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NH MEDICAID TODAY AND TOMORROW: FOCUSING ON VALUE MAY 31, 2017 A SYMPOSIUM SUMMARY

KEY POINTS, COMMENTS AND SLIDES DOCUMENTING THE MAY 2017 SYMPOSIUM

FOR A COMPLETE VIDEO, COPIES OF PRESENTATIONS AND ADDITIONAL DOCUMENTS, VISIT: HTTPS://CHHS.UNH.EDU/IHPP/NH-MEDICAID-TODAY-AND-TOMORROW-FOCUSING-VALUE

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ACKNOWLEDGEMENTS

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SPEAKERS AND PRESENTERS

Jeb Bradley, Senator, State of NH
Stephanie Brown, Director, Office of Behavioral Health, Massachusetts Medicaid
Dr. Barbara Crowley, Chief Transformation Officer, MaineGeneral Health
Dr. Sam DiCapua, Chief Medical Director, NH Healthy Families
Mike Ferrara, Dean, UNH College of Health and Human Services
Deborah Fournier, Medicaid Director, NH Department of Health and Human Services
Yvonne Goldsberry, President, Endowment for Health
Maggie Hassan, Senator, US Government
Dianne Hasselman, Deputy Director, National Association of Medicaid Directors
Lucy Hodder, Professor of Law and Director, UNH Health Law and Policy Programs
Cindy Mann, Partner at Manatt Health (former Director, Center for Medicare & Medicaid Services)
Margaret McCabe, Professor of Law, Associate Dean, UNH School of Law
Tom Policelli, Chief Executive Officer, Minuteman Health
Jo Porter, Director, UNH Institute for Health Policy and Practice
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SYMPOSIUM SUMMARY

This summary provides an overview of "*New Hampshire Medicaid Today and Tomorrow: Focusing on Value,"* a daylong symposium hosted by the Institute for Health Policy and Practice at the University of New Hampshire School of Law on May 31, 2017.

The event brought together over 180 participants from across the state including state and federal government agencies, managed care organizations, policy makers, researchers and academics, industry experts, advocacy groups and consumers.

The Symposium began with opening remarks from several distinguished guests, including:

- Mike Ferrara, Dean of the College of Health and Human Services
- Margaret McCabe, Professor of Law and Associate Dean, UNH School of Law
- Yvonne Goldsberry, President, Endowment for Health
- Jeb Bradley, Senator, State of New Hampshire

Senator Maggie Hassan provided brief remarks noting the enormous implications to New Hampshire of the "repeal and replace" discussions in Washington D.C.

The Symposium featured two keynote addresses. Diane Hasselman, Deputy Executive Director of the National Association of Medicaid Directors discussed the role of state Medicaid directors in payment reform efforts across the country. Cindy Mann, JD, Manatt Health and former Director for Medicaid and Children's Health Insurance Program Services discussed the implications of federal Medicaid policy discussions, such as 'block grants', on state Medicaid programs and New Hampshire.

The day continued with interactive panel discussions and presentations, which focused on the key role that the New Hampshire Medicaid Program plays in the New Hampshire insurance marketplace. The symposium featured an overview of the New Hampshire Medicaid Program, provided research about the program's outcomes in managed care and with expansion populations, provided a review of value based payment reform in New Hampshire and surrounding states, and provided a discussion of key federal policy initiatives that may impact the future of the New Hampshire Medicaid Program.

The event had 3 Sections:

- Section I: Medicaid Today
- Section II: Valued Based Purchasing in Medicaid
- Section III: Medicaid Tomorrow and the Implications of Federal Policy Developments

Presentations and panel discussions are summarized within this document. However, much more content was covered than can be captured here. A recording of the event is available, along with all the presentations and supplemental documents, at http://chhs.unh.edu/ihpp/nh-medicaid-today-and-tomorrow-focusing-value.

The Symposium was sponsored by the Endowment for Health, Wellsense Health Plan and New Hampshire Healthy Families with support from Harvard Pilgrim Health Care and Minuteman Health.

SECTION I: MEDICAID TODAY

SESSION 1: OVERVIEW OF MEDICAID IN NEW HAMPSHIRE, DEBORAH FOURNIER

To provide the foundational content for the day, Deborah Fournier, Medicaid Director, New Hampshire Department of Health and Human Services (NH DHHS), provided an overview of the NH Medicaid program, the population it serves, and some key initiatives.

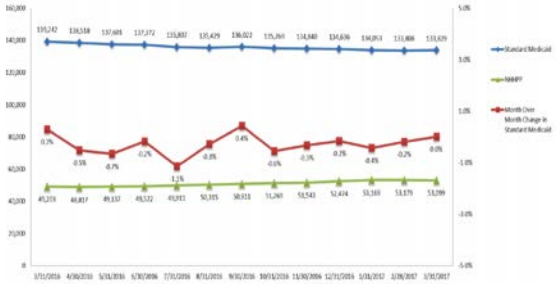
WHAT IS MEDICAID?

Medicaid is a publicly-funded health insurance program for low income people. States who opt to participate in the Medicaid program must cover select groups of people and select groups of services (mandatory eligibility groups). States can elect coverage for additional services and populations (optional eligibility groups). In return for meeting the Medicaid guidelines, the federal government pays a fixed percentage of the cost, known as the Federal Medical Assistance Percentage (FMAP). In New Hampshire, FMAP is always at least 50% of cost. Medicaid in NH includes Medicaid Managed Care, Premium Assistance and NH Health Protection Program (Trust Fund), and Fee-for-Service (FFS).

NH MEDICAID PROGRAM AND POPULATION

As of March 2017, total enrollment[1] for Medicaid in NH reached 186,928 enrollees. Of the total, 133,829 (71.6%) represented standard Medicaid with the remaining 53,099 (28.4%) making up NHHPP.

- Low-Income Children – Non-CHIP: 74,977 or 40.1%
- Low-Income Children – CHIP: 14,199 or 7.6%
- Children with Severe Disabilities: 1,497 or 0.8%
- Foster Care and Adoption Subsidy (Age 0-25): 2,299 or 1.2%
- Low-Income Non-Disabled Adults (Age 19-64): 11,183 or 6%
- Low-Income Pregnant Women (Age 19+): 2,169 or 1.2%



[1] This excludes refugees and those who only have Medicare savings plan coverage.

- Adults with Disabilities (Age 19-64): 18,624 or 10%
- Elderly and Elderly with Disabilities (Ages 65+): 8,732 or 4.7%
- BCCP (Age 19-64): 149 or .08%

Medicaid Managed Care

NH has a full-risk, capitated version of managed care with two Managed Care Organizations (MCOs), Well Sense Health Plan and New Hampshire Healthy Families, operating in the state. Approximately 133,200 Medicaid members receive short-term medical services through these two MCOs.

Premium Assistance and the New Hampshire Health Protection Program

New Hampshire expanded Medicaid effective August 2014, through the New Hampshire Health Protection Program (NHHPP). The MCOs provided coverage during the first year through the "bridge" plan, and then transitioned to a unique premium assistance plan effective January 1, 2016. NH residents between the ages of 19 and 65 who earn incomes between 0 and 138% of the federal poverty level may be eligible to access health coverage through a Qualified Health Plan (QHP) offered through NH's Health Insurance Marketplace. The premiums and most cost sharing are paid by Medicaid. Individuals who are "medically frail" may opt out of the program and participate in an "alternative benefit plan" offered by one of the MCOs.

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**

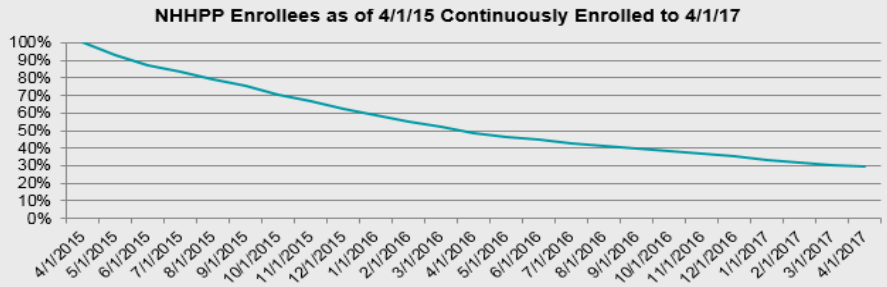
The commercial carriers participating in the NHHPP Premium Assistance Program (PAP) in 2017 are Anthem, Harvard Pilgrim Health Care (HPHC), Minuteman, and Ambetter. Approximately 42,000 participants receive NHHPP PAP coverage for short-term medical services through these four carriers. The state, through 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 served through the Medicaid managed care system. Additional members are covered directly by fee-for-service Medicaid while they select a health plan.

Many people who enroll in the NHHPP do not maintain that coverage for long periods of time. In a review of the 24-month period from 4/2015-4/2017, there were 38,625 enrollees as of 4/1/2015, and 29% (11,315) of these were covered by NHHPP for all 24 months.

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



Earning too much income is the top documented reason members dis-enroll from NHHPP.

Fee-For-Service (FFS)

In addition to Managed Care coverage, a subset of services and members are covered in FFS, which is the traditional reimbursement system where for every Medicaid covered service, Medicaid pays a fee. Traditional FFS Medicaid provides:

- Dental service to children in Medicaid
- Wrap benefits for premium assistance enrollees
- All Medicaid services to members during their selection windows
- Long-term services and supports (LTSS) to roughly 10,000 participants in 4 waivers
- Short term medical service coverage to roughly 1,000 participants excluded from the other delivery systems, e.g., family planning only participants, spend down participants and participants who receive Veterans Benefits.

NH MEDICAID COSTS

While children make up more than 60% of the population in the Medicaid program (excluding NHHPP), costs are concentrated among the elderly, the elderly with disabilities and adults with disabilities. Long-term care services make up the largest single percentage of service costs in NH Medicaid.

An overview of NH Medicaid (non-expansion) provider payments made by DHHS directly or by MCOs for patient services in SFY2016 is detailed below.

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

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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

Working Draft

NH MEDICAID WAIVERS AND PAYMENT REFORM EFFORTS

Federal law allows the Centers for Medicare and Medicaid Services (CMS) to approve certain innovative coverage programs outside the Medicaid program rules, primarily Section 1115 demonstrations and waiver authorities in section 1915 of the Social Security Act. NH operates seven programs under Medicaid waivers. One waiver provides legal authority to mandate enrollment for managed care under Section 1915(b) authority; four waivers are Home and Community Based Care waivers under Section 1915(c) authority (e.g., Developmentally Disabled Waiver, In-Home Supports Waiver, Acquired Brain Disorder Waiver, Choices for Independence Waiver); two waivers are Research and Demonstration waivers under Section 1115(a) demonstration authority (e.g., Premium Assistance Demonstration Waiver, Building Capacity for Transformation DSRIP Waiver).

Of these waivers, the Building Capacity for Transformation Delivery System Reform Incentive Payment Program (DSRIP) waiver focuses on New Hampshire's mental health and substance use disorder (SUD) services (collectively "behavioral health") and transforming care to integrated settings based on the population health principles of coordinated care through physical, behavioral and social service care providers. The DSRIP waiver includes requirements

for developing alternative payment models (APMs) and goals for transitioning at least 50% of payments to Medicaid providers through APMs. The ultimate goal of the transition is to ensure Medicaid is purchasing valuable care for its members. NH's Medicaid program has promised to develop a roadmap for CMS identifying a path to APM transition.

New Hampshire Roadmap Requirements

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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.
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.

The APM Roadmap requires NH's Medicaid MCOs and stakeholders to help define what is and what is not an APM. There additional key decisions NH Medicaid must make, including:

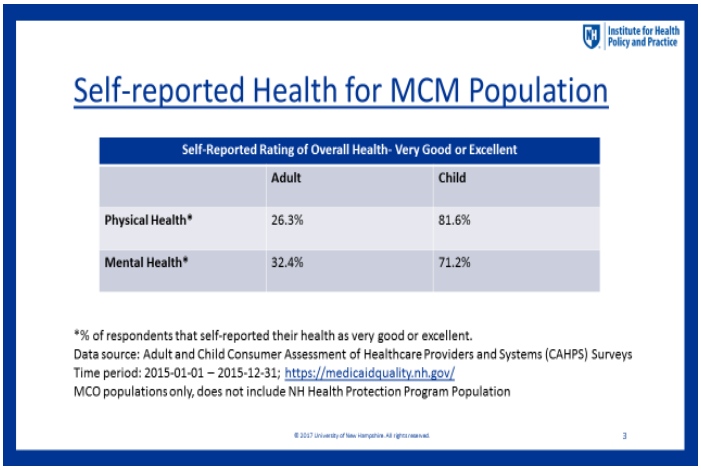
1. What structures will NH need to help oversee implementation?
2. How will the state initiatives align with MACRA?
3. How will the state engage stakeholders, including providers?
4. What data/tools will the state supply in support of value based payment?
5. Will NH take steps to review VBP contracts?
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 Department's 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?

