New Hampshire
Department of Health and Human Services

Building Capacity for Transformation
Section 1115 Demonstration Waiver

Application Amendment

February 25, 2015

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Section I - Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

In New Hampshire, the demand for mental health and substance abuse services is increasing; provider capacity is already strained and the capacity that exists is not well positioned to deliver the comprehensive and integrated care that can most effectively address the needs of patients with severe behavioral health problems or comorbid physical and behavioral health problems. This demonstration responds to this pressing need and proposes to transform the delivery system for some of the most medically complex and costly Medicaid beneficiaries.

A number of factors have come together to make the transformation of New Hampshire's behavioral health delivery system an urgent priority for the State. First, the State expanded Medicaid to cover the new adult group—an estimated one in six of whom have extensive mental health or substance abuse needs—increasing the demands on the delivery system. Second, New Hampshire now covers substance use disorder (SUD) services for the Medicaid expansion population, and Governor Hassan has proposed extending the SUD benefit to the entire Medicaid population in SFY 2017. Dramatically expanding Medicaid coverage for SUD services increases demand on already-strained SUD providers. Finally, the expansion of coverage for new populations and new services coincides with an epidemic of opioid abuse in New England.

Currently, the behavioral health delivery system is not poised to meet the increasing demands. There are too few community-based behavioral health providers, and many of these providers are financially strained. Because of long waits for community-based behavioral health services, many patients' needs are not addressed in the community in a timely fashion. The lack of community-based options creates an over-reliance on inpatient psychiatric care. And when patients reach a crisis, there are too few inpatient psychiatric beds, meaning that they must wait in the emergency room for a bed to become available. Additionally, mental health providers, SUD providers, and physical health providers each operate in silos, with little coordination across provider types or with community-based supports.

New Hampshire seeks to transform its behavioral health delivery system to (1) deliver integrated physical and behavioral health care that better addresses the full range of individuals' needs, (2) expand capacity to address emerging and ongoing behavioral health needs in an appropriate setting, and (3) reduce gaps in care during transitions across care settings by improving coordination across providers and linking patients with community supports.

Through this demonstration, New Hampshire Medicaid will have the resources to invest in transformation and the flexibility to adopt a regionally-based approach. The demonstration funds will enable the State to make performance-based funding available to providers to form

regionally-based integrated delivery networks (IDNs). The IDNs will receive funding to undertake projects to increase integration across providers and community social service agencies, expand capacity, develop new expertise and improve care transitions. By working with managed care plans to require value-based purchasing in the future, the State will also establish a means to sustain the IDNs' activities after the demonstration ends.

To develop its transformation plan as is outlined in this amendment to the State's Building Capacity for Transformation Demonstration, New Hampshire worked intensively with stakeholders throughout the Fall of 2014. Through this process, the Department of Health and Human Services conducted nearly 20 interviews with community-based clinics and hospitals, foundation experts, community based social services agencies and leadership at other state agencies such as the Department of Corrections. It also held a public information session with over 75 attendees. There was striking consensus among the stakeholders—New Hampshire's behavioral health system is in crisis and a comprehensive response is required. And now is the time.

Rationale for the Demonstration

The demonstration is intended to address the following critical issues:

- **Severe capacity issues.** Even as the heroin epidemic continues to wreak havoc in New Hampshire, the state has far too few substance abuse providers—four out of the 13 public health regions in the State do not have any residential substance abuse providers; many have only two to three providers that can provide medication-assisted treatment; and one has no such providers. Last year, foundations in the state had to provide emergency funding to some substance abuse clinics so that they could keep their doors open. And many community mental health centers are also struggling financially. The closure of any substance abuse clinics or community mental health centers would further exacerbate the capacity issues. New Hampshire Hospital, the State's facility for people with severe mental illness, operates at 100 percent capacity, and 2 out of 3 people admitted must spend more than a day waiting in the ER before a bed is available. In the community, new adult patients must wait 26 days for an appointment with a mental health counselor and 49 days if they need to see someone with prescribing authority.

- **"Siloed" care for people with physical and behavioral health issues.** Stakeholders repeatedly raised concerns about the "siloed" way in which care is delivered to Medicaid beneficiaries in New Hampshire. Despite promising pilot projects and discrete initiatives, the reality is that most Medicaid beneficiaries essentially must navigate two different health care systems in New Hampshire if they want to address both their physical and behavioral health needs. With the research showing that people with severe mental illness die on average 25 to 30 years earlier than the general population, often because of serious physical conditions such as diabetes, heart disease, obesity,

and smoking-induced illnesses, the siloed nature of care in New Hampshire must change.

- **High risk of people with behavioral health issues falling through the cracks during care transitions.** Over the past half-decade, New Hampshire has lost ground in providing follow up after a behavioral health discharge – between 2007 and 2012, the percent of patients hospitalized for a mental health disorder who receive follow up care in the 30 days after discharge has deteriorated from 78.8 to 72.8 percent. With more people than ever relying on Medicaid, this trend must be reversed. New Hampshire also views release from jail or prison as a care transition, and one that has taken on increased importance now that it is responsible for providing care to most incarcerated people when they return to the community. Currently, 48 percent of New Hampshire residents who leave a state correctional facility have their parole revoked due to a substance use-related issue, a clear indication that more must be done to provide greater continuity of substance abuse treatment during and after a departure from prison.

Key Elements of the Demonstration

To respond to these challenges, New Hampshire's Demonstration will use the following four tools:

Tool #1: Time-Limited Transition Funding for Safety Net Providers. The Demonstration will make time-limited payments to safety net providers charged with providing SUD and mental health services to growing numbers of New Hampshire. To qualify for transition funding, providers will be required to demonstrate a need for additional funding to sustain their current capacity, commit to maintaining or expanding services provided prior to delivery system reform, and agree to participate in the demonstration. This funding is not designed to solve the state's capacity issues, but it will allow safety net providers to survive long enough that they can develop sustainable models for providing care to the growing numbers of Medicaid beneficiaries.

Tool #2: Integrated Delivery System Networks (IDNs). The Demonstration will support the development of regional networks of providers, known as Integrated Delivery Networks or IDNs. Each IDN will implement a series of projects. The projects will be designed to increase capacity to provide behavioral health services; promote integration of behavioral and physical health along with community social service supports; and support care transitions. IDNs that successfully implement projects and meet metrics will qualify for performance-based payments. A lead applicant will serve as the coordinating entity and single point of accountability for the State, but providers will be expected to work together to design and implement delivery system reform changes. A key purpose of the IDNs is to spur providers to adopt the operational, clinical and cultural changes required to build new partnerships and work outside of existing "silos" of care. In recognition that such fundamental change requires time and resources,

payments initially will be based on meeting process-based metrics, but over time, they will be linked to outcome measures.

Tool #3: Statewide Resources To Support Implementation. New Hampshire will support IDNs through technical assistance and learning collaboratives.

