# Section 438.6(c) Preprint

Section 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts. Section 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract – paragraph (c)(1)(i) provides that States may specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement; paragraph (c)(1)(ii) provides that States have the flexibility to require managed care plan participation in broad-ranging delivery system reform or performance improvement initiatives; and paragraph (c)(1)(iii) provides that States may require certain payment levels for MCOs, PIHPs, and PAHPs to support State practices critical to ensuring timely access to high-quality care.

Under section 438.6(c)(2), contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in section 438.6(c)(1)(i) through (iii).

## Standard Questions for All Payment Arrangements

*In accordance with §438.6(c)(2)(i), the following questions must be completed.*

### DATE AND TIMING INFORMATION:

1. Identify the State's managed care contract rating period for which this payment arrangement will apply (for example, July 1, 2017 through June 30, 2018):

| |
|---|
| September 1, 2019 - June 30, 2020 |

2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2018):

| |
|---|
| September 1, 2019 |

3. Identify the State's expected duration for this payment arrangement (for example, 1 year, 3 years, or 5 years):

| |
|---|
| 10 months (the current contract year): September 1, 2019 - June 30, 2020 |

## STATE DIRECTED VALUE-BASED PURCHASING:

4. In accordance with §438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative. *Check all that apply; if none are checked, proceed to Question 6.* *For expedited review in response to COVID-19, please move to Question 6.*

   ☐ Quality Payments / Pay for Performance (Category 2 APM, or similar)
   ☐ Bundled Payments / Episode-Based Payments (Category 3 APM, or similar)
   ☐ Population-Based Payments / Accountable Care Organization (ACO) (Category 4 APM, or similar)
   ☐ Multi-Payer Delivery System Reform
   ☐ Medicaid-Specific Delivery System Reform
   ☐ Performance Improvement Initiative
   ☐ Other Value-Based Purchasing Model

5. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services (the State may also provide an attachment). If "other" was checked above, identify the payment model. If this payment arrangement is designed to be a multi-year effort, describe how this application's payment arrangement fits into the larger multi-year effort. If this is a multi-year effort, identify which year of the effort is addressed in this application. *For expedited review in response to COVID-19, please move to Question 6.*

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|---|
| N/A |

## STATE DIRECTED FEE SCHEDULES:

*6.* In accordance with §438.6(c)(1)(iii), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. *Check all that apply; if none are checked, proceed to Question 10.*

☐ Minimum Fee Schedule
☐ Maximum Fee Schedule
☒ Uniform Dollar or Percentage Increase

7. Use the checkboxes below to identify whether the State is proposing to use §438.6(c)(1)(iii) to establish any of the following fee schedules:

☐ The State is proposing to use an approved State plan fee schedule
☐ The State is proposing to use a Medicare fee schedule
☐ The State is proposing to use an alternative fee schedule established by the State

8. If the State is proposing to use an alternative fee schedule established by the State, provide a brief summary or description of the required fee schedule and describe how the fee schedule was developed, including why the fee schedule is appropriate for network providers that provide a particular service under the contract (the State may also provide an attachment).

| |
|---|
| N/A |

9. If using a maximum fee schedule, use the checkbox below to make the following assurance:

☐ In accordance with §438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

## APPROVAL CRITERIA FOR ALL PAYMENT ARRANGEMENTS:

10. In accordance with §438.6(c)(2)(i)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract (the State may also provide an attachment).

The New Hampshire Department of Health and Human Services (DHHS) will require each MCO to pay a percentage add-on for specific qualifying services provided by the six safety net provider classes defined in Question 11 for the rating period noted in response to Question 1.

An identified portion of the actuarially sound per member per month capitation payment to the MCOs multiplied by the member months the plan is paid for the month will form a pool to be used every month to make percentage add-on payments to the defined safety net provider classes. The pool will be 1.5% of the capitation payments made to the MCOs, or approximately $12 million for the September 2019 to June 2020 contract year (depending on actual enrollment). DHHS will establish the percentage of the pool that will be allocated to a separate sub-pool for each of the six safety net provider classes based on historical MCO payments to these providers. Please see the attached table on the last page of the pre-print for the estimated percentages and dollar amounts for each provider class.

