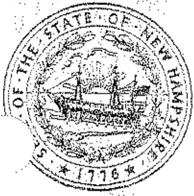



# State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857

603-271-9200 FAX: 603-271-4912 TDD ACCESS: RELAY NH 1-800-735-2964

JEFFREY A. MEYERS
COMMISSIONER


FIS 16 073

*Late Item*

April 11, 2016

The Honorable Neal M. Kurk, Chairman
Fiscal Committee of the General Court
State House
Concord, NH 03301

***Re: INFORMATIONAL ITEM: Health and Human Services Dashboard***

**Information**

The Department of Health and Human Services (DHHS) hereby submits as an information item the department's monthly dashboard in order to inform the legislature and the public on the current status of the utilization of the department's programs and services and the related implications for the department's budget. The monthly dashboard also includes a status report on significant initiatives being implemented to transform and improve the department's programs. Please note that financial and caseload information contained in this monthly dashboard is current through March 2016.

**Explanation**

**Funding Issues**

As of March 31, 2016 the Department has identified a potential budget deficit of $32.5 million, on a cash basis. This deficit results from unexpected costs not budgeted and budget assumptions that either have not been realized or that are not now anticipated to be realized. The principal assumption not realized is the drop in Medicaid caseloads reflected in the budget. Current deficits in the (Non-NHHPP) Medicaid program account for 80% of the identified shortfall.

General Fund Only -Figures in $Millions

| | |
|---|---|
| Medicaid | $26.2 |
| SYSC | $1.7 |
| Other | $4.6 |
| Total Potential Deficit | $32.5 |

At this point in time, there has been no reduction in programs or services to fund the potential deficit. As we move toward the conclusion of SFY 2016, the department will continue to examine the Medicaid caseload trends and areas of potential savings in its budget. In reviewing the department's lapse practice over the past 5 years, the department met or exceeded the legislative lapse in each of those years except 2012, when it met approximately one-half its lapse target.

**Caseload Trends**

| | SFY 14<br>6/30/2014 | SFY 15<br>6/30/2015 | SFY 16<br>12/31/2015 | 1/31/2016 | 2/29/2016 | 3/31/2016 |
|---|---|---|---|---|---|---|
| Medicaid Standard | 139,105 | 138,252 | 138,959 | 138,697 | 138,819 | 139,242 |
| *% increase over prior* | | *-0.60%* | *0.50%* | *-0.20%* | *0.10%* | *0.30 %* |
| NHHPP | - | 41,657 | 46,996 | 47,902 | 49,135 | 49,203 |
| *% increase over prior* | | | *12.80%* | *1.90%* | *2.60%* | *0.10%* |
| Food Stamps (SNAP) | 110,590 | 105,322 | 100,495 | 99,978 | 99,486 | 99,543 |
| *% increase over prior* | | *-4.80%* | *-4.50%* | *-0.10%* | *-0.10%* | *0.05%* |
| FANF Persons | *7,116* | *6,138* | *5,425* | *5,435* | *5,307* | *5,183* |
| *% increase over prior* | | *-13.70%* | *-11.60%* | *0.00%* | *-2.40%* | *-2.30%* |
| APTD Persons | *7,745* | *7,526* | *7,116* | *7,081* | *7,117* | *7,033* |
| *% increase over prior* | | *-2.80%* | *-5.50%* | *0.00%* | *0.00%* | *0.01%* |
| LTC - Persons | *7,271* | *7,109* | *7,191* | *7,114* | *7,206* | *TBD* |
| *% increase over prior* | | *-2.20%* | *1.20%* | *-1.10%* | *1.30%* | *TBD* |

**Medicaid Shortfall**

The current Medicaid shortfall is primarily the result of caseloads not trending as budgeted and increases in the PMPM. When the budget was passed, the caseload was expected to drop 2% beginning July 1, 2015. As seen from the table above, caseloads are trending slightly higher than last year. The aggregate PMPM paid to the MCO's as of June 30, 2015 was $331.01 and the current contract rate is $345.01 (effective 2/1/16).

The General Fund Medicaid shortfall has increased $3.9 million as compared to last month's dashboard, $22.3 million up to $26.2 million. Of the $3.9 million General Funds, $1.9 million General Funds is related to a payment made for Mental Health services on 4/7/16 that was for Dates of Service January 31, 2016 and prior. During the last month's projection, it was not anticipated that there was a delay from providers to DHHS in receiving claims with dates of service dating that far back. The remaining increase is the result of FFS claims for Outpatient Hospital and Provider Payments still trending at the same FFS levels as prior to Feb 1st.

**Sununu Youth Services Center (SYSC)**

N.H. Laws of 2015, Chap. 276, (HB2), requires a reduction in appropriation to SYSC of $1.7 million general funds for SFY16 and $3.5 million for SFY17 and for the Department to develop a plan around the use of SYSC. At present, it appears that the department will lapse approximately $700,000 in certain SYSC vacancies and accounts for FY 2016. The department will therefore be seeking legislative action to reduce or otherwise allow the department to cover the balance of the FY 2016 reduction from other funds, as opposed to a reduction in the SYSC operating line.

**NHH Inpatient Stabilization Unit & Nurse Recruitment**

As a result of the approval to enhance nurse salaries by 15%, under the N130 pay scale, NHH has been able to fill some nursing positions. Five nurse vacancies have been filled with others in various stages of interviews, background checks and reference calls since the enhancement took effect. Despite the salary enhancement, the current hiring process has not identified the full complement of nurses needed for the new 10-bed unit. As a result, the department will contract with one or more staffing agencies in order to hire the additional nurses in May so that those nurses are fully trained and can staff the unit when it opens on or before July 1, 2016.

**Enhanced Child Protective Service Workers (CPSW's)**

DCYF Child Protection Workers (CPSWs) perform child protective investigations in response to child abuse or neglect reports. DCYF has made a concerted effort to examine the capacity of the agency to establish a reasonable and sustainable plan for expanded coverage for abuse and neglect inquiries and reports. The agency reviewed its current child protection business practices, staffing patterns, met with law enforcement and other stakeholders as well as discussed with other New England Child Welfare Commissioners and Directors what they currently have in place to provide continuous coverage.

In late March, the Commission on Child Fatalities chaired by Senator Boutin endorsed the department's plan to use non-DCYF vacant positions to hire 18 new child protective workers and central intake staff to cover a new shift from 12:00 noon to 8:00 pm, together with some overtime money to cover overnight and weekend hours.

**Transformation Initiatives**

The department is currently engaged in a number of significant initiatives that will help transform the delivery of services and programs. This new section provides a summary of key initiatives. While the list is not all inclusive of the Department's projects, it does highlight several of the key projects of highest importance at this time. While the fiscal year progresses, this section will include updates to these projects and will include new initiatives. The initiatives included in this month's dashboard are:

- 1115 Transformation Waiver
- Therapeutic Cannabis
- Community Mental Health Agreement Compliance
- Substance Use Disorder (SUD) Benefit for Standard Medicaid
- Telehealth

Respectfully submitted,

Jeffrey A. Meyers
Commissioner

Enclosure

cc: Her Excellency, Governor Margaret Wood Hassan
The Honorable Neal M. Kurk, Chairman, House Finance Committee
The Honorable Chuck W. Morse, President, NH State Senate
The Honorable Shawn Jasper, Speaker, NH House of Representatives
Michael W. Kane, Legislative Budget Assistant

**Executive Council**

The Honorable Colin Van Ostern
The Honorable Christopher Pappas
The Honorable Joseph D. Kenney
The Honorable Christopher Sununu
The Honorable David Wheeler

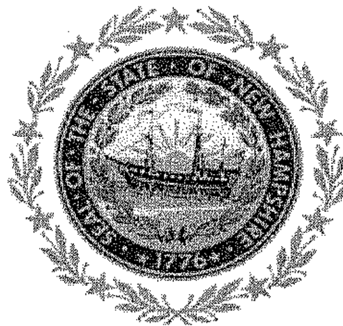
**House Finance Committee**

The Honorable Mary Allen
The Honorable Richard Barry
The Honorable Thomas Buco
The Honorable Frank Byron
The Honorable David Danielson
The Honorable Daniel Eaton
The Honorable Frank Edelblut
The Honorable J. Tracy Emerick
The Honorable Susan Ford
The Honorable William Hatch
The Honorable Peter Leishman
The Honorable Dan McGuire
The Honorable Betsy McKinney
The Honorable Sharon Nordgren
The Honorable Lynne Ober
The Honorable Joseph Pitre
The Honorable Katherine Rogers
The Honorable Cindy Rosenwald
The Honorable Marjorie Smith
The Honorable Peter Spanos
The Honorable Timothy Twombly
The Honorable Karen Umberger
The Honorable Mary Jane Wallner
The Honorable Robert Walsh
The Honorable Kenneth Wyler

**Senate Finance Committee**

The Honorable Jeanie Forrester
The Honorable Lou D'Allesandro
The Honorable Andrew Hosmer
The Honorable Gerald Little
The Honorable John Reagan

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**



**OPERATING STATISTICS DASHBOARD**

**Fiscal Meeting April 2016**

**SFY16**

Budget Summary as of 3/31/16
Data/Caseloads as of 3/31/16 (except for MH as of 2/29/16)

# Department of Health and Human Services
## Financial Summary - CASH BASIS
## As of March 31 --- SFY16
## General Funds Rounded to $000

The budget for SFY16-17 provides insufficient general funds to address the legislative intents for services and obligations that are expected to be incurred.

The items reported on the list include only those which a) are likely to be incurred and b) for which amounts can be reasonably estimated.

**Legislative Lapse Target per Final Budget (3.3%) = $20,856**

| Row | A | B | C | E | F | G |
|---|---|---|---|---|---|---|
| 11 | | | | **As of 1/31/16** | **As of 2/29/16** | **As of 3/31/16** |
| 12 | **Shortfalls** | | | | | |
| 13 | | **Programs** | | | | |
| 14 | | Medicaid (step 1 svs) | Medicaid services (excluding BDS waivers & Nursing/CFI) | $20,500 | $15,400 | $19,100 |
| 15 | | Medicaid | MCO Health Reimbursement Fee | $3,250 | $3,250 | $3,250 |
| 16 | | Medicaid | Part A&B | $994 | $994 | $994 |
| 17 | | Medicaid | Part D: State Phasedown | $3,055 | $2,700 | $2,900 |
| 18 | | | Subtotal Medicaid | $27,799 | $22,344 | $26,244 |
| 19 | | | *Change over prior month* | *$ (5,451)* | *$ (5,455)* | *$ 3,900* |
| 20 | | | | | | |
| 21 | | SYSC | Footnote reduction HB2 | $1,722 | $1,722 | $1,722 |
| 22 | | DFA | APTD & Old Age Assistance cost per case | $507 | $300 | $295 |
| 23 | | NHH | Nursing shortfall - salary enhancement | $465 | $465 | $465 |
| 24 | | NHH | Nursing Temps Pending Contract | | | $375 |
| 25 | | DCYF | Enhanced CPSW coverage | | $252 | $252 |
| 26 | | DCYF | Foster Care & Out of Home Placement Case increases | | | $600 |
| 27 | | | | | | |
| 28 | | **Litigation** | | | | |
| 29 | | | Chase Home Settlement | TBD | TBD | TBD |
| 30 | | | Harbor Homes Settlement (paid) | TBD | $1,300 | $1,350 |
| 31 | | | | | | |
| 32 | | **Operational Challenges** | | | | |
| 33 | | Medicaid | Contracts: Actuarial | $609 | $0 | $0 |
| 36 | | Medicaid | Non-Emergency Medical Transportation | $522 | $522 | $522 |
| 38 | | Public Health | Water Testing Pease | $225 | $225 | $225 |
| 39 | | Medicaid | HIPP program | $50 | $50 | $50 |
| 40 | | Glencliff | Revenue Shortfall - Census Down | | $425 | $425 |
| 41 | | | **Total Estimated Shortfalls** | **$31,899** | **$27,605** | **$32,525** |
| 42 | | | *Change over prior month* | *$ (6,010)* | *$ (4,294)* | *$ 4,920* |
| 43 | **Funds that would otherwise Lapse** | | | | | |
| 44 | | | | | | |
| 45 | | Medicaid | Drug Rebate Revenue | $10,000 | $10,000 | $10,000 |
| 46 | | Medicaid | UCC payments reduction | TBD | TBD | TBD |
| 47 | | DHHS | Salary & Benefits - Department Wide | $7,000 | $7,000 | $6,906 |
| 48 | **Non Salary & Benefit Accounts** | | | | | |
| 49 | | DHHS | Utilities, Rent, Fuel | $2,500 | $2,500 | $540 |
| 50 | | OIS | IT | $500 | $500 | $456 |
| 51 | | Client Services | Misc Contracts (DDU, Transportation, Broker) | $500 | $475 | $244 |
| 52 | | SYSC | Utilities, Prescriptions, misc operations | $400 | $400 | $700 |
| 53 | | GH | Utilities | $100 | $250 | $425 |
| 54 | | NHH | Maintenance, Utilities, Misc Contracts | $500 | $425 | $953 |
| 55 | | Human Services | Misc Operations | $750 | $500 | $502 |
| 56 | | DFA | State Asst Non TANF Interim Disabled Parent (IDP) | $300 | $300 | $295 |
| 57 | | BEAS | Projected spend under budget from Step 2 FFS | $1,250 | $2,750 | $2,239 |
| 58 | | BEAS | Social Services Non-Medicaid Contracts | $1,045 | $1,045 | $1,038 |
| 59 | | BBH | Transfer pending to OMBP to cover BBH FFS | | $2,500 | $4,541 |
| 60 | | PH | Rent, Lab Supplies, Contracts:Emerg Prep & Maternal Child Health | | $585 | $483 |
| 61 | | Other | Other misc lapses | TBD | $550 | $550 |
| 62 | | | **Total Estimated Funds that Would Otherwise Lapse** | **$24,845** | **$29,780** | **$ 29,872** |

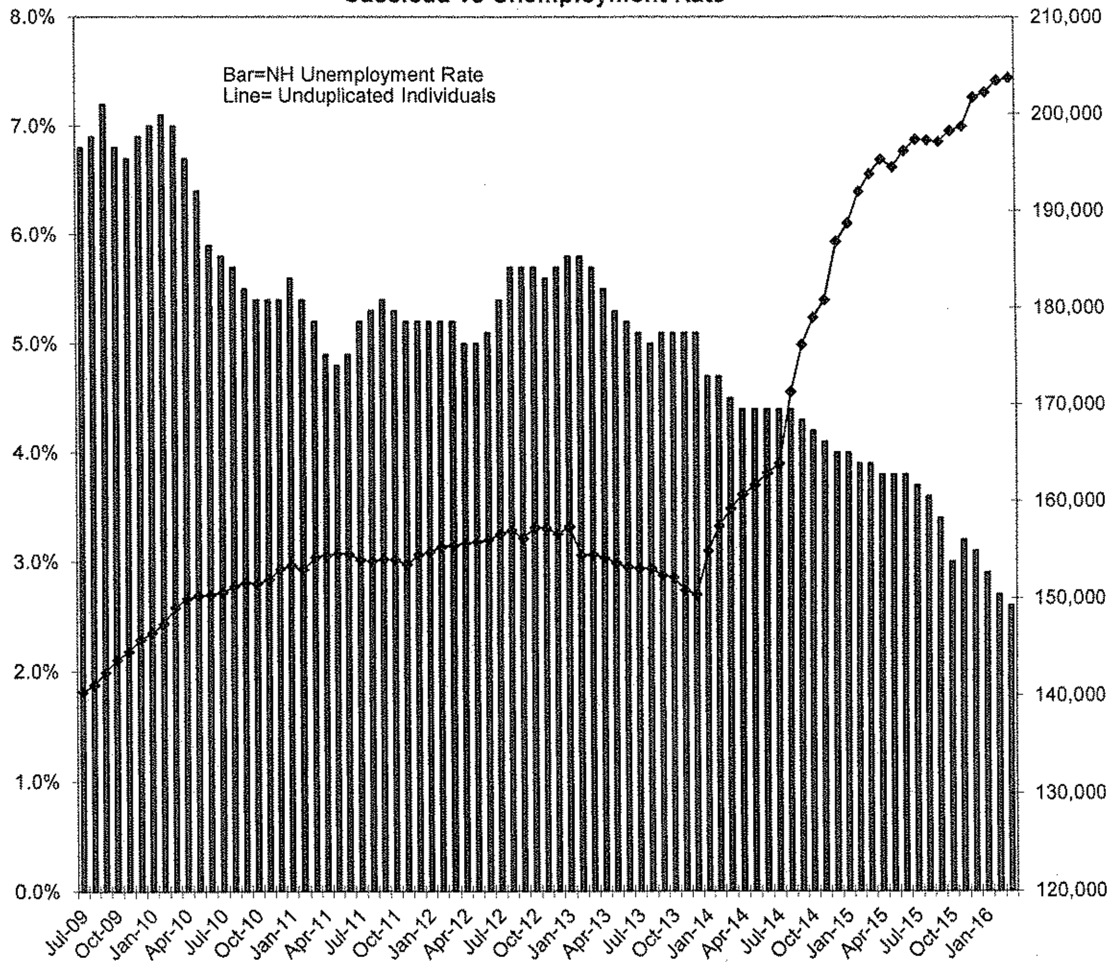


Table B
Department of Health and Human Services
Caseload vs Unemployment Rate
Bar=NH Unemployment Rate
Line= Unduplicated Individuals
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
210,000
200,000
190,000
180,000
170,000
160,000
150,000
140,000
130,000
120,000
Jul-09
Oct-09
Jan-10
Apr-10
Jul-10
Oct-10
Jan-11
Apr-11
Jul-11
Oct-11
Jan-12
Apr-12
Jul-12
Oct-12
Jan-13
Apr-13
Jul-13
Oct-13
Jan-14
Apr-14
Jul-14
Oct-14
Jan-15
Apr-15
Jul-15
Oct-15
Jan-16

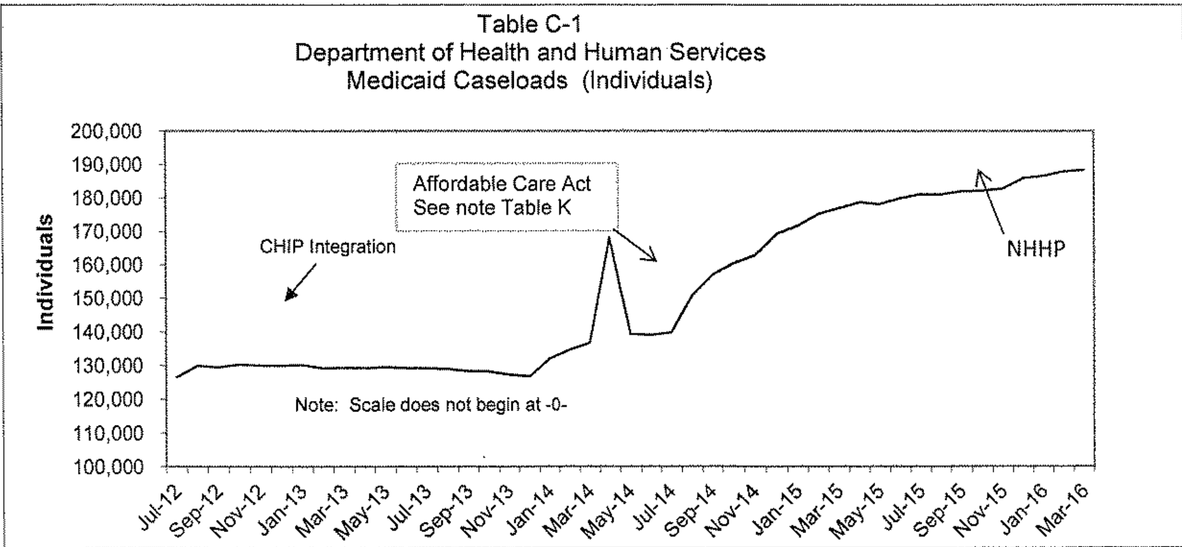


Table C-1
Department of Health and Human Services
Medicaid Caseloads (Individuals)
Individuals
200,000
190,000
180,000
170,000
160,000
150,000
140,000
130,000
120,000
110,000
100,000
Affordable Care Act
See note Table K
CHIP Integration
NHHP
Note: Scale does not begin at -0-
Jul-12
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16

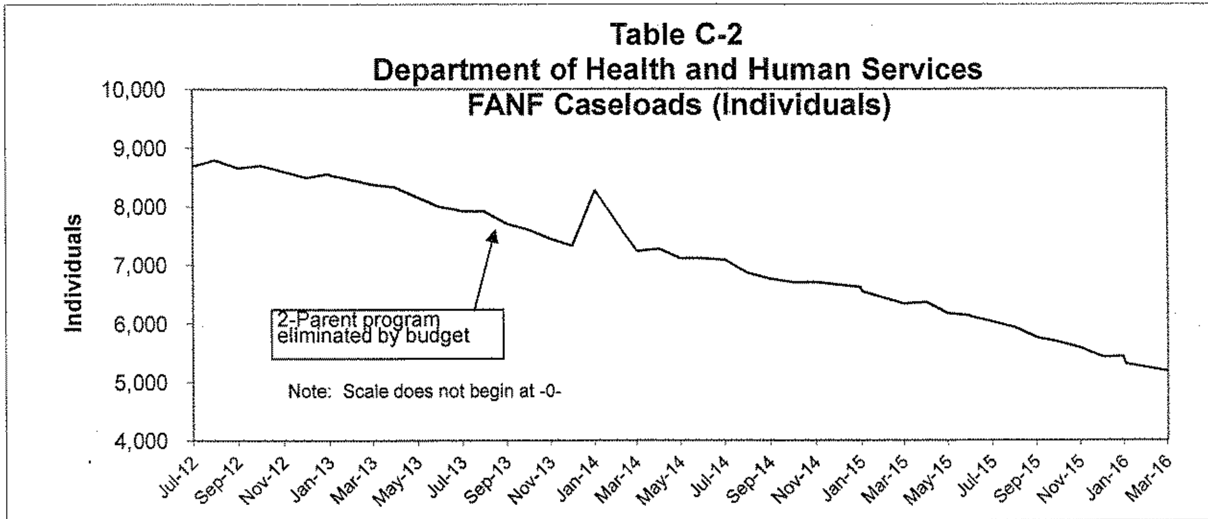


Table C-2
Department of Health and Human Services
FANF Caseloads (Individuals)
Individuals
10,000
9,000
8,000
7,000
6,000
5,000
4,000
2-Parent program eliminated by budget
Note: Scale does not begin at -0-
Jul-12
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16

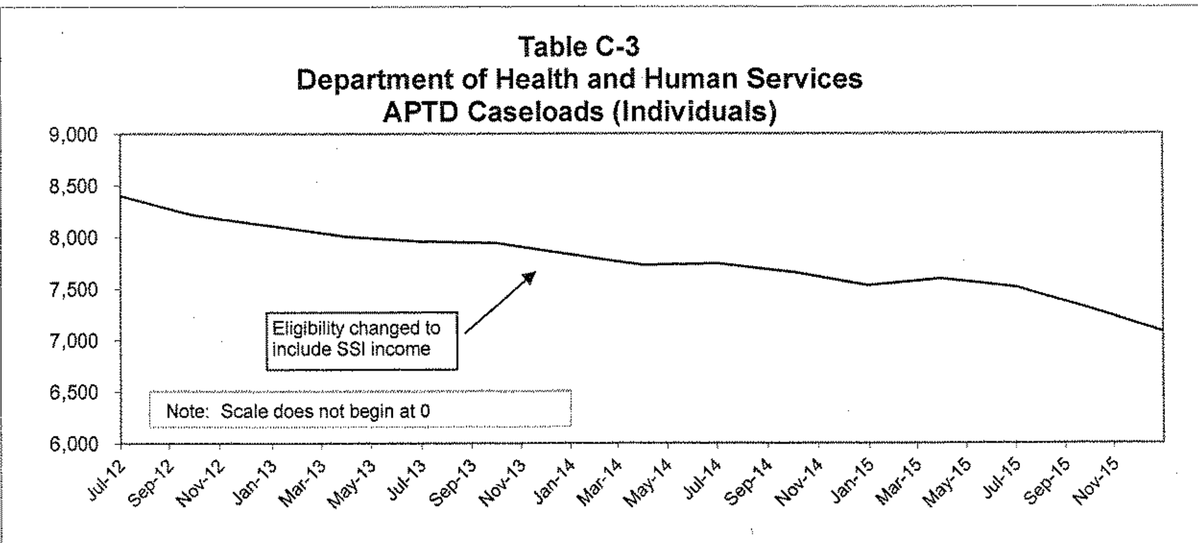


Table C-3
Department of Health and Human Services
APTD Caseloads (Individuals)
9,000
8,500
8,000
7,500
7,000
6,500
6,000
Eligibility changed to include SSI income
Note: Scale does not begin at 0
Jul-12
Sep-12
Nov-12
Jan-13
Mar-13
May-13
Jul-13
Sep-13
Nov-13
Jan-14
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15

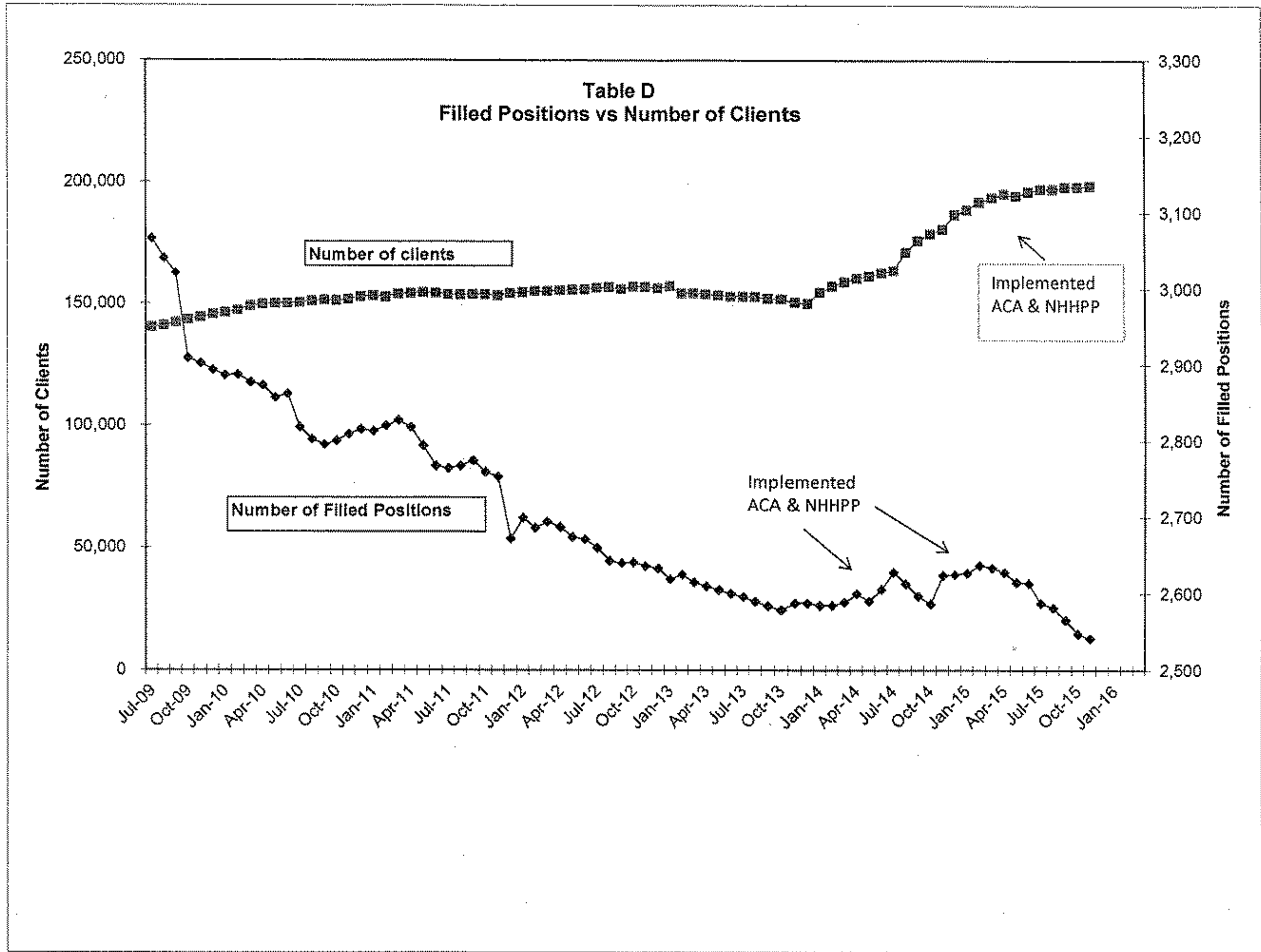


Table D
Filled Positions vs Number of Clients
Number of clients
Number of Filled Positions
Implemented ACA & NHHPP
Implemented ACA & NHHPP
Number of Clients
Number of Filled Positions
250,000
200,000
150,000
100,000
50,000
0
3,300
3,200
3,100
3,000
2,900
2,800
2,700
2,600
2,500
Jul-09
Oct-09
Jan-10
Apr-10
Jul-10
Oct-10
Jan-11
Apr-11
Jul-11
Oct-11
Jan-12
Apr-12
Jul-12
Oct-12
Jan-13
Apr-13
Jul-13
Oct-13
Jan-14
Apr-14
Jul-14
Oct-14
Jan-15
Apr-15
Jul-15
Oct-15
Jan-16

| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 1 | **Table E** | | | | | | | |
| 2 | **Department of Health and Human Services** | | | | | | | |
| 3 | **Operating Statistics** | | | | | | | |
| 4 | **Children In Services** | | | | | | | |
| 5 | | | | | | | | |
| 6-8 | | **DCYF Referrals** | **DCYF Assessments** | **Family Foster Care Placement** | **Residential Placement** | **Child Care Emplmnt Related** | **Child Care Wait List** | **SYSC Secure Census** |
| 9 | | **Actual** | **Actual** | **Actual** | **Actual** | **Actual** | **Actual** | **Actual** |
| 59 | Jul-13 | 1,124 | 772 | 571 | 315 | 5,568 | 0 | 61 |
| 60 | Aug-13 | 1,045 | 591 | 570 | 323 | 5,517 | 0 | 60 |
| 61 | Sep-13 | 1,276 | 544 | 560 | 297 | 5,345 | 0 | 56 |
| 62 | Oct-13 | 1,276 | 603 | 567 | 305 | 5,357 | 0 | 58 |
| 63 | Nov-13 | 1,083 | 536 | 565 | 304 | 5,350 | 0 | 61 |
| 64 | Dec-13 | 1,111 | 649 | 559 | 299 | 5,322 | 0 | 61 |
| 65 | Jan-14 | 1,260 | 706 | 542 | 290 | 5,298 | 0 | 66 |
| 66 | Feb-14 | 962 | 688 | 531 | 309 | 5,238 | 0 | 59 |
| 67 | Mar-14 | 1,307 | 1,016 | 537 | 311 | 5,459 | 0 | 62 |
| 68 | Apr-14 | 1,324 | 972 | 539 | 313 | 5,512 | 0 | 62 |
| 69 | May-14 | 1,370 | 866 | 531 | 317 | 5,737 | 0 | 59 |
| 70 | Jun-14 | 1,267 | 684 | 535 | 324 | 5,694 | 0 | 59 |
| 71 | Jul-14 | 1,049 | 890 | 510 | 319 | 5,742 | 0 | 52 |
| 72 | Aug-14 | 1,273 | 827 | 510 | 254 | 5,626 | 0 | 52 |
| 73 | Sep-14 | 1,485 | 921 | 501 | 282 | 5,543 | 0 | 48 |
| 74 | Oct-14 | 1,356 | 790 | 519 | 301 | 5,341 | 0 | 47 |
| 75 | Nov-14 | 1,090 | 681 | 512 | 308 | 5,384 | 0 | 50 |
| 76 | Dec-14 | 1,312 | 768 | 544 | 313 | 5,438 | 0 | 47 |
| 77 | Jan-15 | 1,169 | 587 | 532 | 303 | 5,370 | 0 | 41 |
| 78 | Feb-15 | 1,079 | 467 | 550 | 301 | 5,259 | 0 | 36 |
| 79 | Mar-15 | 1,427 | 630 | 554 | 319 | 5,494 | 0 | 40 |
| 80 | Apr-15 | 1,281 | 874 | 564 | 334 | 5,474 | 0 | 42 |
| 81 | May-15 | 1,298 | 858 | 566 | 341 | 5,497 | 0 | 43 |
| 82 | Jun-15 | 1,314 | 869 | 578 | 348 | 5,581 | 0 | 47 |
| 83 | Jul-15 | 1,120 | 908 | 564 | 322 | 5,651 | 0 | 48 |
| 84 | Aug-15 | 1,074 | 743 | 571 | 319 | 5,588 | 0 | 51 |
| 85 | Sep-15 | 1,298 | 895 | 570 | 304 | 5,528 | 0 | 49 |
| 86 | Oct-15 | 1,336 | 863 | 591 | 308 | 5,192 | 0 | 54 |
| 87 | Nov-15 | 1,182 | 680 | 605 | 303 | 5,219 | 0 | 59 |
| 88 | Dec-15 | 1,280 | 825 | 647 | 316 | 5,267 | 0 | 65 |
| 89 | Jan-16 | 1,178 | 736 | 658 | 335 | 5,370 | 0 | 72 |
| 90 | Feb-16 | 1,143 | 2,569 | 666 | 336 | 5,201 | 0 | 73 |
| 91 | Mar-16 | 1,458 | 1,165 | 691 | 341 | 5,269 | 0 | 74 |
| 92 | Apr-16 | | | | | | | |
| 93 | May-16 | | | | | | | |
| 94 | Jun-16 | | | | | | | |
| 95 | YEAR-TO-DATE AVERAGE | | | | | | | |
| 96 | SFY11 | 1,115 | 734 | 630 | 412 | 4,695 | 1,570 | 57 |
| 97 | SFY12 | 1,167 | 747 | 592 | 314 | 5,005 | 0 | 58 |
| 98 | SFY13 | 1,147 | 727 | 609 | 316 | 5,120 | 0 | 58 |
| 99 | SFY14 | 1,160 | 678 | 556 | 306 | 5,384 | 0 | 60 |
| 100 | SFY15 | 1,249 | 729 | 526 | 300 | 5,466 | 0 | 46 |
| 101 | SFY16 | 1,230 | 1,043 | 618 | 320 | 5,365 | 0 | 60 |
| 102 | | | | | | | | |
| 103 | **Source of Data** | | | | | | | |
| 104 | Column | | | | | | | |
| 105 | B | DCYF SFY Management Database Report: Bridges. | | | | | | |
| 106 | C | DCYF Assessment Supervisory Report: Bridges. | | | | | | |
| 107 | D | Bridges placement authorizations during the month, unduplicated. | | | | | | |
| 108 | E | Bridges placement authorizations during the month, unduplicated. | | | | | | |
| 109 | F | Bridges Expenditure Report, NHB-OAR8-128 | | | | | | |
| 110 | G | Child Care Wait List Screen: New Heights | | | | | | |
| 111 | H | Bridges Service Day Query - Bed days divided by days in month | | | | | | |

| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 1 | Table F | | | | | | | |
| 2 | Department of Health and Human Services | | | | | | | |
| 3 | Operating Statistics | | | | | | | |
| 4 | Social Services | | | | | | | |
| 5 | | | | | | | | |
| 6 | | FANF | APTD Persons | Food Stamps Persons | Child Support Cases | | | |
| 7–8 | | | | | Current Cases | Former Cases | Never Cases | Total Cases |
| 9 | | Actual | Actual | Actual | Actual | Actual | Actual | Actual |
| 58 | Jul-13 | 7,926 | 7,962 | 115,691 | 4,035 | 17,724 | 13,193 | 34,952 |
| 59 | Aug-13 | 7,922 | 7,955 | 115,499 | 3,866 | 17,901 | 13,180 | 34,947 |
| 60 | Sep-13 | 7,709 | 7,889 | 114,725 | 3,772 | 17,913 | 13,183 | 34,868 |
| 61 | Oct-13 | 7,609 | 7,945 | 114,915 | 3,938 | 17,797 | 13,227 | 34,962 |
| 62 | Nov-13 | 7,449 | 7,882 | 113,514 | 3,793 | 17,908 | 13,325 | 35,026 |
| 63 | Dec-13 | 7,334 | 7,820 | 112,908 | 3,803 | 17,774 | 13,331 | 34,908 |
| 64 | Jan-14 | 7,330 | 7,834 | 113,326 | 3,762 | 17,783 | 13,316 | 34,861 |
| 65 | Feb-14 | 7,353 | 7,803 | 112,791 | 3,767 | 17,695 | 13,329 | 34,791 |
| 66 | Mar-14 | 7,242 | 7,704 | 112,511 | 3,723 | 17,734 | 13,361 | 34,818 |
| 67 | Apr-14 | 7,277 | 7,727 | 112,144 | 3,863 | 17,593 | 13,453 | 34,909 |
| 68 | May-14 | 7,119 | 7,751 | 111,362 | 3,828 | 17,592 | 13,518 | 34,938 |
| 69 | Jun-14 | 7,116 | 7,745 | 110,590 | 3,700 | 17,766 | 13,683 | 35,149 |
| 70 | Jul-14 | 7,085 | 7,741 | 109,239 | 3,672 | 17,849 | 13,748 | 35,269 |
| 71 | Aug-14 | 6,871 | 7,727 | 108,767 | 3,671 | 17,803 | 13,741 | 35,215 |
| 72 | Sep-14 | 6,767 | 7,679 | 108,434 | 3,598 | 17,831 | 13,736 | 35,165 |
| 73 | Oct-14 | 6,705 | 7,657 | 108,343 | 3,702 | 18,674 | 13,214 | 35,590 |
| 74 | Nov-14 | 6,705 | 7,607 | 107,214 | 3,711 | 18,814 | 13,347 | 35,872 |
| 75 | Dec-14 | 6,660 | 7,532 | 107,900 | 3,753 | 18,868 | 13,529 | 36,150 |
| 76 | Jan-15 | 6,622 | 7,530 | 107,934 | 3,917 | 18,811 | 13,735 | 36,463 |
| 77 | Feb-15 | 6,547 | 7,542 | 107,224 | 3,956 | 18,906 | 13,981 | 36,843 |
| 78 | Mar-15 | 6,339 | 7,538 | 107,521 | 3,803 | 19,202 | 14,294 | 37,299 |
| 79 | Apr-15 | 6,366 | 7,596 | 107,283 | 3,842 | 19,249 | 14,538 | 37,629 |
| 80 | May-15 | 6,179 | 7,561 | 106,042 | 3,914 | 19,180 | 14,666 | 37,760 |
| 81 | Jun-15 | 6,138 | 7,526 | 106,322 | 3,820 | 19,207 | 14,742 | 37,769 |
| 82 | Jul-15 | 6,120 | 7,513 | 104,705 | 3,852 | 19,228 | 14,937 | 38,017 |
| 83 | Aug-15 | 5,934 | 7,438 | 103,544 | 3,866 | 19,211 | 15,004 | 38,081 |
| 84 | Sep-15 | 5,764 | 7,343 | 102,869 | 3,685 | 19,344 | 15,133 | 38,162 |
| 85 | Oct-15 | 5,688 | 7,307 | 101,917 | 3,808 | 19,263 | 15,257 | 38,328 |
| 86 | Nov-15 | 5,583 | 7,227 | 100,525 | 3,763 | 19,319 | 15,345 | 38,427 |
| 87 | Dec-15 | 5,425 | 7,116 | 100,495 | 3,614 | 19,366 | 15,373 | 38,353 |
| 88 | Jan-16 | 5,435 | 7,081 | 99,978 | 3,699 | 19,261 | 15,402 | 38,362 |
| 89 | Feb-16 | 5,307 | 7,117 | 99,486 | 3,658 | 19,258 | 15,506 | 38,422 |
| 90 | Mar-16 | 5,183 | 7,033 | 99,543 | 3,558 | 19,390 | 15,694 | 38,642 |
| 91 | Apr-16 | | | | | | | |
| 92 | May-16 | | | | | | | |
| 93 | Jun-16 | | | | | | | |
| 94 | YEAR-TO-DATE AVERAGE | | | | | | | |
| 95 | SFY11 | 13,795 | 8,713 | 111,565 | 5,616 | 17,260 | 13,024 | 35,900 |
| 96 | SFY12 | 11,540 | 8,850 | 115,439 | 5,185 | 17,244 | 12,807 | 35,235 |
| 97 | SFY13 | 8,601 | 8,185 | 118,360 | 4,109 | 17,655 | 12,889 | 34,653 |
| 98 | SFY14 | 7,542 | 7,866 | 113,987 | 3,829 | 17,803 | 13,272 | 34,904 |
| 99 | SFY15 | 6,700 | 7,617 | 108,064 | 3,754 | 18,529 | 13,703 | 35,985 |
| 100 | SFY16 | 5,604 | 7,242 | 101,451 | 3,723 | 19,293 | 15,295 | 38,310 |
| 101 | | | | | | | | |
| 102 | Source of Data | | | | | | | |
| 103 | Column | | | | | | | |
| 104 | B | Office of Research & Analysis, Caseload Statistics | | | | | | |
| 105 | C | Budget Document | | | | | | |
| 106 | D | Budget Document | | | | | | |
| 107 | E-H | DCSS Caseload (Month End Actual from NECSES) | | | | | | |
| 108 | | | | | | | | |
| 109 | Note | * Effective 3/1/12, SSI or SSP is considered when determining FANF | | | | | | |
| 110 | | eligibility. Those child support cases no longer eligible, are now "Former" | | | | | | |
| 111 | | assistance cases. | | | | | | |
| 112 | | | | | | | | |

| | A | B | C | D | E |
|---|---|---|---|---|---|
| 1 | **Table G-1** | | | | |
| 2 | **Department of Health and Human Services** | | | | |
| 3 | **Operating Statistics** | | | | |
| 4 | **Clients Served by Community Mental Health Centers** | | | | |
| 5 | | | | | |
| 6 | | **Annual Totals** | | | |
| 7 | | **Adults** | **Children** | **Total** | |
| 8 | **FY2012** | 36,407 | 13,122 | 49,529 | |
| 9 | **FY2013** | 34,819 | 13,013 | 47,832 | |
| 10 | **FY2014** | 35,657 | 14,202 | 49,859 | |
| 11 | **FY2015** | 34,725 | 10,736 | 45,461 | |
| 12 | | | | | |
| 13 | | **Adults** | **Children** | **Total** | |
| 14 | | | | | |
| 15 | Jul-14 | 14,818 | 5,179 | 19,997 | |
| 16 | Aug-14 | 14,436 | 5,132 | 19,568 | |
| 17 | Sep-14 | 14,981 | 5,382 | 20,363 | |
| 18 | Oct-14 | 15,172 | 5,651 | 20,823 | |
| 19 | Nov-14 | 14,142 | 5,591 | 19,733 | |
| 20 | Dec-14 | 14,734 | 5,775 | 20,509 | |
| 21 | Jan-15 | 14,960 | 5,257 | 20,217 | |
| 22 | Feb-15 | 14,024 | 4,757 | 18,781 | |
| 23 | Mar-15 | 15,083 | 5,044 | 20,127 | |
| 24 | Apr-15 | 14,641 | 5,073 | 19,714 | |
| 25 | May-15 | 15,467 | 5,996 | 21,463 | |
| 26 | Jun-15 | 15,935 | 6,044 | 21,979 | |
| 27 | Jul-15 | 15,467 | 5,741 | 21,208 | |
| 28 | Aug-15 | 15,213 | 5,806 | 21,019 | |
| 29 | Sep-15 | 15,232 | 5,769 | 21,001 | |
| 30 | Oct-15 | 15,324 | 6,027 | 21,351 | |
| 31 | Nov-15 | 14,438 | 5,957 | 20,395 | |
| 32 | Dec-15 | 14,753 | 6,084 | 20,837 | |
| 33 | Jan-16 | 15,150 | 5,637 | 20,787 | |
| 34 | Feb-16 | 15,393 | 5,041 | 20,434 | |
| 35 | Mar-16 | | | | |
| 36 | Apr-16 | | | | |
| 37 | May-16 | | | | |
| 38 | Jun-16 | | | | |
| 39 | | | | | |
| 40 | **Notes:** | | | | |
| 41 | 1. Monthly data is a duplicated count. | | | | |
| 42 | 2. Year-end data is unduplicated. | | | | |

# Table H
## Department of Health and Human Services
## Operating Statistics
## Elderly & Adult Long Term Care

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | | Total Nursing Clients | | CFI Home Health | CFI Midlevel | Other Nursing | Nursing Home Beds | | Pct in NF | APS Clients Assmnts | APS Cases Ongoing | SSBG AIHC Waitlist | Total SSBG IHCS | |
| 7 | | Actual | Budget | Note 2 | | Note 1 | 3 mo. Avg | Budget | | | | | Note 3 | |
| 8 | | | | | | | | | | | | | | |
| 56 | Jul-13 | 7,153 | 7,356 | 2,452 | 421 | 72 | 4,280 | 4,380 | 59.8% | 276 | 1,230 | 1 | | |
| 57 | Aug-13 | 7,284 | 7,356 | 2,532 | 439 | 25 | 4,313 | 4,380 | 59.2% | 263 | 1,225 | 1 | | |
| 58 | Sep-13 | 7,145 | 7,356 | 2,480 | 449 | 20 | 4,216 | 4,380 | 59.0% | 264 | 1,247 | 1 | 474 | YTD |
| 59 | Oct-13 | 7,290 | 7,356 | 2,435 | 459 | 24 | 4,396 | 4,380 | 60.3% | 291 | 1,255 | 1 | | |
| 60 | Nov-13 | 7,264 | 7,356 | 2,422 | 488 | 36 | 4,354 | 4,380 | 59.9% | 224 | 1,242 | 6 | | |
| 61 | Dec-13 | 7,342 | 7,356 | 2,417 | 454 | 27 | 4,471 | 4,380 | 60.9% | 255 | 1,267 | 3 | 573 | YTD |
| 62 | Jan-14 | 7,265 | 7,356 | 2,428 | 481 | 27 | 4,356 | 4,380 | 60.0% | 319 | 1,269 | 3 | | |
| 63 | Feb-14 | 7,041 | 7,356 | 2,372 | 449 | 37 | 4,220 | 4,380 | 59.9% | 258 | 1,270 | 0 | | |
| 64 | Mar-14 | 7,121 | 7,356 | 2,366 | 455 | 27 | 4,300 | 4,380 | 60.4% | 283 | 1,266 | 0 | 652 | YTD |
| 65 | Apr-14 | 7,125 | 7,356 | 2,317 | 493 | 24 | 4,315 | 4,380 | 60.6% | 298 | 1,238 | 0 | | |
| 66 | May-14 | 7,439 | 7,356 | 2,418 | 477 | 24 | 4,544 | 4,380 | 61.1% | 312 | 1,265 | 0 | | |
| 67 | Jun-14 | 7,271 | 7,356 | 2,356 | 475 | 32 | 4,440 | 4,380 | 61.1% | 282 | 1,216 | 0 | 675 | YTD |
| 68 | Jul-14 | 7,337 | 7,421 | 2,431 | 444 | 44 | 4,462 | 4,380 | 60.8% | 363 | 801 | 0 | 0 | |
| 69 | Aug-14 | 7,094 | 7,421 | 2,403 | 439 | 44 | 4,252 | 4,380 | 59.9% | 276 | 786 | 0 | 1168 | |
| 70 | Sep-14 | 7,088 | 7,421 | 2,428 | 431 | 37 | 4,229 | 4,380 | 59.7% | 270 | 794 | 0 | 1438 | |
| 71 | Oct-14 | 7,242 | 7,421 | 2,453 | 492 | 36 | 4,297 | 4,380 | 59.3% | 301 | 757 | 0 | 2177 | |
| 72 | Nov-14 | 7,160 | 7,421 | 2,422 | 460 | 36 | 4,278 | 4,380 | 59.7% | 212 | 752 | 0 | 1276 | |
| 73 | Dec-14 | 7,181 | 7,421 | 2,431 | 469 | 35 | 4,281 | 4,380 | 59.6% | 263 | 764 | 0 | 1990 | |
| 74 | Jan-15 | 6,996 | 7,421 | 2,404 | 469 | 32 | 4,123 | 4,380 | 58.9% | 246 | 736 | 0 | 1845 | |
| 75 | Feb-15 | 7,026 | 7,421 | 2,400 | 472 | 32 | 4,154 | 4,380 | 59.1% | 221 | 739 | 0 | 1589 | |
| 76 | Mar-15 | 7,109 | 7,421 | 2,432 | 448 | 32 | 4,229 | 4,380 | 59.5% | 278 | 716 | 0 | 1802 | |
| 77 | Apr-15 | 7,230 | 7,421 | 2,422 | 484 | 30 | 4,324 | 4,380 | 59.8% | 244 | 723 | 0 | 1958 | |
| 78 | May-15 | 7,170 | 7,421 | 2,428 | 464 | 29 | 4,278 | 4,380 | 59.7% | 210 | 716 | 0 | 1838 | |
| 79 | Jun-15 | 7,109 | 7,421 | 2,404 | 479 | 32 | 4,226 | 4,380 | 59.4% | 294 | 726 | 0 | 1410 | |
| 80 | Jul-15 | 7,045 | 7,232 | 2,409 | 463 | 33 | 4,173 | 4,325 | 59.2% | 316 | 738 | 0 | 1410 | |
| 81 | Aug-15 | 6,949 | 7,232 | 2,339 | 453 | 35 | 4,157 | 4,325 | 59.8% | 301 | 750 | 0 | 1762 | |
| 82 | Sep-15 | 7,042 | 7,232 | 2,335 | 481 | 40 | 4,226 | 4,325 | 60.0% | 320 | 756 | 0 | 1645 | |
| 83 | Oct-15 | 7,056 | 7,232 | 2,302 | 502 | 35 | 4,252 | 4,325 | 60.3% | 332 | 756 | 0 | 1320 | |
| 84 | Nov-15 | 7,047 | 7,232 | 2,317 | 444 | 40 | 4,286 | 4,325 | 60.8% | 276 | 763 | 0 | 1842 | |
| 85 | Dec-15 | 7,191 | 7,232 | 2,428 | 463 | 39 | 4,300 | 4,325 | 59.8% | 284 | 734 | 0 | 1743 | |
| 86 | Jan-16 | 7,114 | 7,232 | 2,434 | 435 | 35 | 4,245 | 4,325 | 59.7% | 289 | 732 | 0 | 1712 | |
| 87 | Feb-16 | 7,225 | 7,232 | 2,505 | 452 | 35 | 4,268 | 4,325 | 59.1% | 289 | 742 | 0 | 1561 | |
| 88 | Mar-16 | 7,231 | 7,232 | 2,671 | 345 | 34 | 4,215 | 4,325 | 58.3% | 352 | 725 | 0 | 1709 | |
| 89 | Apr-16 | | | | | | | | | | | | | |
| 90 | May-16 | | | | | | | | | | | | | |
| 91 | Jun-16 | | | | | | | | | | | | | |
| 92 | | | | | | YEAR-TO-DATE AVERAGE | | | | | | | | |
| 93 | SFY11 | 7,207 | 7,740 | 2,525 | 391 | 33 | 4,291 | 4,063 | 59.5% | 208 | 1,075 | 3 | 560 | |
| 94 | SFY12 | 7,195 | 7,515 | 2,403 | 441 | 33 | 4,351 | 4,400 | 60.5% | 224 | 1,086 | 4 | 646 | |
| 95 | SFY13 | 7,232 | 7,578 | 2,448 | 461 | 36 | 4,323 | 4,422 | 59.8% | 217 | 1,156 | 3 | 619 | |
| 96 | SFY14 | 7,212 | 7,356 | 2,434 | 455 | 33 | 4,323 | 4,380 | 59.9% | 270 | 1,252 | 2 | 566 | |
| 97 | SFY15 | 7,137 | 7,421 | 2,423 | 458 | 36 | 4,256 | 4,380 | 59.6% | 270 | 761 | 0 | 1,476 | |
| 98 | SFY16 | 7,100 | 7,232 | 2,416 | 449 | 36 | 4,236 | 4,325 | 59.7% | 307 | 744 | 0 | 1,634 | |

**Note 1: These clients are also captured under OMBP Provider Payments**

**Note 2: CFI Home Health = CFI Home Support and Home Health Care Waiver Services**

**Note 3: In preparation for 2016, Converted IHCS to monthly paid basis**

**Source of Data**

| Columns | |
|---|---|
| D-F | MDSS monthly client counts |
| G | 3 month Avg of the number of paid bed days in the month/days in prior month by the number of days in the previous month. MDSS |
| J | Options Monthly Protective Reports |
| K | Options Monthly Activity Report |
| L | SSBG Adult In-Home Care verbal report from Adult Protective Services Administrator |
| M | Quarterly Options Paid Claims from Business Systems Unit Manager |

|  | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 1 |  |  |  |  |  |  |  |  |
| 2 | **Developmental Services Long Term Care** |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |
| 4 |  | **BDS Programs served FYTD**** | **BDS Programs FYTD Unduplicated Count** | **Early Supports & Services** | **Special Medical Services** | **Partners in Health Program** | **Devl. Serv. Priority #1 DD Waitlist** | **Devl. Serv. ABD Waitlist** |
| 5 |  |  |  |  | (8-09 to 8-12 Actual) | (8-09 to 8-12 Actual) | **Actual*** | **Actual*** |
| 53 | Jul-13 | 8,995 | 6,364 | 1,865 | 1,646 | 985 | 373 | 15 |
| 54 | Aug-13 | 10,041 | 7,291 | 2,074 | 1,755 | 995 | 186 | 5 |
| 55 | Sep-13 | 10,978 | 8,160 | 2,381 | 1,813 | 1,005 | 103 | 6 |
| 56 | Oct-13 | 11,573 | 8,648 | 2,618 | 1,903 | 1,022 | 108 | 10 |
| 57 | Nov-13 | 12,129 | 9,122 | 2,978 | 1,963 | 1,044 | 116 | 12 |
| 58 | Dec-13 | 12,764 | 9,658 | 3,231 | 2,047 | 1,059 | 51 | 16 |
| 59 | Jan-14 | 13,265 | 10,043 | 3,404 | 2,142 | 1,080 | 40 | 14 |
| 60 | Feb-14 | 13,712 | 10,409 | 3,640 | 2,208 | 1,095 | 59 | 16 |
| 61 | Mar-14 | 14,174 | 10,730 | 3,863 | 2,325 | 1,119 | 69 | 18 |
| 62 | Apr-14 | 14,702 | 11,093 | 4,112 | 2,464 | 1,145 | 81 | 17 |
| 63 | May-14 | 15,144 | 11,488 | 4,383 | 2,508 | 1,148 | 10 | 0 |
| 64 | Jun-14 | 15,525 | 11,742 | 4,577 | 2,614 | 1,169 | 79 | 19 |
| 65 | Jul-14 | 9,996 | 7,049 | 1,810 | 1,979 | 968 | 86 | 0 |
| 66 | Aug-14 | 10,721 | 7,697 | 2,152 | 2,040 | 984 | 95 | 0 |
| 67 | Sep-14 | 11,675 | 8,467 | 2,545 | 2,212 | 996 | 120 | 3 |
| 68 | Oct-14 | 12,567 | 9,127 | 2,785 | 2,421 | 1,019 | 139 | 2 |
| 69 | Nov-14 | 13,078 | 9,567 | 3,010 | 2,476 | 1,035 | 132 | 3 |
| 70 | Dec-14 | 13,538 | 9,880 | 3,187 | 2,618 | 1,040 | 152 | 3 |
| 71 | Jan-15 | 14,027 | 10,286 | 3,406 | 2,708 | 1,033 | 98 | 6 |
| 72 | Feb-15 | 14,424 | 10,600 | 3,613 | 2,778 | 1,046 | 115 | 4 |
| 73 | Mar-15 | 14,837 | 10,893 | 3,837 | 2,876 | 1,068 | 97 | 5 |
| 74 | Apr-15 | 15,389 | 11,313 | 4,172 | 2,995 | 1,081 | 114 | 8 |
| 75 | May-15 | 15,787 | 11,604 | 4,384 | 3,102 | 1,081 | 138 | 8 |
| 76 | Jun-15 | 16,229 | 11,919 | 4,624 | 3,210 | 1,100 | 101 | 8 |
| 77 | Jul-15 | 9,683 | 6,663 | 2,099 | 2,088 | 932 | 186 | 8 |
| 78 | Aug-15 | 11,567 | 8,421 | 2,597 | 2,199 | 947 | 195 | 17 |
| 79 | Sep-15 | 12,228 | 8,964 | 2,816 | 2,298 | 966 | 186 | 0 |
| 80 | Oct-15 | 12,859 | 9,503 | 3,095 | 2,372 | 984 | 196 | 0 |
| 81 | Nov-15 | 13,340 | 9,919 | 3,317 | 2,432 | 989 | 149 | 0 |
| 82 | Dec-15 | 13,776 | 10,264 | 3,546 | 2,515 | 997 | 153 | 0 |
| 83 | Jan-16 | 14,097 | 10,521 | 3,720 | 2,569 | 1,007 | 150 | 0 |
| 84 | Feb-16 | 14,448 | 10,794 | 3,911 | 2,632 | 1,022 | 152 | 0 |
| 85 | Mar-16 | 14,783 | 10,984 | 4,002 | 2,760 | 1,039 | 127 | 2 |
| 86 | Apr-16 |  |  |  |  |  |  |  |
| 87 | May-16 |  |  |  |  |  |  |  |
| 88 | Jun-16 |  |  |  |  |  |  |  |
| 89 | YEAR-TO-DATE AVERAGE *** |  |  |  |  |  |  |  |
| 90 | SFY11 | 12,071 | 9,251 | 2,060 | 1,689 | 1,132 | 20 | 0 |
| 91 | SFY12 | 11,874 | 9,042 | 2,825 | 1,750 | 1,083 | 56 | 5 |
| 92 | SFY13 | 12,052 | 9,054 | 2,804 | 1,941 | 1,057 | 180 | 0 |
| 93 | SFY14 | 11,959 | 8,936 | 2,895 | 1,978 | 1,045 | 123 | 12 |
| 94 | SFY15 | 12,763 | 9,285 | 2,927 | 2,456 | 1,021 | 115 | 3 |
| 95 | SFY16 | 12,976 | 9,559 | 3,234 | 2,429 | 987 | 166 | 3 |
| 96 |  |  |  |  |  | ***(1/4/16 - formulas corrected) |  |  |
| 97 | **Data Sources:** | NHLeads | NHLeads | NHLeads | SMSdb | PIHdb | Registry | Registry |
| 98 |  |  |  |  |  |  |  |  |
| 99 | ***G & *H** | Represent the number of individuals waiting at least 90-days for DD or ABD |  |  |  |  |  |  |
| 100 |  | Waiver funding. |  |  |  |  |  |  |
| 101 | ** | BDS count excludes MTS Students served |  |  |  |  |  |  |
| 102 | **E & F** | Represents year-to-date total number served |  |  |  |  |  |  |