Tool #4: Coordinating with Medicaid Managed Care to Promote Sustainability. To ensure the sustainability of the initiative after the Demonstration funding ends, the State will establish a process to evaluate whether and how to ensure that health plans participating in Medicaid Care Management enter into value-based contracting arrangements with IDNs. This process will build upon the existing requirement that Medicaid Care Management plans develop and implement a payment reform plan. Under the value-based contracting arrangements, the managed care organizations and IDNs will work together to provide high quality, cost-effective care to Medicaid beneficiaries.

In sum, the waiver is a critical component of New Hampshire's broader delivery system and Medicaid reform agenda. It has been designed to build upon and strengthen a number of other initiatives underway in New Hampshire, including the expansion of Medicaid to newly eligible adults; the recent move to comprehensive Medicaid managed care (which includes both physical and behavioral health benefits); the State's Health Improvement Plan; the recently awarded State Innovation Model Planning Grant; the Governor's proposal to extend SUD services to the whole Medicaid population in SFY 2017; and the State's initiative to reorganize the Department of Health and Human Service around a "whole person" approach to providing services. The State will also evaluate whether and how a health home program could further support New Hampshire's delivery system transformation.

In this larger context, the particular role of the 1115 transformation waiver is to help New Hampshire's health care providers and community partners transition to a new way of providing care for people with behavioral health issues. By providing funding to support delivery system transformation—rather than to cover the costs of specific services rendered by providers—the waiver will encourage and enable health care providers and community partners within a region to form relationships focused on transforming care. Once providers have gained experience in jointly implementing new care models for individuals with behavioral health needs, they will build on that experience to transform care more broadly. In effect, the IDNs will provide a platform on which to build broader delivery system reform, including for Medicaid beneficiaries without behavioral health issues and even, potentially, New Hampshire residents who are not enrolled in Medicaid.

2) Include the rationale for the Demonstration

The purpose of this demonstration is to support New Hampshire's effort to provide high quality, integrated, and cost-effective care to individuals with behavioral health issues (mental health and substance abuse). It is designed to complement and strengthen a number of existing

New Hampshire initiatives, including the expansion of Medicaid to newly eligible adults. Under the expansion, newly eligible adults, many of whom have significant behavioral health issues, will qualify for a benefit package that includes mental health and substance use disorder services. Additionally, the proposed expansion of SUD benefits to the remaining Medicaid population in SFY 2017 further amplifies the need to strengthen the SUD delivery system and to improve the integration of behavioral health and physical health services. Taken together, the Medicaid expansion and proposed expansion of the SUD benefit make it critical for New Hampshire to find a way to provide integrated physical and behavioral health care in a deliberate, innovative and, cost-effective way that meets the needs of Medicaid beneficiaries. Without a revamping of its delivery system, New Hampshire risks further straining the already-limited capacity of the State's providers and could result in a missed opportunity to provide high quality care to beneficiaries.

The waiver is focused on the need to improve care for beneficiaries with both long-standing and emerging behavioral health issues because they represent a large and growing share of New Hampshire's Medicaid expenditures. Based on data from SFY 2008- SFY 2011, roughly one in six the State's Medicaid beneficiaries have a behavioral health issue. Since during that period the State did not cover the new adult group or SUD services, that number likely significantly underestimates the current number of beneficiaries with behavioral health issues.

Need for More Integrated Care

People with severe mental illness die on average 25 to 30 years earlier than the general population. They have much higher rates of a range of serious physical conditions such as diabetes, heart disease, obesity, and smoking-induced illnesses. At the same time, people with more modest behavioral health issues often go undiagnosed and untreated even though they do see a primary care provider.

New Hampshire views it as essential for providers to offer better integrated physical and behavioral health care for people with severe problems, as well as for those with more modest behavioral health issues. Providers, too, have indicated their interest in developing more integrated physical and behavioral health care models, and some providers are partnering to improve integration (see appendix for additional details). But more integration is necessary.

To spur integration, the demonstration will provide funding to develop and sustain partnerships among providers to implement projects to integrate behavioral health and primary care services. By integrating care, providers will identify emerging behavioral health issues and ensure that behavioral and physical health treatments are compatible and that beneficiaries are connected to essential community social services resources. The Demonstration will provide them with resources to make the operational, clinical, data integration and cultural changes needed to provide such care. The partnerships are expected to include social services agencies and community-based organizations

given the strong evidence that stable housing and work opportunities are critical to maintaining the health of people with behavioral health issues.

Limited Mental Health Capacity and Need for Greater Community Supports

New Hampshire is facing a crisis in its behavioral health system. New Hampshire Hospital, the state hospital for individuals with severe mental illness, operates at 100 percent of capacity. The demand for intensive psychiatric care has grown across the State, as the number of inpatient psychiatric beds has declined by 27 percent over the past 9 years.[1] At the same time, residential alternatives to inpatient care have diminished resulting in a log jam where people are stuck in inpatient beds because they have no place to go and individuals in need of inpatient beds sit in the Emergency Department (ED). In some instances, people must wait days for an inpatient hospital bed. In fact, close to two in three Medicaid beneficiaries admitted to New Hampshire Hospital waited in an ED for more than a full day before they could secure treatment.[2]

New Hampshire also lacks capacity to deliver needed community-based mental health services. On average, new adult patients must wait 26 days for an appointment with a mental health counselor or therapist.[3] If the patient needs to see a mental health professional with prescribing authority (*e.g.*, a psychiatrist or nurse practitioner), the average wait grows to 49 days. Individuals with emerging behavioral health needs can reach a crisis point during their four to seven week wait for treatment.

New Hampshire has a number of initiatives underway to tackle the problems with its mental health system. The demonstration is not designed to single-handedly solve these problems, but rather to reinforce and strengthen the existing efforts. Specifically, it is designed to serve a two-fold purpose. First, it will provide time-limited transitional funding to behavioral health providers so they can continue to provide care as they prepare for broader delivery system reform. Second, the waiver will support creation of IDNs that can better provide integrated, community-based care. And integrating physical and behavioral health care will expand the capacity of the behavioral health delivery system, as primary care providers gain training to identify and treat emerging behavioral health issues. By supporting more robust community-based options and facilitating early diagnosis and treatment of behavioral health issues, the waiver will help reduce the need for inpatient care and improve care for beneficiaries.

[1] "HELP: People Seeking Mental Health Care in New Hampshire," Foundation for Healthy Communities, February 2013. Available at: http://www.healthynh.com/images/PDFfiles/BehavioralHealth/HELP_Rpt_FINAL_02_22_13.pdf
[2] Ibid.
[3] "Waiting for Help: Barriers to Timely Access for People with Mental Health Care Needs," Foundation for Healthy Communities, April 2014. Available at: https://www.naminh.org/sites/default/files/Summary%20Report%2004%2028%2014%20Waiting%20for%20Help%20FINAL2.pdf

New Hampshire has reached a settlement with the Department of Justice designed to strengthen community-based care for individuals in New Hampshire's hospital system, including through a crisis services system, assertive community treatment teams, better housing and employment options, and stronger family and peer support. Many of the services that New Hampshire is obligated to provide under the settlement are allowable Medicaid expenses. As a result, even in the absence of the waiver, New Hampshire would be using Medicaid to help finance these activities. With the transformation waiver, however, New Hampshire will be able to ensure that the Medicaid services it provides as a result of the settlement are high quality and, as appropriate, provided through integrated delivery networks.