SESSION 2: CURRENT STATE OF NH MEDICAID: FINDINGS IN CURRENT RESEARCH, JO PORTER

Jo Porter, Director of the Institute for Health Policy and Practice at UNH, highlighted outcomes of the NH Medicaid population using data from several NH data sources including the Medicaid Quality Information System (MQIS) and claims analysis from the NH Comprehensive Health Information System (NH CHIS).

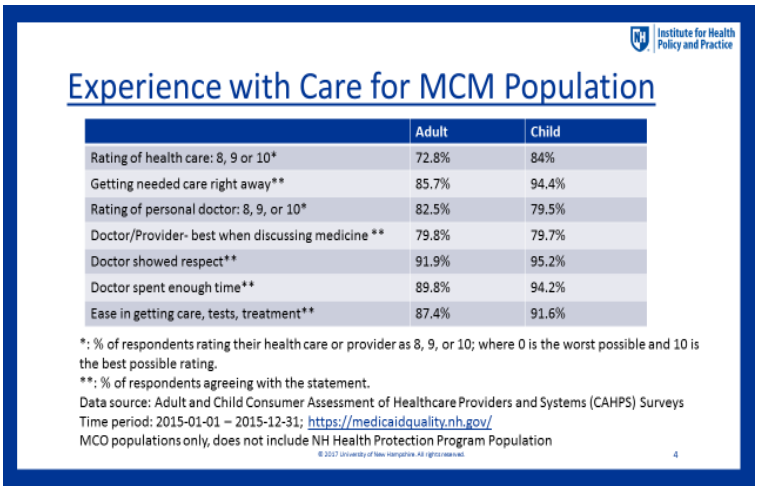
HEALTH STATUS AND RATING OF CARE

MQIS reports data from the Adult and Child Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, collected about the Medicaid Managed Care population. For that survey, members (or members' parents or guardians, if applicable) self-report their health status and experience with their health plan and the health care system. For children in Medicaid, over 80%



rated physical health very good and excellent, and over 70% rated mental health very good or excellent.

In the adult population, however, 26% rated physical health very good or excellent; 32% rated mental health very good or excellent. Given that children, in general, only need to meet income requirements to be eligible for Medicaid, while many adults in Medicaid are eligible because of health conditions, this difference can be expected.

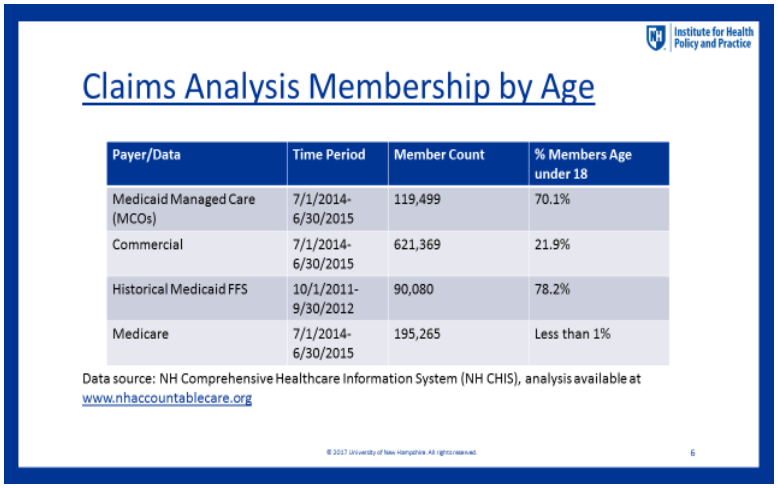


Overall, Medicaid members rated their health care experience highly across a range of measures that includes rating of the personal doctor, the doctor showing respect, and the ability to get care, tests, and treatment.

HEALTH CARE UTILIZATION AND COST

Claims data from NH CHIS was reviewed to better understand the cost and utilization of the Medicaid managed care population. As has been previously discussed, Medicaid in NH is a program made up largely of children. In SFY 15 (July 2014-June 2015), over 70% of the MCO population was under age 18. In contrast, for the commercially insured population, 22% was under age 18. Claims analysis from this same period (SFY 2015) showed that the overall medical claims cost was $222 Per Member, Per Month (PMPM) for Medicaid MCOs, $343 PMPM for Commercial, and $685 PMPM for Medicare.

Claims data were also analyzed to better understand the types of conditions most common in Medicaid and comparison commercial populations, both by members and cost.



TOP CONDITIONS AND PRACTICE CATEGORIES

Major Practice Categories (MPC) are broad classifications based on the types of conditions members have (based on claims experience). Medical claims data were reviewed for SFY15 for commercial data and Medicaid managed care, and SFY12 for Medicaid FFS (for a historical look, prior to the conversion to managed care). When viewing the MPC data by "% of Members," preventative visits were the most common for both commercial and Medicaid populations. Otolaryngology was the next most common for Medicaid, which likely reflects the use of services for ear, nose, and throat issues (e.g., ear infection care), which are common in children.

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Top MPCs by % of Members

Commercial 7/1/14-6/30/15	
MPC	**% mem**
Preventative	50.7%
Orthopedics/rheumatology	28.9%
Isolated signs/symptoms	27.6%
Otolaryngology	27.1%
Dermatology	24.3%
Endocrinology	20.1%
Psychiatry	16.1%
Cardiology	15.1%
Ophthalmology	14.7%
Gastroenterology	13.6%

Medicaid Managed Care 7/1/14-6/30/15	
MPC	**% mem**
Preventative	60.3%
Otolaryngology	39.8%
Psychiatry	29.2%
Dermatology	26.9%
Orthopedics/ rheumatology	22.6%
Isolated signs/symptoms	17.4%
Ophthalmology	16.4%
Pulmonology	16.8%
Gastroenterology	14.9%
Endocrinology	11.1%

Historical Fee For Service Medicaid 10/1/11-9/30/12	
MPC	**% mem**
Preventative	69.2%
Otolaryngology	45.5%
Psychiatry	32%
Dermatology	31.7%
Orthopedics/rheumatology	23.6%
Isolated signs/symptoms	23.4%
Ophthalmology	22.1%
Pulmonology	19%
Gastroenterology	16%
Endocrinology	10.2%

EPISODE TREATMENT GROUPS

Episode Treatment Groups (ETGs) are more granular groupings of claims for conditions or service types. Similar to the MPC, the most common ETG for all groups was "Routine Exam." In the Medicaid MCO population, the most common condition ETG, by the % of members with that ETG, was tonsillitis (at 15%). Again, this reflects that the Medicaid MCO population is primarily children.

Top 5 ETGs by % of Members

Commercial 7/1/14-6/30/15	
ETG's	**% mems**
Routine Exam	44.3%
Immunizations	12.2%
Isolated signs/symptoms	10.1%
Hypertension	9.9%
Tonsillitis, etc.	8.5%

Medicaid Managed Care 7/1/14-6/30/15	
ETG's	**% mems**
Routine Exam	52.2%
Tonsillitis, etc.	15.3%
Otitis media	11.4%
Routine inoculation	11.3%
Visual disturbances	10.1%

Historical FFS Medicaid 10/1/11-9/30/12	
ETG's	**% mems**
Routine Exam	58.6%
Tonsillitis, etc.	17.8%
Visual disturbances	15.1%
Otitis media	14.8%
Immunizations	13.5%

When reviewing ETGs by the medical cost spent in that ETG, behavioral health conditions are the top ETGs in the Medicaid MCO population. In the Medicaid MCOs, depression and neuropsychological disorders were the top two ETGs.

Top ETG by Cost (Total Cost)

Commercial 7/1/14-6/30/15		Medicaid Managed Care 7/1/14-6/30/15		Historical FFS Medicaid 10/1/11-9/30-12	
ETG	**Total $**	**ETG**	**Total $**	**ETG**	**Total $**
Pregnancy with delivery	$93,111,617	Depression	$20,889,837	Intellectual disability	$29,737,237
Routine Exam	$90,352,533	Neuropsychological disorders	$16,269,465	Neuropsychological disorders	$20,424,815
Malignant neoplasm of breast	$72,279,144	Psychotic disorders	$10,758,237	Depression	$19,524,668
Joint degeneration- back	$67,314,015	Pregnancy with delivery	$10,183,889	Neonatal disorders	$12,354,240
Ischemic heart disease	$56,495,134	Routine Exam	$9,394,073	Development disorder	$12,301,225

SESSION 3: PAYER PANEL DISCUSSION: LISABRITT SOLSKY, DR. SAM DICAPUA, STEPHANIE RICHARDSON, TOM POLICELLI, JO PORTER (MODERATOR)

Following the presentations from Deborah Fournier and Jo Porter, leaders from various payers involved in the Medicaid program joined a panel discussion. The panel included:

- Lisabritt Solsky, Executive Director, Well Sense Health Plan (Medicaid MCO)
- Sam DiCapua, DO, Chief Medical Director, NH Healthy Families (Medicaid MCO)
- Stephanie Richardson, Director, Government Programs, Harvard Pilgrim Health Care (NHHPP QHP carrier)
- Tom Policelli, Chief Executive Officer, Minuteman Health (NHHPP QHP carrier)

The panel included a rich discussion about the unique needs of the Medicaid population. Highlights of the conversation included:

Ms. Solsky talked about the interesting complexity of ensuring members receive high quality care in the face of significant concerns around the social determinants of health, including homelessness and lack of transportation. Well Sense Health Plan has put into place a number of high-touch programs with case managers and others to attempt to address the needs of the members beyond just delivery of health care services.

Dr. DiCapua echoed the observations about the often high level of needs for assistance for social determinants for the Medicaid population in his experience with NH Healthy Families, and added that patient engagement can be especially difficult with members, given the myriad other issues that they may have to deal with in their lives. Dr. DiCapua also mentioned that for

some members in the Medicaid population, who have high levels of need for behavioral health care, the interaction between the physical health and behavioral health systems is key.

Ms. Robinson shifted focus to her experience with the Medicaid Expansion population, through HPHC's coverage in the NHHPP. Ms. Robinson talked of the lessons learned in their time offering a plan to the NHHPP population. She reflected that the population has been harder to reach than their other commercial plans. She echoed the importance of coordinated behavioral health care, and also spoke to success in managing prescription drug needs with case managers and pharmacists in the community.

Mr. Policelli also spoke to the uniqueness and challenges in covering the NHHPP population. He noted that Minuteman had found that the NHHPP enrollees were a different population than the others covered on their plan, and that the NHHPP enrollees used more services and had a much higher cost profile than their other commercial enrollees. Mr. Policelli posited that the NHHPP population may be better served by the MCOs, which may have a different infrastructure to address the complex nature of the population.

Sessions 1, 2, and 3 of the Symposium provided an overview and base for understanding the Medicaid program, who it covers, and the types of services most common for the covered population. This information was designed to provide a frame for considering how Medicaid could consider the future opportunities, focusing on value.

SECTION II: VALUE BASED PURCHASING IN MEDICAID

SESSION 4: VALUE BASED PURCHASING IN MEDICAID: A NATIONAL PERSPECTIVE, DIANNE HASSELMAN

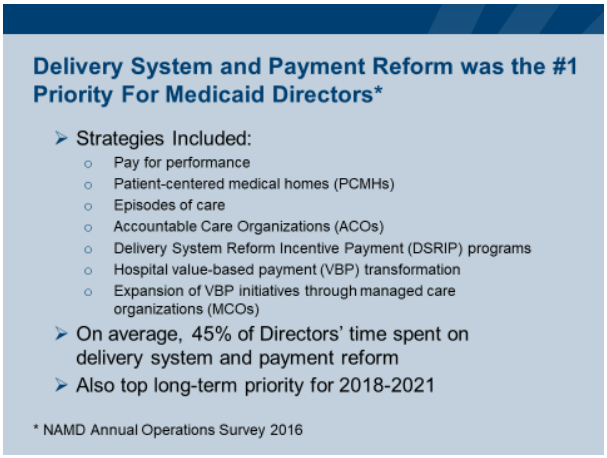
Dianne Hasselman, Deputy Executive Director of the National Association of Medicaid Directors (NAMD), was introduced by Marilee Nihan, former Deputy Commissioner, NH DHHS. Dianne discussed the important role of state Medicaid programs in the movement towards value based purchasing, and touched on progress and challenges across many states considering the current environment in which state Medicaid programs find themselves.

Ms. Hasselman provided important context for New Hampshire, based on the current conversations happening at the federal level, as well as through the programs ongoing through CMS to inform and influence value based payment models. She discussed the uncertainties in Medicaid planning while Congress engages in debates over the Affordable Care Act and Medicaid expansion. The proposed changes could have a significant impact on states' Medicaid programs, particularly the ability of states to support the long term care system.