| | A | B | C | D | E | F | G | H | I | J |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Table I | | | | | | | | | |
| 2 | Department of Health and Human Services | | | | | | | | | |
| 3 | Operating Statistics | | | | | | | | | |
| 4 | Shelters & Institutions | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | NHH | | | | | | BHHS | | Glencliff |
| 7 | | APS & APC Census | APS & APC Admissions | APS Waiting List | APC Waiting List | THS Census | All Shelters | | % of | GH Census |
| 8 | | Actual | Actual | Actual | Actual | Actual | Capacity | Actual | Capacity | Actual |
| 9 | | | | Adult | Adolescent | | | | | |
| 58 | Jul-13 | 155 | 187 | | | n/a | | | | 117 |
| 59 | Aug-13 | 161 | 164 | | | n/a | | | | 116 |
| 60 | Sep-13 | 163 | 165 | | | n/a | | | | 115 |
| 61 | Oct-13 | 161 | 184 | | | n/a | | | | 116 |
| 62 | Nov-13 | 164 | 149 | | | n/a | | | | 119 |
| 63 | Dec-13 | 151 | 144 | | | n/a | | | | 118 |
| 64 | Jan-14 | 160 | 190 | | | n/a | | | | 118 |
| 65 | Feb-14 | 161 | 165 | | | n/a | | | | 116 |
| 66 | Mar-14 | 160 | 181 | | | n/a | | | | 118 |
| 67 | Apr-14 | 163 | 193 | | | n/a | | | | 118 |
| 68 | May-14 | 164 | 184 | | | n/a | | | | 116 |
| 69 | Jun-14 | 162 | 164 | | | n/a | | | | 114 |
| 70 | Jul-14 | 141 | 153 | 23 | 1 | n/a | 13,826 | 11,737 | 85% | 116 |
| 71 | Aug-14 | 135 | 142 | 30 | 1 | n/a | 13,826 | 12,121 | 88% | 117 |
| 72 | Sep-14 | 145 | 173 | 33 | 5 | n/a | 13,380 | 11,625 | 87% | 118 |
| 73 | Oct-14 | 146 | 181 | 29 | 4 | n/a | 13,826 | 12,783 | 92% | 116 |
| 74 | Nov-14 | 150 | 166 | 27 | 6 | n/a | 13,380 | 12,064 | 90% | 117 |
| 75 | Dec-14 | 149 | 180 | 15 | 4 | n/a | 15,004 | 14,056 | 94% | 118 |
| 76 | Jan-15 | 150 | 159 | 22 | 3 | n/a | 15,748 | 15,016 | 95% | 118 |
| 77 | Feb-15 | 152 | 169 | 18 | 4 | n/a | 14,224 | 13,940 | 98% | 116 |
| 78 | Mar-15 | 156 | 171 | 16 | 8 | n/a | 15,748 | 14,996 | 95% | 113 |
| 79 | Apr-15 | 153 | 165 | 10 | 8 | n/a | 13,380 | 11,990 | 90% | 115 |
| 80 | May-15 | 150 | 170 | 14 | 7 | n/a | 13,826 | 11,598 | 84% | 117 |
| 81 | Jun-15 | 150 | 180 | 14 | 5 | n/a | 13,380 | 10,830 | 81% | 114 |
| 82 | Jul-15 | 148 | 169 | 13 | 1 | n/a | 14,694 | 11,628 | 79% | 112 |
| 83 | Aug-15 | 150 | 152 | 20 | 1 | n/a | 14,694 | 12,229 | 83% | 115 |
| 84 | Sep-15 | 151 | 162 | 17 | 5 | n/a | 14,220 | 11,861 | 83% | 116 |
| 85 | Oct-15 | 146 | 154 | 19 | 6 | n/a | 14,694 | 12,452 | 85% | 116 |
| 86 | Nov-15 | 144 | 163 | 18 | 5 | n/a | 14,220 | 12,684 | 89% | 113 |
| 87 | Dec-15 | 152 | 165 | 24 | 7 | n/a | 14,694 | 12,758 | 87% | 114 |
| 88 | Jan-16 | 153 | 133 | 28 | 5 | n/a | 14,694 | 12,351 | 84% | 112 |
| 89 | Feb-16 | 153 | 137 | 31 | 7 | n/a | 13,746 | 12,160 | 88% | 113 |
| 90 | Mar-16 | 156 | 191 | 22 | 5 | | 14,694 | 11,224 | 76% | 113 |
| 91 | Apr-16 | | | | | | | | | |
| 92 | May-16 | | | | | | | | | |
| 93 | Jun-16 | | | | | | | | | |
| 94 | YEAR-TO-DATE AVERAGE | | | | | | | | | |
| 95 | SFY11 | 152 | 186 | | | 42 | 11,059 | 9,218 | 83% | 111 |
| 96 | SFY12 | 146 | 197 | | | 39 | 11,224 | 10,702 | 95% | 115 |
| 97 | SFY13 | 153 | 160 | | | | | | | 118 |
| 98 | SFY14 | 160 | 170 | | | | | | | 117 |
| 99 | SFY15 | 147 | 166 | 24 | 4 | | 14,329 | 13,149 | 92% | 117 |
| 100 | SFY16 | 150 | 158 | 21 | 5 | | 14,483 | 12,150 | 84% | 114 |
| 101 | | | | | | | | | | |
| 102 | Source of Data | | | | | | | | | |
| 103 | Column | | | | | | | | | |
| 104 | B | Daily in-house midnight census averaged per month* | | | | | | | | |
| 105 | C | Daily census report of admissions totalled per month | | | | | | | | |
| 106 | D | Daily Average wait list for adults | | | | | | | | |
| 107 | E | Daily average wait list for adolescents | | | | | | | | |
| 108 | F | Daily Average census in Transitional Housing (privatized 12/2011) | | | | | | | | |
| 109 | G | Total number of individual bednights available in emergency shelters | | | | | | | | |
| 110 | H | Total number of individual bednights utilized in emergency shelters | | | | | | | | |
| 111 | I | Percentage of individual bednights utilized during month | | | | | | | | |
| 112 | J | Daily in-house midnight census averaged per month | | | | | | | | |
| 113 | | | | | | | | | | |
| 114 | | * July 2014 average Census no longer reflects Pts on Leave | | | | | | | | |

| | A | B | E | H | K | N | Q | S | T | U | V | W | X | Y | Z | AA | AB | AC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Table J | | | | | | | | | | | | | | | | | |
| 2 | Medicaid Medical Caseloads (Persons) | | | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | | | | |
| 4 | Enrollment as of | 12/30/13 | 3/31/14 | 6/30/14 | 9/30/14 | 12/31/14 | 3/31/2015 | 5/31/2015 | 6/30/2015 | 7/31/2015 | 8/31/2015 | 9/30/2015 | 10/31/2015 | 11/30/2015 | 12/31/2015 | 1/31/2016 | 2/29/2016 | 3/31/2016 |
| 5 | | | | | | | | | | | | | | | | | | |
| 6 | 1. Low-Income Children (Age 0-18) | 82,129 | 88,064 | 88,961 | 89,702 | 90,618 | 90,249 | 89,400 | 89,849 | 90,104 | 89,934 | 90,345 | 90,197 | 90,298 | 91,089 | 91,095 | 91,105 | 91,276 |
| 7 | 2. Children With Severe Disabilities (Age 0-18) | 1,604 | 1,680 | 1,670 | 1,619 | 1,622 | 1,631 | 1,629 | 1,623 | 1,613 | 1,623 | 1,613 | 1,602 | 1,584 | 1,593 | 1,588 | 1,571 | 1,570 |
| 8 | 3. Foster Care & Adoption Subsidy (Age 0-25) | 1,948 | 2,003 | 2,004 | 2,048 | 2,085 | 2,173 | 2,192 | 2,166 | 2,160 | 2,139 | 2,152 | 2,163 | 2,175 | 2,181 | 2,173 | 2,227 | 2,215 |
| 9 | 4. Low-Income Parents (Age 19-64) | 10,324 | 12,955 | 13,976 | 13,287 | 13,212 | 13,595 | 13,558 | 13,677 | 13,869 | 13,581 | 14,272 | 14,179 | 13,927 | 13,851 | 13,599 | 13,571 | 13,566 |
| 10 | 5. Low-Income Pregnant Women (Age 19+) | 2,275 | 3,051 | 3,246 | 2,846 | 2,602 | 2,532 | 2,412 | 2,432 | 2,430 | 2,356 | 2,297 | 2,290 | 2,220 | 2,244 | 2,208 | 2,189 | 2,284 |
| 11 | 6. Adults With Disabilities (Age 19-64) | 19,997 | 19,961 | 20,222 | 19,830 | 19,540 | 19,627 | 19,730 | 19,727 | 19,629 | 19,543 | 19,413 | 19,346 | 19,206 | 19,111 | 19,139 | 19,218 | 19,388 |
| 12 | 7. Elderly & Elderly With Disabilities (Age 65+) | 8,828 | 8,779 | 8,822 | 8,771 | 8,714 | 8,545 | 8,594 | 8,606 | 8,644 | 8,650 | 8,652 | 8,714 | 8,756 | 8,741 | 8,747 | 8,788 | 8,795 |
| 13 | 8. BCCP (Age 19-64) | 205 | 200 | 204 | 194 | 189 | 177 | 177 | 172 | 168 | 167 | 164 | 154 | 153 | 149 | 148 | 150 | 148 |
| 14 | Sub-Total | 127,310 | 136,693 | 139,105 | 138,297 | 138,582 | 138,529 | 137,692 | 138,252 | 138,617 | 137,993 | 138,908 | 138,645 | 138,319 | 138,959 | 138,697 | 138,819 | 139,242 |
| 15 | 9. NH Health Protection Program (Age 19-64) | | | | 18,617 | 30,711 | 38,402 | 40,456 | 41,657 | 42,579 | 43,126 | 43,107 | 43,577 | 44,568 | 46,996 | 47,902 | 49,135 | 49,203 |
| 16 | Total By Category | 127,310 | 136,693 | 139,105 | 156,914 | 169,293 | 176,931 | 178,148 | 179,909 | 181,196 | 181,119 | 182,015 | 182,222 | 182,887 | 185,955 | 186,599 | 187,954 | 188,445 |
| 17 | Reconciling Differences (Detail to Summary) | (405) | 122 | 0 | (1) | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 18 | Reported On Summary | 126,905 | 136,815 | 139,105 | 156,913 | 169,294 | 176,933 | 178,148 | 179,909 | 181,196 | 181,119 | 182,015 | 182,222 | 182,887 | 185,955 | 186,599 | 187,954 | 188,445 |
| 19 | | | | | | | | | | | | | | | | | | |
| 20 | ENROLLMENT IN MEDICAID CARE MANAGEMENT | | | | | | | | | | | | | | | | | |
| 21 | Enrollment as of | 01/01/14 | 04/01/14 | 07/01/14 | 10/01/14 | 1/1/2015 | 4/1/2015 | 6/1/2015 | 7/1/2015 | 8/1/2015 | 9/1/2015 | 10/1/2015 | 11/1/2015 | 12/1/2015 | 1/1/2016 | 2/1/2016 | 3/1/2016 | 4/1/2016 |
| 22 | | | | | | | | | | | | | | | | | | |
| 23 | Enrolled in Care Management | 108,206 | 116,299 | 120,915 | 133,716 | 145,763 | 155,873 | 158,636 | 161,224 | 162,128 | 162,654 | 163,779 | 163,411 | 161,387 | 128,349 | 136,854 | 138,033 | 137,841 |
| 24 | Premium Assistance Program (NHHPP formerly w/MCO, previously shown in Care Management and not new enrollees) | | | | | | | | | | | | | | 36,884 | 38,063 | 38,675 | 39,557 |
| 25 | Enrolled in Fee-For-Service | 25,186 | 17,708 | 15,549 | 22,090 | 22,067 | 20,197 | 18,067 | 17,594 | 17,219 | 17,098 | 17,191 | 17,117 | 19,887 | 19,100 | 10,217 | 9,951 | 9,414 |
| 26 | Total | 133,392 | 134,007 | 136,464 | 155,806 | 167,830 | 176,070 | 176,703 | 178,818 | 179,347 | 179,752 | 180,970 | 180,528 | 181,274 | 184,333 | 185,134 | 186,659 | 186,812 |
| 27 | | | | | | | | | | | | | | | | | | |
| 28 | | *(6,082)* | *2,686* | *2,641* | *1,108* | *1,463* | *861* | *1,445* | *1,091* | *1,849* | *1,367* | *1,045* | *1,694* | *1,613* | *1,622* | *1,465* | *1,295* | *1,633* |
| 29 | Figures by category versus figures by coverage are taken from two points in time. Medicaid Care Managementis first of the month and the some people drop off during the month and go into Fee-For-Service. FFS is end of the month and builds during the month to include the spend down clients excluded from MCM. The early data points are switched because the MCM data includes retroactive FFS enrollment for those earlier months. | | | | | | | | | | | | | | | | | |

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Table K | | | | | | | | | | | | | | | | | | |
| 2 | Department of Health and Human Services | | | | | | | | | | | | | | | | | | |
| 3 | Caseloads Versus Prior Year & Prior Month | | | | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | | | | | |
| 5 | | Unduplicated Persons | | | Medicaid Persons | | | Long Term Care-Seniors | | | FANF Persons | | | APTD Persons | | | SNAP Persons | | |
| 6 | | Actual | Vs PY | Vs Pmo | Actual | Vs PY | Vs Pmo | Actual | Vs PY | Vs Pmo | Actual | Vs PY | Vs Pmo | Actual | Vs PY | Vs Pmo | Actual | Vs PY | Vs Pmo |
| 68 | Jul-13 | 153,075 | -2.3% | -0.1% | 129,255 | -0.2% | -0.1% | 7,153 | -1.0% | 1.6% | 7,926 | -8.8% | -1.0% | 7,962 | -5.3% | 0.1% | 115,691 | -1.6% | -0.3% |
| 69 | Aug-13 | 153,065 | -2.5% | 0.0% | 129,063 | -0.7% | -0.1% | 7,284 | -2.2% | 1.8% | 7,922 | -9.9% | -0.1% | 7,955 | -4.1% | -0.1% | 115,499 | 0.5% | -0.2% |
| 70 | Sep-13 | 152,338 | -2.4% | -0.5% | 128,364 | -0.9% | -0.5% | 7,145 | -1.9% | -1.9% | 7,709 | -11.0% | -2.7% | 7,889 | -4.0% | -0.8% | 114,725 | -2.4% | -0.7% |
| 71 | Oct-13 | 152,132 | -3.3% | -0.1% | 128,276 | -1.6% | -0.1% | 7,290 | 0.0% | 2.0% | 7,609 | -12.6% | -1.3% | 7,945 | -3.3% | 0.7% | 114,915 | -3.5% | 0.2% |
| 72 | Nov-13 | 150,798 | -4.1% | -0.9% | 127,359 | -2.1% | -0.7% | 7,264 | 0.1% | -0.4% | 7,449 | -13.4% | -2.1% | 7,882 | -3.7% | -0.8% | 113,514 | -4.6% | -1.2% |
| 73 | Dec-13 | 150,372 | -4.0% | -0.3% | 126,905 | -2.4% | -0.4% | 7,342 | 1.2% | 1.1% | 7,334 | -13.6% | -1.5% | 7,820 | -4.2% | -0.8% | 112,908 | -5.0% | -0.5% |
| 74 | Jan-14 | 154,862 | -1.6% | 3.0% | 132,034 | 1.4% | 4.0% | 7,265 | 1.0% | -1.0% | 7,330 | -14.4% | -0.1% | 7,834 | -3.5% | 0.2% | 113,326 | -5.7% | 0.4% |
| 75 | Feb-14 | 157,397 | 2.0% | 1.6% | 134,728 | 4.3% | 2.0% | 7,041 | -0.7% | -3.1% | 7,353 | -13.9% | 0.3% | 7,803 | -3.2% | -0.4% | 112,791 | -4.1% | -0.5% |
| 76 | Mar-14 | 159,213 | 3.0% | 1.2% | 136,815 | 5.7% | 1.5% | 7,121 | 1.0% | 1.1% | 7,242 | -13.6% | -1.5% | 7,704 | -3.8% | -1.3% | 112,511 | -4.2% | -0.2% |
| 77 | Apr-14 | 160,682 | 4.2% | 0.9% | 138,157 | 6.8% | 1.0% | 7,125 | n/a | 0.1% | 7,277 | -12.7% | 0.5% | 7,727 | -3.5% | 0.3% | 112,144 | -4.3% | -0.3% |
| 78 | May-14 | 161,647 | 5.2% | 0.6% | 138,562 | 6.9% | 0.3% | 7,439 | 5.7% | 4.4% | 7,119 | -12.9% | -2.2% | 7,751 | -3.1% | 0.3% | 111,362 | -6.7% | -0.7% |
| 79 | Jun-14 | 162,897 | 6.3% | 0.8% | 139,105 | 7.5% | 0.4% | 7,271 | 3.3% | -2.3% | 7,116 | -11.1% | 0.0% | 7,745 | -2.6% | -0.1% | 110,590 | -4.7% | -0.7% |
| 80 | Jul-14 | 163,903 | 7.1% | 0.6% | 139,881 | 8.2% | 0.6% | 7,337 | 2.6% | 0.9% | 7,085 | -10.6% | -0.4% | 7,741 | -2.8% | -0.1% | 109,239 | -5.6% | -1.2% |
| 81 | Aug-14 | 171,328 | 11.9% | 4.5% | 150,820 | 16.9% | 7.8% | 7,094 | -2.6% | -3.3% | 6,871 | -13.3% | -3.0% | 7,727 | -2.9% | -0.2% | 108,767 | -5.8% | -0.4% |
| 82 | Sep-14 | 176,192 | 15.7% | 2.8% | 156,913 | 22.2% | 4.0% | 7,088 | -0.8% | -0.1% | 6,767 | -12.2% | -1.5% | 7,679 | -2.7% | -0.6% | 108,434 | -5.5% | -0.3% |
| 83 | Oct-14 | 178,952 | 17.6% | 1.6% | 160,334 | 25.0% | 2.2% | 7,242 | -0.7% | 2.2% | 6,705 | -11.9% | -0.9% | 7,657 | -3.6% | -0.3% | 108,343 | -5.7% | -0.1% |
| 84 | Nov-14 | 180,798 | 19.9% | 1.0% | 162,848 | 27.9% | 1.6% | 7,160 | -1.4% | -1.1% | 6,705 | -10.0% | 0.0% | 7,607 | -3.5% | -0.7% | 107,214 | -5.5% | -1.0% |
| 85 | Dec-14 | 186,837 | 24.2% | 3.3% | 169,294 | 33.4% | 4.0% | 7,181 | -2.2% | 0.3% | 6,660 | -9.2% | -0.7% | 7,532 | -3.7% | -1.0% | 107,900 | -4.4% | 0.6% |
| 86 | Jan-15 | 188,750 | 21.9% | 1.0% | 171,732 | 30.1% | 1.4% | 6,996 | -3.7% | -2.6% | 6,622 | -9.7% | -0.6% | 7,530 | -3.9% | 0.0% | 107,934 | -4.8% | 0.0% |
| 87 | Feb-15 | 192,008 | 22.0% | 1.7% | 175,266 | 30.1% | 2.1% | 7,026 | -0.2% | 0.4% | 6,547 | -11.0% | -1.1% | 7,542 | -3.3% | 0.2% | 107,224 | -4.9% | -0.7% |
| 88 | Mar-15 | 193,829 | 21.7% | 0.9% | 176,933 | 29.3% | 1.0% | 7,109 | -0.2% | 1.2% | 6,339 | -12.5% | -3.2% | 7,538 | -2.2% | -0.1% | 107,521 | -4.4% | 0.3% |
| 89 | Apr-15 | 195,333 | 21.6% | 0.8% | 178,752 | 29.4% | 1.0% | 7,230 | 1.5% | 1.7% | 6,366 | -12.5% | 0.4% | 7,596 | -1.7% | 0.8% | 107,283 | -4.3% | -0.2% |
| 90 | May-15 | 194,555 | 20.4% | -0.4% | 178,143 | 28.6% | -0.3% | 7,170 | -3.6% | -0.8% | 6,179 | -13.2% | -2.9% | 7,561 | -2.5% | -0.5% | 106,042 | -4.8% | -1.2% |
| 91 | Jun-15 | 196,212 | 20.5% | 0.9% | 179,910 | 29.3% | 1.0% | 7,109 | -2.2% | -0.9% | 6,138 | -13.7% | -0.7% | 7,526 | -2.8% | -0.5% | 105,322 | -4.8% | -0.7% |
| 92 | Jul-15 | 197,379 | 20.4% | 0.6% | 181,192 | 29.5% | 0.7% | 7,045 | -4.0% | -0.9% | 6,120 | -13.6% | -0.3% | 7,513 | -2.9% | -0.2% | 104,705 | -4.2% | -0.6% |
| 93 | Aug-15 | 197,305 | 15.2% | 0.0% | 181,115 | 20.1% | 0.0% | 6,949 | -2.0% | -1.4% | 5,934 | -13.6% | -3.0% | 7,438 | -3.7% | -1.0% | 103,544 | -4.8% | -1.1% |
| 94 | Sep-15 | 198,157 | 12.5% | 0.4% | 182,017 | 16.0% | 0.5% | 7,042 | -0.6% | 1.3% | 5,764 | -14.8% | -2.9% | 7,343 | -4.4% | -1.3% | 102,869 | -5.1% | -0.7% |
| 95 | Oct-15 | 198,265 | 10.8% | 0.1% | 182,225 | 13.7% | 0.1% | 7,056 | -2.6% | 0.2% | 5,688 | -15.2% | -1.3% | 7,307 | -4.6% | -0.5% | 101,917 | -5.9% | -0.9% |
| 96 | Nov-15 | 198,716 | 9.9% | 0.2% | 182,889 | 12.3% | 0.4% | 7,047 | -1.6% | -0.1% | 5,583 | -16.7% | -1.8% | 7,227 | -5.0% | -1.1% | 100,525 | -6.2% | -1.4% |
| 97 | Dec-15 | 201,743 | 8.0% | 1.5% | 185,957 | 9.8% | 1.7% | 7,191 | 0.1% | 2.0% | 5,425 | -18.5% | -2.8% | 7,116 | -5.5% | -1.5% | 100,495 | -6.9% | 0.0% |
| 98 | Jan-16 | 202,248 | 7.2% | 0.3% | 186,599 | 8.7% | 0.3% | 7,114 | 1.7% | -1.1% | 5,435 | -17.9% | 0.2% | 7,081 | -6.0% | -0.5% | 99,978 | -7.4% | -0.5% |
| 99 | Feb-16 | 203,485 | 6.0% | 0.6% | 187,954 | 7.2% | 0.7% | 7,225 | 2.8% | 1.6% | 5,307 | -18.9% | -2.4% | 7,117 | -5.6% | 0.5% | 99,486 | -7.2% | -0.5% |
| 100 | Mar-16 | 203,739 | 5.1% | 0.1% | 188,445 | 6.5% | 0.3% | 7,231 | 1.7% | 0.1% | 5,183 | -18.2% | -2.3% | 7,033 | -6.7% | -1.2% | 99,543 | -7.4% | 0.1% |
| 101 | Apr-16 | | | | | | | | | | | | | | | | | | |
| 102 | May-16 | | | | | | | | | | | | | | | | | | |
| 103 | Jun-16 | | | | | | | | | | | | | | | | | | |
| 104 | ANNUAL YEAR-TO-DATE AVERAGES | | | | | | | | | | | | | | | | | | |
| 105 | SFY10 | 143,977 | | | 115,947 | | | 7,298 | | | 13,945 | | | 8,150 | | | 95,300 | | |
| 106 | SFY11 | 154,215 | 7.1% | | 119,527 | 3.1% | | 7,154 | -2.0% | | 11,833 | -15.2% | | 8,885 | 9.0% | | 115,213 | 20.9% | |
| 107 | SFY12 | 152,465 | -1.1% | | 119,344 | -0.2% | | 7,197 | 0.6% | | 13,779 | 16.5% | | 8,725 | -1.8% | | 111,869 | -2.9% | |
| 108 | SFY13 | 156,560 | 2.7% | | 129,868 | n/a | | 7,255 | 0.8% | | 8,629 | -37.4% | | 8,207 | -5.9% | | 118,103 | 5.6% | |
| 109 | SFY14 | 153,005 | -2.3% | | 129,498 | -0.3% | | 7,223 | -0.4% | | 7,579 | -12.2% | | 7,886 | -3.9% | | 114,171 | -3.3% | |
| 110 | SFY15 | 179,846 | 17.5% | | 160,886 | 24.2% | | 7,141 | -1.1% | | 6,745 | -11.0% | | 7,627 | -3.3% | | 108,132 | -5.3% | |
| 111 | SFY16 | 199,662 | 11.0% | | 183,744 | 14.2% | | 7,084 | -0.8% | | 5,657 | -16.1% | | 7,268 | -4.7% | | 101,690 | -6.0% | |
| 112 | | | | | | | | | | | | | | | | | | | |

# 1115 TRANSFORMATION WAIVER

| DESCRIPTION | PURPOSE |
|---|---|
| The Section 1115(a)Research and Demonstration "Transformation" Medicaid Waiver provides access to new federal funding to help transform the Medicaid behavioral health delivery system to:<br>1. integrate physical and behavioral health care to better address the full range of individuals' needs<br>2. build capacity to deliver behavioral health care services to address emerging and ongoing behavioral health needs in an appropriate setting<br>3. reduce gaps in care during transitions across care settings by improving coordination across providers and linking patients with community supports. | Under the waiver, New Hampshire has access to up to $30 million in federal funding each of five years (2016-2020) to create a transformation fund, which will make performance-based incentive payments to new regional networks of health care and community service providers called Integrated Delivery Networks or IDNs. The IDNS will select specific projects from a menu of projects that will strengthen the capacity of the state's behavioral health system, integrate mental health and substance use disorder care with primary care, and lower the long-term growth in health care costs for the state. 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. |

## STATUS

- CMS approved the waiver application January 5, 2016. Federal funding is valued at $150 million over a five year period
- 10 scheduled stakeholder information sessions were completed in March of 2016, with an additional session for NH Senate members held on 4/6/16.
- Draft application for Integrated Delivery Networks published for public comment on 3/31/16
- Project and Metric Specifications Guide to support the comprehensive Project Menu of statewide and community-based initiatives is in development and on track to be posted for public comment by 4/29/16
- RFPs published for Independent Assessor and Evaluation Plan Design
- Received confirmation from CMS that NHHPP population is attributable to DSRIP (will be included)
- DHHS website pages for DSRIP in use and being updated regularly: http://www.dhhs.nh.gov/section-1115-waiver/index.htm

| TOP ISSUES (I) & RISKS (R) | RECENT & UPCOMING MILESTONES | DATE |
|---|---|---|
| 1 (R) Risk that procuring independent assessor is not completed by 5/31to score IDN Apps by 6/31and develop project plan applications by 8/1 | *CMS Approves 1115 Transformation Waiver* | *1/5/16* |
| | *Draft Funding Mechanics & Project Menu Submitted to CMS* | *3/1/16* |
| | *9 Stakeholder Information Sessions Completed* | *3/28/16* |
| | *Draft IDN Application and Project and Metric Spec Guide posted for public comment* | *3/31/16* |
| 2 (R) Risk that procuring for IT lead and Workforce lead won't happen in time to advise IDNS in the fall | *15 Non-Binding Letters of Intent Received from Candidate Administrative Leads* | *4/1/16* |
| | Deadline for all Non-Binding Letters of Intent | 4/18/16 |
| | State Releases Final IDN Application | 4/29/16 |
| 3 (R) Risk that JT Fiscal doesn't give permission to accept and expend DSRIP funds | Deadline for IDNs to Submit Applications to State | 5/31/16 |
| | State Announces Names of Approved IDNs & Distributes Initial Capacity Building Funds | 7/1/16 |
| | Deadline for IDNs to Submit Project Plans to State | 9/1/16 |
| 4 (R) Risk That the necessary contracts (assessor, evaluator, HIT technical assistance, learning collaborative) aren't approved by G&C | State Distributes Project Plan Awards | 11/1/16 |

## THERAPEUTIC CANNABIS

| DESCRIPTION | PURPOSE |
| --- | --- |
| The Department is responsible for the administration of the New Hampshire Therapeutic Cannabis Program (Program) by designing and implementing a comprehensive process for the distribution of therapeutic cannabis in the State of New Hampshire, pursuant to RSA 126-X. | The Department's goal is the implementation and continued operation of a self-sustaining (budget neutral) Program that safely and efficiently provides therapeutic cannabis to qualified individuals and their caregivers. Success will be measured by: Program efficiency and security, Program accessibility; and Program financial sustainability |

### STATUS

After a comprehensive and detailed review of applications in response to the RFA released 12/19/14, the Department selected three qualifying entities to begin the post-selection registration: Prime Alternative Treatment Centers of NH, Inc., Temescal Wellness, Inc., and Sanctuary ATC.