High Rates of SUDs and Limited Capacity

New Hampshire has some of the highest rates of alcohol and other drug misuse in the country. It ranks third in the nation for youth alcohol use and sixth in the nation for alcohol use among adults.[4] In recent years, it has been hit hard by the opioid epidemic, facing a sharp increase in heroin use and in related ED visits, with heroin use up an estimated 90 percent over the last ten years and heroin-related ED visits up 100 percent from 2012 to 2013 alone.[5] Increasingly, New Hampshire's local law enforcement officials are reporting growth in drug-related crimes and its hospitals are seeing more babies with neonatal abstinence syndrome—there was a five-fold increase in infants born with neonatal abstinence syndrome between 2000 and 2009.[6] The White House, too, has recognized the critical need for improving care for individuals with opioid addictions, making it a key priority in the President's recently announced budget.

Currently, the State does not have enough recovery support services, withdrawal management services, opioid treatment programs, or residential treatments to serve the needs of residents. In a 2014 assessment of the State's SUD capacity, New Hampshire found only 26 certified individuals providing recovery support services in the State. Four out of 13 public health regions had no SUD residential programs. To the extent services are available, they often are concentrated in selected areas of the State, leaving large swaths of New Hampshire without adequate capacity. Of particular concern is that there are some parts of the State with very few—or, in one instance, zero—providers of medication-assisted treatment. Additionally, many of New Hampshire's SUD providers are grant-funded organizations with little or no experience

[4] "Collective Action, Collective Impact: New Hampshire's Strategy for Reducing the Misuse of Alcohol and Other Drugs and Promoting Recovery," New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment, 2013. Available at: http://www.dhhs.nh.gov/dcbcs/bdas/documents/collectiveaction.pdf

[5] "Collective Action Issue Brief #5: Heroin in New Hampshire: A Dangerous Resurgence," New Hampshire Bureau of Drug and Alcohol Services, June 2014. Available at: http://www.dhhs.nh.gov/dcbcs/bdas/documents/issue-brief-heroin.pdf

[6] "Neonatal Abstinence Syndrome," New Hampshire Department of Health and Human Services. Available at: http://www.dhhs.nh.gov/dphs/bchs/mch/documents/nas-data-brief.pdf

contracting with insurers, in large part since Medicaid did not cover SUD services until now.

The limited availability of SUD providers has had a dramatic impact on the health of New Hampshire residents. A 2014 survey by the federal Substance Abuse and Mental Health Services Administration found that 92 percent of adults surveyed in New Hampshire who had alcohol dependence or abuse issues in the past year did **not** receive treatment.[7] The same survey found that 83.6 percent of New Hampshire adults surveyed who had illicit drug dependence or abuse in the past year did not receive treatment.[8]

To help address these issues, the waiver will provide transitional assistance to SUD providers engaged in delivery system reform to sustain and increase their capacity. Over time, IDNs will be used to continue to increase SUD capacity through workforce initiatives and cross-training of mental health, physical health, and SUD workers. Ultimately, many SUD providers are expected to participate in IDNs where they will share responsibility for providing high quality, integrated care. As already noted, New Hampshire is looking to expand the SUD benefit to its entire Medicaid population by SFY2017.

Note that the topics of mental health capacity and SUD capacity are given separate sections in this rationale for the 1115 waiver. This is because beneficiaries often must travel different pathways to get substance use disorder and mental health services in New Hampshire's current system. But, a key purpose of the waiver is to break down those silos to deliver integrated services to people with behavioral health issues, including those who face both mental illness and SUD. Over time, as the State increasingly relies on integrated delivery networks for the provision of care, there will be much stronger coordination and integration of services for people with dual diagnoses.

Gaps During Transitions in Care

New Hampshire residents with behavioral health issues are at elevated risk of "falling through the cracks" during care transitions.[9] They may be discharged from the hospital with instructions to make a follow up appointment, but then find that they cannot do so. New Hampshire historically has had more success than the rest of the country in

[7] "Behavioral Health Barometer: New Hampshire 2014," Substance Abuse and Mental Health Services Administration, January 2015. Available at: http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_2/BHBarometer-NH.pdf
[8] Ibid.
[9] Rich, E., et al., "Coordinating Care for Adults With Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions," Agency for Healthcare Research and Quality, January 2012. Available at: http://pcmh.ahrq.gov/page/coordinating-care-adults-complex-care-needs-patient-centered-medical-home-challenges-and

providing follow up, but over the past half-decade, it has lost ground – between 2007 and 2012, the percent of patients hospitalized for a mental health disorder who receive follow-up care in the 30 days after discharge has deteriorated from 78.8 to 72.8 percent.

Individuals also experience gaps in care when transitioning out of the justice system and into the community. More than half of all justice-involved persons have behavioral health issues. When transitioning into the community, the behavioral health needs of the justice-involved population are often not adequately addressed. Substance use-related issues accounted for 48 percent of parole revocations by the State Department of Corrections, underscoring that their needs were not adequately addressed after transitioning to the community.[10] Upwards of 95 percent of New Hampshire's justice-involved population will return to the community, and Medicaid will be responsible for providing care to many of them. The State, therefore, needs a cohesive approach to ensure that these individuals make a smooth transition to community-based care.

New Hampshire has a number of initiatives underway to address these challenges, but the demonstration will allow the State to provide performance-based funding to enable IDNs to smooth care transitions across the full continuum of care. For example, New IDNs will be receive funding to establish a behavioral health-specific discharge plan; to promote routine medication reconciliation for discharged patients and ensure follow up visits; to develop special discharge and care coordination plans for individuals leaving the criminal justice system; to support access to social services and community supports; and to prepare partners in the longer run to share risk for behavioral health patients across the continuum of care. While our managed care organizations also are expected to play a leadership role in these activities, the waiver will allow providers to be prepared to tackle these issues and to change their relationships with one another to allow for better continuity of care across care transitions.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

The purpose of the New Hampshire waiver is to test whether creating partnerships of providers with incentives to offer high-quality, integrated physical and behavioral health care that is connected to social supports will improve beneficiary outcomes, reduce the rate of growth in Medicaid per capita spending, and improve the overall health and well-being of the New Hampshire Medicaid population.

Specifically, the State plans to test the following hypotheses:

- Creating integrated delivery networks (IDNs) will improve physical and behavioral health for individuals and reduce the cost of their care;

[10] New Hampshire Department of Corrections, personal communication, January 2015.