"Delivery system and payment reform is the #1 top priority for Medicaid Directors across the country." Reforming Medicaid to a system that pays for value through value based payments is seen as a way to ensure the Medicaid program remains sustainable. The Medicaid program, and each program operated in each state, must also strive to meet the triple aim by bending the cost trend through better, higher quality and lower cost care. State tax payers expect Medicaid to be "wise stewards of tax payer dollars."

Moving towards a value based system will help Medicaid avoid the harsh tools typically employed: scaling back eligibility, reducing services, or cutting rates. Any of these blunt tools can contribute to uncompensated care, diminished access to needed services and longer term costs.

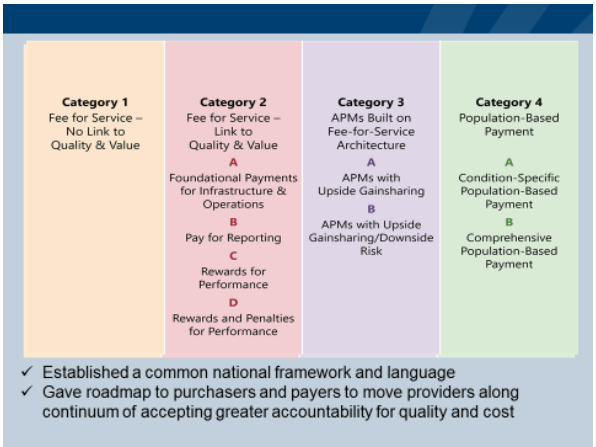
The Medicaid program offers several options for innovation around value based payment reform, including Section 1115 waiver innovation and State Innovation Model (SIM) design funding.



RELYING ON MEDICARE'S LEARNING ACTION NETWORK (LAN) FRAMEWORK

Medicaid programs are also closely following and incorporating the innovation models under demonstration in Medicare, including the types of alternative payment models (APMs) described in the LAN APM Framework.

Ms. Hasselman explained some of the current APM strategies pursued by states, and noted much of Medicaid's activity is in Category 2, "Fee for Service – Link to Quality and Value". Common strategies include:



- Establishing threshold goals for payments made pursuant to VBP Threshold Approach (Arizona, New Mexico, Rhode Island, Washington)
- Prescribing specific alternative payment models to MCOs, e.g., patient centered medical homes, accountable care organizations (ACO), etc. (Wisconsin, Tennessee, Ohio, Massachusetts, Minnesota)
- Focusing APMs on long term care to incent rebalancing of care from nursing homes to home- and community- based services/supports LTSS providers often have limited capacity for payment reform
- APMs and Federally Qualified Health Centers (FQHCs), RHCs and other cost-based providers
    - Goal is to give clinics greater flexibility to deliver services differently
    - Limited cash reserve to make needed investments up front

10 KEY QUESTIONS FOR NH AND THE APM ROADMAP

The final portion of the presentation posited 10 key questions for New Hampshire as it plans for VBP in Medicaid. They were:

1. Does/how does the Medicaid agency want to be more directive in advancing APMs?
2. How does this decision translate into your managed care contracts?
3. What is health plans' role in advancing APMs?
4. How transparent are health plans with their VBP activities?
5. How will quality measures tie directly and reasonably to APMs?
6. What are other purchasers and payers in New Hampshire doing re: VBP and are there opportunities for alignment?
7. How ready is the provider community to accept risk and reward without negatively impacting access to care? What data do they need?
8. How are you involving the provider and stakeholder community in the design of APMs?
9. How will the state Medicaid team's role and responsibilities change as a result of APMs and VBP?
10. How would national health care reform impact your approach?

These 10 questions framed the subsequent sessions, which focused on VBP in New Hampshire and the greater New England region.

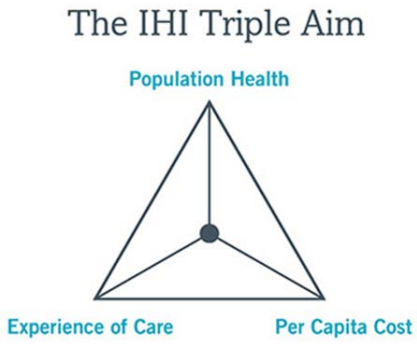
SESSION 5: VALUE BASED PURCHASING IN NH: OPPORTUNITY AND REGULATORY BARRIERS LUCY HODDER, PROFESSOR OF LAW, DIRECTOR OF HEALTH LAW AND POLICY PROGRAMS, UNH

This session focused on Value Based Purchasing activities in NH across all payers, and key developments in APM design in Maine, Massachusetts and Vermont in their Medicaid programs.

The session aimed to answer:

- What does paying for "value" mean in Medicaid?
- What are other non-Medicaid purchasers and payers in the state doing regarding APMs and are there opportunities for alignment?
- How ready is the provider community to accept risk and reward without negatively impacting access to care?
- What can we learn from our neighboring states?

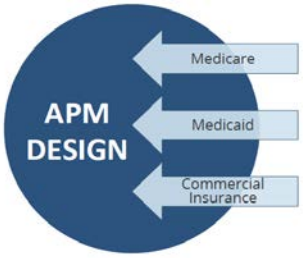
As inspired by the triple aim, Professor Hodder defined VBP for attendees as the process by which the payments for services to address health needs are made in exchange for valuable care measured by the best achievable quality outcome and the patient experience for the price offered.[2]



WHAT ARE OTHER PAYERS (AND PROVIDERS) DOING IN THE STATE AROUND ALTERNATIVE PAYMENT MODELS?

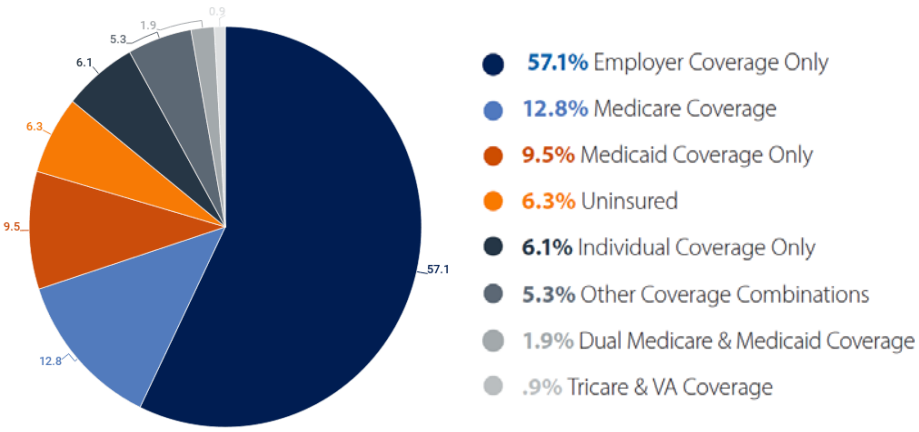
Leveraging Investments in APMs

Questions: "Are enough players participating in the model or aligned with your proposal to create a strong business case and supportive business relationships for providers to participate?"



FACTS ABOUT NEW HAMPSHIRE COVERAGE

New Hampshire is a state of approximately 1.3 million people, most of whom have health insurance through an employer sponsored group plan (57.1% in 2015, and 56% in 2016). Below is a chart showing the health insurance status of NH residents in 2015 by coverage category.



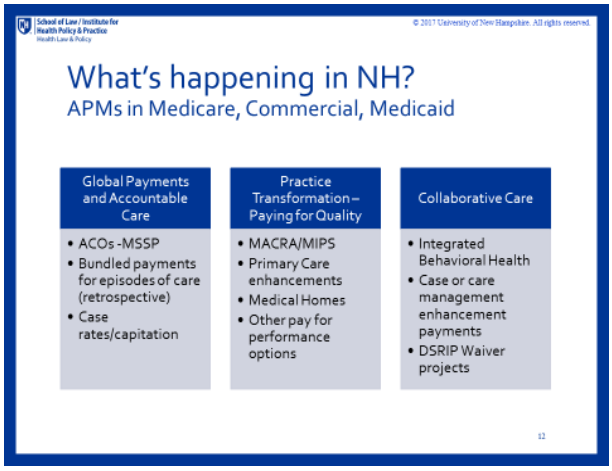
[2] Reference: The IHI Triple Aim. Institute for Healthcare Improvement. Accessed May 2017, http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

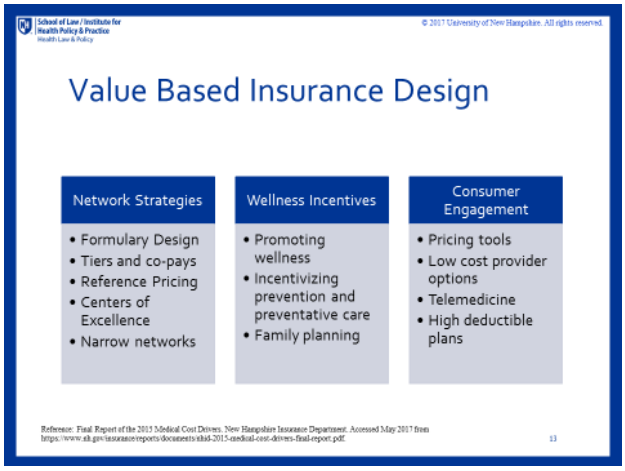
The largest decrease in the uninsured rate from 2011-2015 in people under 65 was among those who were unemployed. Within that group, the uninsured rate decreased from 33.5% to 24.5% from 2014 to 2015. [3]

WHAT'S HAPPENING IN NH?

APMs in Medicare, Commercial, Medicaid

New Hampshire's move towards APMs has been largely driven by pressure from Medicare as a significant payer for many providers, and growing demand for value by public health plans and employer groups. Providers too have worked closely with health insurance plans and third party administrators to move towards new ways of paying for care. In addition, health plans have changed the structure of their benefits to promote more value based choices and outcomes. Despite efforts, progress towards true risk based APMs has been slow and sporadic.





MEDICARE TRANSFORMATION

In 2015, former DHHS Secretary Burwell announced Medicare's intention to engage in a system wide delivery system reform effort aimed at realigning incentives to pay for better patient outcomes and higher value, advancing care models that emphasize coordination and prevention, and leveraging health care data, including electronic health records and information on cost and quality of care, to improve patient care. The Secretary set the following goals:

- 30% of Medicare payments are tied to quality or value through APMs by the end of 2016, and 50% by the end of **2018**

[3] Reference: Covering the Care: Health Insurance Coverage in New Hampshire. Institute for Health Policy and Practice, University of New Hampshire. Accessed May 2017 from http://chhs.unh.edu/sites/chhs.unh.edu/files/departments/institute_for_health_policy_and_practice/covering_the_care-_health_care_coverage_in_nh_050917_0.pdf.

- 85% of all Medicare FFS payments are tied to quality or value by the end of 2016, and 90% by the end of **2018**

The Secretary encouraged transformation across all payers.

New Hampshire's Move to APMs: Practice Transformation and Accountable Care

During the State Innovation Model Design II effort, a broad stakeholder group set goals for New Hampshire to move to transform the delivery system.[4] The resulting NH Health Innovation Plan set goals for payment reform, including to: 1) develop an overarching financial model for statewide healthcare finance and payment reform; 2) design a value based reimbursement program(s) to improve population health across New Hampshire and reduce costs; 3) identify alternative payment methodologies to align multi-payer and other financial incentives and support collaboration and coordination of care; 4) design a method to track cost savings from value based reimbursement innovations; 5) identify opportunities and models to finance RHCE functions; 6) design an approach to monitor and evaluate changes in total cost of care from multiple stakeholder perspectives. The goals depend upon leveraging payment reform efforts across all payers in order to achieve success.

Primary Care Transformation: Medicare Reform

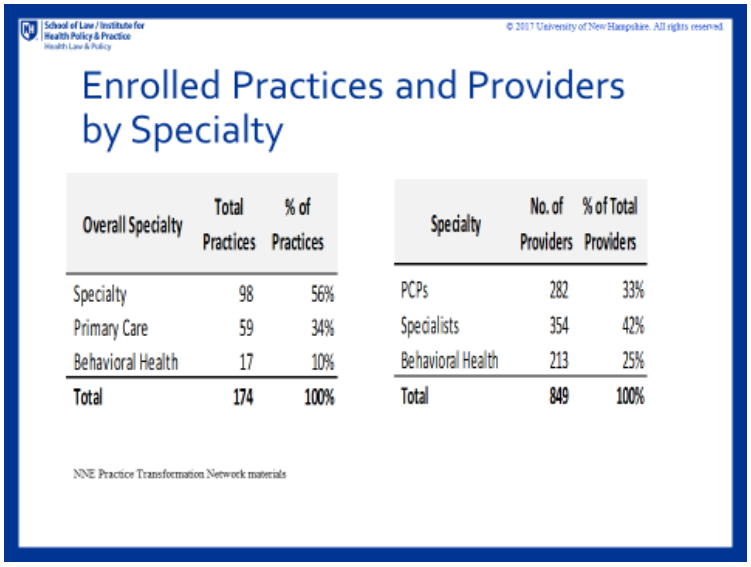
Medicare reform and the goals of the LAN Framework begin with primary care and provider practice transformation. A snapshot of New Hampshire's primary care delivery system is as follows:

- Approximately 1,885 Primary Care Physicians practicing in New Hampshire (1,531 active according to DHHS).
- As of July 2015, 477 PCPs and NPs achieved Patient Centered Medical Home recognition at 21 organizations/82 sites.
- NH has 11 FQHCs, 14 rural health centers and several additional health clinics, and 20 clinic sites for family planning, including 5 Planned Parenthood clinics (serving over 50% of the FP patients).
- All Community Mental Health Centers (CMHCs), FQHCs and hospitals (and hospital owned practices) and a high percentage of independent practices have adopted Electronic Health Records in NH.