On 11/25/15 the Department issued the first qualifying patient registry identification card. As of 04/08/16,

- 679 applications for registration cards were received for qualifying patients
- 36 applications for registration cards were received for caregivers
- The Department issued 357 qualifying patient cards and 21 designated caregiver cards.

On 10/23/15 changes to the ATC rules became effective allowing the Department to grant conditional registration certificates to cultivation centers in order to allow ATCs to begin growing therapeutic cannabis. On January 8, 2016, Sanctuary ATC (Geographic Area 4) was granted the first conditional registration certificate to operate its cultivation center. On February 26, 2016, this was updated to permit transportation of cannabis. On January 22, 2016, Temescal Wellness, Inc. (Geographic Areas 1 and 3) was granted a conditional registration certificate to operate its cultivation center. On March 9, 2016, this was updated to permit transportation of cannabis. Prime Alternative Treatment Centers (Geographic Area 2) will be ready for inspection at a later date, presumably late May. It is anticipated that Sanctuary ATC will be ready to begin dispensing cannabis late April/early May 2016 with Temescal Wellness Inc. to follow shortly thereafter. Additionally, on April 4, 2016, the Department certified the first New Hampshire lab, permitting it to test therapeutic cannabis.

| TOP ISSUES (I) & RISKS (R) | |
| --- | --- |
| 1 | (R) Until ATC dispensaries are operational, qualifying patients have no legal access to therapeutic cannabis in NH |
| 2 | (R) Litigation regarding ATC selection could delay implementation |
| 3 | (I) Level of effort and expertise required to administer and oversee this new, fee-funded program will continue to be a significant challenge for the Department |

| RECENT & UPCOMING MILESTONES | DATE |
| --- | --- |
| *RFA for ATCs Issued* | *10/20/14* |
| *Registry Rules Adopted* | *11/30/14* |
| *ATCs Selected* | *01/23/15* |
| *Inspection Program Established* | *04/10/15* |
| *Begin Inspection of ATC Cultivation Sites* | *09/27/15* |
| *Issuance of Registry ID Cards Begins* | *11/15/15* |
| *Sanctuary ATC Conditionally Certified to Cultivate* | *01/08/16* |
| *Temescal ATC Conditionally Certified to Cultivate* | *01/22/16* |
| Sanctuary & Temescal Certified & Operational to Dispense | 05/31/16 |
| Prime ATC Certified & Operational to Dispense Cannabis | Summer '16 |

## COMMUNITY MENTAL HEALTH AGREEMENT

| DESCRIPTION | PURPOSE |
|---|---|
| For adults with Severe Mental Illness (SMI), establish and enhance community-based programs, including: mobile crisis services; supported employment; Assertive Community Treatment (ACT); supported housing; peer and family support; transition planning; and quality assurance of programs. | To meet the terms of the Community Mental Health Agreement (CMHA) to provide immediate and long-term support to individuals with SMI to reduce the institutionalization and risk of institutionalization of adults with SMI. |

**STATUS**

- DHHS Behavioral Health Central team operational meetings held monthly to facilitate transitions from NH Hospital and the Glencliff Home to community-based settings.
- Continued progress made toward objectives of the CMHA including: (a) Implementation of the NH Hospital policy for referrals to ACT for conditional discharges, (b) Working with stakeholders on the draft rule for the Bridge Subsidy Housing Program; and (c) Improving standard data measures and reporting processes.
- First Mobile Crisis Team and crisis apartments fully implemented in Concord.
- Request for Proposals issued for Mobile Crisis Team and Crisis Apartments for Greater Manchester area.
- Two-day session with Expert Reviewer, Steve Day and TA consultant Lyne Rucker regarding Quality Service Review (QSR) process.
- Continue to work with the Community Mental Health Centers and community partners to address milestones that are not yet met, including (a) Supported employment penetration rate of individuals with SMI; (b) Capacity of ACT teams, and (c) Transitions of individuals from Glencliff Home.

| | TOP ISSUES (I) & RISKS (R) | RECENT & UPCOMING MILESTONES | DATE |
|---|---|---|---|
| 1 | (I) Redoubling efforts in areas of concerns outlined in the Expert Reviewer's January 2016 Report | Mobile Crisis capacity in Concord area | 6/30/15 |
| | | Increase supported housing units to 340 | 6/30/15 |
| | | ACT Teams w/ capacity to serve 1300 individuals by 6/30/15 | TBD |
| 2 | (R) Capability of the Community Mental Health Centers (CMHCs) to meet ACT/SE requirements | Transition 4 individuals from Glencliff by 6/30/15 | TBD |
| | | Achieve 16.1% SMI penetration rate of SMI eligible by 6/30/15 | 6/30/16 |
| | | ACT Teams w/ capacity to serve 1500 individuals | TBD |
| | | Achieve 18.1% Supported Employment penetration rate of SMI eligible | 6/30/16 |
| | | Mobile Crisis capacity in Manchester area | 6/30/16 |

## SUBSTANCE USE DISORDER (SUD) BENEFIT FOR STANDARD MEDICAID

| DESCRIPTION | PURPOSE |
|---|---|
| HB2 Chapter 276:231 requires the commissioner of the department of health and human services to submit a state plan amendment (SPA) to the Centers of Medicare and Medicaid (CMS) to provide substance use disorder services to Title XIX and Title XXI beneficiaries. The commissioner shall design the benefit consistent with Substance Abuse and Mental Health Service Administration (SAMHSA) treatment guidelines. The commissioner shall also determine the process and timeline for implementing services and; if necessary, phase in the benefit. | To implement the already defined SUD Benefit array offered to the NH Heath Protection Program population to the Standard Medicaid population. The benefits include a continuum of SUD services to meet the range of needs from misuse, addiction and withdrawal. |

**STATUS**

- Project Charter signed by State Medicaid Director Katie Dunn
- Policy decisions made to include same benefit as NHHPP, same rates as NHHPP and implementation of the entire benefit on 7/1/16.
- Fiscal Impact Statement complete
- Administrative Rules complete and to LJCAR May 20, 2016
- MMIS systems requirements submitted and in development
- Meeting with MCOs to coordinate communications
- Stakeholder meeting on 3/3/16 complete
- Peer Recovery provider type created

| TOP ISSUES (I) & RISKS (R) | RECENT & UPCOMING MILESTONES | DATE |
|---|---|---|
| 1 (I)Limited SUD provider Network | *Kick off meeting* | *11/16/15* |
| 2 (R) As a result of a limited provider network, recipients may not be able to access services in a timely manner. | *Systems changes identified* | *1/19/16* |
| | *Policy Decisions Communicated to MCOs* | *2/11/16* |
| | *SUD Rules approved by JLCAR* | *5/20/16* |
| | *Stakeholder Engagement Completed* | *3/3/16* |
| | State Plan Approved by CMS | 9/30/16 |
| | MCO Contract Approved by G&C | 6/15/16 |
| | SUD Benefits Available to Expanded Population | 7/1/16 |

## TELEHEALTH

| DESCRIPTION | PURPOSE |
|---|---|
| Chapter 206, Laws of 2015 requires the Department to develop a telehealth services program to commence on July 1, 2016 which will include telehealth services provided by medical specialists and which will not result in increased costs to the Medicaid Program.. | Provide the standards and guidelines for a statewide Telehealth network to be delivered through the use of Dartmouth Hitchcock Center for Telehealth's infrastructure.<br>Ensure telehealth services provided under Medicaid are to be "cost neutral." |

**STATUS**

- Telehealth 101 hosted by DRED provided status of current statewide infrastructure to support telehealth implementation
- Received Fiscal Committee approval on January 22, 2016 to proceed with Pilot Project which is to begin on July 1, 2016
- Pilot Project will provide data for analysis of utilization of telehealth consultations for specialty services.
- Pilot Project Planning Meeting February 26, 2016 with DHMC staff.
- Pilot Project Plan sent to DHMC for review and comment Tuesday, April 5, 2016.

| TOP ISSUES (I) & RISKS (R) | RECENT & UPCOMING MILESTONES | DATE |
|---|---|---|
| (R) Fee for Service population may not provide sufficient client pool to support determination of "cost neutrality." | *Fiscal Committee approval for Pilot Project* | *1/22/2016* |
| | *House & Senate Financial Committees & HHS Oversight Committee Progress Report* | *3/1/2017* |
| | *Pilot Project Planning Meeting* | *2/26/2016* |
| | Pilot Project Plan Completed | 4/29/2016 |
| | Pilot Project Implementation | 7/1/2016 |
| | Data Collection & Analysis Starts | 8/1/2016 |
| | | |

State of New Hampshire
DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9200 FAX: 603-271-4912 TDD ACCESS: RELAY NH 1-800-735-2964

JEFFREY A. MEYERS
COMMISSIONER

April 11, 2016

Representative Neal Kurk
Chairman, Fiscal Committee of the General Court
Legislative Office Building, Room 210
Concord, N.H. 03301

Re: DHHS Building Capacity for Transformation Waiver

Dear Representative Kurk:

You have submitted to the department a number of questions regarding the Section 1115 Medicaid waiver granted to New Hampshire on January 5, 2016 by the Centers for Medicare and Medicaid Services (CMS). This waiver is known, alternatively, as a delivery system reform incentive payment (DSRIP) waiver because it allows access to federal funds for the transformation of New Hampshire's behavioral health system through incentive payments to networks of providers.

Below, I have provided responses to the questions you submitted in your email to me of March 31, 2016. As we discussed, this letter is also being sent to the LBA and all members of the Fiscal Committee. Prior to addressing your specific questions, I wish to emphasize certain facts about the waiver and its purpose.

1. *The legislature directed the department to apply for a Section 1115 waiver and the amended application of the waiver (which focuses on behavioral health) was presented to the Fiscal Committee prior to its submission to CMS in February 2015.* Senate Bill 413, which enacted the provisions of the New Hampshire Health Protection program in 2014, directed the department to apply for a Section 1115 Medicaid waiver. The bill stated, in part, that " to the greatest degree possible programs funded under the demonstration waiver shall complement the mental health settlement and shall be designed to promote innovation, reform delivery systems, and reduce the number of uninsured patients who seek treatment from health care providers."

The amended application submitted by the Governor and the department in February 2015 focused on the transformation of the behavioral health delivery system in order that New Hampshire could develop the capacity and integrated services that would allow for improved access and treatment of behavioral health conditions in the Medicaid program. The amended application, which was presented to the legislative Fiscal Committee prior to submission to CMS, described the department's plan to establish new integrated delivery networks in order to increase capacity for substance use disorder and mental health services, promote integration of behavioral health services with medical care, improve care transitions for persons being discharged from New Hampshire Hospital and other types of inpatient facilities (e.g. county jails, nursing homes, residential treatment programs) that needed services in the community to continue their path toward health.

To our knowledge, the waiver granted to New Hampshire on January 5, 2016 is the first incentive payment waiver comprised solely around delivery system reform for behavioral health that is funded solely through designated state health program matching funds.

In the foregoing answers, I refer periodically to the formal approval document for the waiver known at the Special Terms and Conditions (STCs) and the Project Planning Protocol, which lists the proposed projects and outcomes measures among other information. Both of these documents are attached.

1. *The Section 1115 waiver awarded to New Hampshire is not a grant.* It is an incentive payment waiver that must be earned in years three through five by achieving outcome measures on a state and local network level. A total of over $ 9 million in federal funding is at risk in the three later years and conditioned upon both the state and the integrated networks demonstrating achievement of outcome measures. The specific outcomes the state and the delivery networks must achieve are addressed in the answer to your specific questions below, as well as in the Project Planning Protocol.

2. *New Hampshire is required under the waiver approval to seek public input on the projects to be funded and the outcome measures to be achieved, prior to finalization of those projects and measures.* Under the waiver approval, the projects to be funded are to be selected in part by the state and in part by the local community in order to ensure that the waiver programs address local needs within the context of the statewide goals of the waiver. Each IDN will be required to undertake three mandatory projects focused on capacity and integration, as well as select from a menu of optional projects in three waiver categories (capacity, integration and care transitions). The final selection of a delivery networks' optional projects will not occur until the integrated delivery networks are selected later this year and the selected IDNs obtain public input in their regions as to the optional projects that will best address local needs. The local communities are critical participants in this process.

Similarly, the final outcome measures must reflect stakeholder input. The state has now held 12 public information sessions around the state in order to provide public input by all those interested in this waiver program. The department is required to evaluate the public input. Proposed outcome measures will be finalized and submitted to CMS for approval so that the delivery networks understand what is expected when they apply for funding beginning in early May.

3. *This Section 1115 waiver is a demonstration waiver.* Health outcomes under the waiver will be tracked, reported and evaluated during the course of the waiver and in the final waiver evaluation report. The purpose of the waiver is to utilize evidence based methods to influence the transformation of the delivery and payment for services that will improve the behavioral health system in New Hampshire. The federal approval requires the department and the integrated delivery networks to collect, evaluate, and report the data and information developed on the waiver programs in order that the state gains valuable information that will assist in the transformation and strengthening of the behavioral health system over the five year period. The waiver represents an investment by the federal government in the capacity and integration of the delivery system, which it believes will strengthen New Hampshire's ability to provide behavioral health services.

The rationale of the waiver and its objectives were spelled out in the amended application, as follows:

"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."

*Responses to Questions Posed:*

Question 1. *Describe in detail and, if possible, enumerate the populations to be affected or served by the waiver program. If possible, provide a five-year history and a ten-year projection (five waiver years and five post-waiver years) of these populations.*

Response: Under the STCs, the waiver programs must serve those persons who are eligible for Medicaid in New Hampshire. That population includes the standard Medicaid population, as well as the NHHHP population. The NHHPP population is approximately 48,500 persons, and the standard population is currently approximately 139,000 persons. The standard Medicaid population was 129,000

in SFY 2009. The change from that period to the current time is approximately a 9.3% increase. Of the standard Medicaid population today, approximately 66% (91,000) are children under the age of 18.

The history of the Medicaid population is contained in the department's Dashboard submitted to the Fiscal Committee. The most recent Dashboard identifies the population back to 2013. Any projection of the Medicaid population during the five years of the waiver and for the five years post waiver would have to be performed by an actuary and would depend on whether and to what extent the NHHPP program were extended beyond December 2018, among other potential eligibility changes made by the state and federal government.

Question 2. *What are the outcome measures by which a determination of the success or failure of the waiver program can be made? (Outcome measures focus on the additional number of individuals starting in 2021 and each year thereafter who, for example, will be healthier, will have abstained from drug/alcohol abuse for x years, will leave the program earlier, etc. as a direct result of waiver programs. Outcome measures are not concerned with, for example, the improved nature of provider networks.)*

Response: Under the proposals that the State has submitted to CMS, the specific outcomes that New Hampshire, as a state, would be required to meet are as follows:

1. **At least 65,000 New Hampshire residents will receive core standardized assessments to diagnose and treat substance use disorders and mental health conditions**. In 2014, 92 percent of NH adults with alcohol dependence or abuse did not receive treatment, and 84 percent of NH adults with illicit drug dependence or abuse did not receive treatment. The core standardized assessment will allow providers to identify Medicaid beneficiaries with undiagnosed and untreated substance use disorders and connect them to care. For those with diagnosed behavioral health issues, the core standardized assessments will ensure they are connected to care for physical health needs, such as diabetes and heart disease that are a major driver of poor outcomes. It is estimated that Americans with major mental illness die on average 25 years earlier than the general population, and much of this disparity is due to these untreated co-occurring physical health risk factors.

2. **A sharp drop in the approximately 1,800 readmissions to the hospital within 30 days of hospital discharge for patients with behavioral health conditions.** Currently, approximately 26 percent of people with behavioral health conditions admitted to a hospital in New Hampshire (for any reason) are re-admitted within 30 days of discharge, representing close to 1,800 annual readmissions. The majority of these are preventable with better community-based care and stronger care transitions. New Hampshire will reduce the 30-day readmission rate to the level reflecting the highest-performing systems, as measured by the IDN performing at the 75$^{th}$ percentile.

3. **A sharp drop in the approximately 19,000 emergency room (ER) visits in New Hampshire for ambulatory sensitive conditions.** Among the beneficiaries with mental health and substance use conditions, there are approximately 144.5 emergency department visits a year per 1,000 members with a behavioral health conditions for ambulatory sensitive conditions. Many are due

to people overdosing, experiencing a mental health crisis or other health problem that could have been prevented with better community-based care, or facing complications from physical health issues linked with substance use disorders and mental illness (e.g., diabetes attributable to use of behavioral health medications). By the end of the demonstration, the State will reduce the rate of preventable ER visits for ambulatory sensitive conditions to a level that reflects the highest-performing systems.

4. **Reductions in the number of people in psychiatric crisis – now averaging 19 per day – sitting in emergency rooms awaiting admission.** Currently, New Hampshire residents in psychiatric crisis, including children, must wait lengthy periods of time in emergency departments to secure an inpatient bed. On a typical day, we have 19 people sitting in ERs awaiting placement. By the end of the demonstration, the State will reduce this average daily rate to the level achieved by the highest-performing systems, adjusted for population size.

For Statewide measures two through four, the State will set the specific targets based on the performance of the IDN at the 75th percentile of performance (i.e., "highest-performing systems") in the spring/summer of 2016 after the IDNs have formed and the State has data on current IDN performance. Note that these outcome goals are based on technical protocols that the State submitted to the Centers for Medicaid and Medicaid Services (CMS) on March 1, 2016, and it is possible that CMS will require modifications.

In addition, the IDNs will also be required to meet specific outcomes.

The goals of the transformation waiver are to build greater behavioral health capacity; improve integration of physical and behavioral health; and improve care transitions for Medicaid beneficiaries with behavioral health conditions. IDNs will further these objectives by participating in Statewide projects on the behavioral health workforce and the HIT infrastructure required to support the improved collaboration among behavioral health and primary care providers through a larger well-trained work force and access to the information providers need at the point of care to properly diagnose, treat and manage patients. In addition, each IDN must ensure its providers conduct standardized core assessments of the behavioral and physical health needs of beneficiaries, as well as social factors that directly affect their health. Finally, based on a community needs assessment, each IDN will pick three specific projects rooted in local priorities, allowing it to address pressing mental health or substance use challenges consistent with waiver objectives. Appendix A lists the projects.

Each IDN must meet performance targets and demonstrate outcomes to earn incentive payments. Since it is expected that it will take two years or more to achieve quantifiable results, the transformation waiver initially distributes incentive payments to IDNs for achievement of process-based outcomes that measure whether they have implemented projects as expected. By 2017, ten percent of IDN funding will be distributed based on outcomes rather than these process metrics. Over time, the share of funds distributed based on outcomes increases and by 2019, IDNs are reimbursed entirely on outcome metrics.

Question 3. *Will the waiver program result in the department seeking an increase in federal or general funds for the state's Medicaid or any other program starting in 2021 for any reason, including an*

*increase in the number of participants, the nature of their treatment, the rate of provider reimbursement, etc., compared to what would be sought had there been no waiver program?*

Response: The terms of the waiver do not require an increase in federal or general funds following its termination in 2020 and any such increase would be subject to legislative and executive branch approval at that time.

Question 4. *What impact will the waiver program have on the ability of MCOs to negotiate networks and provider rates in each of the seven IDN areas both during the waiver program and after it ends? What will be the impact on per member/per month rates paid by the state to MCOs?*

Response: The waiver program should have no negative impact on the ability of the MCOs to negotiate provider networks and provider rates in the IDN regions – related to the behavioral health services in managed care. Firstly, the waiver is focused on behavioral health and not on general medical services. Second, the waiver is not anticipated to duplicate existing services but to deliver and pay for services that are not now necessarily being provided by the MCOs. Capitation rates are set by actuaries based upon a number of factors, including the populations covered, the services provided, the medical loss ratios established and other factors. No aspect of the waiver program would require increased payments to the MCOs over the course of the five year waiver or following its completion.

Question 5. *Please provide the "projected levels" ("Building Capacity for Transformation," updated 3/18/16, p. 21) and explain how they were calculated. Specifically, would they be different, and if so to what extent, were there no waiver program?*

Response. The statement on page 21 of the department's waiver presentation, to which this question refers, is "[the] State must keep per capita spending on Medicaid beneficiaries below projected levels over the five-year course of the waiver." The per capita levels during the five year waiver period are documented in the state's budget neutrality submission to CMS on Table A. A copy of the submission is attached.

CMS approved this waiver -- and approves all 1115 waiver -- based upon a budget neutrality demonstration that establishes that costs to the federal government with the waiver do not exceed projected costs without the waiver. The department's actuary, Milliman, has established that the cost of Medicaid services for the behavioral health population in New Hampshire with the waiver will not exceed the costs for that population without the waiver.

Question 6. *Will the waiver program (a) treat more patients or (b) provide more or (c) other services than would be the case in its absence? Please enumerate.*

Response: The waiver will treat the Medicaid population. To the extent that the Medicaid population decreases or increases over the five year period, those persons eligible for Medicaid will be the beneficiaries of the waiver programs.

More importantly, this waiver is unique because it will allow for the provision of services by the integrated delivery networks that are not traditionally eligible for payment by Medicaid. For example, persons being released from a county jail that have either or both a mental health condition and a

substance use disorder condition may need community supports on release such as transportation, supported housing, or peer supports that will enable them to address their health conditions successfully in the community. Medicaid does not traditionally pay for these social services. In short, the waiver will not only provide medical services but will provide a new form of integrated health care that will address the socials determinants of health as well as medical care.

Question 7. *Are all services provided to patients under the waiver program covered by Medicaid both during the waiver program and after it terminates? Are any of these services not now provided to patients? If so, please describe the services, the number of additional patients to be served and the estimated post-2020 cost in both general and federal funds.*

Response: The response to Question 6 addresses this question as well. Under the waiver, the integrated delivery networks will provide an array of medical and social services to promote an integrated model of health care for behavioral health in New Hampshire. The proposed projects and services are described in detail in the Project Protocol, which is attached to this letter. As explained in the answer to Question 6, some of the services to be offered under the waiver are not traditional Medicaid services such as family peer support, supported housing for recovering addicts, or wellness programs.

Question 8. *Does acceptance of the waiver program bring with it any "strings" that affect the state after its termination?*

Response: The terms and conditions of the waiver approval, a copy of which is attached, requires the state to place 50% of its managed care delivery system payments into alternative payment models by the end of year five of the waiver. Alternative payment models have not been fully defined by CMS, but will include a variety of payment models other than fee for service. Capitation rates, global budgets, bundled payments or payments for episodes for care are all alternative payment models that the state may ultimately employ in satisfying this requirement.

Paragraph 33 of the Special Terms and Conditions describes in detail how the state will amend its contracts with its managed care delivery partners to achieve the alternative payment models and sustain the investment in IDNs being made by the federal government.

Question 9. *Will approval of the waiver program cost the state more general funds during its term or after it concludes than would be the case were it not approved?*

Response: Under the terms off the waiver approval, the state is required to maintain the level of general fund spending for those designated state health programs for which it is claiming new federal match. These programs are listed in Paragraph 58 of the Special Terms and Conditions. Were the state to reduce general fund spending for these programs, then the state would have to make available other funds in order to sustain the same level of IDN funding, or, alternatively, seek to amend the waiver to reduce the amount of IDN funding.

There is no requirement under the waiver to maintain or increase general funds for either the designated state health programs being matched under the waiver or any program established by an IDN after the termination of the waiver.

Question 10. *May the state end the program during its term, and if so would it incur any repayment or other obligations?*

Response: The State may terminate its participation in the demonstration upon 6 months prior notice to CMS and compliance with a phase out plan approved by CMS. There are no repayment obligations, but there are obligations in the forms of certain grievance and appeals rights requested prior to the termination and administrative renewals for affected beneficiaries to determine if they qualify for other eligibility categories. The termination provisions are addressed in STC 10.

Question 11. *If the various outcome measures are not being met satisfactorily, may the legislature at some time during the term of the waiver program re-direct some of the federal waiver funds to (a) provide additional Medicaid services to the current population or (b) serve additional Medicaid-eligible populations or (c) or provide the same Medicaid services to an increased Medicaid population -- in each case increasing, not supplanting, spending?*

Response: The allocation of the delivery system incentive payment funds are governed by the Special Terms and Conditions issued by CMS. The department does not believe that the legislature may unilaterally re-direct funding under the waiver. The waiver does contain provisions for amendment during the term of the waiver. The department intends to communicate fully with the legislature and the governor over the terms of the waiver and will work with them and all stakeholders to ensure its success.

Question 12. *Have any other states implemented this type of program, and what benefits have they recognized in terms of improved care and lower costs?*

To the extent this question is asking if other states have entered into DSRIP waivers that, like New Hampshire, are focused on behavioral health, the only such recent waiver the department is aware of is a 2014 amendment to the larger California Bridge to Reform DSRIP waiver that focused on substance use disorder treatment programs at the county government level. I will provide a copy of that waiver amendment to the LBA. I am unaware of any evaluation of that program.

The 1115 waiver program at CMS has been in place for over 20 years. The complete list of 1115 waivers, including applications and approvals can be found at the following CMS webpage: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html.

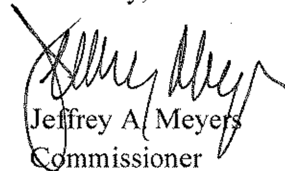
The New Hampshire DSRIP waiver is also modeled in structure (as opposed to substance) on New York's 2015 MRT Medicaid waiver, which established similar delivery networks with a focus on expanding managed care services and reducing hospital re-admission rates. CMS used the MRT waiver structure to inform its approval of New Hampshire's waiver. The MRT waiver may be found here: https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm.

The department has not undertaken research into other state evaluations of DSRIP waivers for the principal reason that New Hampshire's waiver is built around unique New Hampshire behavioral health system needs that have been brought to light by prior New Hampshire based evaluations such as those cited in New Hampshire's Amended DSRIP application dated February 25, 2015, on pages 8-10.

The department has not undertaken research into other state evaluations of DSRIP waivers for the principal reason that New Hampshire's waiver is built around unique New Hampshire behavioral health system needs that have been brought to light by prior New Hampshire based evaluations such as those cited in New Hampshire's Amended DSRIP application dated February 25, 2015, on pages 8-10.

I hope that this information is helpful to you and to the other members of the Fiscal Committee.

Sincerely,



Jeffrey A. Meyers
Commissioner

Enclosures
cc: Fiscal Committee members
LBA

**CENTERS FOR MEDICARE AND MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS**

**NUMBER: 11-W-00301/1**

**TITLE: New Hampshire Building Capacity for Transformation**

**AWARDEE: New Hampshire Department of Health and Human Services**

## I. PREFACE

The following are the Special Terms and Conditions (STC) for New Hampshire Building Capacity for Transformation section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable the State of New Hampshire (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs further set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period. The STCs are effective on the date of the signed approval letter through December 31, 2020.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description And Objectives
III. General Program Requirements
IV. Populations Affected by the Demonstration
V. Delivery System Reform Program
VI. General Reporting Requirements
VII. General Financial Requirements
VIII. Designated State Health Programs (DSHP)
IX. Monitoring Budget Neutrality
X. Evaluation of the Demonstration
XI. Schedule of State Deliverables for the Demonstration Period
Attachment A: Quarterly Report Template
Attachment B: DSHP Claiming Protocol
Attachment C: DSRIP Planning Protocol
Attachment D: DSRIP Program Funding & Mechanics Protocol

## II. PROGRAM DESCRIPTION AND OBJECTIVES

In New Hampshire the demand for mental health and substance abuse services is increasing; current provider capacity is not well positioned to deliver the comprehensive and integrated care that can most effectively address the needs of New Hampshire residents with severe behavioral health or comorbid physical and behavioral health problems. A number of factors make behavioral health transformation a priority of the state including the enactment of the New Hampshire Health Protection Program (NHHPP) to cover the new adult group, an estimated one in six of whom have extensive mental health or substance use needs. New Hampshire now covers substance use disorder (SUD) services to the NHHPP population and the state is proposing to extend the SUD benefit to the entire Medicaid population in state fiscal year 2017. Finally, the expansion of coverage for new populations and new services coincides with an epidemic of opioid abuse in the state and across New England.

New Hampshire seeks to transform its behavioral health delivery system through:

- Integrating physical and behavioral health to better address the full range of beneficiaries' needs;
- Expanding provider capacity to address behavioral health needs in appropriate settings; and
- Reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues.

Delivery System Reform Incentive Payment (DSRIP) funding will enable the state to make performance based funding to regionally-based Integrated Delivery Networks (IDNs) that furnish Medicaid services. The state will use the IDNs as a vehicle to foster relationships between behavioral health providers and other health care and community service providers that are necessary to achieve the state's vision for Medicaid system transformation including the establishment of financial and governance relationships and investing in IT systems that enable data exchanges. The IDNs will be comprised of individual providers that will form coalitions and be evaluated by DSRIP project performance metrics—collectively as a single IDN. The lead applicant for each coalition, as described in STC 22, is responsible for coordinating between providers within the IDN to achieve metrics associated with the chosen projects.

The state also seeks to support IDNs through technical assistance and learning collaboratives—and by reforming its managed care organization (MCO) and Medicaid delivery contracts to include performance-based IDN funding and ensure sustainability of IDNs post-demonstration. During the demonstration period, the state will develop and implement DSRIP projects with the aim of moving to alternative payment model(s) in the MCO and Medicaid delivery contracts by the end of the demonstration period.