- Investing in greater behavioral health capacity and workforce development, including community-based care options, will allow the State to provide care in the most appropriate setting possible;
- Promoting evidence-based approaches to improving care transitions for individuals with behavioral conditions will improve their outcomes, reduce costs, and prevent avoidable re-hospitalizations; and
- Connecting individuals with behavioral issues to social services will improve their health and reduce the rate of Medicaid spending growth.

Evaluation Question	**Hypothesis**	**Waiver Component Being Addressed**	**Data Source**
What are the effects on physical and behavioral health of creating integrated delivery networks?	Individuals with co-occurring physical and behavioral health issues will receive higher quality of care after integrated delivery networks are operating	Expenditure authority for payments	CHIS & Medicaid claims and encounter data, CAHPS
	The total cost of care will be lower for individuals with co-occurring physical and behavioral health issues after integrated delivery networks are operating	Expenditure authority for payments	CHIS & Medicaid claims and encounter data
	The rate of avoidable re-hospitalizations for individuals with co-occurring physical and behavioral health issues will be lower at the end of the Demonstration than prior to the Demonstration	Expenditure authority for payments	CHIS & Medicaid claims and encounter data
What will be the impact of investing in greater behavioral health capacity and workforce development, including community-based care options?	Percentage of Medicaid beneficiaries waiting for inpatient psychiatric care will be lower at the end of the Demonstration than prior to the Demonstration	Expenditure authority for payment	State-administered provider survey
	Average wait times for outpatient appointment at community mental health centers will be lower at the end of the Demonstration than prior to the Demonstration.	Expenditure authority for payment	State-administered provider survey
	Average length of stay for inpatient psychiatric care will be lower at the end of the Demonstration than prior to the Demonstration, as options for community-based care increase.	Expenditure authority for payment	State-administered provider survey

Within 120 days of approval of the terms and conditions for the waiver, New Hampshire will develop an evaluation proposal for review by CMS. No later than 60 days after receiving comments on the draft evaluation design from CMS, the State will submit the final design to CMS. The State will submit progress reports in quarterly and annual demonstration reports, and submit a draft final evaluation report within 120 days of the expiration of the Demonstration. When it develops its waiver evaluation proposal, the State will:

- Test the hypotheses described above;
- Describe specific measures that will be used to evaluate outcomes;
- Detail the data sources and sampling methodologies that will be used to assess these outcomes; and
- Detail the State's plan for reporting to CMS on the identified outcome measures and the content of those reports.

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate

The demonstration will operate on a statewide basis, but IDNs will be regionally-based.

New Hampshire has two larger cities, but otherwise is dominated by rural areas, many of which have a limited number of traditional providers. By adopting a regional approach, New Hampshire's intent is to allow communities to develop strategies and interventions consistent with their own needs and resources. To promote some consistency across regions, however, the State will facilitate the availability of statewide resources, such as the creation of learning collaboratives and technical assistance that is useful to all IDNs.

5) Include the proposed timeframe for the Demonstration

As is further discussed in Section V, the demonstration will be implemented as soon as feasible after approval of the terms and conditions and will operate for a five-year period. Since the State's Medicaid expansion already has gone into effect, it is important to move quickly to implement the delivery system reforms outlined in this proposal.

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems

No. The demonstration will not modify the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost-sharing or delivery systems.

Section II – Demonstration Eligibility

1) **Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included). Please refer to Medicaid Eligibility Groups when describing Medicaid State plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.**

   New Hampshire's Demonstration waiver will affect all Medicaid populations covered under the Medicaid State Plan, except for individuals covered under New Hampshire's QHP Premium Assistance Demonstration. Newly eligible adults who are medically frail are excluded from the QHP Premium Assistance Demonstration and so are included in this Demonstration.

2) **Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan (if additional space is needed, please supplement your answer with a Word attachment).**

   The Demonstration will not alter the State's Medicaid eligibility standards. As such, eligibility assessment and determination processes will remain consistent with those outlined in the Medicaid State Plan.

3) **Specify any enrollment limits that apply for expansion populations under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment).**

   Enrollment limits are not applicable for the Demonstration.

4) **Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.**

   As noted previously, the Demonstration will affect 140,000 individuals–the vast majority of New Hampshire's Medicaid population. The one exception is the newly eligible adults who will enrolled in QHPs are not expected to be directly affected, since IDNs will initially focus efforts on individuals served through fee-for-service Medicaid or Medicaid Care Management . (As of February 2015, there are some 34,000 newly-eligible adults.) Newly eligible adults who are enrolled in QHPs, like all insured New Hampshire

residents, will benefit indirectly from improved capacity in the behavioral health care system.

5) **To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).**

   Post-eligibility treatment of income will remain consistent with the Medicaid State Plan.

6) **Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013)**

   Eligibility procedures will remain consistent with the Medicaid State Plan.

7) **If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.**

   Eligibility standards will remain consistent with the Medicaid State Plan.

Section III – Demonstration Benefits and Cost Sharing Requirements

1) **Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:**

   No. Since, the Demonstration is focused on delivery system transformation, it will not alter the benefits outlined in the Medicaid State Plan.

2) **Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:**

   No. Since the Demonstration is focused on delivery system transformation, it will not impact cost sharing requirements outlined in the Medicaid State Plan.

(Note: Questions 3-7 skipped as a result of answering "No" to questions 1 and 2)

Section IV – Delivery System and Payment Rates for Services

1) **Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:**

   Yes.

2) **Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.**

   Demonstration Vision

   New Hampshire's behavioral health delivery system is at a critical juncture. New Hampshire once led the nation providing community-based care for the mentally ill. But in recent years, capacity in its behavioral health delivery system has declined, and the system can no longer meet the needs of New Hampshire residents. At the same time capacity has declined, the demand for behavioral health services in New Hampshire has increased as a result of the State's population growth, the opioid epidemic, and the expansion of coverage under the New Hampshire Health Protection Program.

   The intersection of declining capacity and increasing need jeopardizes the well-being of New Hampshire residents. Today, New Hampshire residents face long wait times for both inpatient and outpatient treatment—creating barriers to providing care in appropriate settings. As is noted above, some patients remain in inpatient beds because there are no adequate residential treatment centers to provide care after discharge, while other patients wait in emergency rooms for an inpatient bed. Further, not all areas of the State have adequate access to the full spectrum of treatment options, requiring some individuals to travel long distances to receive care.

   The State intends to use the Demonstration as part of a multi-pronged strategy to address this crisis in behavioral health care by providing integrated physical and behavioral health (mental health and substance abuse) services and reducing the rate of growth in Medicaid spending. The Demonstration will also further New Hampshire's "whole person" approach to health care for its residents by establishing sustainable care

models that tailor treatment based on patients' unique sets of health and social needs, rather than treat conditions in isolation.