[4] https://www.dhhs.nh.gov/ocom/documents/about-sim.pdf

CMS and the Northern New England Practice Transformation Network

The NNE-PTN is a partnership of NH Citizens Health Initiative, Maine Quality Counts, and the Vermont Program for Quality in Health Care. It is funded by CMS. NH Partners include North Country Health Consortium and NH Health Information Organization. The goals are CMS Innovation in Preparation for MIPS, which include building better systems for providing high-quality, patient-centered care, improving the health of clinicians and practice team, and improving the health of the practice in order to avoid penalties.



New Hampshire's Medicare Accountable Care Organizations

NH hosts several ACOs across the state.[5]

Dartmouth-Hitchcock Health Next Generation ACO

- Dartmouth-Hitchcock health clinics (Concord, Keene, Bedford/Manchester, Nashua), numerous skilled nursing facilities
- DHMC's net Medicaid revenue represents 28.4% of reported total Medicaid net revenue by NH hospitals for FY 2015
- Number of enrollees attributed (2017): 22,607

NH Accountable Care Partners MSSP ACO (6 hospitals/1 FQHC/1 CMHC/1 VNA)

- Concord Hospital, Catholic Medical Center, Wentworth-Douglass Health System (MGH affiliate), Elliot Health Systems, Exeter Health Resources, Southern NH Health Systems, Mid-State Health Center, Riverbend Community Mental Health, Concord VNA
- Participating hospitals' net Medicaid revenue represents 37.4% of reported total Medicaid net revenue by NH hospitals for FY 2015
- Number of enrollees attributed (2017) : 55,000

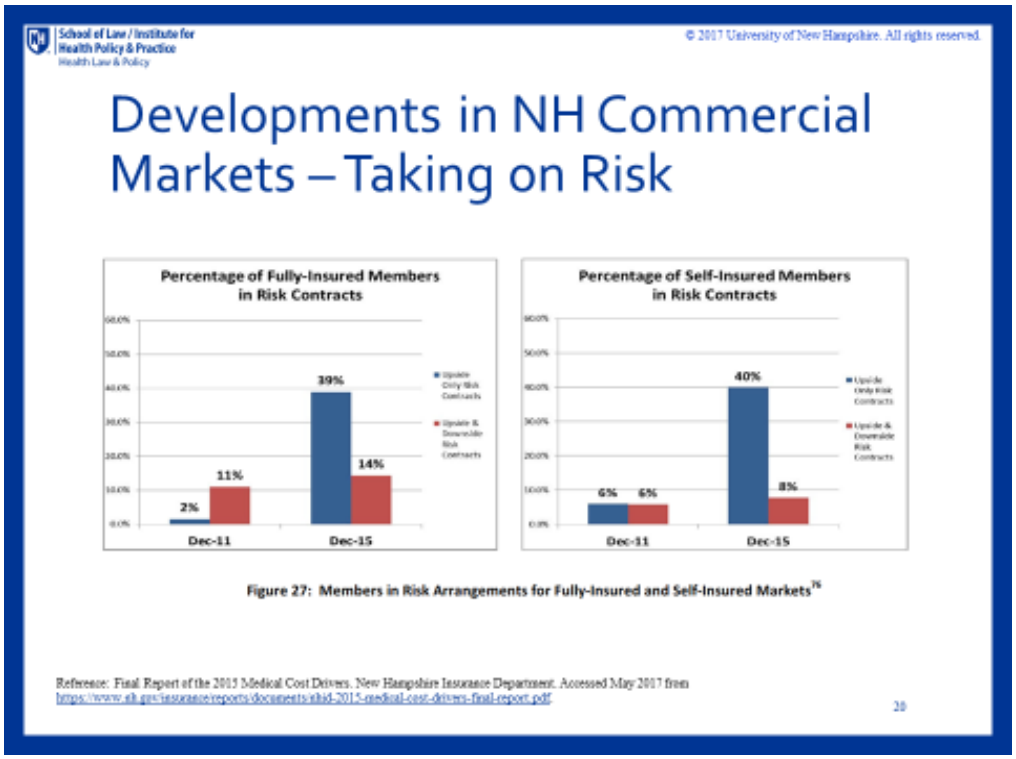
[5] Kevin Stone, Helms and Co., who has worked with several iterations of the Dartmouth-Hitchcock ACOs offers helpful insights into the upsides and downsides of Medicare ACO arrangements during the Payment Reform panel discussion below.

New Hampshire Rural ACO- initial Level 1 (6 hospitals/3 FQHCs)

- Androscoggin Valley Hospital (Berlin), Weeks Medical Center (Lancaster), Upper Connecticut Valley Hospital (Colebrook) Littleton Regional Hospital, Cottage Hospital (Woodsville), Monadnock Community Hospital (Peterborough), Coos County Family Health Center, Indian Stream Health Center, Ammonoosuc Health Center
- Participating hospitals net Medicaid revenue represents 9% of reported total Medicaid net revenue by NH hospitals for FY 2015
- Number of enrollees attributed (2017): 11,788

APM DEVELOPMENTS IN COMMERCIAL INSURANCE

The percentage of fully-insured members in upside only risk contracts as of December 2015 was 39% (by 2016 the number had dropped to 26%). Only 14% of members were in upside and downside risk contracts in 2015 (the number rose to 23% by December 2016). The percentages were similar for self-insured members (40% upside/8% upside-downside). [6]



[6] NHID Health Care Premium and Claim Cost Driver Reports 2016 and 2017.

Integrated Innovation - Commercial Markets

Assessing the progress of APM implementation efforts by providers and commercial health plans in New Hampshire is critical to understanding what works and doesn't work.

Benevera Health

- A partnership among Harvard Pilgrim Health Care, Dartmouth-Hitchcock, Elliot Health System, Frisbie Memorial Hospital and St. Joseph Hospital
- Integrated joint venture in care management for HPHC patients focusing on care management for patients with high needs
- Practice based care managers for high need patients connecting with patients and with community services
- Shared upside risk for outcomes of 35,000 enrollees

Tufts Freedom Plan

- A joint venture health insurance plan between Granite Health and Tufts Health Plan sharing up and downside risk
- Catholic Medical Center, Concord Hospital, LRGHealthcare, Southern NH Health, Wentworth-Douglass Hospital (MGH affiliate)
- Focusing on practice centered care management
- Data sharing for population health care management
- 16,500 members in first year

What are key hurdles for APMs?

Regulatory hurdles are many and complex, including:

- Payment and reimbursement requirements
- Fraud and abuse regulations
- Federal/state privacy law regulations
- Anti-trust laws and regulations of health care entities
- Professional responsibility/licensing/ethics
- The Fee-For-Service (FFS) infrastructure is well entrenched both as a claims payment methodology, a technology investment and a permeable measure
- Misaligned motivations/incentives arise and are compounded by complexities of payment and complexities of funding
- Risk of financial loss
- Access to information and data
- Lack of centralized information source regarding health care delivery and payment

OUR NEIGHBORING STATES

What do the Medicaid programs in our neighboring states look like? Medicaid Overview

State	Population (2016 Census estimate)	Medicaid Enrollees (as of March 2017)	Number of Hospitals and FQHCs	Percentage of Federal and State Budget on Medicaid (CY2015)
Maine	1,331,479	267,252 (20.1% population)	34 hospitals (16 critical access) 18 FQHCs	State – 37.5%, Federal – 62.5%
Massachusetts	6,811,779	1,631,999 (24% population)	76 hospitals (3 critical access) 39 FQHCs	State – 45.9%, Federal – 54.1%
New Hampshire	1,334,795	186,941 (14% population)	28 hospitals (13 critical access) 11 FQHCs	State –40.1%, Federal – 59.9%
Rhode Island	1,055,607	282,368 (26.8% population)	11 hospitals (no critical access) 8 FQHCs	State – 41.1%, Federal – 58.9%
Vermont	624,594	168,961 (27.1% population)	14 hospitals (8 critical access) 11 FQHCs	State – 39.4%, Federal – 60.6%

How are our neighboring states progressing towards payment reform?

State	Managed Care	Alternative Payment Model focus	Medicaid Expansion	Payment Reform Goals
Maine	No, operates a FFS Model	Accountable Communities; Patient Centered Medical Homes	No	(SIM) Transformation
Massachusetts	Yes, but also operates FFS Models	Accountable Care Organizations	Yes	By 7/1/15 pay for healthcare using APMs for 80% eligible members
New Hampshire	Yes, 2 MCOs, no LTSS or DD yet	Integrated Delivery Networks – integrated behavioral health	Yes	50% of Medicaid payments based on APMs; plan due 7/17
Rhode Island	Yes, 2 MCOs	Broad spectrum of APMs – ACO focused	Yes	50% APMs in commercial and Medicaid; 80% payment linked to value 2018
Vermont	Yes, implementing All-Payer Model	All Payer Transformation Model	Yes	Global Commitment to Health Waiver – accountable care

SESSION 6: REGIONAL INNOVATION PANEL DISCUSSION: STEPHANIE BROWN, DR. BARBARA CROWLEY, DIANNE HASSELMAN, KEVIN STONE, LUCY HODDER (MODERATOR)

THE MAINEGENERAL EXPERIENCE, BARBARA CROWLEY

In this session, Dr. Barbara Crowley, a pediatrician and Executive VP of Maine General Health, provided an overview of MaineGeneral's experience on the "innovation" journey moving towards value based payment models both in Medicaid and with other payers. Dr. Crowley reminded the audience that "*we are providing care in one of the most complex times.*" She frequently returns to the paradigm expressed by Edward H. Wagner, MD's chronic care model:

Where health care happens is between an engaged individual and a prepared team.

The focal questions for our Medicaid programs are: *how do we help the Medicaid population be more engaged? How do we help our beleaguered workforce be prepared to meet their needs fully yet have satisfying days at work?*

Dr. Crowley noted that large hospital systems are not incentivized to move to value based payment in Medicaid for many reasons. She explained that MaineGeneral moved forward with Medicaid VBP for three primary reasons:

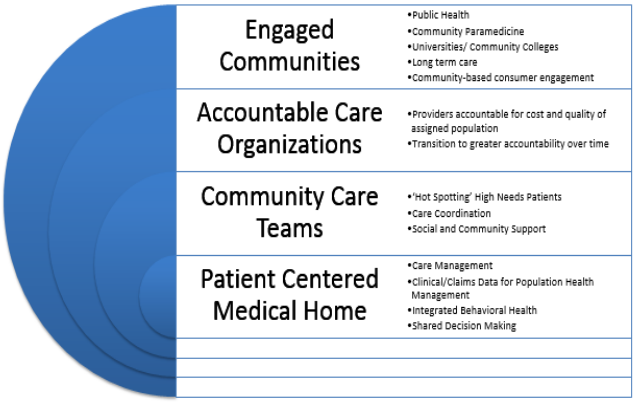
1. We were already moving to VBP;
2. **We needed to learn and needed the data** – "You can't learn about a population unless you have the data";
3. We were willing to change our inpatient payer mix.

Dr. Crowley believes that what ultimately convinced the Board of the hospital to work with Medicaid was the opportunity to reduce the number of inpatient beds occupied by a Medicaid patient. "If I could reduce [Medicaid beds] by one or by two, and fill that bed with a Medicaid or commercial [patient], there would be a significant delta." The Medicaid program, to be

sustainable, must think about the sustainability of the providers who serve Medicaid patients as well.

In Maine, the transition to accountable communities happened in stages and was resourced through a State Innovation Model design. The Medicaid program began working with hospitals on high emergency department utilization and then focused on medical health homes. The Department of Health and Human Services then helped create "care management teams" across the state to work on high utilizing patients, then behavioral health homes and finally accountable communities.

Multi-Payer HealthCare Innovation Model: Interlocking Initiatives



There were lessons learned along the way. For example, the behavioral health homes were intended to allow for facilitated communication with primary care, however, the programs were developed at mental health centers and the communications just didn't happen.

Staging the progress of value based payment models ultimately to accountable community models was helpful in order to allow providers to work together, develop data pathways, and work out issues.