At the end of the month, the amount in each sub-pool will be divided by the payments made by the MCOs to the defined safety net provider class for qualifying services adjudicated in the month. This calculation will determine the amount of the uniform percentage add-on for the month. The additional payments will be sent to the safety net providers in the following month. It is anticipated that payments will be made on the following schedule:

- May 2020 payment: based on September 2019 to April 2019 encounters
- June 2020 payment: based on May 2020 encounters
- July 2020 payment: based on June 2020 encounters

Every add-on payment will be directly tied to a qualifying paid encounter. DHHS and CMS will be able to tie each payment to a specific service provided to a specific beneficiary through the data consistent with the managed care rule.

The non-federal funding source for this arrangement is state general funds for the Standard Medicaid population and the Granite Advantage Trust Fund for the Granite Advantage Health Care Program population; there is no local funding for this arrangement from IGTs or hospital assessments.

11. In accordance with §438.6(c)(2)(i)(B), identify the class or classes of providers that will participate in this payment arrangement.

The directed payment will apply to the six classes of safety net providers below. Please see the attached table on the last page for the estimated percentages and dollar amounts.

- FQHCs and RHCs (percentage increase to T1015, the most common encounter code)
  - Note that for Hospital Based RHCs, it will be an increase to their percent of charge amount for revenue code 0521 services for selected codes to be determined.
- Critical Access Hospitals (percentage increase to the DRG Price per Point and a uniform percentage increase to ER outpatient payments)
- SUD Residential Treatment Providers (percentage increase to codes H0018, H0018-U4, T1006, H0010)
- Home Health Providers (percentage increase to selected codes to be determined)
- Private Duty Nursing Providers (percentage increase to codes S9123 and S9124)

12. In accordance with §438.6(c)(2)(i)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract (the State may also provide an attachment).

As described in the answer to Question 10, all qualifying services delivered by providers in the six safety net provider classes are eligible to receive payments from the monthly funding sub-pools on an equitable basis. By dividing the monthly sub-pools of funds by payments for all qualifying services delivered by providers in each safety net provider class adjudicated by the MCOs in the month, every qualifying provider in a particular safety net provider class receives the same percentage increase for qualifying services paid by the MCOs in that month.

## QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS:

13. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per §438.340.

a. Hyperlink to State's quality strategy (consistent with §438.340(d), States must post the final quality strategy online beginning July 1, 2018; if a hyperlink is not available, please attach the State's quality strategy):

https://medicaidquality.nh.gov/sites/default/files/MCM%202.0%20Quality%20Strategy%20SFY%202020.pdf

b. Date of quality strategy (month, year):

September 2019

c. In the table below, identify the goal(s) and objective(s) (including page number references) this payment arrangement is expected to advance:

| **Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives** | | |
|---|---|---|
| **Goal(s)** | **Objective(s)** | **Quality strategy page** |
| NH Medicaid Care Management Quality Strategy Goal #2: Assure members have access to care and a quality experience of care | Objective 2.1 – Ensure that the MCO provider networks meet the 90% standard of time or distance for each New Hampshire County. | Page 9-10 |
| | | |
| | | |
| | | |
| | | |
| | | |
| If additional rows are required, please attach. | | |

d. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Question 13(c). If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and that of the multi-year payment arrangement.

Medicaid revenue is critical to maintaining the viability of the safety net providers that support the delivery of quality care for Medicaid enrollees in New Hampshire. These payments will help ensure access to care for Medicaid managed care enrollees in light of the COVID-19 emergency.

There is concern that these providers are at financial risk due to the decrease in elective visits and services. The directed payments described herein are intended to help the providers remain operational.

14. Use the checkbox below to make the following assurance (and complete the following additional questions):

☒ In accordance with §438.6(c)(2)(i)(D), the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goal(s) and objective(s) in the quality strategy required per §438.340.

a. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 13(c). If this is any year other than year 1 of a multi-year effort, describe prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. If the State has an evaluation plan or design for this payment arrangement, or evaluation findings or reports, please attach.

The State is contractually requiring the plans to pay the providers listed in response to Question 11 in this manner to ensure access to care for Medicaid managed care enrollees in light of the COVID-19 emergency.