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid program and Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing within 30 calendar days of receipt.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such a change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day, such state legislation becomes effective, or on the last day, such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state Plan is affected by a change to the demonstration, a conforming amendment to the appropriate

state plan may be required except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements specified in these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the secretary in accordance with section 1115 of the Act. The state must not implement or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to, failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the State consistent with the requirements of STC 15 to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group (EG)) the impact of the amendment;

    c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

    d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI state plan amendment, if necessary; and

    e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12

months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 10.

a. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.

b. Upon application from the state, CMS reserves the right to temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

9. **Compliance with Transparency Requirements 42 C.F.R. §§ 431.412:** As part of any demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 C.F.R. §§ 431, 412 and the public notice and tribal consultation requirements outlined in STC 15 as well as include the following supporting documentation:

a. Demonstration Summary and Objectives. The state must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.

b. Special Terms and Conditions. The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

c. Quality. The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and state quality assurance monitoring and any other documentation of the quality of care provided under the demonstration.

d. Compliance with the Budget Neutrality Cap. The state must provide financial data (as set forth in the current STCs) demonstrating that the state has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.

e. Interim Evaluation Report. The state must provide an evaluation report reflecting the hypotheses being tested and any results available.

**10. Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. **Phase-out Plan Requirements:** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. **Phase-out Procedures:** The state must comply with all notice requirements found in 42 C.F.R. section 431.206, section 431.210, and § 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 C.F.R. section 431.220 and section 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 C.F.R. section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.

d. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP will be limited to, normal

closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

e. **Post Award Forum:** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report as specified in STC 41 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 43.

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The state does not relinquish its rights to administratively and/or judicially challenge CMS' finding that the state materially failed to comply.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. The CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009 and the tribal consultation requirements at outlined in the state's approved state plan, when any program changes to the demonstration including (but not limited to) those referenced in STC

6, are proposed by the state. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state must to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any amendment or extension of this demonstration. The state must also comply with the Public Notice Procedures set forth in 42 C.F.R. section 447.205 for changes in statewide methods and standards for setting payment rates.

16. **FFP.** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.

17. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The state shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter.

## IV. POPULATIONS AFFECTED BY THE DEMONSTRATION

Under the demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan.

18. **Eligibility Groups Affected By the Demonstration.** The demonstration will provide new incentives for the providers participating in IDNs, which serve all Medicaid beneficiaries through the fee-for-service system or Medicaid Care Management program . All affected groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable.

19. **Eligibility Groups Excluded from the Demonstration.** Individuals served under the New Hampshire Health Protection Program (NHHPP) Premium Assistance section 1115 demonstration (11-W-00298/1) are excluded from this demonstration and will continue to receive Medicaid benefits through qualified health plans (QHP).

## V. DELIVERY SYSTEM REFORM PROGRAM

This demonstration is part of a multi-pronged approach to address barriers to providing behavioral health services in the appropriate setting and to address behavioral health capacity issues in the state. Specifically, the goals of the behavioral health delivery system transformation are to:

1. Deliver integrated physical and behavioral health care that better addresses the full range of a beneficiaries' needs;
2. Expand provider capacity to address emerging and ongoing behavioral health needs in an appropriate setting; and

3. Reduce gaps in care during transition across care settings

The state will make performance-based incentive payments available to providers to form regionally-based integrated delivery networks (IDNs). The IDNs will serve as the vehicle to foster relationships between behavioral health providers and other health care providers that are necessary to achieve the state's vision for system transformation; including the financial relationships, data exchanges and business relationships. Specifically, IDNs will receive incentive payments for its performance on projects to increase integration across providers and community social service agencies, expand provider capacity, develop new expertise and improve care transitions

20. **Integrated Delivery Network Transformation Fund**. The terms and conditions contained herein apply to the state's exercise of expenditure authority two (2): Expenditures Related to the IDN Fund. These requirements are further elaborated by the DSRIP Planning Protocol (Attachment C) and the DSRIP Program Funding and Mechanics Protocol (Attachment D).

    As described further below, system transformation funding is available to *networks* that consist of *providers* whose *project plans* are approved and funded through the process described in these STCs and who meet particular *milestones* described in their approved IDN Project Plans. IDN Project Plans are based on *projects* specified in the DSRIP Planning Protocol (Attachment C) and DSRIP Funding and Mechanics Protocol (Attachment D) and are further developed by to be directly responsive to the needs and characteristics of the low-income communities that they serve and to achieve the transformation objectives furthered by this demonstration.

21. **IDNs.** The provider networks that are funded to participate in projects are called IDNs. Participating providers must form regional coalitions that apply collectively for pool funds as a single IDN. IDNs must complete project milestones and measures as specified in the DSRIP Planning Protocol (Attachment C) and are the only entities that are eligible to receive IDN incentive payments.

22. **Attributed Population**. After consultation with community members, providers, and other stakeholders, the state will approve a defined population for each IDN based on geographic and member service loyalty factors, as described in the DSRIP Program Funding and Mechanics Protocol (Attachment D). Coalitions will be evaluated on performance of IDN milestones collectively as a single entity. Coalitions are subject to the following conditions in addition to the requirements specified in the DSRIP Program Funding and Mechanics Protocol (Attachment D):

    a. IDNs will be composed of a lead applicant and several partners. Networks must designate a lead provider who will be held responsible under the IDN for ensuring that the coalition meets all requirements of IDNs, including reporting to the state and CMS.

    b. IDNs must establish a clear business relationship between the component providers, including a joint budget and funding distribution plan that specifies in advance the methodology for distributing funding to participating

providers. The funding distribution plan must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Act); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act). State approval of an IDN plan does not alter the responsibility of Integrated Delivery Networks to comply with all federal fraud and abuse requirements of the Medicaid program.

c. Each IDN must, in the aggregate, identify a proposed geographic catchment area for the IDN. The proposed geography will support the population attribution methodology specified in the DSRIP Program Funding and Mechanics Protocol (Attachment D).

d. Each IDN must have a data agreement in place to share and manage data on system-wide performance.

23. **Project Objectives**. IDNs will design and implement projects that further each of the objectives, which are elaborated further in the DSRIP Planning Protocol (Attachment C). Each IDN is responsible for project activity that addresses each of the four objectives.

a. Creating appropriate behavioral health capacity in order to expand effective community based-treatment models; reduce unnecessary use of emergency rooms and hospitals as the site of care for individuals with behavioral health issues; and support prevention through screening, early intervention, and population health management initiatives. Projects will bolster behavioral health capacity by supporting workforce development programs; medication adherence trainings; cross training of mental health, physical health and substance use providers; development of new treatment and intervention capacity (e.g., behavioral health community crisis stabilization and ambulatory detoxification initiatives); and expansion of community-based health navigation services with community based social service agencies.

b. Promoting integration of physical and behavioral health providers through physical or virtual integration. Projects may include: co-location of behavioral health providers with primary care providers as a first step at sites that currently have little to no integration, but, more often will be used to foster fuller integration thorough bi-directional embedding of providers; adoption of evidence-base standards of integrated care including medication management for individuals with serious mental illness, medication-assisted treatment for individuals with substance use disorders; and use of team-based approaches to care delivery that address physical, behavioral and social barriers to improved outcomes. Along with directly promoting integration, the projects will promote ancillary changes by supporting the IT capacity and protocols needed for

integration, offering training to providers on how to adopt the required changes; and creating integrated care delivery protocols and models.

c. Promoting smooth transitions across the continuum of care for beneficiaries and incentivizing coordination of providers. Projects will be used to promote evidence-based practices such as behavioral health specific discharge and care coordination plans, coordinated referrals to socials service agencies, medication adherence and management plans, medication assisted treatment and continuity of care for individuals transitioning between the community and institutions, including hospitals, prisons, and jails.

d. Ensuring IDNs participate in Alternative Payment Models that are adopted by the State with Medicaid Service delivery and Medicaid managed care plans.

**24. Project Milestones.** Progress towards achieving the goals specified above will be assessed by specific milestones, which will be measured by particular metrics that are further defined in the DSRIP Planning Protocol (Attachment C). These milestones are to be developed by the state in consultation with stakeholders and members of the public and approved by CMS. They are organized into the following Stages:

a. *Project planning and progress milestones (Stage 1).* Creation of plans for investments in technology, tools, stakeholder engagement, and human resources that will allow IDNs to build capacity to serve target populations and pursue IDN project goals in accordance with community-based priorities. Performance in this stage is measured by a common set of project progress milestones that will include evaluation of the appropriateness and viability of proposed project development plans, consistency with statewide goals and metrics, and implementation of project plans.

b. *Project utilization milestones (Stage 2).* that assess process-based improvements, as established by the state, in the delivery of care and gains in clinical outcomes consistent with the demonstration's objectives of building capacity; promoting greater integration of behavioral and physical care; and fostering smoother transitions of care. Performance in this domain will be evaluated by state developed measures consistent with the objectives of the demonstration outlined in STC 23, such as initiation of treatment following a substance abuse-related hospitalization or incarceration; reductions in waiting times for behavioral health treatment; use of behavioral health screening in primary care settings; and integration of care for adults with severe mental illness.

c. *System transformation utilization milestones (Stage 3).* These state-established outcomes measure the overall systemic impact of IDNs and progress toward the statewide objectives of the waiver, such as material increase in system-wide workforce capacity for the delivery of substance use disorder services; greater use of community-based care; fewer hospitalizations and institutionalizations by individuals with behavioral health issues; reductions in the inappropriate use of emergency departments across the state, and reductions in undiagnosed and untreated physical and behavioral health conditions

among Medicaid beneficiaries.

d. *Alternative Payment Model milestones (Stage 4).* These measures will evaluate IDNs ability to respond to system wide transformation to alternative payment models and to accept alternative payments to promote sustainability. In the early years of the demonstration, these measures will be used to assess whether IDNs are making adequate preparations, such as whether they have the data infrastructure, financial infrastructure, and other changes that may be required. In later years, IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals outlined in STC 33.

25. **IDN Performance Indicators & Outcome Measures.** The state will choose performance indicators and outcome measures that are connected to the achievement of the goals identified above and in the DSRIP Planning Protocol, Attachment C. The DSRIP performance indicators and outcome measures will comprise the list of reporting measures that IDNs will be required to report under each of the DSRIP Stages.

26. **DSRIP Planning Protocol.** The state must develop and submit to CMS for approval a DSRIP Planning Protocol no later than March 1, 2016. Once approved by CMS, this document will be incorporated as Attachment C of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure authorities and STCs. Changes to the protocol will apply prospectively unless otherwise indicated in the protocols. The DSRIP Planning Protocol must:

a. Outline the global context, goals and outcomes that the state seeks to achieve through the combined implementation of individual projects by IDNs;

b. Specify the Stage, as required in STC 24, and for each Stage specify a menu of activities, along with their associated population-focused objectives and evaluation metrics, from which each eligible IDN will select to create its own projects;

c. Detail the requirements of the IDN Project Plans, consistent with STC 28, which must include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;

d. Specify a set of outcome measures that must be collected and reported by all IDNs, regardless of the specific projects that they choose to undertake;

e. Include required baseline and ongoing data reporting, assessment protocols, and monitoring/evaluation criteria aligned with the evaluation design and the monitoring requirements in sections IV and X of the STCs.

f. Include a process that allows for potential IDN Project Plan modification

(including possible reclamation, or redistribution, pending state and CMS approval) and an identification of circumstances under which a plan modification may be considered, which shall stipulate that the state or CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved.

g. When developing the DSRIP Planning Protocol, the state should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section X of the STCs. The state must select a preferred evaluation plan for the applicable evaluation question, and provide a rationale for its selection. To the extent possible, participating IDNs should use similar metrics for similar projects to enhance evaluation and learning experience between IDNs.

27. **DSRIP Program Funding and Mechanics Protocol**. The state must develop a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval no later than March 1, 2016. Once approved by CMS, this document will be incorporated as Attachment D of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure authorities and STCs. Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols. DSRIP payments for each participating IDN are contingent on the participating providers fully meeting project metrics defined in the approved IDN Project Plan. In order to receive incentive funding relating to any metric, the IDN must submit all required reporting, as outlined in the DSRIP Program Funding and Mechanics Protocol (Attachment D). In addition, the DSRIP Program Funding and Mechanics Protocol must:

a. Describe, and specify the role and function, of a standardized IDN report to be submitted to the state on a semi-annual basis for the utilization of DSRIP funds that outlines a status update on the IDN Project Plan, as well as any data books or reports that IDNs may be required to submit to report baseline information or substantiate progress. IDNs must use a standardized reporting form to document their progress and qualify to receive DSRIP Payments if the specified performance levels were achieved;

b. Specify a review process and timeline to evaluate IDN progress based on the IDN's quarterly reports on their IDN Project Plans.

c. Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating IDN may be eligible to receive during the implementation of the DSRIP project, consistent with these STCs and a formula for determining the incentive payment amounts associated with the specific activities and metrics selected by each IDN, such that the amount of incentive payment is commensurate with the value and level of effort required.

d. Specify that IDN's failure to fully meet a performance metric under its IDN DSRIP Plan within the time frame specified will result in a penalty, including but not limited to, forfeiture of the associated incentive payment.

e. Describe a process by which a IDN that fails to meet a performance metric in a timely fashion may possibly reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric, or by which a payment missed by one IDN can be redistributed to other IDNs, including rules governing when missed payments can be reclaimed or must be redistributed; and

f. Include a state process for developing an evaluation of DSRIP as a component of the draft evaluation design as required by STC 72.

g. Payment of funds allocated in an IDN DSRIP Plan to outcome measures may be contingent on the IDN reporting DSRIP performance indicators to the state and CMS, on the IDN meeting a target level of improvement in the DSRIP performance indicator relative to base line, or both. At least some of the funds so allocated in DSRIP Year 2 and DSRIP Year 3, and all such funds allocated in DSRIP Year 4 and DSRIP Year 5, must be contingent on meeting a target level of improvement, IDNs may not receive credit for metrics achieved prior to approval of their IDN DSRIP Plans.

**28. IDN Project Plans.** IDNs must develop and secure approval from the state of an IDN Project Plan that is designed to meet the transformation objectives of this demonstration. The plan must be based on the DSRIP Planning Protocol (Attachment C), and further developed by the IDN to be directly responsive to the needs and characteristics of the low-income communities that it serves. In developing its IDN Project Plan, an IDN must solicit and incorporate community input to ensure it reflects the specific needs of its region. IDN Project Plans must be approved by the state and may be subject to additional review by CMS. The DSRIP Planning Protocol (Attachment C) will provide a structured format for IDNs to use in developing their IDN Project Plan submission for approval. At a minimum, it will include the elements listed below.

a. Each IDN Project Plan must identify the target populations, projects, and specific milestones for the proposed project, which must be chosen from the options described in the approved IDN Project Planning Protocol (Attachment C).

b. Goals of the IDN Project Plan should be aligned with each of the objectives as described in STC 23 of this section.

c. Milestones should be organized as described above in STC 23 and STC 24 of this section reflecting the overall goals of the demonstration and subparts for each goal as necessary.

d. The IDN Project Plan must describe the need being addressed and the starting point of the IDN related to the project. The starting point of the IDN Project Plan must be after January 1, 2017.

e. Based on the starting point, the IDN must describe its expected outcome for each of the stages described in STC 24 of this section. IDNs must also describe why the IDN selected the project drawing on evidence for the potential for the interventions to achieve these changes.

f. The IDN Project Plan must include a description of the processes used by the IDN to engage and reach out to stakeholders, including a plan for ongoing engagement with the public, based on the process described in the DSRIP Planning Protocol (Attachment C).

g. IDNs must demonstrate how the project will transform the delivery system for the target population and do so in a manner that is aligned with the central goals of the IDN, the statewide objectives of the IDN Fund, and in a manner that will be sustainable after DSRIP Year 5. The projects must implement new, or significantly enhance existing health care initiatives; to this end, providers must identify existing, notable delivery system reform initiatives related to the objectives of this demonstration in which they currently participate or already plan to participate and explain how the proposed IDN activities are not duplicative of activities that are already or have recently been federally funded (e.g. SIM grants).

h. For each stated goal or objective of a project, there must be an associated outcome metric that must be reported in all years. The initially submitted IDN DSRIP Plan must include baseline statewide data on all quality improvement and outcome measures.

i. IDN DSRIP Plans shall include specific allocation of funding proposed within the IDN DSRIP Plan.

j. Each individual IDN DSRIP Plan must report on progress to receive DSRIP funding. Eligibility for DSRIP payments will be based on successfully meeting metrics associated with approved activities as outlined in the IDN DSRIP Plans. IDNs may not receive credit for metrics achieved prior to approval of their IDN DSRIP Plans.

**29. Project Valuation.** IDN payments are earned for meeting the performance milestones (as specified in each approved IDN Project Plan). The value of funding for each milestone and for IDN projects overall should be proportionate to its potential benefit to the health and health care of Medicaid beneficiaries, as further explained in the DSRIP Program Funding and Mechanics Protocol (Attachment D).

a. *Maximum project valuation.* As described further in the IDN Program Funding and Mechanics Protocol (Attachment D), a maximum valuation for each project on the project menu shall be calculated based on valuation components as specified in the IDN

Program Funding and Mechanics Protocol.

b. *Progress milestones and outcome milestones.* An IDN project's total valuation will be distributed across the milestones described in the IDN Project Plan, according to the specifications described in the DSRIP Program Funding and Mechanics Protocol (Attachment D). An increasing proportion of IDN funding will be allocated to performance on outcome milestones each year, as described in the DSRIP Program Funding and Mechanics Protocol.

c. *Performance based payments.* IDNs may not receive payments for metrics achieved prior to the baseline period set by CMS and the state in accordance with these STCs and the DSRIP Funding and Mechanics Protocol. Achievement of all milestones is subject to audit by CMS and the state. The state shall also monitor and report proper execution of project valuations and funds distribution as part of the implementation monitoring reporting required under STC 45 of this section. In addition to meeting performance milestones, the state and IDN providers must comply with the financial and reporting requirements for IDN payments specified in STCs and any additional requirements specified in the DSRIP Program Funding and Mechanics Protocol.

**30. Data.** The state shall make the necessary arrangements to assure that the data needed from the IDNs, and data needed from other sources, are available as required by the CMS approved DSRIP Planning Protocol (Attachment C).

**31. Pre-implementation Activities.** In order to authorize IDN funding for DY 1 to DY 5, the state must meet the following implementation milestones according to the timeline outlined in these STCs. Failure to complete these requirements will result in a state penalty, as described below:

a. During calendar year 2016, the state may provide allotted amounts to providers for IDN design and implementation from a designated IDN Project Design and Capacity Building Fund. This funding will enable providers to develop specific and comprehensive IDN Project Plans and to begin to develop the capacity and tools required to implement these plans. New Hampshire may expend up to 65 percent of demonstration Year 1 payments from the IDN Fund for this purpose. IDN Project Design and Capacity Building payments count against the total amounts allowed for IDN under the demonstration.

   i. Submitting an application for IDN Project Design and Capacity Building Funding. Providers and coalitions must submit an IDN Project Design and Capacity Building application that outlines the IDN's design proposal.

   ii. Use of IDN Project Design and Capacity Building Funds. The providers and coalitions that are approved to be IDNs will receive IDN Project Design and Capacity Building funds that must be used to prepare an IDN Project Plan and to begin developing capacity to implement projects. Providers and coalitions that receive IDN Project Design and Capacity Building funds must submit an IDN Project Plan.

b. *Stakeholder engagement.* The state must engage the public and all affected stakeholders (including community stakeholders, Medicaid beneficiaries, physician groups, hospitals, and health plans) by soliciting feedback and comment on the draft DSRIP Planning Protocol (Attachment C) and DSRIP Program Funding and Mechanics Protocol (Attachment D) including all relevant background material.

c. *Allowable changes to IDN protocols.* The state must post any technical modifications the state makes to the DSRIP Planning Protocol (Attachment C) and the DSRIP Program Funding and Mechanics Protocol (D). The state will submit the final protocols and CMS will review and take action on the changes (e.g. approve, deny or request further information or modification) no later than 30 business days after the state's submission.

d. *Baseline data on IDN measures.* The state must use existing data accumulated prior to implementation to identify performance goals for IDN providers. The state must identify high performance levels for all anticipated measures in order to ensure that providers select projects that can have the most meaningful impact on the Medicaid population, and may not select projects for which they already are high performers, with the exception of projects needed for the State to meet statewide objectives

e. *Procurement of entities to assist in the administration and evaluation of IDNs.* The state will identify independent entities with expertise in delivery system improvement, including an independent assessor and any other entity required for the state to implement, monitor and evaluate the performance of IDNs and the demonstration as a whole. At a minimum, the independent entities will work in cooperation with one another to do the following:

   i. Independent Assessor: Conduct a transparent review of all proposed IDN Project Plans and make project approval recommendations to the state.

   ii. Administrative Costs: The state may use a share of the IDN Fund for the administrative costs associated with the entities assisting it with the design, implementation, administration, and evaluation of the waiver. Any costs paid for with IDN Fund will be matched at the state's regular administrative matching rate.

      1. The state must describe the functions of each independent entity and their relationship with the state as part of its DSRIP Planning Protocol (Attachment C).

      2. Spending on the independent entities and other administrative cost associated within the IDN Transformation Fund is classified as a state administrative activity of operating the state plan as affected by this demonstration. The state must ensure that all administrative costs for the independent entities are proper and efficient for the administration of the IDN Transformation Fund.

f. *Submit evaluation plan.* The state must submit an evaluation plan for the demonstration consistent with the requirements of STC 72 of this section no later than 120 days after award of the demonstration and must identify an independent evaluator.

32. **Post Approval Protocols.** The state must submit for CMS approval a draft DSRIP Planning Protocol and DSRIP Funding & Mechanics Protocol for approving, overseeing, and evaluating IDN project implementation funding no later March 1, 2016 as identified in STC 26 and STC 27 above. The protocols are subject to CMS approval. The state shall provide the final protocols within 30 calendar days of receipt of CMS comments. If CMS finds that the final protocols adequately accommodates its comments, then CMS will approve the final protocols within 30 business days. These protocol will become Attachments C and D of these STCs

33. **MCO and Medicaid Service Delivery Contracting Plan.** In recognition that the IDN investments represented in this demonstration must be recognized and supported by the state's MCO and Medicaid service delivery contracts as a core component of long term sustainability, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid beneficiaries with diagnosed or emerging behavioral health issues through comprehensive payment reform, strengthened provider networks and care coordination, the state must take steps to plan for and reflect the impact of IDN in Medicaid provider contracts and rate-setting approaches. Prior to the state submitting to CMS contracts and rates for approval for any contract period beginning July 1, 2017, the state must submit a roadmap for how it will amend contract terms and reflect new provider capacities and efficiencies in Medicaid provider rate-setting. Recognizing the need to formulate this plan to align with the stages of IDN, this should be a multi-year plan developed in consultation with managed care plans and other stakeholders, and necessarily be flexible to properly reflect future IDN progress and accomplishments. This plan must be approved by CMS before the state may claim FFP for Medicaid provider contracts for the 2018 state fiscal year. The state shall update and submit the MCO and Medicaid service delivery contracting plan annually on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the MCO and Medicaid service delivery contracting plan will also be included in the quarterly demonstration report. The Medicaid service delivery plan should address the following:

    a. What approaches service delivery providers will use to reimburse providers to encourage practices consistent with IDN objectives and metrics, including how the state will plan and implement a goal of 50 percent of Medicaid provider payments to providers using Alternative Payment Methodologies.
    b. If and when plans' currents contracts will be amended to include the collection and reporting of IDN objectives and measures.
    c. How the IDN objectives and measures will impact the administrative load for Medicaid providers, particularly insofar as plans are providing additional technical assistance and support to providers in support of IDN goals, or themselves carrying out programs or activities to further the objectives of the waiver. The state should also discuss how these efforts, to the extent carried out by plans, avoid duplication with IDN funding or other state funding; and how they differ from any services or

administrative functions already accounted for in capitation rates.

d. How alternative payment systems deployed by the state and MCO/Medicaid service delivery contracts will reward performance consistent with IDN objectives and measures.

e. How the state will assure that providers participating in and demonstrating successful performance through IDNs will be included in provider networks.

f. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by IDNs, including how up-to-date data on these matters will be incorporated into capitation rate development.

g. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with IDNs that the plans will undertake. How plans will be measured based on utilization and quality in a manner consistent with IDN objectives and measures, including incorporating IDN objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.

h. How the state will use IDN measures and objectives in their contracting strategy approach for MCO/Medicaid service delivery contract plans, including reform.

i. How the state has solicited and integrated community and MCO/Medicaid service delivery contract provider organization input into the development of the plan.

**34. Federal Financial Participation (FFP) for DSRIP.** The following terms govern the state's eligibility to claim FFP for DSRIP.

a. IDN payments are not direct reimbursement for expenditures or payments for services. Payments from the IDN Funds are intended to support and reward IDNs and their participating providers for integrating physical and behavioral health, expanding provider capacity and reducing gaps in care during transitions. Payments from the IDN Transformation Fund are not considered patient care revenue, and shall not be offset against disproportionate share, IDN expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) or administrative expenses as defined under these Special Terms and Conditions, and/or under the State Plan.

b. The state may not claim FFP for DSRIP until after CMS has approved the DSRIP Planning Protocol (Attachment C) and DSRIP Funding and Mechanics Protocol (Attachment D).

c. The state may claim FFP for payments to IDNs out of the IDN Project Design and Capacity Building Fund application and for submission and approval of their IDN DSRIP Project Plans. The state may claim FFP for incentive payments to IDNs.

d. The state may not claim FFP for DSRIP payments in DSRIP Year 1 through DSRIP Year 5 until both the state and CMS have concluded that the IDNs have met the performance indicated for each payment. IDNs' reports must contain sufficient data and documentation to allow the state and CMS to determine if the IDN has fully met the specified metric, and IDNs must have available for review by the state or CMS, upon

request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved IDN DSRIP Plan.

e. The non-federal share of Fund payments to IDNs may be funded by state general revenue funds, certified public expenditures or any other allowable source of non-federal share consistent with federal law. The funding will flow to the participating providers according to the methodology specified in the DSRIP Funding and Mechanics Protocol.

f. The state must inform CMS of the funding of all DSRIP payments to providers through quarterly reports submitted to CMS within 60 calendar days after the end of each quarter, as required in STC 41. This report must identify the funding sources associated with each type of payment received by each provider.

**35. IDN DSRIP Funding.** The amount of demonstration funds available for the IDN DSRIP program is shown in Chart A below.

a. _Funding At Risk for Outcomes and Quality Improvement._ A share of total IDN funding will be at risk if the state fails to demonstrate progress toward meeting the demonstration's objectives. The percentage at risk will gradually increase from 0 percent in DY 1-3 to 5 percent in DY 3 to 10 percent in DY 4 and 15 percent in DY 5. The at-risk outcome measures will be developed by the state and included in the DSRIP Planning Protocol for approval by CMS. They must be statewide and measure progress toward the state's goal of building greater behavioral health capacity; better integrating physical and behavioral health; and improving care transitions.

**Chart A: IDN DSRIP Fund**

| | DY 1<br>01/01/16-<br>12/31/16 | DY 2<br>01/01/17-<br>12/31/2017 | DY 3<br>01/01/18 -<br>12/31/18 | DY4<br>01/01/19 -<br>12/31/19 | DY5<br>01/01/20 -<br>12/31/20 |
|---|---|---|---|---|---|
| **Maximum Allowable Funds** | $30,000,000 | $30,000,000 | $30,000,000 | $30,000,000 | $30,000,000 |
| **Percent At Risk for Performance** | 0% | 0% | 5% | 10% | 15% |
| **Dollar Amount at Risk for Performance** | $ | $ | $1,500,000 | $3,000,000 | $4,500,000 |

**36. Life Cycle of Five-Year Demonstration.** Synopsis of anticipated activities planned for this demonstration and the corresponding flow of funds.

a. ***Demonstration Year 1- Planning and Design:*** In the first year of the demonstration, New Hampshire will undertake implementation activities, including the following:

i. *Submit the DSRIP Planning Protocol (Attachment C) and DSRIP Program Funding and Mechanics Protocol (Attachment D)* Working closely with stakeholders and CMS, the State will submit the two required protocols in accordance with STCs 26, 27 and 32 by March 1, 2016.

ii. *Develop and oversee application process for IDNs.* The State will develop an application that IDNs must complete to be certified as an IDN and to receive IDN Project Design and Capacity Building funding. The application will require, among other things, that the IDNs: (1) describe the qualifications of the lead applicant and participating providers; (2) describe the stakeholder process used to solicit community input; and (3) identify how IDN Project Design and Capacity Building funding will be used to build capacity and prepare a project plan by December 31, 2016. The State will review and approve or reject IDN applications and requests for IDN Project Design and Capacity Building funds by June 30, 2016.

iii. *Review and approve project plans submitted by IDNs.* Once the IDNs submit project plans and they are reviewed by the independent assessor, the state will approve applications and initial IDN Fund payments by December 31, 2016 in accordance with the DSRIP Funding and Mechanics Protocol.

iv. *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 delivery system reform efforts in New Hampshire.

b. ***Demonstration Years 2-4- Implementation, Performance Measurement and Outcomes:***

i. In these years, New Hampshire will move the distribution of IDN Fund payments to more outcome-based measures, making them available over time only to those IDNs that meet performance metrics.

ii. In Year 3, the state will prepare a report on using IDNs as the basis for alternative payment methodologies by MCO and MDC plans in the state, and, depending on the recommendations, may begin implementing changes as early as Year 4.

c. ***Demonstration Year 5- Performance Measurement and Alternative Payment Model Integration:*** IDN Fund payments to IDNs that meet performance standards will continue, but, increasingly, IDNs may be expected to be working with MCO and MDC plans in the State and others to facilitate the use of alternative payment methods on behalf of Medicaid beneficiaries.