An Accountable Community in Maine was specifically defined to be flexible and simple. Accountable Communities must be:

1. Responsible for the populations health and health costs
2. Provider owned and driven
3. Structured with strong consumer participation and community collaboration, and
4. Include shared accountability for cost and quality.

Results: Only four (including a large FQHC) came forward to serve as accountable communities. None of the systems took "model 2" with upside and downside risk. "*But the systems had no data… and thus were not likely to take on risk*." One of the major problems facing the willing

communities was that their primary care practices were using 11 different Electronic Health Record systems.

MaineCare (Medicaid) uses the following model for risk sharing:

Maine Health Homes Proposal

The Maine Health Homes project will have two stages.

Stage A:

- Health Home = Medical Home practice + CCT (most of the payment goes to the medical home)
- Members who join the Health Home during this stage:
  - Two or more health problems that last a long time (chronic conditions)
  - One health problem that lasts a long time and the chance that the member may get another serious health problem.

Stage B:

- Health Homes = CCT that are experts in behavioral health + Medical Home practice (most of the payment goes to the CCT)
- Members who join the Health Home during this stage:
  - Adults with Serious and Persistent Mental Illness (SPMI)
  - Kids with Serious Emotional Disturbance (SED)

6

Leveraging Current Initiatives: Health Homes

Patient-Centered Medical Homes (PCMHs)

Maine has 26 practices engaged in a multi-payer PCMH Pilot. Other practices are recognized by NCQA as Medical Homes.

PCMHs are primary care practices that:

- Care for members using a team approach to care coordination.
- Focus on a long term relationship between member and PCP.
- Have electronic medical records.
- Have open access scheduling and convenient hours.

+

Community Care Teams (CCTs)

- Are part of Medicare Multi-Payer Advance Primary Care Practice (MAPCP) grant and will be starting in January 2012.
- Community Care Teams will work with PCMHs to coordinate and connect the highest need patients to additional healthcare and community resources.

=

Health Homes

- PCMHs and the CCTs together enable MaineCare to better serve our highest need populations and qualify for the Affordable Care Act's "Health Home" State Plan option.
- CMS will provide a 90/10 match for Health Home services to members for eight quarters.

Dr. Crowley advised that: ***"The payment model must be aligned across all payers! It is almost impossible, from a hospital system perspective, to do a Medicaid model that is unique to Medicaid."***

Shared Savings/ Loss Models

	Model I	Model II
Minimum Attributed Members	1000	2000
Minimum Savings/ Loss Rate	+/- 2% (savings back to first $1)	+/- 2% (savings back to first $1)
Shared Savings Rate	50% max depending on quality	60% max depending on quality
Performance Payment	Performance payments capped at 10% of TCOC	Performance payments capped at 15% of TCOC
Shared Loss Rate	No downside risk	Shared loss payment percentage will vary based on quality performance, ranging from 40-60% TCOC.
Loss Recoupment Limit		•Yr 1: No downside risk •Yr 2: Risk capped at 5% TCOC •Yr 3: Risk capped at 10% TCOC

The payment model must also be anchored in primary care. But primary care offices and practitioners are overwhelmed with the many burdens of focusing innovation and changing practice patterns on them. "*We have to do a better job of helping primary care to respond well to the different populations they take care of*."

Dr. Crowley observed that Medicaid has many who have mental health and disability, but most of the complicating factors result from being poor. In addition, not all populations have the same issues across payers that drive the high need and high cost:

- *Commercial*: Cancer, trauma and catastrophic illness
- *Medicaid*: Behavioral Health, Disabilities and Socio-economic issues
- *Medicare*: Chronic Disease and function loss

As Dr. Crowley noted, Medicaid may be half children but it is not a children's program. The key cost drivers in Medicaid are the populations that fall under the category of "aged, blind and disabled." When managing new payment models, MaineGeneral works best with data segregated by population.

Each attributed population can be segmented into low risk, moderate and rising risk, and high-risk so that an appropriate resources strategy can be assigned. For example, low risk patients need to stay health and engaged. The strategy for high-risk patients may be to trade high-cost services for low-cost management. MaineGeneral has developed an internal tool to monitor the risk of its attributed population based on emergency room visits and inpatient days in order to best address the risks of the patient and succeed in the risk model.

It has been a long road, but the collaboration and work with the state has been rewarding and ultimately good for the patients and the system.

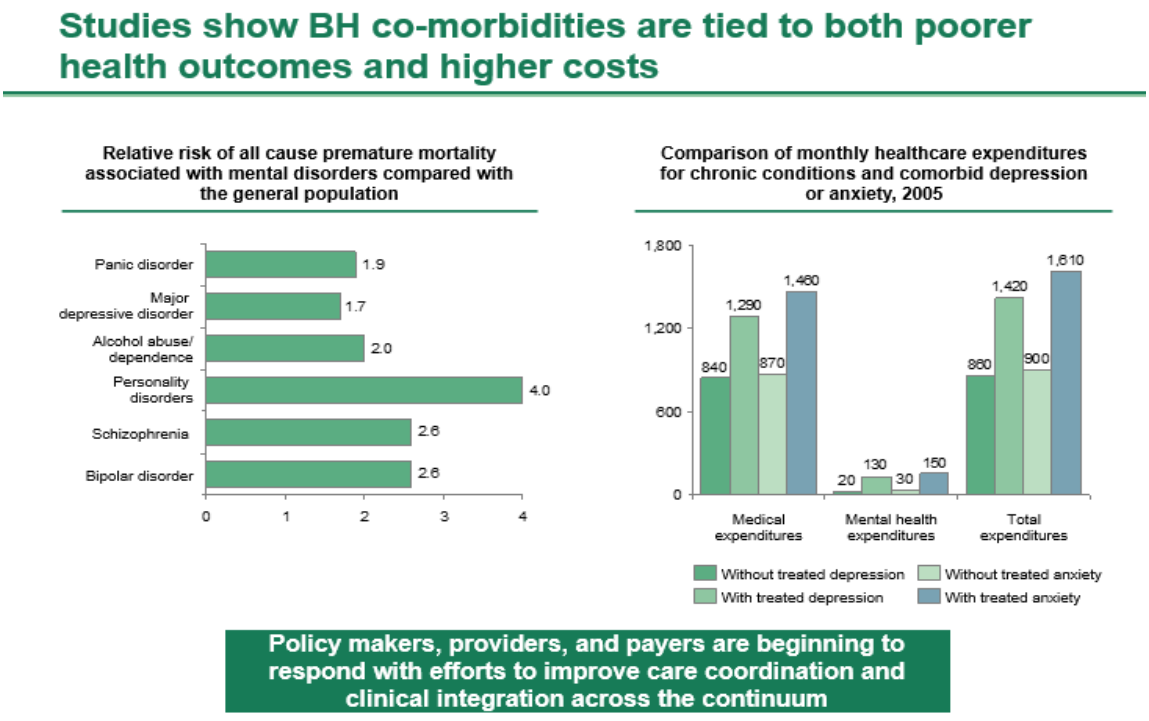
MASSHEALTH DELIVERY SYSTEM RESTRUCTURING OVERVIEW, STEPHANIE JORDAN BROWN

In this session, Stephanie Brown, Director of the Office of Behavioral Health for MassHealth (Massachusetts Medicaid), a self-avowed "health reform strategist," provided an overview of Medicaid delivery reform in Massachusetts.

Director Brown focuses her reform efforts on the behavioral health needs of the Massachusetts population but described the overall plan for Medicaid reform and the part that behavioral health reforms play in the overall vision. She confirmed that Massachusetts sees in the cost data the impact of behavioral health needs across the spectrum of care, and particularly in the area of specialty care. "*In Massachusetts we spend $16 billion in the Medicaid program. We have 60 % prevalence of behavioral health diagnosis. We spend $1.4 billion on behavioral health services.*"

In Massachusetts, Director Brown noted, the vision for reform is not as simple as having something for everyone. She noted, however, that reforms previously tried and implemented have not penetrated the behavioral health needs. "*The shared risk models have done very little to move the needle on access and continuity of care on mental health*." In fact most of the current alternative payment models do not pay attention to the management of behavioral health. Part of the remedy for the consistent isolation of mental health and substance use disorder care from the current medical models is "*integration, integration, integration*."

Director Brown provided national information about the impact of behavioral health co-morbidities and their tie to poorer health outcomes and health costs.



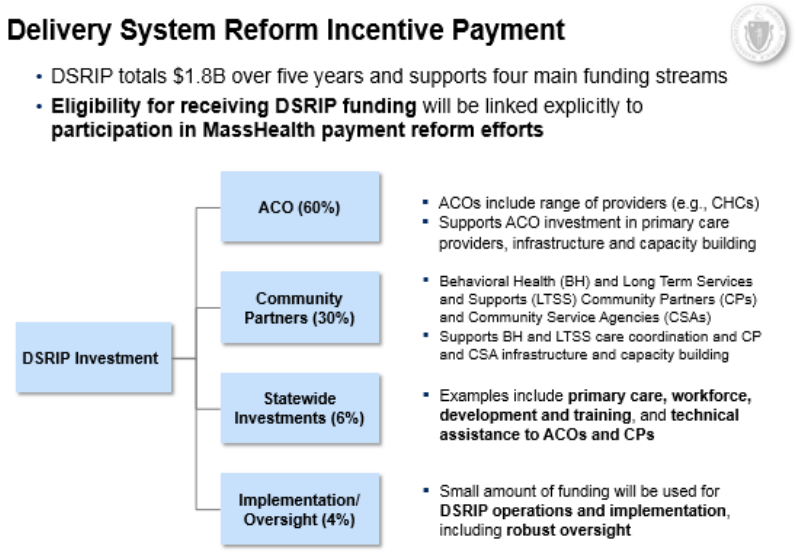
The driver behind the Massachusetts reform is cost and quality. "As we try to do this payment reform experiment in a budget deficit situation where we are driven by revenue neutrality, we have a shared responsibility to imagine and to explicitly design for the reinvestment of dollars under capitation to better fund the rest of this continuum." Director Brown, who has worked on provider-based care management and capitated primary care programs, posited that bundled payment for acute behavioral health episodes could be pursued in the context of a Medicaid ACO.

Architecture for MA 1115 waiver

On November 4, 2016, Massachusetts received federal approval of its request for an amendment and extension of the 1115 Demonstration Waiver, providing MassHealth additional flexibility to design and improve programs. The Waiver authorizes $52.4B in spending over five years, including $1.8B in Delivery System Reform Incentive Payments (DSRIP) to fund MassHealth's restructuring and transition to accountable care. In addition to MassHealth's existing Managed Care Organization (MCO) program and the Primary Care Clinician Plan (PCC Plan), the Waiver also recognizes two new types of entities, **ACOs and Community Partners (CPs).**

The Waiver has a particular focus on behavioral health and expands the MassHealth benefit to include the full continuum of medically necessary 24-hour community-based rehabilitation services for MassHealth members with substance use disorders, generating $150 M in federal revenue to further invest in capacity and access to SUD services.

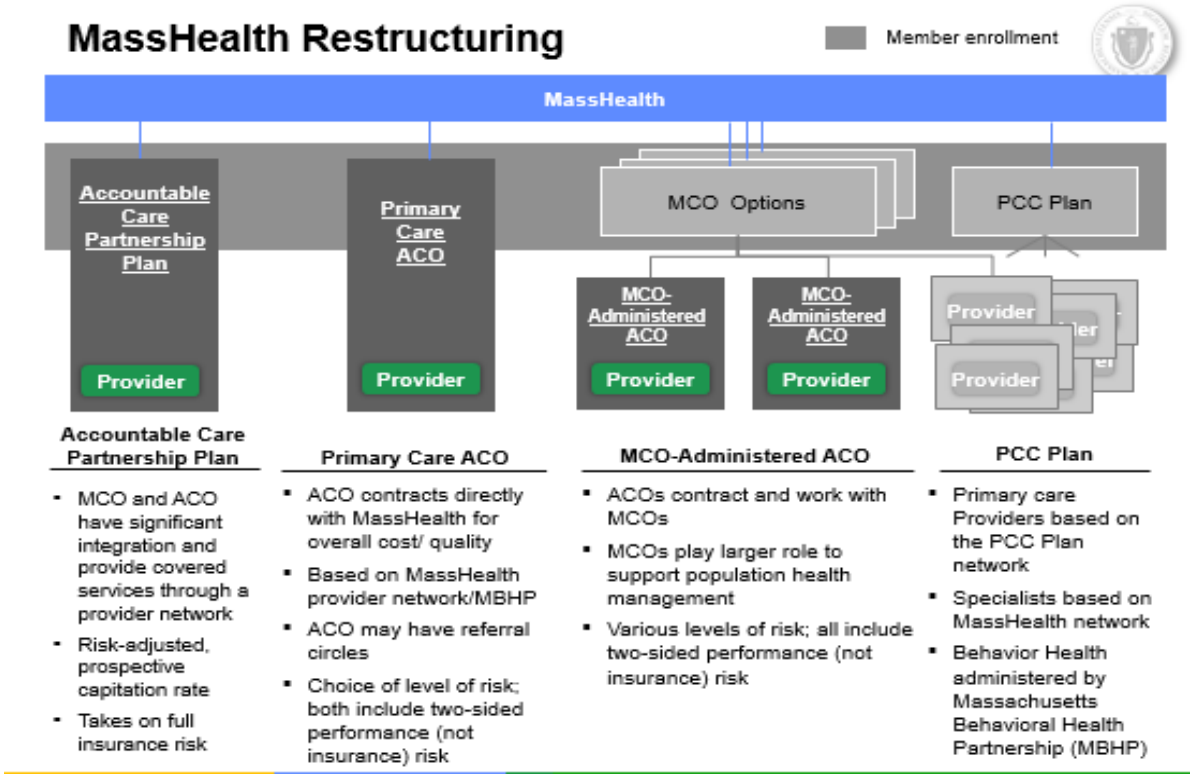
Massachusetts tried not to be too prescription in its overall payment reform plan. The plan focuses on the development of ACOs, but also supports Community Partners for providing specialty complex care coordination for seriously mentally ill, and requires ACOs develop memorandums of understanding with Community Partners around integrated care coordination, information exchange and member assignment and triage.