To reform the delivery system, the Demonstration will use the following four tools:

Tool #1: Time-Limited Transition Funding for Safety Net Providers
Several behavioral health providers are financially compromised and are being sustained only by short-term philanthropic funding. Other providers are unable to maintain or expand services to address the growing need for behavioral health services. Time-limited transition funding will be used to strengthen Medicaid safety net providers so they can provide mental health and substance use disorder services to growing numbers of State residents as they begin to undertake the necessary delivery system reforms.

In order to qualify for transition funding, providers will need to demonstrate a need for additional funding, commit to maintaining or expanding services provided prior to delivery system reform, and agree to participate in the broader delivery system reform program by becoming part of an IDN. The State will evaluate requests for transition funding and allocate funding across providers based on a formula to be developed by the State.

The State anticipates using approximately 10 percent of the available funding in each of the first two years of the Demonstration payment on transition payments to providers.

Tool #2: Integrated Delivery System Networks (IDNs)
At the heart of the Demonstration will be regional networks of providers, known as Integrated Delivery Networks or IDNs, which will be responsible for implementing a series of projects. The projects will promote integrated care that addresses the physical and behavioral needs of beneficiaries and connect them with social services. In the IDN model, a lead applicant will serve as the coordinating entity and single point of accountability for the State. They will work with other participating providers to design and implement delivery system reform changes. All types of organizations (e.g., hospitals, community mental health centers, federally qualified health centers, physician groups, community-based long-term care providers, and social services organizations) will be eligible to serve as lead applicants or as participating providers. To be selected as lead applicants, organizations will need to demonstrate specific organizational and financial capabilities given the role that they play in serving as the coordinating entity and point of accountability for the IDN.

For many Medicaid providers, the transition to being part of an integrated delivery network will represent a significant operational, clinical and cultural shift, requiring them to build new partnerships and work outside of existing

"silos" of care. To facilitate the effort, New Hampshire will make initial planning funds available to interested providers to establish IDNs and then provide incentive payments over time for meeting performance benchmarks. Initially, the incentive payments will depend on the IDNs showing progress toward establishing the necessary infrastructure for delivery system reform. Over time, they increasingly will be linked to performance on outcome measures associated with successful implementation of projects.

Tool #3: Statewide Resources To Support Implementation
New Hampshire will support IDNs with statewide resources to provide technical assistance to the IDNs and facilitate learning collaboratives. These statewide resources will be coordinated with other emerging and ongoing health reform efforts in New Hampshire. Since implementation under this Demonstration will coincide with planning under the State Innovation Model grant, New Hampshire is well-positioned to strategically align resources to promote statewide health reform.

Tool #4: Coordinating with Medicaid Managed Care to Promote Sustainability
To ensure the sustainability of the initiative after the Demonstration funding ends, the State will establish a process to evaluate whether and how to ensure that plans participating in Medicaid Care Management enter into value-based contracting arrangements with IDNs. This process will build upon the existing requirement that Medicaid Care Management plans develop and implement a payment reform plan. Under the value-based contracting arrangements, the managed care organizations and IDNs will work together to provide high quality, cost-effective care to Medicaid beneficiaries.

Over the first few years of the Demonstration, New Hampshire will evaluate specific approaches to promoting value-based contracts between Medicaid Care Management plans and IDNs. In general, the State anticipates that the IDNs will act as a contracting vehicle for providers, but the exact role of any given IDN in the contracting process may vary depending on its capabilities. At one end of the spectrum, the IDN may contract with payers to perform specific care coordination activities proven as effective during the term of the demonstration. Providers' individual payment relationships with payers would remain in place, and the IDN's contract would layer on top of those existing contracts. At the other end of the spectrum, the IDN may contract with payers for the full set of medical services, either on a shared savings or capitated basis.

Enabling Pathways and Projects for IDNs

The State has identified the following three distinct areas (referred to as "enabling pathways") where transformation projects are needed:

- Building capacity in the behavioral health system

- Promoting provider integration
- Fostering partnerships and data sharing across the care spectrum in support of care transitions

The State will create projects and performance metrics for each pathway. IDNs will apply to participate in selected projects and will be responsible for reporting their progress toward Demonstration goals. The State will also establish statewide performance metrics to assess whether the overall Demonstration vision is achieved.

Pathway #1: Building Capacity in the Behavioral Health System
As described above, New Hampshire's behavioral health system lacks the capacity to meet the current needs of New Hampshire's residents. The time-limited transition funding for safety net providers will assist in the short term to support capacity, but New Hampshire is committed to finding a more systematic and sustainable approach to resolving the capacity issues in the longer run. Specifically, it will make payments to IDNs that undertake projects to strengthen community-based capacity and tackle the inpatient capacity issue.

The projects in this pathway will be used to support workforce initiatives aimed at increasing the ability of providers to meet the complex, often-intertwined physical, mental health, and substance abuse issues of Medicaid beneficiaries; creation or expansion of community-based treatments and intervention programs; and other care delivery models that reduce the need for institutionalized care. Examples of the kinds of projects that IDNs will be expected to pursue to increase capacity include:

<u>Examples of Potential Projects:</u>

- Creating a mental health workforce development program to support access to behavioral health providers in underserved areas.
- Establishing a specific workforce development initiative for SUD providers to promote more SUD treatment capacity, including medication-assisted treatment and recovery support services. For example, an IDN might support cross training of mental health workers to allow them to serve people with SUDs, as well as people with a dual diagnosis.
- Increasing access to behavioral health community crisis, intervention, and stabilization services.
- Developing an evidence-based medication adherence program in community-based sites for beneficiaries with behavioral health issues.
- Implementing telemedicine programs to support and deliver behavioral health services, particularly in rural areas of the State.

Pathway #2: Promoting Integration of Care

Individuals with severe mental illness have much higher rates of serious physical conditions, such as diabetes, heart disease, and obesity. When operating in silos, physical and behavioral health providers are often unable to adequately treat both sets of conditions, leading individuals with serious co-morbidities to die 25 to 30 years earlier than average. Patients with less serious behavioral health issues often fail to receive an appropriate diagnosis or treatment, even when they have a regular primary care provider. Much of the physical health co-morbidity is driven by obesity and smoking among individuals with behavioral health, substance use disorders, and complex physical health conditions. And when these patients do receive a diagnosis and treatment, treatment of their physical and behavioral health conditions are often uncoordinated.

To promote integration of care, New Hampshire anticipates pursuing two related types of projects – 1) initiatives aimed at integration among providers, and 2) related care initiatives aimed at providing integrated treatment and related services directly to beneficiaries. In developing the provider integration projects, New Hampshire believes that integration—more than mere co-location—of physical and behavioral health providers is necessary to ensure that the whole range of a patient's needs are addressed in a coordinated manner. For some patients, receiving behavioral health care at the primary care provider's office will be most appropriate; for other patients, particularly those with long-term or severe behavioral health issues, receiving primary care services at the behavioral health provider may be preferable.