## VI. GENERAL REPORTING REQUIREMENTS

37. **General Financial Reporting Requirements.** The state must comply with all general financial requirements under title XIX of the Social Security Act in section VII of the STCs.

38. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 C.F.R Section 438 et. seq. except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.

39. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section IX of the STCs, including the submission of corrected budget neutrality data upon request.

40. **Monthly Monitoring Calls.** The state must participate in monitoring calls with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addresses include, but are not limited to, IDN operations and implementation activities, care integration activities, mental health capacity and community supports, and gaps during transitions in care. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

41. **Quarterly Operational Reports.** The state must submit progress reports in the format specified by CMS, no later than 60 calendar days following the end of each quarter along with any other Protocol required deliverables described in these STCs. The intent of these reports is to present the state's analysis and the status of the various operational areas in reaching the goals of the DSRIP activities. These quarterly reports, using the quarterly report guideline outlined in Attachment A, must include, but are not limited to the following reporting elements:

    a. Summary of quarterly expenditures related to IDNs, DSRIP Project Plans, and the IDN Funds;
    b. Updated budget neutrality spreadsheets
    c. Summary of all public engagement activities, including, but not limited to the activities required by CMS;
    d. Summary of activities associated with the IDNs, DSRIP Project Plans, and the IDN Fund. This shall include, but is not limited to, reporting requirements in STC 41 of this section and the DSRIP Planning Protocol (Attachment C):
    e. Provide updates on state activities, such as changes to state policy and procedures, to support the administration of the IDN Fund,
    f. Provide updates on provider progress towards the pre-defined set of activities and associated milestones that collectively aim towards addressing the state's goals;
    g. Provide summary of state's analysis of IDN Project Plans;

h. Provide summary of state analysis of barriers and obstacles in meeting milestones;
i. Provide summary of activities that have been achieved through the IDN DSRIP Fund; and
j. Provide summary of transformation and clinical improvement milestones and that have been achieved.
k. Summary of activities and/or outcomes that the state and MCO and Medicaid service delivery plans have taken in the development of and subsequent approval of the MCO and Medicaid service delivery IDN Contracting plan; and
l. Evaluation activities and interim findings.

**42. Rapid Cycle Assessments.** The state shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment of IDN projects, performance indicators and outcomes, and for monitoring and evaluation of the demonstration.

**43. Annual Report**. The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under STC 41. The state must submit the draft annual report no later than October 1st of each year. Within 60 calendar days of receipt of comments from CMS, a final annual report must be submitted.

**44. Final Report.** Within 120 calendar days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 calendar days after receipt of CMS' comments.

**45. State Monitoring Requirements.** The state will be actively involved in ongoing monitoring of IDN DSRIP Project Plans, including but not limited to the following activities.

a. *Review of milestone achievement.* IDNs seeking payment under the DSRIP program shall submit semi-annual reports to the state as required in STC 24 demonstrating progress on each of their projects as measured by project-specific milestones and metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved according to the approved DSRIP project plan. The IDNs shall have available for review by New Hampshire or CMS, upon request, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to IDNs for achievement of DSRIP milestones.

b. *Learning collaboratives.* With funding available through this demonstration, the state will support regular learning collaboratives regionally and at the state level, which will be

a required activity for all IDNs, and may be organized either geographically, by the goals of the DSRIP, or by the specific DSRIP projects as described in the DSRIP Planning Protocol (Attachment C). Learning collaboratives are forums for IDNs to share best practices and get assistance with implementing their DSRIP projects. Learning collaboratives should primarily be focused on learning (through exchange of ideas at the front lines) rather than teaching (i.e. large conferences), but the state should organize at least one face-to-face statewide collaborative meeting a year. Learning collaboratives should be supported by a web site to help providers share ideas and simple data over time. In addition, the collaboratives should be supported by experts who can travel from site to site in the network to answer practical questions about implementation and harvest good ideas and practices that they systematically spread to others.

c. *Rapid cycle evaluation.* In addition to the comprehensive evaluation of DSRIP described in these STCs of this section, the state will be responsible for compiling data on DSRIP performance after each milestone reporting period and summarizing DSRIP performance to-date for CMS in its quarterly reports. Summaries of DSRIP performance must also be made available to the public on the state's website along with a mechanism for the public to provide comments.

d. *Additional progress milestones for at risk projects.* Based on the information contained in an IDN's semiannual report or other monitoring and evaluation information collected, the state or CMS may identify particular projects as being "at risk" of not successfully completing its DSRIP project in a manner that will result in meaningful delivery system transformation. The state or CMS may require these projects to meet additional progress milestones in order to receive DSRIP funding in a subsequent semi-annual reporting period.

## VII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

46. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the expenditures as specified in section IX of the STCs.

47. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

   a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the

demonstration project number (11-W-00301/1) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered.

b) Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

c) Pharmacy Rebates. When claiming these expenditures the State may refer to the July 24, 2014 CMCS Informational Bulletin which contains clarifying information for quarterly reporting of Medicaid Drug Rebates in the Medicaid Budget and Expenditures (MBES) (http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-24-2014.pdf). The State must adhere to the requirement at section 2500.1 of the State Medicaid Manual that all state collections, including drug rebates, must be reported on the CMS-64 at the applicable Federal Medical Assistance Percentage (FMAP) or other matching rate at which related expenditures were originally claimed. Additionally, we are specifying that states unable to tie drug rebate amounts directly to individual drug expenditures may utilize an allocation methodology for determining the appropriate Federal share of drug rebate amounts reported quarterly. This information identifies the parameters that states are required to adhere to when making such determinations.

   Additionally, this information addresses how states must report drug rebates associated with the new adult eligibility group described at 42 CFR 435.119. States that adopt the new adult group may be eligible to claim drug expenditures at increased matching rates. Drug rebate amounts associated with these increased matching rates must be reported at the same matching rate as the original associated prescription drug expenditures.

d) Use of Waiver Forms. For each demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below. Expenditures should be allocated to these forms based on the guidance found below.

   1) **DSHP:** Expenditures authorized under the demonstration for the Designated State Health Programs (DSHP)

   2) **IDN:** Expenditures authorized under the demonstration for delivery system transformation payment made to and by IDN.

48. **Expenditures Subject to the Budget Neutrality Agreement**. For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for the EGs outlined in section IV of the STCs, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

49. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

50. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms, in order to properly account for these expenditures in determining budget neutrality.

51. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:

    a. For the purpose of calculating the budget neutrality agreement and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 41, the actual number of eligible member months for the populations affected by this demonstration as defined in STC 19. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

    b. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

    c. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

52. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. New Hampshire must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 calendar days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

53. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole for the following, subject to the limits described in Section IX of the STCs:

    a. Administrative costs, including those associated with the administration of the demonstration;

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Net medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period.

**54. Sources of Non-Federal Share.** The state provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The state further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. The CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

**55. State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.

b. To the extent, the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies as allowable under 42 C.F.R. § 433.51 used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match;

The state may use intergovernmental transfers to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

d. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between

health care providers and state and/or local government to return and/or redirect to the State any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

56. **Monitoring the Demonstration.** The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

57. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

## VIII. DESIGNATED STATE HEALTH PROGRAMS

58. **Designated State Health Programs (DSHP).** The state may claim FFP for certain DSHP expenditures following procedures and subject to limits as described below. FFP may be claimed for expenditures made for the following DSHPs beginning January 1, 2016 through December 31, 2020 except as noted in Chart C below.

**Chart B: Approved DSHP through December 31, 2020.**

| Agency | Program |
|---|---|
| DHHS | Community Mental Health Center Emergency Services |
| DHHS | Adult Assertive Community Treatment (ACT) Teams |
| DHHS | Children Assertive Community Treatment (ACT) Teams |
| DHHS | Family Planning Program |
| DHHS | Tobacco Prevention |
| DHHS | Immunization Program |
| DHHS | Governor's Commission on Drug and Alcohol Abuse, Prevention and Treatment, and Recovery |

**Chart C: Approved DSHP through July 1, 2017**

| Agency | Program |
|---|---|
| Counties | County Funding for Payment of Medical Services for Nursing Home Residents ("County Nursing Home") |

59. **Limit of FFP for DSHP.** The amount of FFP that the state may receive for DSHP may not exceed the limits described below. If upon review, the amount of FFP received by the state is found to have exceeded the applicable limit, the excess must be returned to CMS as a negative adjustment to claimed expenditures on the CMS-64.

a. The state may claim up to $30 million (total computable) annually for DSHP expenditures incurred through June 30, 2017. The total computable DSHP amount for DY2 will not exceed $19,419,390. Beginning in DY3, the total computable DSHP amount will be reduced by nine (9) percent, per year, as detailed in Table D below.

b. The state may claim FFP via 1115 expenditure authority for county medical nursing home expenditures through June 30, 2017 (DY2a). As of July 1, 2017 (DY2b), the state will no longer exercise 1115 expenditure authority to receive FFP for these expenditures will expire.

c. The state may continue receiving FFP for DSRIP in DY 2 through DY 5 up to $30 million, as long as the state has an allowable source of non-federal share for the amounts between the total computable DSHP annual limit (see Table D) and $30 million.

**Table D. DSHP Annual Limits: Total Computable**

| | **DY 1 01/01/16-12/31/2016** | **DY 2a 01/01/17-06/30/17** | **DY 2b 07/01/17-12/31/17** | **DY 3 01/01/18-12/31/18** | **DY4 01/01/19-12/31/19** | **DY5 01/01/20-12/31/20** |
|---|---|---|---|---|---|---|
| General DSHP* | $8,995,761 | $8,995,761 | | $8,186,143 | $7,376,524 | $6,566,906 |
| DSHP: County Nursing Home** | $20,847,257 | $10,423,629 | - | - | - | - |
| **Total DSHP** | **$29,843,018** | **$19,419,390** | | **$8,186,143** | **$7,376,524** | **$6,566,906** |

* "General DSHP" represents the DSHPs in Chart B approved through December 31, 2020.
** "DSHP: County Nursing Home" represents the county medical nursing home expenditures in Chart C. The state will be authorized to receive FFP for these expenditures via 1115 authority through June, 30 2017 (DY2a).

**60. DSHP Claiming Protocol.** The state will develop a CMS-approved DSHP claiming protocol with which the state will be required to comply in order to draw down DSHP funds for the demonstration. State expenditures for the DSHP listed above must be documented in accordance with the protocols. The state is not eligible to receive FFP until an applicable protocol is approved by CMS. Once approved by CMS, the protocol becomes Attachment B of these STCs, and thereafter may be changed or updated with CMS approval. Changes and updates are to be applied prospectively. For each DSHP, the protocol must contain the following information:

a. The sources of non-federal share revenue, full expenditures and rates.

b. Program performance measures, baseline performance measure values, and improvement goals. (CMS may, at its option, approve the DSHP Claiming Protocol for a DSHP without this feature.)

c. Procedures to ensure that FFP is not provided for any of the following types of expenditures:
   i. Grant funding to test new models of care

ii. Construction costs (bricks and mortar)
iii. Room and board expenditures
iv. Animal shelters and vaccines
v. School based programs for children
vi. Unspecified projects
vii. Debt relief and restructuring
viii. Costs to close facilities
ix. HIT/HIE expenditures
x. Services provided to undocumented individuals
xi. Sheltered workshops
xii. Research expenditures
xiii. Rent and utility subsidies normally funded by the United State Department of Housing and Urban Development
xiv. Prisons, correctional facilities, services for incarcerated individuals and services provided to individuals who are civilly committed and unable to leave
xv. Revolving capital fund
xvi. Expenditures made to meet a maintenance of effort requirement for any federal grant program
xvii. Administrative costs
xviii. Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans)
xix. Cost of services for which payment was made by Medicare or Medicare Advantage
xx. Funds from other federal grants
xxi. Needle-exchange programs

61. **DSHP Claiming Process.** Documentation of each designated state health program's expenditures, as specified in the DSHP Protocol, must be clearly outlined in the state's supporting work papers and be made available to CMS. In order to assure CMS that Medicaid funds are used for allowable expenditures, the state will be required to document through an Accounting and Voucher system its request for DSHP payments. The vouchers will be detailed in the services being requested for payment by the state and will be attached to DSHP support.

Federal funds must be claimed within two years following the calendar quarter in which the state disburses expenditures for the DSHP. Federal funds are not available for expenditures disbursed before January 1, 2016 or after December 31, 2020.

Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHP listed above, they shall not be used as a source of non-federal share. The administrative costs associated with the DSHP listed above, and any others subsequently added by amendment to the demonstration, shall not be included in any way as demonstration and/or other Medicaid expenditures. Any changes to the DSHP listed above

shall be considered an amendment to the demonstration and processed in accordance with STC 7 in Section III.

62. **Reporting DSHP Payments**. The state will report all expenditures for DSHP payments to the programs listed above on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name "DSHP" as well as on the appropriate forms.

## IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

63. **Budget Neutrality Effective Date.** Notwithstanding the effective date specified in section I of the STCs or in any other demonstration documentation, all STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning January 1, 2016.

64. **Limit on Title XIX Funding**. New Hampshire will be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the state using the procedures described in section VII, STC 47. The data supplied by the state to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.

65. **Risk.** New Hampshire shall be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, New Hampshire will not be at risk for changing economic conditions which impact enrollment levels. However, by placing New Hampshire at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

66. **Demonstration Populations Used to Calculate Budget Neutrality Expenditure Limit.**

All eligible populations as referenced in STC 18 must be used in the budget neutrality expenditure limit calculations.

| Demonstration Year (DY) | Without Waiver Ceiling | With Waiver | Savings |
|---|---|---|---|
| DY1 (1/01/16 - 12/31/16) | $1,030,048,714 | $1,055,659,968 | ($25,611,253) |
| DY2 (1/01/17 - 12/31/17) | $1,062,196,255 | $1,077,912,322 | ($15,716,067) |
| DY3 (1/01/18 - 12/31/18) | $1,095,355,227 | $1,077,867,460 | $17,487,767 |
| DY4 (1/01/19 - 12/31/19) | $1,129,547,358 | $1,089,688,768 | $39,858,591 |
| DY5 (1/01/20 - 12/31/20) | $1,164,794,760 | $1,111,014,432 | $53,780,328 |
| **TOTALS:** | **$5,481,942,314** | **$5,412,142,949** | **$69,799,365** |

67. **Expenditures Excluded From Budget Neutrality Test.** Regular FMAP will continue for costs not subject to budget neutrality limit tests. Those exclusions include:

   a) Expenditures made on behalf of enrollees who are institutionalized in a nursing facility, chronic disease or rehabilitation IDN, intermediate care facility for the mentally retarded, or a state psychiatric IDN for other than a short-term rehabilitative stay;

   b) Expenditures for covered services currently provided to Medicaid recipients by other state agencies or cities and towns, whether or not these services are currently claimed for federal reimbursement;

   c) All other non-MMIS payments, such as DSH, GME, Medicaid Quality Incentive Payments (MQIP), Proportionate Share Payments, gross adjustments, reconciliations, and other settlement payments.

   d) New Hampshire's Healthy Kids Silver program (CHIP) from January 1, 2009 – June 30, 2012. CHIP members transitioned to Medicaid and are included in the historical base data as of July 1, 2012.

   e) Individual enrolled in the New Hampshire Health Protection Program (NHHPP),

   f) The Medically frail population; and

   g) Allowable administrative expenditures.

68. **Composite Federal Share Ratio.** The federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C. with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for extended family planning program must be subtracted from numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method.

69. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulation with respond to the provisions of services covered under this demonstration.

**70. Enforcement of Budget Neutrality.** CMS shall enforce the budget neutrality agreement over the life of the demonstration, rather than on an annual basis However, if the State exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval.

| Demonstration Year | Cumulative Target Definition | Percentage |
|---|---|---|
| DY 1 | Cumulative budget neutrality limit plus: | 2.0percent |
| DY 1 through DY 2 | Cumulative budget neutrality limit plus: | 1.5 percent |
| DY 1 through DY 3 | Cumulative budget neutrality limit plus: | 1.0 percent |
| DY 1 through DY 4 | Cumulative budget neutrality limit plus: | .5 percent |
| DY 1 through DY 5 | Cumulative budget neutrality limit plus: | 0 percent |

In addition, the state may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap indicates a possibility that the demonstration will exceed the cap during this extension.

**71. Exceeding Budget Neutrality**. If the budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds must be returned to CMS using the methodology outlined in STC 68, composite federal share ratio. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

## X. EVALUATION OF THE DEMONSTRATION

**72. Submission of a Draft Evaluation Design Update.** The state must submit to CMS for approval a draft evaluation design no later than 120 calendar days after CMS' approval date of the demonstration. At a minimum, the draft evaluation design must include a discussion of the goals, objectives, and evaluation questions specific to the entire delivery system reform demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population, specific testable hypothesis, including those that focus on target populations for the demonstration and more generally on beneficiaries, providers, plans, market areas and public expenditures. The draft design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented. It must discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring within the state i.e. SIM grant. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as

appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results. Information from the external quality review organization (EQRO) may be considered for the purposes of evaluation, as appropriate.

The state must acquire an independent entity to conduct the evaluation. The evaluation design must describe the state's process to contract with an independent evaluator, including a description of the qualifications the entity must possess, how the state will ensure no conflict of interest, and budget for evaluation activities.

73. **Demonstration Hypothesis.** The state will test the following hypotheses in its evaluation of the demonstration.

    a. Individuals with co-occurring physical and behavioral health issues will receive higher quality of care after IDNs are operating.
    b. The total cost of care will be lower for Medicaid beneficiaries with co-occurring physical and behavioral health issues after IDNs are operating.
    c. 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.
    d. Percentage of Medicaid beneficiaries waiting for inpatient psychiatric care will be lower at the end of the demonstration than prior to the demonstration.
    e. Average wait times for outpatient appointments at community mental health centers will be lower at the end of the demonstration than prior to the demonstration.

74. **Domains of Focus**. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the state may propose a more narrow focus for the evaluation.

    a. Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement? To what degree can improvements be attributed to the activities undertaken under DSRIP?

    b. To what extent has the DSRIP enhanced the state's health IT ecosystem to support delivery system and payment reform? Has it specifically enhanced these four key areas through the IDNs: governance, financing, policy/legal issues and business operations?

    c. To what extent has the DSRIP improved integration and coordination between providers, including bi-directional integrated delivery of physical, behavioral health services, SUD services, transitional care, and alignment of care

coordination and to serve the whole person?

**75. Evaluation Design Process:** Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the DSRIP Planning Protocol, the state should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design. From these, the state must select a preferred research plan for the applicable research question, and provide a rationale for its selection.

To the extent applicable, the following items must be specified for each design option that is proposed:

i. Quantitative or qualitative outcome measures;
ii. Baseline and/or control comparisons;
iii. Process and improvement outcome measures and specifications;
iv. Data sources and collection frequency;
v. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);
vi. Cost estimates;
vii. Timelines for deliverables.

**76. Levels of Analysis:** The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

**77. Final Evaluation Design and Implementation.** CMS shall provide comments on the draft Evaluation Design within 60 business days of receipt, and the state shall submit a final Evaluation Design within 60 calendar days after receipt of CMS comments. The state shall implement the Evaluation Design and submit its progress in each of the quarterly and annual reports.

**78. Evaluation Reports.**

a. **Interim Evaluation Report.** The state must submit a Draft Interim Evaluation Report 90 calendar days following the completion of DY 4. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings, and plans for completing the evaluation design and submitting a Final Evaluation Report according to the schedule outlined in (b). The state shall submit the final Interim Evaluation Report within 60 calendar days after receipt of CMS comments.

b. **Final Evaluation Report.** The state must submit to CMS a draft of the Final Evaluation Report by January 30, 2021. The state shall submit the final evaluation report within 60 calendar days after receipt of CMS comments.

79. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state must submit the required data to CMS or the contractor.

## XI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

| Date | Deliverable | STC |
|---|---|---|
| **Administrative** | | |
| 30 days after approval date | State acceptance of demonstration STCs and Expenditure Authorities | Approval letter |
| **Post Approval Protocols** | | |
| March 1, 2016 | Submit Draft DSRIP Planning Protocol and DSRIP Program Funding & Mechanics Protocol | STCS 27, 27, 32 |
| 60 days after approval date | Submit Draft DSHP Protocol | STC 60 |
| **Evaluations** | | |
| 120 calendar days after approval date | Submit Draft Design for Evaluation Report | STC 72 |
| 90 days after the completion of DY 4 | Submit Draft Interim Evaluation Report | STC 78 |
| 60 business days after receipt of CMS comments | Submit Final Interim Evaluation Report | STC 77, 78 |
| January 31, 2021 | Submit Draft Final Evaluation Report | STC 78, 44 |
| 60 business days after receipt of CMS comments | Submit Final Evaluation Report | STC 78 |
| **Quarterly/Annual/Final Reports** | | |
| Quarterly Deliverables Due 60 calendar days after end of each quarter, except 4th quarter | Quarterly Progress Reports | STC 41 |
| | Quarterly Expenditure Reports | STC 46 |
| Annual Deliverables - Due 120 calendar days after end of each 4th quarter | Annual Reports | STC 43 |
| Final Report Due 120 days after the end of the demonstration | | STC 44 |

## ATTACHMENT A:
## QUARTERLY REPORT FORMAT

**Quarterly Report Template**

Pursuant to STC 41 (Quarterly Operational Reports), the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

**NARRATIVE REPORT FORMAT:**

| | |
|---|---|
| Title Line One: | New Hampshire Building Capacity for Transformation Section 1115 Waiver Demonstration |
| Title Line Two: | Section 1115 Quarterly Report |
| Demonstration/Quarter Reporting Period: | ***[Example: Demonstration Year: 1 (1/1/2016– 12/31/2016)*** <br> ***Federal Fiscal Quarter:*** <br> ***Footer: Date on the approval letter through end of demonstration period]*** |

**Introduction**

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

**Integrated Delivery Network (IDN) Attribution and Delivery System Reform Information**

Discuss the following:

1. Trends and any issues related to access to care, quality of care, care integration and health outcomes.
2. Any changes, issues or anticipated changes in populations attributed to the IDNs, including changes to attribution methodologies.
3. Information about each regional IDN, including the number and type of service providers, lead provider and cost-savings realized through IDN development and maturation.
4. Information about the state's Health IT ecosystem, including improvements to governance, financing, policy/legal issues, business operations and bi-directional data sharing with IDNs.
5. Information about integration and coordination between service providers, including bi-directional integrated delivery of physical, behavioral health services, SUD services, transitional care and alignment of care.
6. Information about specific SUD-related health outcomes including opioid and other SUD-dependency rates, opioid and other SUD-related overdoses and deaths—and trend rates related to Hepatitis C and HIV acquisition.

Please complete the following table that outlines all attribution activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

**Attribution Counts for Quarter and Year to Date**

Note: Enrollment counts should be unique enrollee counts by *each* regional IDN, not member months

| IDN Attributed Populations | Total Number of IDN participants<br>Quarter Ending – MM/YY | Current Enrollees (year to date) | Disenrolled in Current Quarter |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**IV. Outreach/Innovative Activities to Assure Access**

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration participants or potential eligibles.

**VI. Operational/Policy/Systems/Fiscal Developments/Issues**

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

**IX. Financial/Budget Neutrality Development/Issues**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

**XI. Consumer Issues**

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

**XII. Quality Assurance/Monitoring Activity**

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

**XIII. Managed Care and Medicaid Delivery Contracts Reporting Requirements**

Address network adequacy reporting from plans including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates; summary of RCO appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of RCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation. The state must include additional reporting requirements within the annual report as outlined in STC 43.

## XIV. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

## XV. Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

## XVI. State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

**RESERVED FOR ATTACHMENT B**
**DSHP Claiming Protocol**

**RESERVED FOR ATTACHMENT C**
**DSRIP Planning Protocol**
**(Reserved)**

**RESERVED FOR ATTACHMENT D**
**DSRIP Funding & Mechanics Protocol**
**(Reserved)**

## New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration

## ATTACHMENT C: DSRIP PLANNING PROTOCOL

### I. Preface

#### *a. Delivery System Reform Incentive Payment Fund*

On January 5, 2016, the Centers for Medicare and Medicaid Services (CMS) approved New Hampshire's request for expenditure authority to operate its section 1115(a) Medicaid demonstration (hereinafter "demonstration") entitled *Building Capacity for Transformation*, a Delivery System Reform Incentive Payment (DSRIP) program. Under the DSRIP demonstration program, the state will make performance-based funding available to regionally-based Integrated Delivery Networks (IDNs) that serve Medicaid beneficiaries, with the goal of transforming New Hampshire's behavioral health delivery system by strengthening community-based mental health and substance use services and combatting the opioid crisis. The demonstration is currently approved through December 31, 2020.

The Special Terms and Conditions (STCs) of the waiver set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period.

#### *b. DSRIP Planning Protocol*

The requirements specified in the STCs are supplemented by the Quarterly Report Format (Attachment A), the DSHP Claiming Protocol (Attachment B), the DSRIP Planning Protocol (Attachment C), and the DSRIP Program Funding and Mechanics Protocol (Attachment D).

In accordance with STC 26, the DSRIP Planning Protocol (this attachment, Attachment C) describes the context, goals and objectives of the waiver in Section II; identifies a menu of delivery system improvement projects in Section III; specifies a set of project stages, milestones and metrics to be reported by IDNs in Section IV; details the requirements of the IDN Project Plans in Section V; and specifies a process to allow for potential IDN project plan modification in Section VI.

This version of the DSRIP Planning Protocol is approved as of [DATE]. In accordance with STC 26, the state may submit modifications to this protocol for CMS review and approval. Any changes approved by CMS will apply prospectively unless otherwise specified by CMS.

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*c. Supporting Project and Metrics Specification Guide*

This attachment will be supplemented by a Project and Metrics Specification Guide developed by the state and approved by CMS. This Guide will assist IDNs in developing and implementing their projects and will be used in the state's review of the IDN Project Plans, described in Section V below. The Project and Metrics Specification Guide will also provide additional information on the stages, milestones and metrics described in Section IV below, including the data source for each measure, the measure steward for each metric (if applicable), and the methodology used to establish outcome goals and improvement targets, as described in the Program Funding and Mechanics Protocol (Attachment D).

## II. Context, Goals and Objectives

*a. New Hampshire Context*

New Hampshire's *Building Capacity for Transformation* Section 1115 Demonstration Waiver aims to transform the way care is delivered to some of the most medically complex and costly Medicaid beneficiaries in the state as well as to individuals with undiagnosed or untreated behavioral health conditions. A number of factors make behavioral health transformation a priority of the state including the expansion of coverage through the New Hampshire Health Protection Program (NHHPP) to cover the new adult group, an estimated one in six of whom have extensive mental health or substance use needs. In addition, New Hampshire now covers substance use disorder (SUD) services for the NHHPP population, and the state is targeting g extension of the SUD benefit to the entire Medicaid population in state fiscal year 2017. Finally, the expansion of coverage for new populations and new services coincides with an epidemic of opioid abuse in the state and across New England.

The demand for mental health and substance abuse services is increasing, and the existing capacity is not well-positioned to deliver the comprehensive and integrated care that can most effectively address the needs of patients with behavioral health conditions or comorbid physical and behavioral health diagnoses. This demonstration responds to this pressing need to transform New Hampshire's behavioral health delivery system.

Under the demonstration, diverse sets of health and social service providers within regions across the state will create IDNs capable of implementing evidence-supported programs that address the needs of Medicaid beneficiaries with behavioral health conditions. The principle elements of these programs will include:

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- Integrating physical and behavioral health to better address the full range of beneficiaries' needs;
- Expanding mental health and substance use disorder treatment capacity to address behavioral health needs in appropriate settings; and
- Reducing gaps in care during transitions across care settings through improved coordination for individuals with behavioral health conditions.

The population to be addressed by the demonstration includes Medicaid beneficiaries of all ages with, or at risk for, behavioral health conditions ranging from moderate depression and anxiety to substance use, to serious mental illness. While some of these conditions respond well to prevention strategies, early intervention and a short term course of treatment, others are serious chronic illnesses that require a long term recovery process often resulting in ongoing treatment and management.

*b. Demonstration Goals and Objectives*

The demonstration is aimed at achieving the following goals:

- Improve the health and well-being of Medicaid beneficiaries and other New Hampshire residents with behavioral health conditions through the implementation of evidence-supported programs coupled with access to appropriate community-based social support services to improve physical and behavioral health outcomes.

- Improve access to behavioral health care throughout all of NH's regions by:
    - Increasing community-based behavioral health service capacity through the education, recruitment and training of a professional, allied-health, and peer workforce with knowledge and skills to provide and coordinate the full continuum of substance use and mental health services,
    - Establishing robust technology solutions to support care planning and management and information sharing among providers and community based social support service agencies, and
    - Incentivizing the provision of high-need services, such as medication-assisted treatment for substance use disorders, peer support and recovery services.