DSRIP spending includes workforce development investments in psychiatry and social worker disciplines.

COMMUNITY PARTNERS:

- MassHealth will procure **Community Partners (CP)**—entities experienced with Behavioral Health and Long Term Services and Supports to support ACOs and MCOs in providing quality care to certain members.
- **CPs will:**
  - Support members with high behavioral health needs and complex LTSS needs to help them navigate the complex systems of BH services and LTSS in Massachusetts
  - Improve member experience, continuity and quality of care by holistically engaging members
  - Create opportunity for ACOs and MCOs to leverage the expertise and capabilities of existing community-based organizations serving populations with BH and LTSS needs
  - Improve collaboration across ACOs, MCOs, CPs, community organizations addressing the social determinants of health, and BH, LTSS, and health care delivery systems in order to break down existing silos and deliver integrated care.



There are multiple ways to serve as an ACO under the plan:

- *Accountable Care Partnership Plan*: Fully capitated managed care product, with a co-joined provider ACO partner. They bid together, sharing upside and downside risk with performance tied to quality.
- *Primary Care ACO Entity*: The ACO contracts directly with MassHealth. The concept includes a fee for service budget target with behavioral health still managed under the state model.
- *MCO Administered ACO*: "Make the managed care entities contract with us" – managed care plan is required to contract with the provider entities that have been deemed by the state as ACOs (3 bidders).
- *PCC Plan*: The MassHealth Primary Care Clinician plan will remain an option for Members whose Primary Care Clinician is not affiliated with an ACO or who do not select an MCO .

Supplemental information from "Behavioral Health and Alternative Payment: A (Non-Scientific) Progress Report"

Director Brown is clear that there are different models and needs based on the acuity of the behavioral health needs. Primary care management of behavioral health needs is critical *when* primary care can effectively manage SUD and mental health issues. Primary care integration cannot be the only solution for the performance of the specialty behavioral health system, as it is not a model to address the seriously mentally ill.

"In our enthusiasm to provide a behavioral health medical home model, we can't forget that patients may also need specialty care, and in Massachusetts, that specialty mental health system needs help."

Regardless, Massachusetts has not to date landed on a payment reform model that can fully support integration across the behavioral health spectrum.

Nevertheless, integration efforts are still largely being financed through a patch-work quilt of funding sources

Level of Integration (AHRQ Lexicon levels of integration measurable with IPAT)	FFS Codes Currently Covered (billable today by contracted providers)	Additional FFS Billing Opportunities (could be made available to qualifying practices)	Additional Care Management/Medical Home Allocations (typically program specific)	Additional Infrastructure Dollars for HIT, eHealth, overhead etc.
Collaborative Referral to Outpatient BH Provider	• Case Consult (adult & youth) • Family Consult (youth) • Collateral Contact	• **New codes that could be made reimburseable:** • **Telehealth codes**	• E.g., Practice-Based Care Management Payment/Incentive	• Grant Funding (SAMHSA, other)
Co-Located Outpatient BH Provider in Primary Care Clinic	• Case Consult (adult & youth), • Family Consult (youth), • Collateral Contact • Diagnostic Evaluation • OP Therapy Codes (as per specs and DPH regs) • Medication Mgmt Codes (as per specs and DPH regs)	• **New codes that could be made reimburseable:** • **Telehealth codes** • **Health & Behavioral Assessment and Intervention Codes** • **SBIRT Codes** • **Transition of Care Codes**	• E.g., Practice-Based Care Management Payment/Incentive	• Grant Funding (SAMHSA, other) • Contractual arrangements with partner Primary Care Sites to share medical home dollars, other incremental financing, or gain share
Fully Integrated Outpatient BH Provider on Primary Care Team	• Case Consult (adult & youth), • Family Consult (youth), • Collateral Contact • Diagnostic Evaluation • OP Therapy Codes (as per specs and DPH regs) • Medication Mgmt Codes (as per specs and DPH		• E.g., Practice-Based Care Management Payment/Incentive	• Grant Funding (SAMHSA, other) • Contractual arrangements with partner Primary Care Sites to share medical home dollars, other incremental financing , or gain share

Key Challenges in Integrating Behavioral Health in Payment Reforms

- Information exchange and privacy protections
- Right sizing payment to ensure adequate financing of current and new services
- Governance of partnerships and funds flows
- Safeguarding consumer choice

Massachusetts is looking to reforms that can work across payer sources.

Designs across Public and Private Payers Incorporating Behavioral Health

- Pay for performance on quality metrics
- Rate increases tied to quality measures
- bundled payment for ADHD and ODD
- MAT episode payment (DRG)
- Integrated medical home PMPMs
- Global budget inclusive of BH with gain/loss tied to quality
- Primary care prospective capitation inclusive of BH w/ shared savings tied to quality
- Prospective global capitation

1115 Waiver Provisions for Substance Use Disorder Treatment

Massachusetts is also focusing on SUD treatment in its waiver, and in a massive shift Medicaid is moving residential rehabilitation services into the MassHealth Benefit in the hopes of providing a continuum of care for substance use disorders patients.

- Moves Residential Rehabilitation Services into the MassHealth Benefit
- Generates $150M in funding over five years for the expansion of Substance Use Disorder (SUD) treatment to address the opioid crisis
- Additional capacity for 450 residential rehabilitation beds
- Expansion of MassHealth benefit to cover recovery support navigators, and recovery coaches
- Increased investment in Medication Assisted Treatment and critical time intervention for homeless individuals
- MassHealth and the Department of Public Health will adopt a standardized American Society of Addiction Medicine (ASAM) assessment across all SUD providers

Massachusetts plans to incorporate SUD into ACO coverage if possible in an effort to counteract the isolation of SUD treatment and services in the medical delivery system. In a national survey of 635 Substance Use Treatment organizations:

- Only 15% of these organizations had signed agreements with ACOs
- Another 6.5% were planning to sign such an agreement and 4% were in discussions

VERMONT MEDICAID VBP EVOLUTION- SSP TO NEXT GENERATION - KEVIN STONE

Kevin Stone, Senior Consultant and Principal with Helms and Company, brought the Vermont perspective to the symposium.

Mr. Stone noted some of the key differences between Vermont and New Hampshire. In Vermont, Medicaid is the largest payer and covers almost a third of the state's population. Vermont is highly regulated and has strict Certificate of Need laws controlling new health care services. Vermont created the Green Mountain Care Board that approves both hospital expenditure budgets and insurance premiums for health plans. The Board stands behind its regulatory authority: if hospitals exceed their revenue targets, *they* typically return surplus through service payment reductions or community supports. Recently the University of Vermont Medical Center had to give back money because the hospital exceeded its budget. Blue Cross Blue Shield of Vermont (BCBS) was forced to lower their premiums by the Board. It's "*regulation with some teeth*"!

In addition, Vermont has little competition among providers. There are no free-standing imaging, urgent care or ambulatory surgical centers.[7] Vermont hosts only two small group health insurers, BCBS and MVP Healthcare. In Vermont, all individual *and* small group insurance is sold on the exchange.

Vermont also has a significant history with ACOs and payment reform.

- Health First is an independent practice association created by and made up of independent physicians. https://vermonthealthfirst.org/ .
- Community Health Accountable Care, LLC, made up of FQHCs operated a Medicare ACO (although its Board terminated its participation the October 2017) http://www.communityhealthaccountablecare.com/, and
- OneCare Vermont (https://onecarevt.org/) is made up of the Vermont hospitals, several New Hampshire hospitals and numerous other affiliated providers. [8]

In recent years Vermont Medicaid, Medicare and the Exchange plans have contracted with one or more of these ACOs.

Vermont wants a common method of payment across all payers, and has considered several versions, first with ACOs, then single payer model, and most recently a state and federal "All Payer Model".

[7] The GMCB approved a CON to a Burlington ASC after the Symposium.

[8] Vermont hosts two hospitals that result from a merger of a hospital into an FQHC.

Vermont ACO & Payment Reform History

3 ACOs Originally– Shared Savings Program Model Initially
- –HealthFirst– Private MDs– largely in greater Burlington
- –Community Health Accountable Care (CHAC)– FQHCs
- –One Care Vermont (OCV)– All 14 Hospitals; Some private MDs

State & Federal "All Payer Model" program –2017 – 2022
- –Common Risk Model for Medicare; Medicaid; Exchange
- – "Modified" Medicare Next Generation Model Platform
- –Providers Asked to Create "Single ACO"– Vermont Care Org.
- –2017 Medicaid Pilot in 4 Counties

All Payer Model Goals

Reduce Overall Cost Trend – "lock-in" 3.5% (vs. 5.5% estimated)
Reduce Cost Shift to Employers
Improve Overall Population Health–Statewide Health Outcomes:
- –Substance Abuse
- –Suicide Prevention
- –Chronic Disease– COPD/Asthma; HBP; Diabetes; Tobacco Use
- –Access–PCP; Timely Info
- –ACO Quality Measures

Method– Common Risk Model for Providers in Single ACO

Vermont OneCare and the Next Generation ACO

OneCare Vermont Early Results
Statewide ACO w/Multiple Provider Types

Much variation across community network

Measure	OCV Range
ER visits per 1,000 beneficiaries	434 – 824
30 day all cause readmission rates	10% – 15%
Spend per SNF/swing encounters/month	$658 – $1,929
Spend per home health admits/month	$239 – $350

ISSUE – How Treat Various ACO Members with Different Performance?

OneCareVermont

Vermont OneCare has experience under the Medicare Shared Savings model and despite meeting its quality targets, OneCare actually received no shared savings. Because Vermont is already a low cost state relative to the U.S., it is extremely difficult to achieve shared savings payments under the Medicare SSP model. OneCare performs in the "high value quadrant"- lower than average cost and higher than average quality- but since the SSP model rewards cost trend change and not cost attainment or quality improvement the Vermont ACOs have not received Medicare SSP shared savings payments.

The new model for Medicaid as well as Medicare and the Commercial Exchange is the Next Generation ACO. While each payer will have its own specific contract with the ACO, the basic concept it that the ACO will be locked into a 3.5% aggregate cost trend (Vermont costs are projected to trend at a 5.5% growth). While each payer will have some specific areas of clinical focus, there are general quality measures applicable across all 3 in the model.

Vermont OneCare receives an administrative payment from Medicaid ($6 PMPM) and plans to flow the payment through to primary care physicians, keeping some portion for the administrative costs of the ACO. OneCare also receives an additional $2.50 PMPM for care management. Members are assigned attribution on the front end.

Under the model, OneCare does not achieve any reward unless it meets or beats the cost targets. Medicaid agreed to waive its prior authorization requirements on its Medicaid members attributed to the ACO, and that was critically important to the providers. The original plan was forthe ACO to be 100% responsible for the first 5% risk corridor and then 30% ACO and 70% the Medicaid program for a second risk corridor. For the first year, Medicaid and

OneCare agreed to have just one risk band of 3% taking possible data and start-up issues into account. OneCare hospitals and their providers agree to accept a global cost budget for their attributed lives and most will receive a capitation payment for the internally rendered services portion of this global budget.. Medicaid pays all the claims outside the capitated services using its regular processing procedures. An incentive pool to reward quality is established from the overall global budget funds.