The State anticipates that IDNs will pursue the following types of integration models:

- **On-site Integration:** Integrating physical and behavioral health providers in the same care setting to enable more effective coordination, care management, and timely access to care.
- **Virtual Integration:** Recognizing that not all providers will be able to integrate at the same physical site, some projects also will be designed to enable providers to virtually integrate their practices through data sharing and care protocols.

<u>Examples of Potential Projects:</u>

Sample integration projects include:

- Developing necessary infrastructure to support care coordination models, including shared clinical protocols and coordination/sharing of clinical data.
- Promoting virtual or physical integration among physical and behavioral health staff.

- Expanding the InSHAPE program to additional populations and provider settings.
- Developing models to integrate physical and behavioral health care with developmental services for individuals with co-occurring developmental disabilities and behavioral health issues.

Pathway #3: Fostering Partnerships Across the Care Spectrum in Support of Care Transitions

New Hampshire recognizes that its healthcare delivery system can improve how it handles transitions from one care setting to another. Currently, many of the State's inpatient and outpatient providers operate separately with limited, if any, coordination. Inpatient providers, for example, may arrange for post-discharge follow up care in an outpatient setting, but the outpatient provider may not have access to key information gleaned during the patient's inpatient stay. Additionally, medical providers may not coordinate with social support organizations, and gaps in social supports may lead to increased emergency room utilization and readmissions.

Fostering partnerships among health care providers and community support organizations will enable IDNs to more effectively coordinate care and transitions across the care spectrum. Projects will promote smoother care transitions by creating incentives for IDNs to adopt evidence-based practices for the treatment of behavioral health patients during transitions and incentivizing provider collaboration.

<u>Examples of Potential Projects:</u>

- Establishing and implementing a behavioral-health specific discharge planning for individuals moving between care settings or returning to the community.
- Promoting routine medication reconciliation for discharged patients with structured follow up visits.
- Screening for and supporting facilitation of access to social services and community supports.
- Planning among partners to share risk for behavioral health patients across the continuum of care.
- Establishing and implementing a plan for individuals being released from jails and prisons to ensure that their full range of physical health, behavioral health, and social needs are addressed appropriately in the community.

IDNs will use demonstration dollars to fund investments in re-defining their care processes. The State anticipates that the IDNs will use waiver funds to cover costs associated with developing relationships among providers in the region, defining new

care models, and obtaining the tools needed to implement the new care models. For example, an IDN might use waiver dollars to fund investments in care management software that its providers can use to identify high-risk patients and coordinate their care. Demonstration funds will not be used to pay providers specifically for delivering care coordination services.

The State also intends to explore using other Medicaid vehicles to reimburse providers for any new services they are providing. Among other things, the State is evaluating whether to implement a health home program for individuals with behavioral health needs. A health home program could complement the demonstration–the demonstration would fund transformation of providers while the health home program would fund services. Similarly, New Hampshire continues to work with its managed care organizations on the need for stronger care coordination, and, it anticipates that by investing in IDNs, the state can ensure that they have strong provider networks with which to work in the future on addressing these issues.

Financing the Demonstration

New Hampshire believes that the investments made under this waiver on high quality, integrated behavioral and physical health care will slow the rate of growth in per capita Medicaid spending. By averting costs that the Medicaid program otherwise would incur, the State will be able to fully offset the cost of its delivery system reform investments. Specifically, the investments in better community-based care and social supports are expected to reduce unnecessary hospitalizations and treatments for mental health or substance use problems. In addition, New Hampshire anticipates that it will see reductions in the rate of growth on the physical health spending associated with people with behavioral health issues as they receive better integrated care. As a growing body of evidence collected by SAMSHA highlights, the cost of serving a Medicaid beneficiary with a common chronic condition is 75 percent higher if they have a mental health condition than if they do not. Moreover, Medicaid beneficiaries with a common chronic condition and a co-occurring mental health or substance abuse issue cost two to three times as much as an average Medicaid beneficiary. If New Hampshire can more effectively provide care to beneficiaries with co-occurring conditions, there will be an enormous opportunity to improve their care and reduce costs.
To finance the non-federal share for payments made under the Demonstration, the State requests authority to receive federal matching dollars for the following designated state health programs (DSHPs) in an amount not to exceed $30 million per year for the following programs:

- NH Hospital State General Funds -- for transition planning for release only
- New 10-bed Designated Receiving Facility
- State General Funds for Community Mental Health Center Training
- Care Transitions for Justice-Involved Populations
- Children in Need of Services Program

- Department of Health and Human Services Ten Year Mental Health Plan/DOJ Settlement
- Municipal Spending on 2013 Report of Appropriations Actually Voted (M-2 Form) reported to the Department of Revenue Administration
  - Health Administration
  - Health Agencies & Hosp. & Other
- County Funding for Community Mental Health Centers

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- ✓ Managed Care
  - Managed Care Organization (MCO)
- ✓ Fee-for-service (including Integrated Care Models)

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option.

Most beneficiaries will continue to receive services through the Medicaid Care Management program–the State's managed care program authorized under the Section 1932 option. Beneficiaries who are currently exempt from Medicaid Care Management under the State Plan will continue to receive services through fee-for-service Medicaid. As is noted above, individuals in the new adult group, except for the medically frail, will receive coverage through the New Hampshire Health Protection Program Section 1115 demonstration, which requires enrollment into Qualified Health Plans. The new adults covered under the New Hampshire Health Protection demonstration will not be included in this demonstration.

5) If the Demonstration will utilize a managed care delivery system:

a. Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

Demonstration enrollment is "mandatory" in the sense that all Medicaid beneficiaries except newly-eligible adults enrolled in QHPs are included in the Demonstration and could find the way that they receive care affected by the creation of IDNs and related investments. However, the Demonstration does not alter the rules regulating the circumstances under which people can select or change their Medicaid managed care plan. Beneficiaries will continue to have a

choice of plans and the ability to change plans in accordance with federal requirements.

b. Indicate whether managed care will be statewide, or will operate in specific areas of the state.

Managed care will continue to be provided statewide, consistent with the State Plan.

c. Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state).

Managed care will continue to be provided statewide, consistent with the State Plan.

d. Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

The State's approach to assuring choice of MCOs, access to care and provider network adequacy will continue to be consistent with the State Plan and will not be altered by this Demonstration.

e. Describe how the managed care providers will be selected/procured.

The State's approach to selecting/procuring managed care providers will be consistent with the State Plan.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

Not applicable.

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration.

The Demonstration will provide personal care and long-term services and supports consistent with the State Plan.

8) **If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.**

   Fee-for-service payments will be consistent with the State Plan.

9) **If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.**

   Managed care payments will be consistent with the State Plan.