- Foster the creation of IDNs that are built upon collaboration among partners including Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), SUD clinics (including recovery providers), hospitals, independent primary care providers (PCPs), psychiatrists, psychologists and other behaviorists, medical specialists, county organizations such as nursing facilities and sheriffs), peer and family support counselors, and community-based social support agencies that serve the target

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population in a region or regions. As described in detail in the Program Funding and Mechanics Protocol (Attachment D), IDNs must ensure they have a network of both medical and non-medical providers that together represent the full spectrum of care and related social services that might be needed by an individual with a mental health or substance use disorder in their geographic region (e.g., housing, food access, income support, transportation, employment services, and legal assistance).

- Reduce the rate of growth in the total cost care for Medicaid beneficiaries with behavioral health conditions by reducing avoidable admissions and readmissions for psychiatric and physical diagnoses and avoidable use of the Emergency Department (ED) through more effective use of community-based options.

To achieve these goals the IDNs will be charged with selecting and implementing specific evidence-supported projects and participating in statewide planning efforts. These projects are built around three enabling pathways: mental health and substance use disorder treatment capacity building, integration of physical and behavioral care, and improving transitions of care across settings. In addition the IDNs will engage in a phased transition to Alternative Payment Models (APMs). These four elements are embedded in the following demonstration objectives:

1. Increase the state's capacity to implement effective community based behavioral health prevention, treatment and recovery models that will reduce unnecessary use of inpatient and ED services, hospital readmissions, the cycling of justice-involved individuals between jail and the community due to untreated behavioral health conditions, and wait times for services.

2. Promote integration of physical and behavioral health providers in a manner that breaks down silos of care among primary care, SUD and mental health providers. The level of integration to be achieved will be based on existing standards being developed through the State Innovation Model (SIM) planning process and the SAMHSA-defined standards for *Levels of Integrated Healthcare*.

3. Enable coordinated care transitions for all members of the target population regardless of care setting (e.g. CMHC, primary care, inpatient hospital, corrections facility, SUD clinic, crisis stabilization unit). The objective is to ensure that the intensity level and duration of transition services are fully aligned with an individual's documented care plan, which will be based on an up-to-date, standard core comprehensive assessment.



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4. Ensure IDNs participate in Alternative Payment Models (APMs) that move Medicaid payment from primarily volume-based to primarily value-based payment over the course of the demonstration period.

To achieve these objectives, each IDN will be required to build a care continuum with the capacity to meet the needs of Medicaid beneficiaries with behavioral health conditions (diagnosed and undiagnosed) and to implement projects to further the objectives and goals of the demonstration. Additional details on the projects that IDNs are expected to implement and related metrics are provided in Sections III and IV.

## III. Project Protocols Menu

### *a. Overview of Project Categories*

Each IDN will be required to implement six projects to address the needs of Medicaid beneficiaries with diagnosed and undiagnosed behavioral health conditions within the population it serves. These six projects will be spread across the following three categories:

- Statewide Projects (2 mandatory projects for all IDNs)
- Core Competency Project (1 mandatory project for all IDNs); and
- Community Driven Projects (IDNs select 3 projects among options)

For each project, the IDN will develop detailed plans and focused milestones as part of the IDN's Project Plan. As described in Section IV, project performance will be measured based on milestones and metrics that track: project planning/implementation progress; clinical quality and utilization indicators; and progress towards transition to Alternative Payment Models.

### *b. Description of Project Categories*

### 1. Statewide Projects (Mandatory for all IDNs)

Each IDN will be required to implement two Statewide Projects that are designed to address the following critical elements of New Hampshire's vision for transformation: (1) a workforce that is equipped to provide high-quality, integrated care throughout the state and, (2) an HIT infrastructure that allows for the exchange of information among providers and supports a robust care management approach for beneficiaries with behavioral health conditions.

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IDNs will be required to implement the following two Statewide Projects:

- **A1. Behavioral Health Work Force Capacity Development**
- **A2. Health Information Technology Planning and Development**

The effectiveness of these projects is dependent on active coordination across IDNs, and as such they will be supported by a state-wide planning effort that includes representatives from across New Hampshire. All IDNs will be required to participate in each of these projects through their respective collaborative statewide work groups with members drawn from across the mental health and substance use provider communities in each IDN, as well as those with expertise in HIT and other members who can bring relevant experience and knowledge. These work groups will be charged with identifying the workforce capacity and technology requirements to meet demonstration goals and with assessing the current gaps across the state and IDN regions. Using the work groups' findings, the IDNs will be required to develop regional approaches to closing the work force and technology gaps that impact the capacity for coordinated care management and information sharing; among medical, behavioral and social service providers. The work groups will assess the current state and develop a future state vision that incorporates strategies to efficiently implement statewide or regional technology and workforce solutions. IDNs must participate in these projects and fulfill state-specified requirements in order to be eligible for performance funding.

2. **Core Competency Project (Mandatory for all IDNs)**

Each IDN will be required to implement one Core Competency Project to ensure that behavioral health conditions are routinely and systematically addressed in the primary care setting and vice versa. Foundational to transformation efforts, IDNs are required to integrate mental health and substance use disorder services and primary care through the following Core Competency project:

- **B1. Integrated behavioral health and primary care**
  Primary care providers, behavioral health providers, and social services organizations will partner to implement an integrated care model that reflects the highest possible levels of collaboration/integration as defined within the SAMHSA Levels of Integrated Healthcare. The model will enable providers to collaborate to prevent and quickly detect, diagnose, treat and manage behavioral and medical conditions using standards of care that include:
    - Core standardized assessment framework that includes evidence based universal screening for depression and SBIRT
    - Health promotion and self-management support
    - Integrated electronic medical record

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- Multi-disciplinary care teams that provide care management, care coordination and care transition support
- An electronic assessment, care planning and management tool that enables information sharing among providers

IDNs must participate in this project and fulfill state-specified requirements in order to be eligible for DSRIP incentive payments. Given the foundational nature of the project, IDNs are required to complete the process requirements for the project by no later than December 31, 2018.

3. **Community Driven Projects (IDNs can select among options).**

Each IDN is required to select a total of three community-driven projects from a Project Menu established by the state. The IDN Project Menu is broken down into three categories, and IDNs will select one project within each of the following categories: (1) Care Transition Projects designed to support beneficiaries with transitions from institutional settings into the community; (2) Capacity Building Projects designed to strengthen and expand workforce and program options; and (3) Integration Projects designed to integrate care for individuals with behavioral health conditions among primary care, behavioral health care and social service providers.

The IDN Community Driven Menu of projects gives IDNs the flexibility to undertake work reflective of community-specific priorities identified through a behavioral health needs assessment and community engagement. IDNs will be required to conduct a behavioral needs assessment as part of development of the IDN Project Plans described further in Section V. The menu of community-driven projects gives IDNs the flexibility to target key sub-populations; to change the way that care is provided in a variety of care delivery settings and at various stages of treatment and recovery for sub-populations; and to use a variety of approaches to change the way care is delivered. The goal is to employ these services across the state to ensure a full spectrum of care is accessible for individuals with active diagnoses and those who are undiagnosed or at risk.

1. **Care Transitions Projects:** Support beneficiaries with transitions from institutional setting to community
   - **C1. Care Transition Teams**
   - **C2. Community Reentry Program for Justice-Involved Individuals**
   - **C3. Nursing Home Transitions of Care**
   - **C4. Supportive Housing**

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2. **Capacity Building Projects:** Expand availability and accessibility of evidence supported programs across the state and supplement existing workforce with additional staff and training
   - **D1. Medication Assisted Therapy (MAT)**
   - **D2. Mental Health First Aid for Medical Providers, Law Enforcement, and Social Services Providers**
   - **D3. Treatment Alternatives to Incarceration (CIT)**
   - **D4. Parachute Program for the Unserved**
   - **D5. Zero Suicide**
   - **D6. Community-Based Stabilization**
   - **D7. Coordinated Specialty Care for First Episode Psychosis**
   - **D8. Peer Support for Full Range of Behavioral Health Services/Community Health Worker Program**

3. **Integration Projects***:* Promote collaboration between primary care and behavioral health care
   - **E1. InSHAPE Program**
   - **E2. School-Based Screening and Intervention**
   - **E3. Treatment Alternatives to Incarceration (Universal Screening)**
   - **E4. Early Childhood Prevention and Interventions**
   - **E5. Collaborative Care/IMPACT Model**
   - **E6. Integrated Dual Disorder Treatment**
   - **E7 Enhanced Care Coordination for High Risk/High Utilization- Multiple Chronic Condition Populations**

**Table 1. Project Protocols Menu**

| # | PROJECT | DESCRIPTION |
|---|---|---|
| A. STATE-WIDE PROJECTS | | *IDNs required to implement both projects* |
| A1 | **BH Workforce Capacity Development** | Cross-IDN, statewide, workforce capacity planning, including: (1) gap analysis of professionals, allied professionals and peers; (2) regional workforce capacity targets; (3) training curricula; and (4) pipeline improvement plans. IDNs to use statewide planning work products to develop and implement IDN project. |
| A2 | **Health Information Technology Planning and Development** | IDNs to participate in statewide HIT/E planning to: (1) develop requirements for electronic coordinated care management system and information sharing; (2) assess current state of technology use in care planning, management and tracking; (3) consider strategies to efficiently implement statewide or regional technology solutions; and (4) develop milestones for IDNs to demonstrate steps towards having a technology platform to share care coordination data across all IDN providers inclusive of social service providers.. |
| B. CORE COMPETENCY PROJECTS | | *IDNs required to implement this project* |

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| # | PROJECT | DESCRIPTION |
|---|---|---|
| **B1** | **Integrated Behavioral Health and Primary Care** | Pediatric and adult behavioral health and primary care providers, working in concert with social services organizations, will implement a collaborative, integrated care model that reflects the highest feasible levels of collaboration/integration as defined within the SAHMSA Levels of Integrated Healthcare (e.g., Level 5 or 6).<br><br>Primary care providers, behavioral health providers, and social services organizations will partner to:<br>• Provide prevention, detection, accurate diagnosis, treatment, and follow-up of both behavioral health and physical conditions, and referral to community and social support services<br>• Address health behaviors (including those contributing to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization<br><br>Standards will include:<br>• Use of a core standardized assessment framework, including universal evidence-supported screening for depression, substance use (e.g., PHQ2 & 9, SBIRT), and medical conditions , and a patient activation tool/measure (e.g., Patient Activation Measure, or PAM)<br>• Integrated electronic medical records<br>• Health promotion and self-management support<br>• Use of multi-disciplinary care teams that provide care to the whole person through a 'no wrong door' model of care management and care coordination services including comprehensive transitional care from inpatient to other settings, patient monitoring and follow-up support services<br>• An electronic care planning/tracking tool that can be shared among a patient's provider team inclusive of social support service providers |
| **C. COMMUNITY-DRIVEN PROJECTS** | | *IDNs to select one project from the Care Transitions, Capacity Building, and Integration Categories* |
| **C. Care Transitions** | | *IDNs to select one project from this category* |
| **C1** | **Care Transition Teams )** | Time limited care transition program with multi-disciplinary team that follows 'Critical Time Intervention' approach to provide care at staged levels of intensity to support SMI patients with transitions from an institutional setting back to the community. |
| **C2** | **Community Reentry Program for Justice-Involved Individuals** | Community reentry planning: a time-limited program for justice-involved populations transitioning back into the community including supports for substance use disorder, co-occurring disorders, and mental health service coordination with Department of Corrections Probation and Parole |
| **C3** | **Nursing Home Transitions of Care** | Early intervention by multi-disciplinary team identifies, assesses, treats and manages care for residents with behavioral health conditions using consulting psychiatrist to prevent unnecessary inpatient admissions, and provide smooth care transitions as necessary. |
| **C4** | **Supportive Housing** | IDNs will partner with community housing providers to develop transitional and/ or permanent supportive housing for high risk patients who, due to their physical or behavioral condition, have difficulty transitioning safely to the community or are in need of short term interventions to safely transition to the community. |
| **D. Capacity Building** | | *IDNs to select one project from this category* |
| **D1** | **Medication Assisted Therapy (MAT)** | Implement evidence based program combining behavioral therapy and medications to treat SUD. |

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| # | PROJECT | DESCRIPTION |
|---|---|---|
| D2 | **Mental Health First Aid for Medical Providers, Law Enforcement, and Social Services Providers** | Adult public education program to train adults to assist individuals with mental health and SUD who are in crises through ALGEE process: Assess, Listen, Give reassurance, Encourage professional help; Encourage self-help; |
| D3 | **Treatment Alternatives to Incarceration (Crisis Intervention Team)** | The Crisis Intervention Team (CIT) model provides police officers 40 hours of training provided by mental health clinicians, consumer and family advocates, and police trainers. Training includes: information on signs and symptoms of mental illnesses; mental health treatment; co-occurring disorders; legal issues; and de-escalation techniques. Information is presented in didactic, experiential and practical skills/scenario based training formats. |
| D4 | **"Parachute Program"** | A comprehensive crisis response program centered around 24/7 Crisis Respite Centers that offer an alternative to hospitalization for people experiencing emotional crises, and are largely staffed by trained peers who themselves have had their own experiences with the mental health system. Mobile crisis teams are an important component of the model. This program will be expanded to underserved regions under the Demonstration to ensure accessibility to populations not currently served. |
| D5 | **Zero Suicide** | Zero Suicide is a systemic approach that aims to improve quality through use of evidence based practices directed at suicide prevention. It aims to close gaps in care, provide training to systematically identify and assess suicide risk among people receiving care. |
| D6 | **Community-Based Stabilization** | Community based medication assisted treatment withdrawal management and harm reduction service programs paired with mental health services for individuals with substance use disorders that are linked to treatment and care management services. |
| D7 | **Coordinated Specialty Care for First Episode Psychosis** | Multi- disciplinary team with small client to staff ratio intervenes with individuals during or shortly after their first psychotic episode. The program is intense and time limited (2-3 years) using multi-disciplinary team members including peers and provides family support services. |
| D8 | **Peer Support for Full Range of Behavioral Health Services/Community Health Worker Program** | Counselor with lived experience with mental health or substance use conditions and who is trained in the provision of peer recovery support services assists clients with recovery by recognizing and developing strengths, and setting goals. |
| **E. Integration** | | *IDNs to select one project from this category* |
| E1 | **InSHAPE Program** | Wellness program that brings together community organizations concerned with health, exercise and nutrition to provide participants with health mentors, fitness activities, nutrition counseling, smoking cessation support, medical support, etc. |
| E2 | **School-based Screening/Intervention** | IDN-wide program planning for school based mental health and substance use screening and brief intervention. School based staff trained to identify at risk students and to handle low severity mental health and risky substance use. Development of referral to treatment protocols required. |
| E3 | **Treatment Alternatives to Incarceration (Universal Screening)** | Evidence based depression and substance use screening and treatment for Medicaid eligible individuals entering the justice system with post-discharge follow up services through community re-entry program. |
| E4 | **Early Childhood Prevention and Interventions** | Promote the wellness of young children ages birth to 8 by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development. Prevention and intervention includes: improved screening activities; mental health consultation to early child care settings; promotion of family support; parent education; and evidence-based home visiting to support optimal social-emotional wellness. |

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| # | PROJECT | DESCRIPTION |
|---|---|---|
| E5 | **Collaborative Care/IMPACT Model** | Implement evidence-based depression care model based in primary care practices using depression care manager and consulting psychiatrist to support PCP in treatment of patients with mild to moderate depression and anxiety. |
| E6 | **Integrated Dual Disorder Treatment (IDDT)** | An evidence based multi-disciplinary program combining SUD treatment and mental health treatment using 'stages of change/treatment' approach along with pharmacological and psychosocial therapies and holistic program supports |
| E7 | **Enhanced Care Coordination for High Risk/High Utilizing Populations/Multiple Chronic Condition Populations** | Comprehensive care management services for high need populations including opioid addicted individuals, those with co-occurring intellectual disability and mental health conditions, and other identified high utilizing individuals with multiple chronic conditions and/or social factors that are barriers to improved well-being. |

## IV. Project Stages, Milestones, and Metrics

### *a. Stage :1 Capacity Building Elements Description, Progress Milestones, and Metrics*

During DSRIP Year 1, IDNs will be accountable for the development, submission, and approval of an IDN Project Plan. As part of this Project Plan, in accordance with STC 28c, IDNs must identify 'Stage 1' process milestones for each project that will demonstrate progress against meeting project objectives during Years 2 and 3. Additional parameters and guidance related to these milestones will be reflected in the Project and Metrics Specification Guide and the IDN Project Plan template.

### *b. Stages 2 and 3: Project Utilization Milestones and System Transformation Utilization Milestones*

The following project utilization and system transformation metrics will be used to measure IDN progress against meeting project goals and targeted levels of improvement against performance indicators. Section IV(c) of Attachment D goes into further detail on how these measures will be used to evaluate IDN performance.

**Table 2. Project Metrics Menu**

| | Measure Name | Associated Projects | State-Wide Measure? |
|---|---|---|---|
| **Workforce Capacity** | | | |
| | Wait list in ED for inpatient BH admission | C1-4, D2, D4, D7, E7 | x |
| | Wait times for intake and treatment for mental health | A1, D2, D4 | |
| | Wait times for intake and treatment for SUD | A1 | |
| | Expansion of workforce | A1 | |

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| | Measure Name | Associated Projects | State-Wide Measure? |
|---|---|---|---|
| **Follow-up after ED visit or hospitalization** | | | |
| | Follow-up after Emergency Department visit for alcohol and other drug dependence - within 30 days | A1, A2, B1, C1-2, D1, D6-8, E1-2, E7 | |
| | Follow-up after Emergency Department visit for mental illness - within 30 days | A1, A2, B1, C1, D1-8, E2, E5, E7 | |
| | Follow-up after hospitalization for mental illness – within 30 days | A1-2, B1, C1, D1-8, E1-2, E7 | |
| | Follow-up after hospitalization for mental illness – within 7 days | A1-2, B1, C1, D1-8, E1-2, E7 | |
| | Timely transmission of transition record (discharges from an inpatient facility to home/self-care or any other site of care) | A2, B1 | |
| | EHR tracking of IOM social determinants | A2, B1 | |
| **Screening and Assessment** | | | |
| | Percent of total population served who were assessed with appropriate standardized core assessment or screening tool(s) at appropriate intervals. | B1, D5, E4, E7 | x |
| | Screening for clinical depression using standardized tool (whole population as indicated by assessment) | B1, D5, E3, E5, E6, E2 | |
| | Screening for substance use including alcohol / SBIRT (whole population as indicated by assessment) | B1, D5, E3-4, E6, E7 | |
| | Progress toward meeting criteria of B1 project (e.g. adoption of standardized assessment framework, universal screening, care management services, multi-disciplinary care teams, health promotion and self-management, full use of certified EHR, electronic care planning tools with information sharing capability etc.) | B1, E4 | |
| **Integration of Care** | | | |
| | Progress along SAMHSA framework for Levels of Integrated Care | B1, E4 | |
| | Integration of services addressing social determinants via selected community based organizations | A2, B1, C1-4, D2-3, D6, D8, E1-3, E7 | |
| | Global score for selected general HEDIS measures for BH population (e.g., Diabetes Care) | B1, E1, E4, E7 | |
| | Smoking and tobacco cessation counseling visit for tobacco users | B1, E1-2, E4, E7 | |
| | Global score for USPSTF A & B recommendations for BH Population (e.g., cancer screening, aspirin, blood pressure, Hep B&C, intimate partner violence) | B1, E1-4, E7 | |
| | Recommended well care visits for BH Population | A2, B1, E4 | |
| | Smoking and tobacco cessation counseling visit for tobacco users | E1-2, E4 E7 | |
| **ED and Inpatient Utilization** | | | |
| | Potentially preventable ED visits for BH population and total Population | A1-2, C4, B1, D1, D3-4, D5, 6, D8, E1-2, E6, E7 | x |
| | Readmission to hospital for BH population for any cause at 30 days | B1, C1-4, E1, 4, 7 | x |
| | Frequent BH ED visits for BH population | B1, D2, D4, D7, E6, | |

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| | Measure Name | Associated Projects | State-Wide Measure? |
|---|---|---|---|
| | | E7 | |

*c. Stage 4 Alternative Payment Model Milestones*

Pursuant to STC 44, the state must ensure IDNs participate in Alternative Payment Models (APMs) that move Medicaid payment from primarily volume-based to primarily value-based payment over the course of the demonstration period. Table 3 identifies the APM milestones for meeting this demonstration objective.

**Table 3. APM Milestones Menu**

| Alternative Payment Model (APM) Milestones |
|---|
| Engage in periodic meetings with Managed Care Organizations to support planning for transition to APMs |
| Conduct IDN baseline assessment of current use of APMs among partners |
| Participate in development of statewide APM roadmap |
| Develop IDN-specific roadmap for transition towards APMs |

## V. Requirements for IDN Project Plans

Once IDNs have been selected though the process described in the Program Funding and Mechanics Protocol (Attachment D), IDNs will prepare and submit Project Plans. Generally, the Project Plan will provide a blueprint of the work that an IDN intends to undertake, explain how its work responds to community-specific needs and furthers the objectives of the demonstration, and provide details on its composition and governance structure. In order to be eligible to receive IDN incentive payments, an IDN must have an approved IDN Project Plan.

The state will develop and post a draft IDN Project Plan Template for public comment by [6/1/16], and issue a final version by [8/1/16]. IDNs may use their capacity building and project design funds to prepare their Project Plans. As they develop their Project Plans, they must solicit and incorporate community input to ensure they reflect the specific needs of the regions they are serving. After the Project Plans are submitted to the state, they will be reviewed by an independent assessor, as described in the Attachment D, and may be subject to additional review by CMS.

Each IDN Project Plan must include the following:

1. *IDN Mental Health and Substance Use (MHSU) Needs Assessment:* Each IDN must conduct and report on a needs assessment that includes:



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- A demographic profile of the Medicaid and general population living in the IDN Service Region, including by race, ethnicity, age, income, and education level
- Prevalence rates of MHSU disorders among both the general and the Medicaid population including rates of serious mental illness, substance use (alcohol, tobacco, opioids), and, to the extent possible, undiagnosed conditions.
- An assessment of the gaps in care for the target population and sub populations, (e.g., age groups, opiate users, those with co-occurring (MH/SU) disorders including the developmentally disabled)
- Identification of the current community mental health and substance use resources available for beneficiaries living in an IDN's region across the care continuum, including during recovery
- Identification of current community-based social services organizations and resources that could provide social supports to beneficiaries with behavioral health conditions, including housing, homeless services, legal services, financial help, nutritional assistance, and job training or other employment services

2. *IDN Community Engagement:* In developing its Project Plan, the IDN must demonstrate that it has solicited and incorporated input from individual members of the target population, the broader community and organizations that serve the community, particularly those who serve the Medicaid population and those individuals and populations with mental health and substance use disorders. The Plan must also describe the process the IDN will follow to engage the public and how such engagement will continue throughout the demonstration period.

3. *IDN Composition:* The IDN Project Plan will describe the membership composition of the network. IDNs must include a range of organizations that can participate in required and optional projects. Together, these partners must represent the full spectrum of care and related social services that might be needed by an individual with a mental health or substance use condition. Partners will include CMHCs, primary care providers , substance use providers including recovery services, peer supports, hospitals, home care providers, nursing homes and community based social support service providers. Please refer to the Program Funding and Mechanics Protocol (Attachment D) for additional detail on specific IDN composition requirements.

4. *IDN Governance:* The IDN Project Plan will describe how the IDN shall ensure that the governance processes established in the organizational structure of the IDN provide for full participation of IDN partners in decision-making processes and that the IDN partners, including the administrative lead, are accountable to each other, with clearly defined mechanisms to facilitate decision-making. Each IDN must have

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an organizational structure that enables accountability for the following domains: financial governance and funds allocation, clinical governance, data/information technology, community engagement and workforce capacity.

5. *Financial governance and funds allocation:* The IDN Project Plan must describe how decisions about the distribution of funds will be made, the roles and responsibilities of each partner in funds distribution, and how the IDN will develop an annual fund allocation plan. The plan should also include a proposed budget that includes allocations for central services support, IT, clinical projects, and workforce capacity.

6. *Clinical governance:* The IDN Project Plan must describe how and by whom standard clinical pathways will be developed and a description of strategies for monitoring and managing patient outcomes.

7. *Data/Information Technology:* The IDN Project Plan must provide a data governance plan and a plan to provide needed technology and data sharing capacity among partners and reporting and monitoring processes in alignment with state guidance.

8. *Workforce capacity:* The IDN Project Plan must develop a plan aligned with the Statewide Workforce project goals to increase the numbers and types of providers needed to provide rapid access and integrated treatment in mental health and substance use programs, support services and primary care.

9. *IDN Project Selection:* The IDN Project Plan must describe its rationale for selecting from among the community driven projects. The plan must describe how these projects align with the transformation waiver objectives and how they will transform care delivery within the IDN. IDNs should select projects principally based on the findings from the MHSU Needs Assessment and should consider opportunities for rapid deployment among other factors.

10. *Implementation Timeline and Project Milestones:* The IDN Project Plan must provide a timeline for implementation and completion of each project, in alignment with state parameters. In addition, in accordance with STC 28c, the IDN must identify milestones for each project that will demonstrate progress against meeting project objectives. Additional parameters and guidance related to these milestones will be included in the IDN Project Plan template.

11. *Project Outcomes:* In accordance with STC 28e, the IDN Project Plan must describe outcomes it expects to achieve in each of the four project stages, in alignment with metrics and parameters provided by the state.

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12. *IDN Assets and Barriers to Goal Achievement*: Each IDN Project Plan must describe the assets that =the IDN brings to its delivery transformation program, and the challenges or barriers the IDN expects to confront in improving outcomes and lowering costs of care for the target population. The Plan must also address how the IDN will mitigate the impact of these challenges and what new capabilities will be required to be successful.

## VI. Process for IDN Project Plan Modification

No more than once a year, IDNs may submit proposed modifications to an approved IDN Project Plan for state and CMS review. In certain extremely limited cases it may become evident that the methodology used to identify a performance goal and/or improvement target is no longer appropriate, or that unique circumstances/developments require the IDN to modify its original plan. As part of the Plan modification process, an IDN may seek to "reclaim" incentive funding that is unearned because unique circumstances led to the IDN's failure to achieve certain performance metrics for a given reporting period. As described in Section VII of Attachment D, funding amounts that are unearned will be available to the IDN for two immediate, subsequent reporting periods. Project Plan modifications may not decrease the scope of a project unless they also propose to decrease the project group's valuation, nor can they lower expectations for performance because it has proven more difficult than expected to meet a milestone.

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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.

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[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

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[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.

Examples of Potential Projects:

- 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.

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[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

15800 Bluemound Road
Suite 100
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3680

milliman.com

John D. Meerschaert, FSA, MAAA
Principal and Consulting Actuary

john.meerschaert@milliman.com

November 23, 2015

Mr. Jeffrey A. Meyers
Director, Intergovernmental Affairs
NH Department of Health and Human Services
Brown Building
129 Pleasant Street
Concord, NH 03301

**Re: Revised 1115 Budget Neutrality Projections – Building Capacity for Transformation**

Dear Jeff:

This letter provides the New Hampshire Department of Health and Human Services (DHHS) with budget neutrality projections for New Hampshire's *Building Capacity for Transformation* Section 1115 Demonstration Waiver. These projections update the initial budget neutrality projections dated April 15, 2015 to reflect comments from the Centers for Medicare and Medicaid Services (CMS). This letter includes documentation of the budget neutrality methodology and provides CMS template forms and related worksheets. This information is appropriate for including in the waiver application to CMS.

**OVERVIEW OF METHODOLOGY**

New Hampshire will maintain budget neutrality over the five-year lifecycle of the *Building Capacity for Transformation* Section 1115 Demonstration Waiver, with total spending under the waiver not exceeding what the federal government would have spent without the waiver. New Hampshire's budget neutrality methodology projects "without-waiver" expenditures to be $6.150 billion and "with-waiver" expenditures to be $6.133 billion over the five-year demonstration period (CY 2016 – CY 2020).

New Hampshire expects its delivery system reforms to produce savings compared to the without-waiver projections that more than offsets the $30 million of annual funding for new Integrated Delivery Network (IDN) Transformation Fund. A significant portion of the initial year of the demonstration period will be spent organizing the IDNs, identifying and approving initiatives, and implementing the approved initiatives, therefore New Hampshire does not expect to see cost savings during the first demonstration year. Modest savings is expected to start in demonstration year 2, with more significant savings expected in demonstration years 3 - 5. The largest impact will be attained in the population that currently is diagnosed with behavioral health and substance use disorder (SUD) conditions, but New Hampshire also expects to reduce costs in the undiagnosed population by increasing the rate of diagnosis and treatment. Savings assumptions are supported through literature documenting cost savings attributable to integrating the management of medical and behavioral health services.

Note that Medicaid expansion populations covered under the New Hampshire Health Protection Program (NHHPP) are excluded from the budget neutrality projections for the *Building Capacity for Transformation* Section 1115 Demonstration Waiver, with the exception of the medically frail population that are excluded from participation in New Hampshire's approved Premium Assistance Program.

The rest of this document includes the information requested in the Budget Neutrality Form available at www.medicaid.gov regarding historical expenditure data and projected expenditures. Attachment A includes the budget neutrality projections using the CMS template, which is also attached in Excel format.