On a semi-annual basis, the MCM Quality Program evaluates each MCO's network for time and distance standards that are established in the MCO contract. Standards developed in the MCO contract are compliant with requirements in 42 CFR 438.68(c). Networks are analyzed at the county level for each provider type. For provider types that do not meet time and distance standards, the MCO is required to submit a request for an exception to time and distance standards

Through this process, the State will ensure routine monitoring of access to care as required under §§ 438.66, 438.206, and 438.207

b. Indicate if the payment arrangement targets all enrollees or a specific subset of enrollees. If the payment arrangement targets a specific population, provide a brief description of the payment arrangement's target population (for example, demographic information such as age and gender; clinical information such as most prevalent health conditions; enrollment size in each of the managed care plans; attribution to each provider; etc.).

All enrollees

c. Describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

N/A

d. Provide additional criteria (if any) that will be used to measure the success of the payment arrangement.

N/A

**REQUIRED ASSURANCES FOR ALL PAYMENT ARRANGEMENTS:**

15. Use the checkboxes below to make the following assurances:

☒ In accordance with §438.6(c)(2)(i)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

☒ In accordance with §438.6(c)(2)(i)(F), the payment arrangement is not renewed automatically.

☒ In accordance with §438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with §438.4, the standards specified in §438.5, and generally accepted actuarial principles and practices.

## Additional Questions for Value-Based Payment Arrangements

*In accordance with §438.6(c)(2)(ii), if a checkbox has been marked for Question 4, the following questions must also be completed.*

**APPROVAL CRITERIA FOR VALUE-BASED PAYMENT ARRANGEMENTS:**

16. In accordance with §438.6(c)(2)(ii)(A), describe how the payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified above) providing services under the contract related to the reform or improvement initiative (the State may also provide an attachment).

## QUALITY CRITERIA AND FRAMEWORK FOR VALUE-BASED PAYMENT ARRANGEMENTS:

17. Use the checkbox below to make the following assurance (and complete the following additional questions):

☐ In accordance with §438.6(c)(2)(ii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

a. In the table below, identify the measure(s) that the State will tie to provider performance under this payment arrangement (provider performance measures). To the extent practicable, CMS encourages States to utilize existing validated performance measures to evaluate the payment arrangement.

| **TABLE 17(a): Payment Arrangement Provider Performance Measures** | | | | | |
|---|---|---|---|---|---|
| **Provider Performance Measure Number** | **Measure Name and NQF #** (if applicable) | **Measure Steward/ Developer** (if State-developed measure, list State name) | **State Baseline** (if available) | **VBP Reporting Years*** | **Notes**** |
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| If additional rows are required, please attach. | | | | | |

*If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement the measure will be collected in.
**If the State will deviate from the measure specification, please describe here. Additionally, if a State-specific measure will be used, please define the numerator and denominator here.

b. Describe the methodology used by the State to set performance targets for each of the provider performance measures identified in Question 17(a).

**REQUIRED ASSURANCES FOR VALUE-BASED PAYMENT ARRANGEMENTS:**

18. Use the checkboxes below to make the following assurances:

☐ In accordance with §438.6(c)(2)(ii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

☐ In accordance with §438.6(c)(2)(ii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

## Attachment 1

As referenced in Questions 10 and 11, this table shows the percentage distribution and initial allocation of the separate sub-pools based on January 2019 to June 2019 MCO encounter payments.

**Table 1**
**New Hampshire Department of Health and Human Services**
**Medicaid Care Management Program**
**Initial Allocation of Directed Payment Sub-Pools**

| Safety Net Provider Class | Percentage Distribution of January to June 2019 MCO Payments for Selected Services Only | Approximate September 2019 to June 2020 Direct Payment (Total)[1] | Approximate September 2019 to June 2020 Direct Payment (Monthly)[1] |
|---|---|---|---|
| FQHCs and RHCs | 32.0% | $3,744,000 | $374,400 |
| Critical Access Hospitals | 29.8% | 3,486,600 | 348,660 |
| SUD Residential Treatment | 16.8% | 1,965,600 | 196,560 |
| Home Health | 4.9% | 573,300 | 57,330 |
| Private Duty Nursing | 8.8% | 1,029,600 | 102,960 |
| Personal Care | 7.7% | 900,900 | 90,090 |
| **Total Pool** | **100.0%** | **$11,700,000** | **$1,170,000** |

[1] *Approximate values of the direct payment pool are based on the initial enrollment projections in the January 14, 2020 rate setting report. Actual monthly pool funding will be determined by actual MCM program enrollment multiplied by the PMPM directed payment funding for each rate cell in the September 2019 to June 2020 MCM program capitation rates.*