10) **If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.**

    Performance metrics will be established at the state- and provider-levels to monitor progress toward achieving the overall waiver vision. Payments from the State to providers will be contingent on meeting these performance metrics. Measures will be consistent with the overall waiver vision and will be used to assess whether ongoing support payments will be provided to providers. To the extent possible, the State will leverage metrics it currently tracks or plans to track, as well as AHRQ's list of measures for integration of physical and behavioral health. Examples of provider performance metrics include:

    - Follow up visits within 7 days and 30 days of a hospitalization for a mental illness
    - Initiation and engagement of alcohol and other drug dependence treatment

Section V – Implementation of Demonstration

1) **Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.**

   The demonstration will be implemented as soon as feasible after approval of the terms and conditions and will operate for a five-year period. Since the State's Medicaid expansion already has gone into effect, it is important to move quickly to implement the delivery system reforms outlined in this proposal. New Hampshire intends to begin implementation as soon as June 1, 2015.

YEAR 1: In the first year of the waiver, New Hampshire will undertake several key implementation activities, including the following:

- *Develop application process for transition funding.* With input from stakeholders and CMS, the State will establish a process for safety-net providers of behavioral health services to qualify to receive transition funding. At a minimum, the State will require that providers demonstrate a need for transition funding, commit to maintain or expand service levels, and agree to participate in the broader Demonstration.
- *Review and approve requests for transition funding.* The State will review requests for transition funding, approving requests that meet the criteria.
- *Distribute transition funding.* The State will distribute transition funding to qualifying providers.
- *Develop requirements for IDNs.* Working closely with stakeholders and CMS, the State will establish requirements for IDNs, including criteria for which entities may act as a "lead applicant" and how the providers will work together to make decisions and implement projects.
- *Create menu of projects.* New Hampshire will convene clinicians, advocates, and policymakers to create a menu of 8-12 projects across the three enabling pathways. The menu of projects will describe the elements of the project and will identify applicable performance metrics. The State may permit IDNs to develop their own projects, so long as the proposed projects support the Demonstration's overall goals. IDNs will have flexibility within parameters established by the State for how to implement the projects in their region.
- *Develop application for IDNs to participate in Demonstration.* The State will develop an application that IDNs must complete to participate in the Demonstration. The application will require, among other things, that the IDNs: (1) describe the qualifications of the lead applicant; (2) outline the IDN's approach to joint decision making; (3) describe how the IDN will implement the 1-3 projects selected; and (4) describe how the IDN will allocate funding to providers within the IDN.
- *Review and approve applications submitted by IDNs.* Once the IDNs submit applications, the State will review and approve applications.
- *Establish Statewide Resources To Support IDNs.* The State will also support IDNs with statewide resources. Specifically, IDNs will be provided with technical assistance and the opportunity to participate in learning collaboratives that facilitate the sharing of best practices and lessons learned across IDNs. The statewide resources will be developed to coordinate with other ongoing and emerging health reform efforts in New Hampshire.

- *Distribute payments.* In this initial year, incentive payments will be distributed to IDNs that can demonstrate clear progress in establishing the infrastructure needed to carry out their functions over the life of the waiver.

YEAR 2 – 4: In these years, New Hampshire will move the distribution of incentive payments to more outcome-based measures, making them available over time only to those IDNs that meet performance metrics. The transition funding will phase out as IDNs create a more sustainable basis for the delivery of high-quality, integrated physical and behavioral health care. In Year 3, the State will prepare a report on using IDNs as the basis for value-based purchasing by managed care entities in the State, and, depending on the recommendations, may begin implementing changes as early as Year 4.

YEAR 5: Incentive payments to IDNs that meet performance standards will continue, but, increasingly, IDNs may be expected to be working with managed care entities in the State and others to facilitate the use of value-based purchasing on behalf of Medicaid beneficiaries and others.

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration

IDNs will be selected by geographic region. This approach avoids the need for a complicated enrollee attribution process, since enrollees will be attributed by region. The regions will align with the regions currently being identified as part of the organizational redesign of the Department of Health and Human Services.

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action

The State will not contract with managed care organizations to carry out the Demonstration activities; instead, it will contract with IDNs. As noted previously, Integrated Delivery Networks will apply to participate in projects identified by the State or in projects proposed by applicants and approved by the State.

Each IDN will have a lead applicant that will be responsible for advancing the waiver vision, including building greater behavioral health capacity, promoting the integration of care and preparing for greater value-based purchasing through implementation of projects. Specifically, lead applicants will:

- Organize partners in geographic region
- Coordinate program application
- Act as single point of accountability for the Department of Health and Human Services (DHHS)
- Receive funds from DHHS and distribute funds to partners

- Compile required reporting

Lead applicants are not required to be a specific provider type (e.g., hospital or community mental health center). Any organization meeting the following criteria can act as lead applicant:

Organizational Requirements

- Previous collaborative experience with partners in the region
- Project management experience
- Experience implementing clinical transformation projects, including grant-funded pilots
- Relationships with social services organizations or the ability to establish such relationships

Financial Stability Requirements

- Lead applicant must demonstrate financial stability
- Adequate performance on standard benchmarks for current financial stability (e.g., days cash on hand, operating margin)
- Capacity to absorb unexpected financial shocks in the future
- A history of and commitment to using financial practices that will allow for transparency and accountability with respect to Demonstration funds

Once the IDN is approved to participate in selected projects, the State will provide Demonstration funds to the IDN to support planning activities. IDNs will be responsible for reporting their performance against a set of metrics as defined by the State. Ongoing funding to the IDNs will be contingent on the IDNs' performance metrics.

Section VI – Demonstration Financing and Budget Neutrality

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: http://www.medicaid.gov/Medicaid- CHIP-Program-Information/By-Topics/Demonstrations/1115/Downloads/Interim1115-Demo-Financing-Form.pdf includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will be applicable to every demonstration application. The Budget Neutrality form and spreadsheet: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Demonstrations/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

Section VII – List of Proposed Demonstrations and Expenditure Authorities

1) Provide a list of proposed waivers and expenditure authorities.

The demonstration is one piece of a broader set of initiatives intended to improve care for all Medicaid beneficiaries, and the State ensured that it used State Plan Amendments to achieve its aims to the greatest extent possible. As a result, the State is requesting only those waivers and expenditure authorities critical to enabling delivery system transformation.

- § 1902(a)(1): Authority to operate the program on a less-than-statewide basis.
- § 1902(a)(17): Authority to allow IDNs to target projects to different sub-populations.
- § 1903: Authority to receive up to $30 million per year in federal matching dollars for the following designated state health programs:
    - NH Hospital State General Funds -- for transition planning for release only
    - New 10-bed Designated Receiving Facility
    - State General Funds for Community Mental Health Center Training
    - Care Transitions for Justice-Involved Populations
    - Children in Need of Services Program
    - Department of Health and Human Services Ten Year Mental Health Plan/DOJ Settlement
    - Municipal Spending on 2013 Report of Appropriations Actually Voted (M-2 Form) reported to the Department of Revenue Administration
        - Health Administration
        - Health Agencies & Hosp. & Other
    - County Funding for Community Mental Health Centers
- § 1903: Authority to receive federal matching dollars for payments made under the Demonstration.
- § 1903: Authority to receive federal matching dollars for transition fund payments made under the Demonstration.