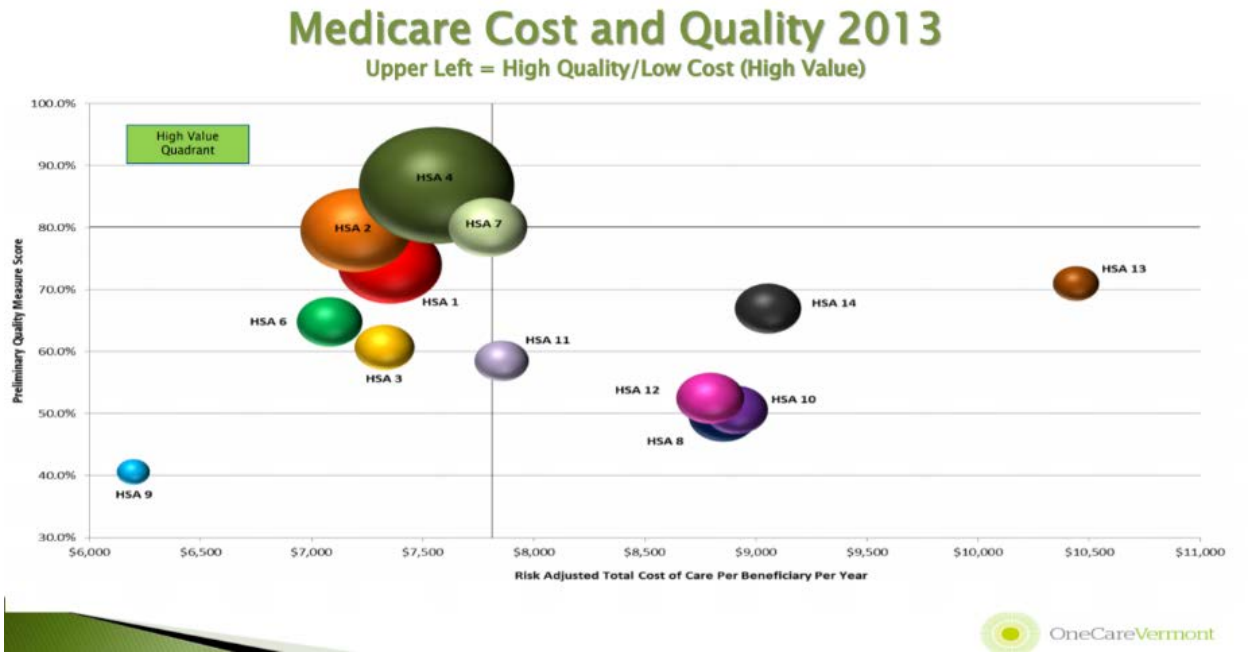
OneCare worked with the payers to develop a common set of quality measures-many of which were already in use- to avoid the cost and disruption of creating payer specific new measures.

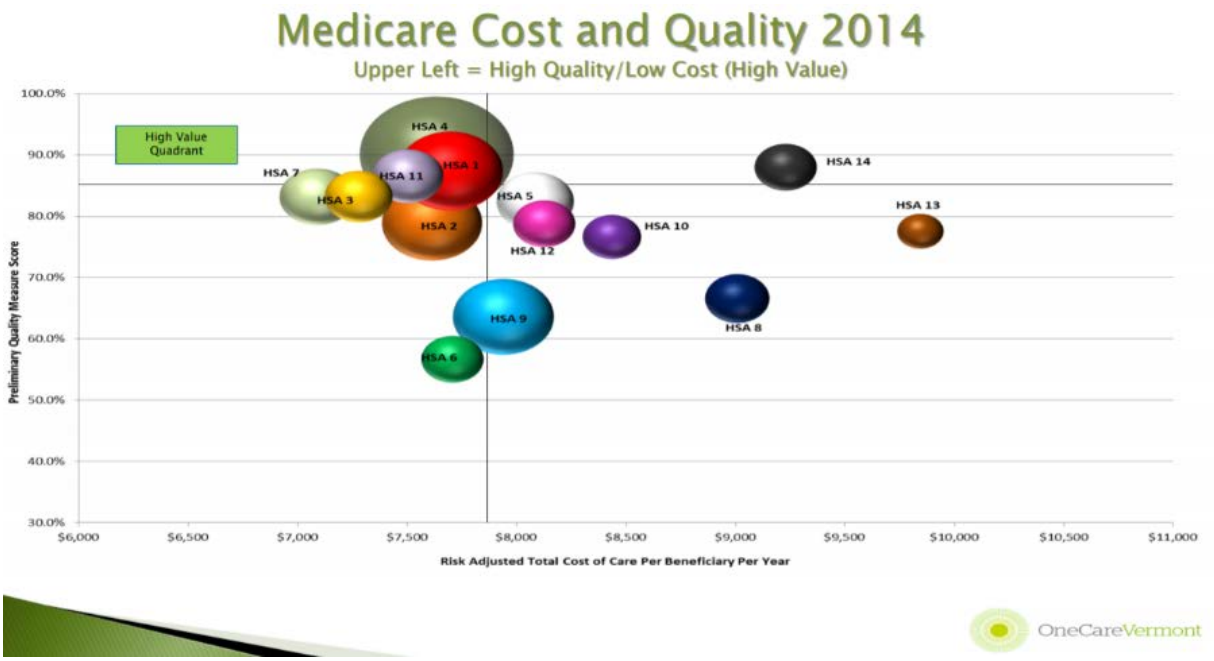
A key component of the ACO efforts to to achieve savings is by engaging providers and patients in high risk targeted care management. This will include development of 'shared care plans' where all providers and the patient will have access to a care plan to achieve agreed upon health attainment goals.

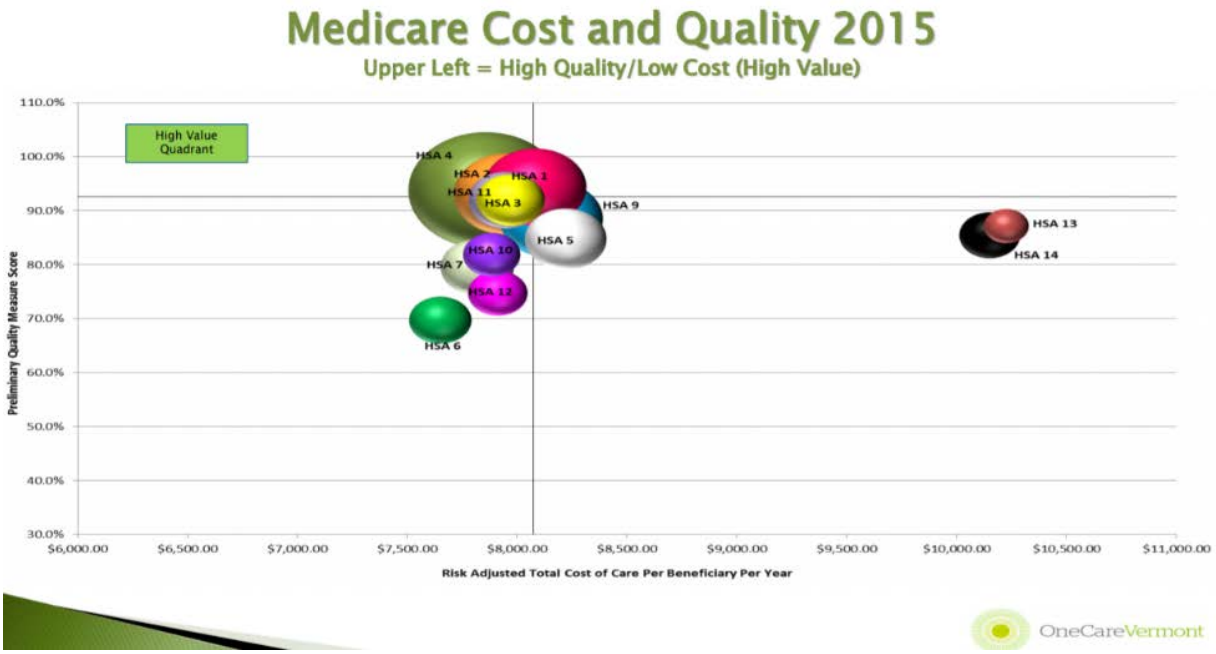
Medicare Cost and Quality 2013- 2015

OneCare is a state wide ACO and thus can look at the cost and quality of the various communities over time. While initially there was much variation among the ACO Communities, there has been a significant reduction in variation during the years of Medicare ACO participation. Nationally, providers have had similar experiences confirming the ACO as a good model despite the difficulty of achieving savings.

OneCare Vermont studied its Medicare Cost and Quality, measuring the risk adjusted total cost of care per beneficiary per year versus the quality measure score over the years 2013, 2014 and 2015. By looking at all three graphs we can see that there is reduced variation across communities as they trend towards lower cost and higher value.







In considering how the Vermont experience could inform NH endeavors, one of the major problems New Hampshire faces is that "frankly from the provider perspective, the woefully low reimbursement that currently exists."
"Imagine going to the providers and saying…have I got a deal for you…let's put some of that money that doesn't cover your costs at risk. Are you with us?"

QUESTIONS FOR APM PANEL

Behavioral health integration in primary care is a critical effort, but Maine noted that integrated behavioral health has not been calculated as part of the budget for the accountable communities. Massachusetts agreed that the model is very effective in the FQHCs, however, the behavioral health data shows that some patients are so involved in mental health care they instead need to have primary care incorporated into the specialty mental health services. Massachusetts has used community support providers to help navigate that specialized system, and to navigate how to engage folks wherever they seek care. All presenters noted that they have not discovered a sustainable payment and budget neutral model for integrated behavioral health yet.

Behavioral Health Workforce Development: Massachusetts noted that not all problems can be solved through Medicaid reforms. However, Medicaid does have an obligation to focus on the delta between cost of providing care and reimbursement rates. Massachusetts is going through a process of rate normalization in order to address this.

"I don't think you can solve for workforce if you have a system that continues to be chronically underfunded."

This issue is especially acute in the area of psychiatry. Massachusetts is contemplating bundling services under the capitation rate in order to try to address this issue.

Kevin Stone noted that the reallocation of fees in a fee for service system seems "hopeless." The hope is that the bundled and capitation payment models will allow for a better redistribution.

The larger health systems are simply not investing in behavioral health.

One presenter noted concern about MACRA/MIPS for independent practitioners, expressing the difficulty of staying in private practice under the new Medicare reform requirements.

The provider culture is going to be a bigger challenge than integration.

Bi-State Primary Care Association is trying to align with larger systems in Vermont and the cultural differences are difficult. The smaller providers just don't have the resources to provide "one more metric."

Community providers need fair and stable payment, incentives for quality and resources for innovation.

Kevin Stone noted that OneCare ACO achieved significant savings Year 1, less so Year 2 and Year 3 the ACO is not meeting the target. Some of these models push for change really fast, and that's difficult for providers. It's still hard to move into 2-way risk, and the funding for financing the new APM structure comes out of the reimbursement, which doesn't work well.

Gina Balkus, CEO of the Home Care Association, noted that Medicaid is the largest payer for home and community based providers and long-term care services – and asked whether any of

the Medicaid programs are addressing payment reform for LTSS? Ms. Brown responded that in Massachusetts, LTSS will be brought into the ACO model in the third year of the program. Right now, Massachusetts has contracted with a third party administrator to help LTSS begin to work within a care management framework.

One presenter asked whether the politicians who hold the purse strings understand the many years it takes to achieve a return on investment in community services. The key is being able to think and plan for long term savings and system wide savings.

Dr. Crowley advised providers to take into consideration the delay in "data" results. The delay is difficult for the providers. For example, MaineGeneral was waiting in May 2017 for the results from 2015.

Kate Crary is a Project Director and has been with IHPP since 2011. Aside from her work in facilitation, project management, and policy, Kate is also a graphic recording artist, and uses her listening and artistic skills to create murals in real time to support a variety of public health related projects and meetings.

