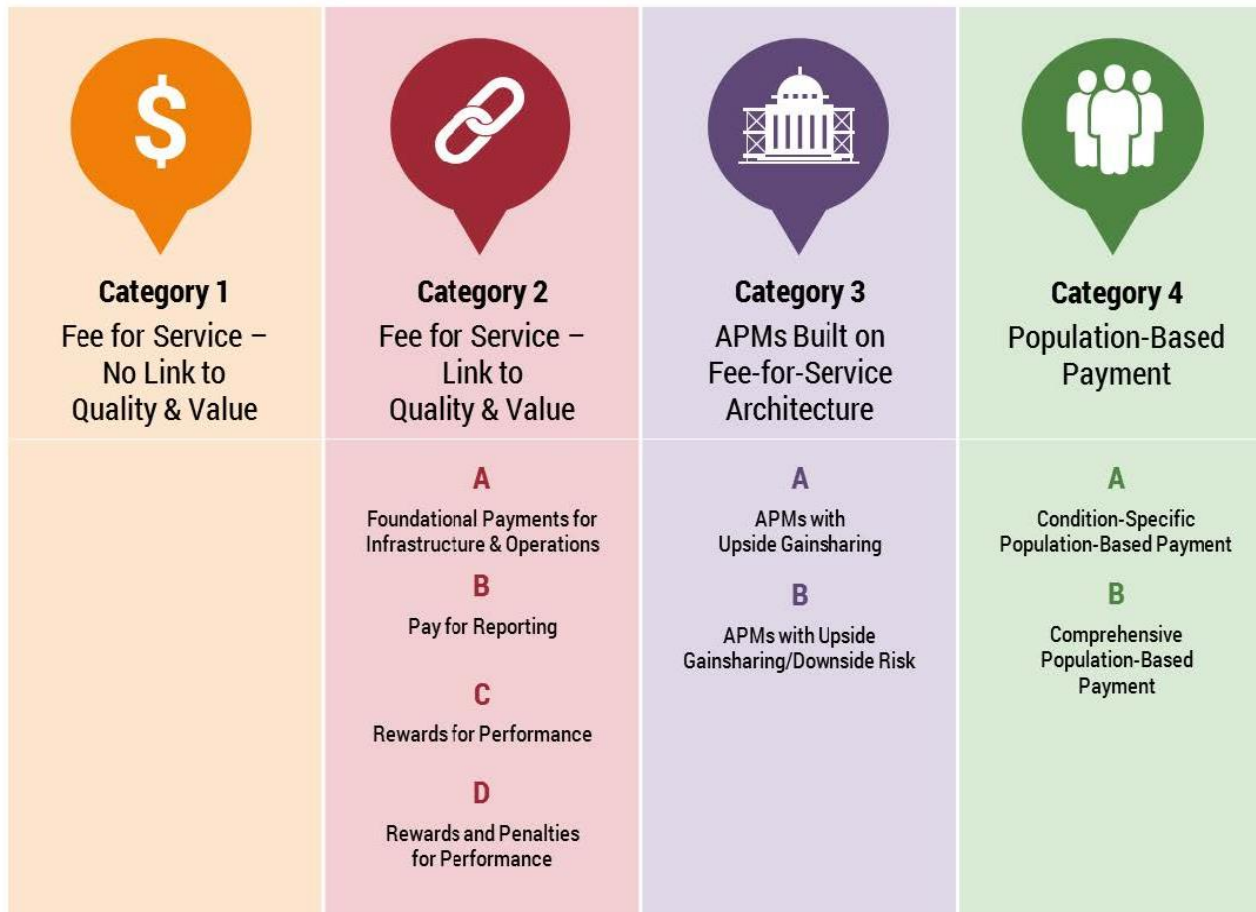




# What Counts as an Alternative Payment Model?

## New Hampshire Approach – Likely Categories 3 and 4

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



# What Counts as an Alternative Payment Model?

## New Hampshire Select Experiences to Date

- **Six of our 10 FQHCs have shared savings arrangements with one of our Medicaid Managed Care Organizations in which the shared savings is accessible for hitting particular quality and cost targets**
- **Ten Community Mental Health Centers had risk-sharing agreements with Managed Care Organizations that include quality metric targets.**