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(1)	To permit the State to operate the Demonstration on a less-than-statewide basis	The State will strongly encourage, but not require, that providers in each region form an IDN. It is possible that one region will not have an IDN. Additionally, IDNs in different regions may select different projects, meaning

Waiver Authority	Use for Waiver	Reason for Waiver Request
		that the projects will not be carried out on a statewide basis.
§ 1902(a)(17)	To permit the State to allow IDNs to target projects to different sub-populations.	This waiver authority will enable IDNs to target particular projects to specific populations.
§ 1903	To permit the State to receive federal matching dollars for specified designated state health programs.	This waiver authority will allow the State to fund the non-federal share of payments and transition payments.
§ 1903	To permit the State to receive federal matching dollars for payments made under the Demonstration.	This waiver authority will allow the State to make payments to IDNs for achieving specific milestones and metrics for specific projects undertaken to support the Demonstration vision.
§ 1903	To receive federal matching dollars for transition payments to providers.	This waiver authority will allow the State to strengthen and support providers to enable them to participate in delivery system reform.

Section VIII – Public Notice

To support the initial Demonstration development in early 2014, DHHS gathered stakeholder input through a required public notice process that included two public hearings and a dedicated website. The website for public information on this Demonstration is http://www.dhhs.nh.gov/section-1115-waiver/index.htm. The web page include a copy of the waiver concept paper, waiver application draft, materials from public hearings, and instructions (with links) on how to submit comments on the waiver application draft.

The full public notice was also posted on the State's website and is in *Appendix D*. An abbreviated public notice was published in two newspapers, *The Telegraph* and *New Hampshire Union Leader*, on Monday, April 21, 2014. In addition, the abbreviated public notice was e-mailed on Monday, April 21, 2014 to DHHS stakeholders, MCO account managers, advocacy groups and county representatives.

The public comment period for New Hampshire's proposed Demonstration was from Monday, April 21, 2014 until Tuesday, May 20, 2014 at 5 p.m. (Eastern Time). Comments received within 30 days of the posting of this notice were reviewed and considered for revisions to the Demonstration application. Two public hearings on the proposed Demonstration were held

prior to submitting the application to CMS to discuss waiver concepts and solicit comments from stakeholders. The dates for the public hearings were May 8, 2014 and May 12, 2014. Both hearings included teleconferencing and web capability to maximize accessibility. Written and verbal comments received from the public are included in *Appendix E*.

In addition to the public hearings, state staff met individually with stakeholder groups and advocates, including, but not limited to the following groups:

- New Hampshire Association of Counties
- New Hampshire Hospital Association
- Behavioral Health Association (the governing body and trade association for CMHCs)
- New Hampshire Dental Society
- Medicaid Care Management Commission (MCAC)
- SUD Stakeholder Representatives

There are no recognized tribes in New Hampshire to conduct tribal consultation.

As part of the State's oversight of its MCM program, Governor Maggie Hassan established a commission that brings together members of the public representing a broad range of experience in health care issues to review and advise on the implementation of an efficient, fair, and high-quality Medicaid care management system.[11] The Governor's Commission on Medicaid Care Management was actively engaged in the development of this Demonstration application. Specifically, the second public hearing was held in conjunction with a meeting of the Governor's MCAC.

The State Legislature was also significantly involved in the development of this Demonstration. This process formally began on March 27, 2014 when SB413 was signed into law requiring DHHS to submit a statewide Section 1115 Demonstration by June 1, 2014. DHHS meets regularly with legislative leadership in both informal and formal venues, including the legislature's Fiscal Committee. This Demonstration application was approved by the legislature's Fiscal Committee on May 28, 2014 before its submission to CMS.

As part of the Demonstration amendment process, the State interviewed a wide range of stakeholders during August through November 2014. Among others, the State consulted with State officials, community mental health centers, hospitals, federally qualified health centers, philanthropic organizations, and criminal justice officials. After developing a proposed approach to the Demonstration amendment, the State validated the approach with the stakeholders and the State Legislature. On December 19th, the State convened a public hearing to address feedback from stakeholders on the proposed waiver amendment. Throughout this process, the State consistently received positive feedback from a diverse set of stakeholders.

[11] "Press Release: Governor Hassan Issues Executive Order Creating Commission on Medicaid Care Management," Office of the Governor, April 2013. Available at: http://www.governor.nh.gov/media/news/2013/pr-2013-04-10-medicaid-care.htm

Section IX – Demonstration Administration

The contact information for the State's point of contact for the Demonstration application is below.

Name and Title: Jeffrey A. Meyers, Director, Intergovernmental Affairs
New Hampshire Department of Health and Human Services

Telephone Number: (603) 271-9210
Email Address: jeffrey.meyers@dhhs.state.nh.us

Appendix: Examples of Provider Collaboration

- **New Hampshire Accountable Care Project.** The New Hampshire Accountable Care Project is working to improve outcomes and decrease health disparities for patients with depression and a co-occurring chronic medical condition by facilitating payment reform among a variety of providers, including federally qualified health centers and an academic medical center. The project is intended to allow providers the flexibility to incorporate a range of services into the care of patients and tailor interventions to meet patients' needs and create better outcomes.[12]

- **Multi-Stakeholder Commercial Medical Home Pilot.** The Accountable Care Project builds on the promising Multi-Stakeholder Commercial Medical Home Pilot, running from 2008 to 2011. The medical home pilot brought together four payers and nine provider sites to accelerate Primary Care Medical Home transformation in New Hampshire. Nine sites underwent rapid transformation to achieve National Committee on Quality Assurance Level III Patient-Centered Medical Home Certification.

- **Capital Regional Family Health Center and Concord Hospital.** Capital Regional Family Health Center and Concord Hospital have created a collaboration through which traditional mental health providers are co-located with a primary care practice.

- **Cheshire Medical Center in Keene.** There are also embedded behavioral health services at Cheshire Medical Center in Keene. The medical center has a behavioral health team that meets regularly to review practices and provide team updates; moreover, there are psychologists on the team that provide traditional mental health services but are working to transition to more brief interventions in primary care and services that support primary care.

- **White Mountain Community Health Center.** The White Mountain Community Health Center contracts with a local mental health provider for a psychiatrist to spend time once a month reviewing charts and consulting with providers. The clinic also employs a social worker who sees patients for traditional mental health services. While this list is not exhaustive, it demonstrates the level of interest in integrating primary care and behavioral health care in the Granite State.[13]

[12] "New Hampshire Accountable Care Project," NH Citizens Health Initiative, Accessed February 24, 2015. Available at: http://citizenshealthinitiative.org/accountable-care-project

[13] "The Integration of Behavioral Health and Primary Care in New Hampshire: Analysis and Recommendations," Cherokee Health Systems, December 2014. Available at: http://www.endowmentforhealth.org/uploads/images/PDFs/Health%20Policy/Cherokee_BHPC_Integration_Final%20Report_12-9-14.pdf