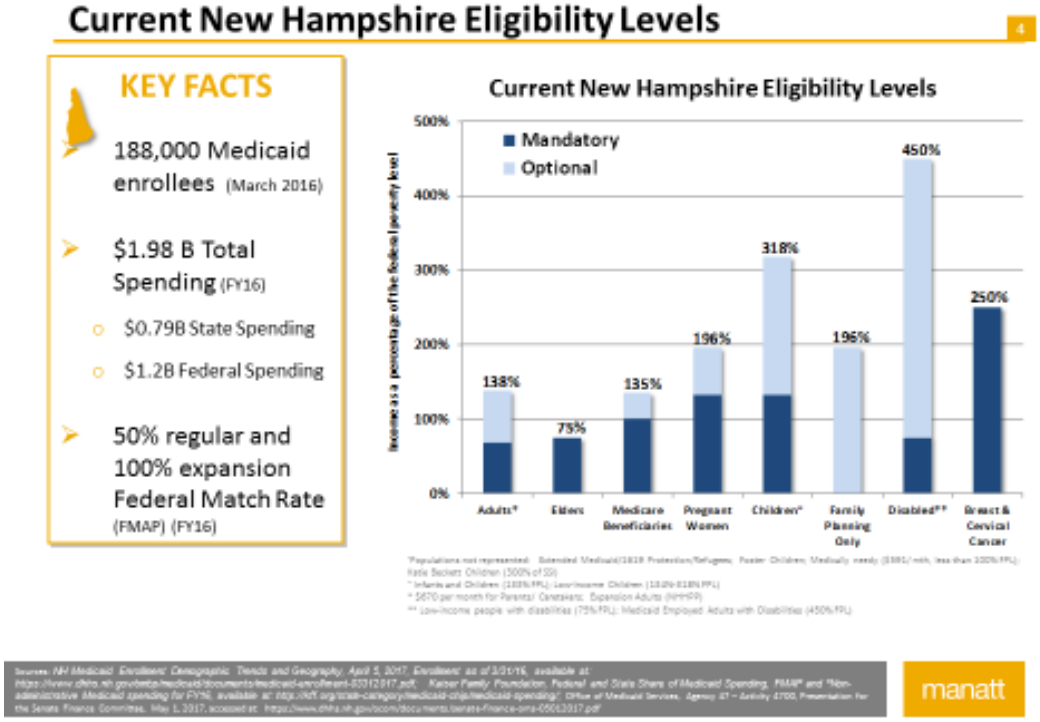
SECTION III: MEDICAID TOMORROW AND THE IMPLICATIONS OF FEDERAL POLICY DEVELOPMENTS

United States Senator Maggie Hassan opened the afternoon session, which focused on the impact of uncertainty and shifting federal policy on New Hampshire. Senator Hassan discussed the debates in Washington. Current proposals could dramatically reduce Medicaid resources in New Hampshire, change the health policy landscape and limit resources for innovation and reform. She reminded the audience to stay in touch with their Federal delegations to ensure that the needs of New Hampshire residents are known and made part of the Federal conversations.

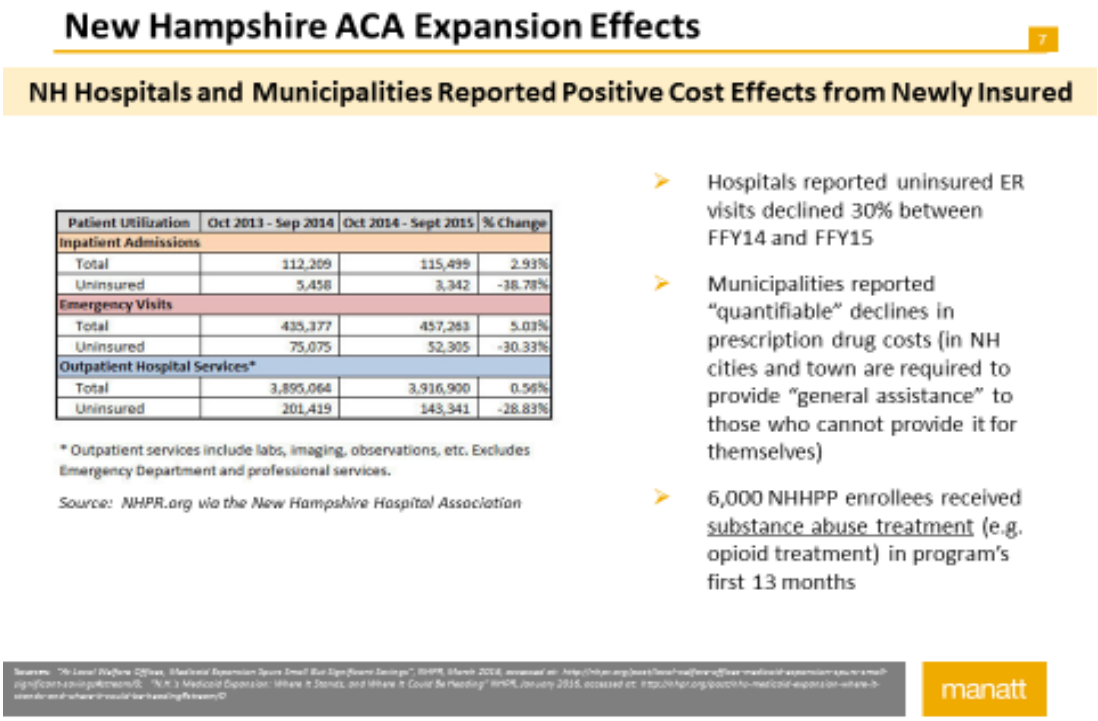
SESSION 7: MEDICAID TOMORROW: THE IMPLICATIONS OF FEDERAL POLICY DEVELOPMENTS, CINDY MANN

Cindy Mann, Partner at Manatt Health and former Director of the Center for Medicaid and Children's Health Insurance Program Services (CMCS) at CMS, presented on the federal Medicaid landscape and the implications of current and federal policy developments.

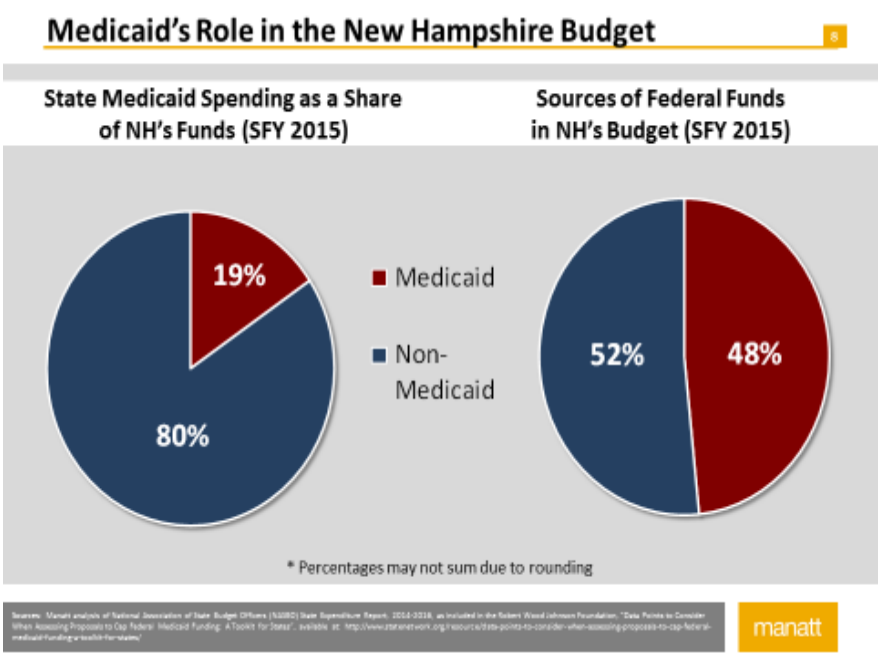
Ms. Mann provided a summary of research done by Manatt that described New Hampshire's Medicaid population, with an emphasis on the eligibility thresholds for Medicaid coverage, spending on Medicaid in state and federal sources, and the types of services covered by Medicaid. This summary framed a larger discussion of the potential impact on eligibility, spending and coverage based on certain proposed changes in federal Affordable Care Act policies.



The conversation also included looked at how increasing the number of New Hampshire residents with insurance coverage has favorably reduced uncompensated care costs at New Hampshire hospitals and other providers.



Cindy Mann reminded the audience of the structure of New Hampshire's Health Protection Program, the number of individuals included in the newly covered population (52,000), and the fact that the costs of including the newly eligible able bodied adults in the NHHPP was paid for 100% by the federal government during the initial years of the program, with the federal contribution dipping to 94% for CY 2018.



She also explained that New Hampshire receives 48% of the federal funds in its budget through the Medicaid program while the state's own general fund spending on Medicaid is only 19% for its share.

Medicaid's Financing Structure: Current v Proposed 11

	Current	Block Grants	Per Capita Cap
Federal Funding	Open ended	Aggregate cap	Per enrollee cap (by eligibility group)
Risk	Federal government and state share enrollment and spending risk	States bear risk of both higher enrollment and health care costs	States bears spending risk of higher health care costs
Trend Rates	Determined by health care costs in the state and individual state spending decisions	National trend rate	National trend rate
Ability to Accommodate Medical Advances or Public Health Crises	Federal payments automatically responsive	Federal payments not responsive	Federal payments not responsive
Spending Outside of Cap	N/A	Unknown/TBD	Unknown/TBD
State Flexibility	State flexibility subject to federal minimum standards; Section 1115 waivers provide additional flexibility	Increased flexibility, but some minimal standards and accountability	Increased flexibility, but some minimal standards and accountability

The proposed federal policy changes may have a significant impact on Medicaid, including a possible movement to block grants or per capita capitation programs. The presentation provided a summary of the differences in those approaches, all of which are likely to decrease Federal spending on Medicaid, and thus decrease federal dollars spent on health care in New

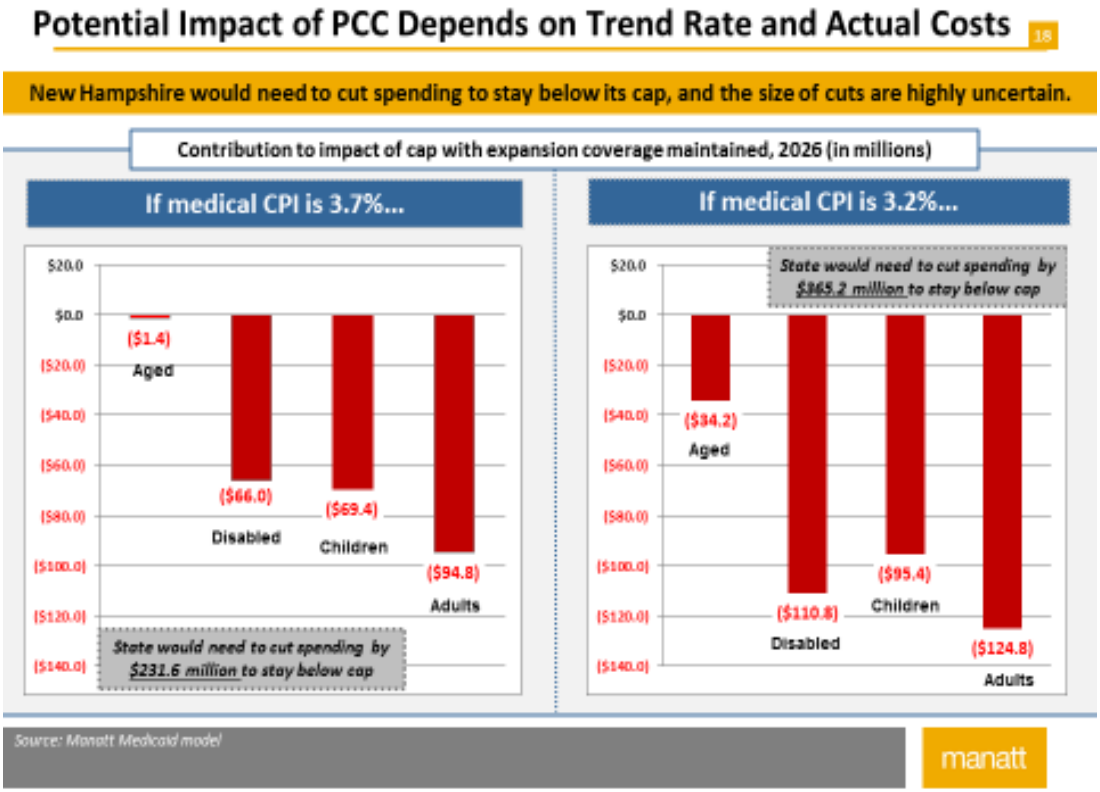
Hampshire. Ms. Mann presented analysis by Manatt that sought to estimate the potential financial impact in New Hampshire of those costs.

Based on varying potential trends in the growth rate of medical spend (3.7% or 3.2%), the analysis indicated that New Hampshire would need to decrease spending by at least $200 million, in a capped funding model.

The presentation also included specific focus on potential impact of a per capita cap or block grant model for Medicaid funding in New Hampshire, which may not sufficiently account for changes in the demographic profile of New Hampshire. More specifically, New Hampshire's population of those age 65 and older is growing, and funding models may not accurately account for the funding needed to cover costs for those populations.

Ms. Mann included several important considerations for New Hampshire going forward. These include:

- States will be at risk for all costs above the caps; will New Hampshire spend more state dollars without federal match?
- If not, state spending reductions will add to federal funding reductions
- Cost pressures may cause states to limit enrollment, benefits, and provider rates and create challenges for managing risk and population health
- Reduced funding will increase competition among stakeholders for limited resources



SESSION 8: WHERE DO WE GO FROM HERE? PANEL AND Q&A; DEBORAH FOURNIER, CINDY MANN, YVONNE GOLDSBERRY (MODERATOR)

The Symposium wrapped up with a Q&A session for the audience with Deborah Fournier and Cindy Mann, moderated by Yvonne Goldsberry from the Endowment for Health. Most questions focused on understanding what New Hampshire needs to do to plan for anticipated changes in the Medicaid program. The presenters agreed there is a need for continued dialogue and tracking of the impact of changes for policy makers, providers, community organizations, and citizens.

THE END