# Other Key Decisions

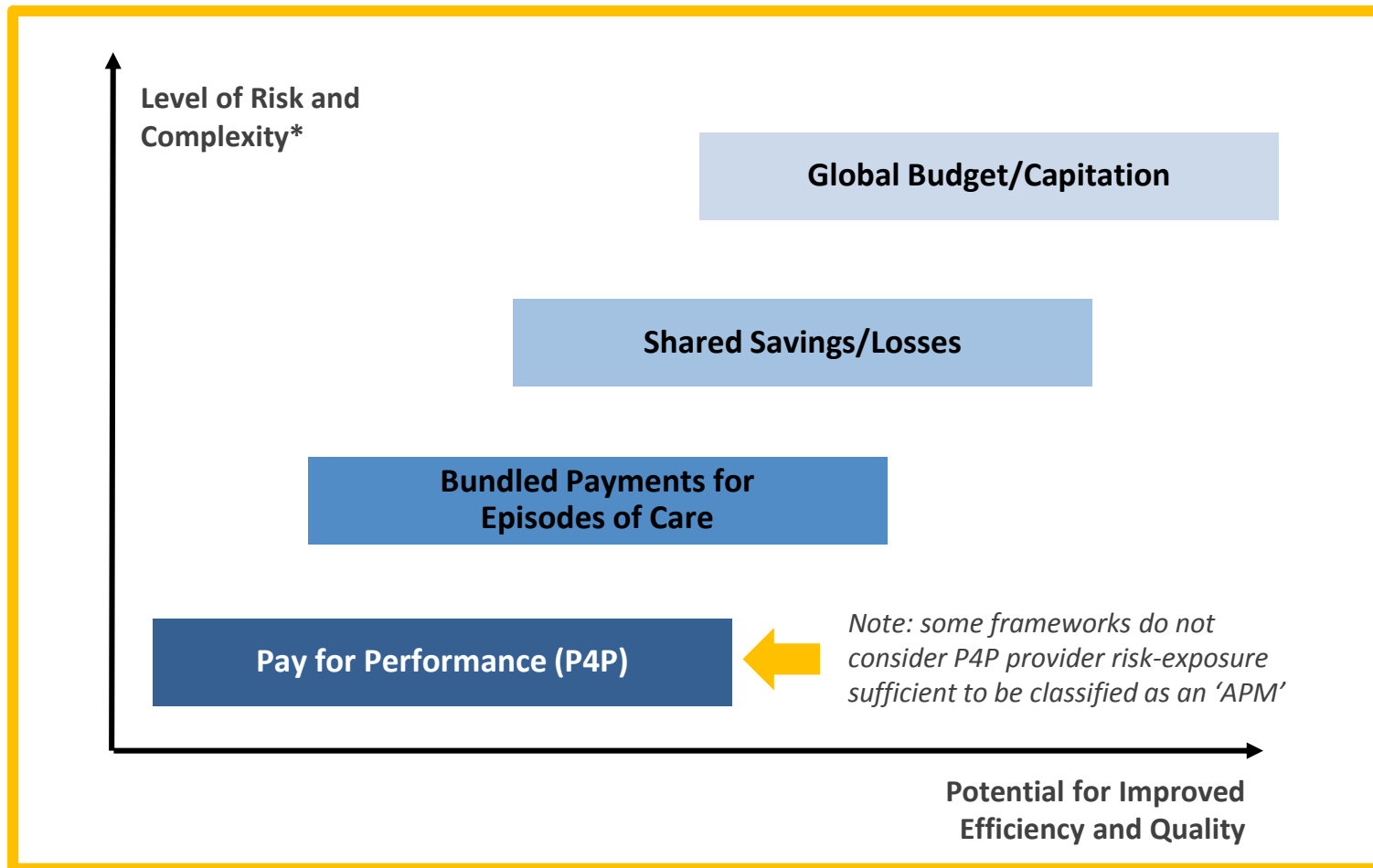
## Additional threshold decisions could include:

1. What structures will NH need to help oversee implementation?
2. How will the state initiatives align with Medicare and Commercial activities?
3. What data/tools will the state supply in support of value-based payment?
4. Will NH take steps to review APM contracts?
5. 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)
6. 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?
7. Are there some high impact services that the state may want to exclude from value-based payments?



# Range of APM Contracting Models

APM approaches tend to differ based on the level of risk providers assume and the structure of payments



Note: actual level of risk can vary depending on specific arrangement; e.g., a bundled payment program with upside and downside risk-sharing may have potential for greater losses than a limited shared-savings program.



# APM Contracting Models: Capabilities Required

APM arrangements at higher levels of risk will require increasing provider capabilities

Less Risk

More Risk

## Pay for Performance

Provider Network Management

Clinical and Care Management

Financial Management

Governance and Corporate Structure

Analytics and Information

## Bundled Payments

Provider Network Management

Clinical and Care Management

Financial Management

Governance and Corporate Structure

Analytics and Information

## Shared Savings/Losses\*

Provider Network Management

Clinical and Care Management

Financial Management

Governance and Corporate Structure

Analytics and Information

## Global Budget/Capitation

Provider Network Management

Clinical and Care Management

Financial Management

Governance and Corporate Structure

Analytics and Information

Level of risk can vary depending on arrangement

### Level of Capabilities Required

Low Medium High

Note: \*Shared savings arrangements with lower levels of risk may require fewer capabilities.