## HISTORICAL DATA

Historical base data was derived from New Hampshire's MMIS claims and eligibility data for calendar years 2009 – 2013. The historical period enrollment and expenditures reflect the following information:

- Include all Medicaid beneficiaries (i.e., Medicaid-only, full dual eligibles, and partial dual eligibles). The historical data is divided into two groups of beneficiaries:

    1. **Behavioral Health Population:** Beneficiaries who have behavioral health and / or SUD diagnoses, use behavioral health services, or are eligible for enhanced behavioral health services through the Bureau of Behavioral Health (BBH). The definition is meant to be very inclusive and includes beneficiaries with mild, as well as severe, behavioral health conditions. An individual is placed in the Behavioral Health population on an annual basis if their claims data includes one or more diagnosis, service, or BBH eligibility marker.

    2. **All Other Population:** The All Other population includes all other Medicaid beneficiaries who are not placed into the Behavioral Health population.

- Include all covered Medicaid acute care services and services provided through New Hampshire's home and community based service (HCBS) waiver, including the Choices for Independence, Developmentally Disabled, In Home Supports, and Acquired Brain Disorder waivers. The claims are compiled on an incurred basis (not on a paid basis). We added a 1% allowance to the CY 2013 claims to allow for incurred but not paid (IBNP) claims that will be paid after the data cutoff period.

- Exclude nursing facility services.

- Exclude New Hampshire's Healthy Kids Silver program (CHIP) from January 1, 2009 – June 30, 2012. CHIP members transitioned to Medicaid and are included in the historical base data as of July 1, 2012.

- Exclude administrative expenditures and collections.

- Exclude all other non-MMIS payments, such as DSH, GME, Medicaid Quality Incentive Payments (MQIP), Proportionate Share Payments (ProShare), gross adjustments, reconciliations, and other settlement payments. These payments will also be excluded under 1115 budget neutrality reporting.

We excluded December 2013 from the historical data due to the implementation of the MCM program on December 1, 2013. Attachment A annualizes CY 2013 using (12 / 11) * January – November 2013 data.

## KNOWN ISSUES WITH HISTORICAL DATA

DHHS provided us with three different eligibility and claims data formats to cover dates of service within the CY 2009 – CY 2013 historical period. As a result, there may be some inconsistencies in how eligibility categories were defined in each data set. Also, it appears that a subset of partial dual eligibles (SLMB and QDWI) beneficiaries were excluded from the data starting in July 2012. We do not believe this data exclusion materially impacts the budget neutrality targets.

Coding of behavioral health and SUD diagnoses appears to have increased in the new MMIS data as of July 2012, increasing the Behavioral Health population member months (and decreasing the All Other population member months) compared to prior years. We believe the CY 2013 data is the most accurate representation of the split between the Behavioral Health and All Other populations.

**TREND ANALYSIS AND PROJECTIONS**

As shown in Attachments A and B, New Hampshire's historical data trends show an average annual trend over the five year (CY 2009 – CY 2013) period of 0.4% for the Behavioral Health population and 0.3% for the All Other population. We do not believe New Hampshire's historical trend rate is a reasonable estimate of future trend for the New Hampshire Medicaid program because CY 2009 – CY 2013 was a historically low period of medical cost trend. We expect future per capita trends to be significantly higher than the historical trends and have accordingly used higher trends to calculate New Hampshire's MCM program capitation rates. As another point of comparison, we evaluated national Medicaid trend patterns using the 2014 Actuarial Report on the Financial Outlook for Medicaid published by the CMS Office of the Actuary, which also predicts a significant increase in per capita trends from CY 2013 through CY 2020.

Based on information in Table 16 of the 2014 Actuarial Report on the Financial Outlook for Medicaid, national Medicaid benefit expenditures per enrollee trend rates were -1.4% in 2010, 3.0% in 2011, -2.4% in 2012 and 2.7% in 2013, for an average per enrollee trend of 0.4% during the five year historical period. New Hampshire's historical trend of 0.3% - 0.4% is very consistent with the national trend reported by the CMS Office of the Actuary, and is significantly below future trend projections. States, including New Hampshire, made efforts to constrain spending in the historical period, first due to the economic downturn in 2008 and 2009, and then in response to the 2011 phase out of the temporary enhanced FMAP funding included in the American Recovery and Reinvestment Act (ARRA) of 2009. CY 2009 – CY 2013 was a historically low trend period, not only in New Hampshire, but across the Medicaid program in general.

The budget neutrality projections for New Hampshire's *Building Capacity for Transformation* Section 1115 Demonstration Waiver use trends that are consistent with national per enrollee trend projections in the 2014 Actuarial Report on the Financial Outlook for Medicaid published by the CMS Office of the Actuary. To establish our trend estimates, we used information included in Tables 15 and 16 of the CMS report, as shown in Table 1. We excluded the newly eligible adult population in our trend calculation because most of New Hampshire's newly eligible adults are excluded from New Hampshire's *Building Capacity for Transformation* Section 1115 Demonstration Waiver.

**Table 1**
**Calculation of Projected Trend Factors for Budget Neutrality Projections**
**Based on Tables 15 and 16 of 2014 Actuarial Report on the Financial Outlook for Medicaid Published by the CMS Office of the Actuary[3]**

| | Aged Population | | Disabled Population | |
|---|---|---|---|---|
| Fiscal Year | Enrollees[1] | Cost per Enrollee[2] | Enrollees[1] | Cost per Enrollee[2] |
| 2013 | 5.3 | $15,483 | 10.1 | $17,352 |
| 2015 | 5.6 | $15,999 | 10.2 | $18,285 |
| 2020 | 6.5 | $19,946 | 10.6 | $22,573 |

| | Child Population | | Adult Population | | Total Population | |
|---|---|---|---|---|---|---|
| Fiscal Year | Enrollees[1] | Cost per Enrollee[2] | Enrollees[1] | Cost per Enrollee[2] | Enrollees[1] | Cost per Enrollee[2] |
| 2013 | 27.9 | $2,807 | 14.7 | $4,391 | 58.0 | $6,900 |
| 2015 | 29.6 | $2,926 | 15.0 | $4,817 | 60.4 | $7,201 |
| 2020 | 31.3 | $3,685 | 15.8 | $6,152 | 64.2 | $9,057 |

Average Annual Cost per Enrollee Trend 2013 – 2015 = ($7,201 / $6,900) ^ 0.5 = **2.2%**

Average Annual Cost per Enrollee Trend 2015 – 2020 = ($9,057 / $7,201) ^ 0.2 = **4.7%**

[1] *From Table 15 (in millions of person-year equivalents)*
[2] *From Table 16 (in dollars per person-year equivalent enrollee)*
[3] *Retrieved from http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2014.pdf*

Medicaid provider reimbursement rates in New Hampshire have historically been low compared to other payers, and have remained relatively flat during the five year historical period. Low provider reimbursement rates have contributed to the low historical trend rate. CMS has noted New Hampshire's low trend rate in other situations, requiring DHHS to report access to care measures to CMS on a quarterly basis.

As DHHS enhances Medicaid provider reimbursement in the future through the New Hampshire Health Protection Program and increases to DSH funding, trend rates are expected to increase to reflect expanded access to care and higher provider payments. Therefore, we expect future trends will be consistent with the CMS Office of the Actuary's 4.7% estimate.

**BRIDGE PERIOD TO BASE YEAR**

*Building Capacity for Transformation* will begin on January 1, 2016. There are 24 months between the end last historical year (CY 2013) and the end of the Base Year (CY 2015) prior to the first demonstration year (CY 2016). We used the following trend rates to establish estimates for the Base Year in the template worksheet (CY 2015):

- Annual enrollment trend = 4.0%

  New Hampshire experienced significant enrollment trend in early 2014. We set the bridge period enrollment trend rate to be consistent with the actual enrollment trend rate from CY 2013 to CY 2015 of 4.0%.

- PMPM cost trend = 2.2%

  PMPM expenditures for the last historical year (CY 2013) were trended to the base year (CY 2015) using the 2.2% annual trend rate calculated in the "Trend Analysis and Projections" section of this letter.

We also added a new population to the base year enrollment and costs. The NHHPP population that self-identifies as medically frail is included in the *Building Capacity for Transformation* Section 1115 Demonstration Waiver (and is excluded from the *Premium Assistance Program* Section 1115 Demonstration Waiver). This population began enrollment on August 15, 2014. We used the emerging MCO experience from September 2014 – August 2015 that forms the basis for the January 2016 – June 2016 capitation rates for this population to estimate the Base year (CY 2015) enrollment and cost of this population for this budget neutrality projection.

**WITHOUT-WAIVER PROJECTIONS**

We used the following trend rates to trend the Base Year estimates to the demonstration period:

- Annual enrollment trend = 1.0%

  New Hampshire expects the growth in its current Medicaid population to slow from recent years. We assumed a 1.0% annual growth rate throughout the demonstration period.

- PMPM cost trend = 4.7%

  The Base Year PMPM expenditures were trended to the demonstration period using the 4.8% annual trend rate calculated in the "Trend Analysis and Projections" section of this letter.

## BUDGET NEUTRALITY METHODOLOGY

New Hampshire expects to establish a "Per Capita Method" budget neutrality methodology where it will be at risk for the PMPM Cost of individuals under the Demonstration. Under a per capita method, New Hampshire will not be at risk for the number of member months of participation in the Demonstration.

## WITH-WAIVER PROJECTIONS

The with-waiver projections use the same enrollment and PMPM trend as the without-waiver projections.

New Hampshire expects its delivery system reforms to produce savings compared to the without-waiver projections. Since specific project criteria and projects will be subject to stakeholder input post-approval of the waiver, the precise delivery system changes that will be implemented in New Hampshire cannot be identified now. Instead, we have reviewed available literature in order to develop reasonable high level estimates of the impact of expanding behavioral health service capacity and integrating the management of medical and behavioral health services on the total acute care costs of individuals with diagnosed behavioral health and SUD conditions.

The following information is an excerpt from an April 2014 report authored by Milliman consultants Stephen P. Melek, Douglas T. Norris, and Jordan Paulus that was developed for the American Psychiatric Association titled "Economic Impact of Integrated Medical-Behavioral Healthcare, Implications for Psychiatry". In part, the report summarizes available literature on cost-effectiveness research studies for integrated medical-behavioral healthcare programs. This research is relevant given that the IDNs will be designed to build the capacity to deliver integrated medical-behavioral health services in New Hampshire.

> *"A variety of approaches to integrated medical-behavioral healthcare have been the focus of cost-effectiveness research over the past three decades, with most studies finding that integrated care can lead to reductions in total healthcare costs. Typical cost savings estimates range from 5% to 10% of total healthcare costs over a two to four year period for patients receiving collaborative care, although the most robust evidence is in the care of depression in older adults.*
>
> *One study focused on a collaborative depression care management program directed toward low-income, predominantly Hispanic diabetics. The program, called the Multifaceted Diabetes and Depression Program (MDDP), was administered through a randomized clinical trial, and was compared with enhanced usual care (EUC). Although not statistically significant, medical cost savings of approximately $39 per member per month (PMPM) were observed during the eighteen months following the implementation of the MDDP program. The study identified the 95% confidence interval for the savings of the program as savings of $110 PMPM at the upper limit to an additional cost (or negative savings) of $32 PMPM at the lower limit.*
>
> *The Pathways study focused on the outcomes of a program utilizing specialized nurses to deliver a twelve-month depression treatment program for patients with diabetes. This program was administered through a randomized controlled trial that compared the systematic depression treatment program with care as usual. Total outpatient costs were approximately equal during the 12-month intervention period for both the intervention group and the usual care group, but during the 12-month period following the intervention, median outpatient costs for the intervention group were $50 PMPM lower than costs for the usual care group. Over the entire two year period, including the intervention period, total healthcare costs (including inpatient and outpatient health services) were $46 PMPM lower for the intervention group than for the usual care group. This represents savings of about 5% of total healthcare costs for the intervention group over a two year period.*

*The IMPACT study focused on a twelve-month collaborative care management program for elderly patients with depression. The program was administered through a randomized clinical trial that compared a collaborative care intervention using teams of depression care managers, primary care doctors and psychiatrists to the usual care for depression. Total healthcare costs were tracked for a 4-year period following the intervention, and costs for the intervention group were an average of $70 PMPM lower than costs for those receiving usual care. This represents savings of about 10% of total healthcare costs for the intervention group over a four year period. Patients in the collaborative care management program had lower costs in every category that was observed, and the results of a bootstrap analysis indicated that patients in the collaborative care program were 87% more likely to have lower total healthcare costs than those receiving usual care.*

*Missouri established Community Mental Health Center healthcare homes in 2012 for Medicaid eligible persons with serious and persistent mental illnesses, comorbid mental health and substance use disorders, and certain chronic medical conditions comorbid with a mental health or substance use disorder. Their early results showed that independent living increased by 33%, vocational activity increased by 44%, legal involvement decreased by 68%, psychiatric hospitalization decreased by 52%, and overall healthcare costs decreased by 8.1%.*

*A meta-analysis of cost-effectiveness research studies identified 23 studies addressing the economics of collaborative care over the past three decades. In nearly all of these studies, collaborative care programs were found to be at least cost neutral, with most studies indicating actual savings. One study compared the financial outcomes of clinics newly practicing collaborative care to demographically similar clinics practicing usual care. Healthcare costs increased for both groups of clinics following the introduction of collaborative care, but clinics practicing collaborative care saw only 73% of the increase that clinics practicing usual care experienced, and their patients were 54% less likely to use the emergency department, and 49% less likely to use inpatient psychiatric care. Additional studies and innovation projects will be needed to confirm these findings in other populations and non-research settings."*

Undoubtedly, there are Medicaid beneficiaries in the All Other population that have undiagnosed behavioral health or SUD conditions. New Hampshire expects its delivery system reforms to increase the rate of diagnosis and treatment of this undiagnosed population. We applied 25% of the projected Behavioral Health population savings estimates to the All Other population to reflect the cost savings potential for the effective treatment of currently undiagnosed individuals. We applied the average of the Behavioral Health and All Other population factors to the NHHPP Medically Frail population.

Table 2 summarizes our savings assumptions. Since a significant portion of the first year of the waiver demonstration period will be used to work with local providers to identify and select specific initiatives, we do not expect cost savings in the first year of the waiver. We chose relatively conservative (low) savings estimate in other years to model an achievable level of savings. The savings assumptions are consistent with the low end of observed savings in our literature review.

**Table 2
Waiver Cost Savings Estimates
Applied to Total Service Costs**

| Demonstration Year | Behavioral Health Population | All Other Population | NHHPP Medically Frail Population |
|---|---|---|---|
| 1 | 0.00% | 0.00% | 0.00% |
| 2 | 1.00% | 0.25% | 0.63% |
| 3 | 3.00% | 0.75% | 1.88% |
| 4 | 5.00% | 1.25% | 3.13% |
| 5 | 6.00% | 1.50% | 3.75% |

The with-waiver projections also include $30 million of new expenditures per year related to the proposed IDN Transformation Fund. In total, the anticipated delivery system reform savings is expected to offset the IDN Transformation Fund expenditures.

## DISPROPORTIONATE SHARE HOSPITAL EXPENDITURE OFFSET

New Hampshire is not proposing to use a reduction in Disproportionate Share Hospital (DSH) claims to offset Demonstration costs in the calculation of budget neutrality.

## BUDGET NEUTRALITY WORKSHEET

The budget neutrality projections using the CMS template are included as Attachment A of this letter, which is also attached in Excel format. We customized the CMS template to be consistent with New Hampshire's budget neutrality approach.

## ADDITIONAL INFORMATION TO DEMONSTRATE BUDGET NEUTRALITY

We look forward to working with CMS and New Hampshire to discuss and refine the budget neutrality projections.

## CAVEATS AND LIMITATIONS ON USE

This letter is intended for the internal use of the New Hampshire Department of Health and Human Services (DHHS) and it should not be distributed, in whole or in part, to any external party without the prior written permission of Milliman. We do not intend this information to benefit any third party even if we permit the distribution of our work product to such third party. We understand this letter will be part of New Hampshire's application to CMS.

This letter is designed to provide DHHS with budget neutrality projections for the *Building Capacity for Transformation* Section 1115 Demonstration Waiver. This information may not be appropriate, and should not be used, for other purposes.

Actual without-waiver and with-waiver results will vary from estimates due to costs and savings under the demonstration being higher or lower than expected. DHHS should monitor emerging results and take corrective action when necessary.

In preparing this information, we relied on information from DHHS regarding historical expenditures, historical enrollment, projected costs under the demonstration, and the expected return on investment for certain initiatives. We accepted this information without audit but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate.

I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

The terms of Milliman's Consulting Services Agreement with DHHS signed on November 16, 2012 apply to this letter and its use.

❖ ❖ ❖ ❖ ❖

Please call Mathieu Doucet or me at (262) 784-2250 if you have any questions.

Sincerely,

John D. Meerschaert
Principal and Consulting Actuary, FSA, MAAA

Attachments

JDM/vrr

# ATTACHMENT A
# CMS BUDGET NEUTRALITY TEMPLATE

| | A | B | C | D | E | F | G | H | I | J |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | **5 YEARS OF HISTORIC DATA** | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | **SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:** | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | **Behavioral Health Population** | **CY 2009*** | **CY 2010*** | **CY 2011*** | **CY 2012*** | **CY 2013**** | **5-YEARS** | | | |
| 6 | **TOTAL EXPENDITURES** | $ 577,887,513 | $ 658,695,168 | $ 668,686,664 | $ 673,188,957 | $ 718,696,830 | $ 3,297,155,132 | | | |
| 7 | **ELIGIBLE MEMBER MONTHS** | 608,784 | 664,600 | 683,020 | 676,872 | 746,270 | | | | |
| 8 | **PMPM COST** | $ 949.25 | $ 991.12 | $ 979.01 | $ 994.56 | $ 963.05 | | | | |
| 9 | **TREND RATES** | | | | | | **5-YEAR** | | | |
| 10 | | | | **ANNUAL CHANGE** | | | **AVERAGE** | | | |
| 11 | TOTAL EXPENDITURE | | 13.98% | 1.52% | 0.67% | 6.76% | 5.60% | | | |
| 12 | ELIGIBLE MEMBER MONTHS | | 9.17% | 2.77% | -0.90% | 10.25% | 5.22% | | | |
| 13 | PMPM COST | | 4.41% | -1.22% | 1.59% | -3.17% | 0.36% | | | |
| 14 | | | | | | | | | | |
| 15 | **All Other Population** | **CY 2009*** | **CY 2010*** | **CY 2011*** | **CY 2012*** | **CY 2013**** | **5-YEARS** | | | |
| 16 | **TOTAL EXPENDITURES** | $ 162,142,201 | $ 174,410,138 | $ 176,156,959 | $ 177,391,995 | $ 167,226,861 | $ 857,328,154 | | | |
| 17 | **ELIGIBLE MEMBER MONTHS** | 929,995 | 965,219 | 984,096 | 1,006,324 | 946,109 | | | | |
| 18 | **PMPM COST** | $ 174.35 | $ 180.69 | $ 179.00 | $ 176.28 | $ 176.75 | | | | |
| 19 | **TREND RATES** | | | | | | **5-YEAR** | | | |
| 20 | | | | **ANNUAL CHANGE** | | | **AVERAGE** | | | |
| 21 | TOTAL EXPENDITURE | | 7.57% | 1.00% | 0.70% | -5.73% | 0.77% | | | |
| 22 | ELIGIBLE MEMBER MONTHS | | 3.79% | 1.96% | 2.26% | -5.98% | 0.43% | | | |
| 23 | PMPM COST | | 3.64% | -0.94% | -1.52% | 0.27% | 0.34% | | | |
| 24 | | | | | | | | | | |
| 47 | | | | | | | | | | |
| 48 | * Excludes Healthy Kids Silver (CHIP) population from 1/1/2009 - 6/30/2012 (transitioned to Medicaid as of 7/1/2012) | | | | | | | | | |
| 49 | ** Annualized using 12/11 * January - November 2013 data. December 2013 is excluded from the historical base due to the implementation of the Medicaid Care Management program on 12/1/2013. | | | | | | | | | |

| | A | B | C | D | E | F | G | H | I | J | K |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS | | | | | | | | | | |
| 2 | | | | | | | | | | | |
| 3 | | | | | | | | | | | |
| 4 | | | | | | DEMONSTRATION YEARS (DY) | | | | | |
| 5 | | TREND | MONTHS | BASE YEAR | TREND | DY 01 | DY 02 | DY 03 | DY 04 | DY 05 | TOTAL |
| 6 | GROUP | RATE 1 | OF AGING | DY 00 | RATE 2 | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | WOW |
| 7 | | | | | | | | | | | |
| 8 | **Behavioral Health Population** | | | | | | | | | | |
| 9 | **Pop Type:** | **Medicaid** | | | | | | | | | |
| 10 | Eligible Member Months | 4.0% | 24 | 807,165 | 1.0% | 815,237 | 823,389 | 831,623 | 839,939 | 848,339 | |
| 11 | PMPM Cost | 2.2% | 24 | $ 1,005.89 | 4.7% | $ 1,053.17 | $ 1,102.67 | $ 1,154.50 | $ 1,208.76 | $ 1,265.57 | |
| 12 | Total Expenditure | | | | | $ 858,583,102 | $ 907,926,704 | $ 960,109,003 | $ 1,015,285,207 | $ 1,073,632,189 | $ 4,815,536,204 |
| 13 | | | | | | | | | | | |
| 14 | **All Other Population** | | | | | | | | | | |
| 15 | **Pop Type:** | **Medicaid** | | | | | | | | | |
| 16 | Eligible Member Months | 4.0% | 24 | 1,023,312 | 1.0% | 1,033,545 | 1,043,880 | 1,054,319 | 1,064,862 | 1,075,511 | |
| 17 | PMPM Cost | 2.2% | 24 | $ 184.61 | 4.7% | $ 193.29 | $ 202.37 | $ 211.88 | $ 221.84 | $ 232.27 | |
| 18 | Total Expenditure | | | | | $ 199,773,860 | $ 211,250,031 | $ 223,389,104 | $ 236,229,023 | $ 249,808,890 | $ 1,120,450,908 |
| 19 | | | | | | | | | | | |
| 20 | **NHHPP - Medically Frail Population*** | | | | | | | | | | |
| 21 | **Pop Type:** | **Expansion** | | | | | | | | | |
| 22 | Eligible Member Months | NA | NA | 24,000 | 1.0% | 24,240 | 24,482 | 24,727 | 24,974 | 25,224 | |
| 23 | PMPM Cost | NA | NA | $ 1,500.00 | 4.7% | $ 1,570.50 | $ 1,644.31 | $ 1,721.59 | $ 1,802.50 | $ 1,887.22 | |
| 24 | Total Expenditure | | | | | $ 38,068,920 | $ 40,256,655 | $ 42,570,142 | $ 45,016,529 | $ 47,603,692 | $ 213,515,939 |
| 25 | | | | | | | | | | | |
| 38 | | | | | | | | | | | |
| 39 | * Estimated based on emerging MCO experience from September 2014 - August 2015 | | | | | | | | | | |

Attachment A
New Hampshire Building Capacity for Transformation Section 1115 Demonstration Waiver
Budget Neutrality Template

| | A | B | C | D | E | F | G | H | I |
|---|---|---|---|---|---|---|---|---|---|
| 1 | DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | DEMONSTRATION YEARS (DY) | | | | | |
| 5 | | DY 00 | DEMO TREND | DY 01 | DY 02 | DY 03 | DY 04 | DY 05 | |
| 6 | ELIGIBILITY GROUP | CY 2015 | RATE | CY 2016 | CY 2017 | CY 2018 | CY 2019 | CY 2020 | TOTAL WW |
| 7 | | | | | | | | | |
| 8 | **Behavioral Health Population** | | | | | | | | |
| 9 | **Pop Type:** | **Medicaid** | | | | | | | |
| 10 | Eligible Member Months | 807,165 | 1.0% | 815,237 | 823,389 | 831,623 | 839,939 | 848,339 | |
| 11 | | | | | | | | | |
| 12 | PMPM Cost | $ 1,005.89 | 4.7% | $ 1,053.17 | $ 1,102.67 | $ 1,154.50 | $ 1,208.76 | $ 1,265.57 | |
| 13 | Projected Impact of Delivery System Changes | | | 0.00% | -1.00% | -3.00% | -5.00% | -6.00% | |
| 14 | PMPM Cost After Delivery System Changes | | | $ 1,053.17 | $ 1,091.64 | $ 1,119.87 | $ 1,148.32 | $ 1,189.64 | |
| 15 | | | | | | | | | |
| 16 | Total Expenditure | | | $ 858,583,102 | $ 898,847,437 | $ 931,305,733 | $ 964,520,947 | $ 1,009,214,257 | $ 4,662,471,476 |
| 17 | | | | | | | | | |
| 18 | **All Other Population** | | | | | | | | |
| 19 | **Pop Type:** | **Medicaid** | | | | | | | |
| 20 | Eligible Member Months | 1,023,312 | 1.0% | 1,033,545 | 1,043,880 | 1,054,319 | 1,064,862 | 1,075,511 | |
| 21 | | | | | | | | | |
| 22 | PMPM Cost | $ 184.61 | 4.7% | $ 193.29 | $ 202.37 | $ 211.88 | $ 221.84 | $ 232.27 | |
| 23 | Projected Impact of Delivery System Changes | | | 0.00% | -0.25% | -0.75% | -1.25% | -1.50% | |
| 24 | PMPM Cost After Delivery System Changes | | | $ 193.29 | $ 201.86 | $ 210.29 | $ 219.07 | $ 228.79 | |
| 25 | | | | | | | | | |
| 26 | Total Expenditure | | | $ 199,773,860 | $ 210,721,906 | $ 221,713,686 | $ 233,276,160 | $ 246,061,757 | $ 1,111,547,369 |
| 27 | | | | | | | | | |
| 28 | **NHHPP - Medically Frail Population** | | | | | | | | |
| 29 | **Pop Type:** | **Expansion** | | | | | | | |
| 30 | Eligible Member Months | 24,000 | 1.0% | 24,240 | 24,482 | 24,727 | 24,974 | 25,224 | |
| 31 | | | | | | | | | |
| 32 | PMPM Cost | $ 1,500.00 | 4.7% | $ 1,570.50 | $ 1,644.31 | $ 1,721.59 | $ 1,802.50 | $ 1,887.22 | |
| 33 | Projected Impact of Delivery System Changes | | | 0.00% | -0.63% | -1.88% | -3.13% | -3.75% | |
| 34 | PMPM Cost After Delivery System Changes | | | $ 1,570.50 | $ 1,634.03 | $ 1,689.31 | $ 1,746.17 | $ 1,816.45 | |
| 35 | | | | | | | | | |
| 36 | Total Expenditure | | | $ 38,068,920 | $ 40,005,051 | $ 41,771,951 | $ 43,609,763 | $ 45,818,554 | $ 209,274,239 |
| 37 | | | | | | | | | |
| 38 | **IDN Transformation Fund Expenditures** | | | | | | | | |
| 39 | **Pop Type:** | **All** | | | | | | | |
| 40 | Total Expenditure | | | $ 30,000,000 | $ 30,000,000 | $ 30,000,000 | $ 30,000,000 | $ 30,000,000 | $ 150,000,000 |

Attachment A
New Hampshire Building Capacity for Transformation Section 1115 Demonstration Waiver
Budget Neutrality Template

| | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| 1 | **Budget Neutrality Summary** | | | | | | |
| 2 | | | | | | | |
| 3 | **Without-Waiver Total Expenditures** | | | | | | |
| 4 | | **DEMONSTRATION YEARS (DY)** | | | | | **TOTAL** |
| 5 | | **DY 01** | **DY 02** | **DY 03** | **DY 04** | **DY 05** | |
| 6 | | **CY 2016** | **CY 2017** | **CY 2018** | **CY 2019** | **CY 2020** | |
| 7 | **Medicaid Populations** | | | | | | |
| 8 | **Behavioral Health Population** | $ 858,583,102 | $ 907,926,704 | $ 960,109,003 | $ 1,015,285,207 | $ 1,073,632,189 | $ 4,815,536,204 |
| 9 | **All Other Population** | $ 199,773,860 | $ 211,250,031 | $ 223,389,104 | $ 236,229,023 | $ 249,808,890 | $ 1,120,450,908 |
| 10 | **NHHPP - Medically Frail Population** | $ 38,068,920 | $ 40,256,655 | $ 42,570,142 | $ 45,016,529 | $ 47,603,692 | $ 213,515,939 |
| 11 | | | | | | | |
| 18 | | | | | | | |
| 19 | **TOTAL** | $ 1,096,425,882 | $ 1,159,433,390 | $ 1,226,068,249 | $ 1,296,530,759 | $ 1,371,044,772 | $ 6,149,503,051 |
| 20 | | | | | | | |
| 21 | **With-Waiver Total Expenditures** | | | | | | |
| 22 | | **DEMONSTRATION YEARS (DY)** | | | | | **TOTAL** |
| 23 | | **DY 01** | **DY 02** | **DY 03** | **DY 04** | **DY 05** | |
| 24 | | **CY 2016** | **CY 2017** | **CY 2018** | **CY 2019** | **CY 2020** | |
| 25 | **Medicaid Populations** | | | | | | |
| 26 | **Behavioral Health Population** | $ 858,583,102 | $ 898,847,437 | $ 931,305,733 | $ 964,520,947 | $ 1,009,214,257 | $ 4,662,471,476 |
| 27 | **All Other Population** | $ 199,773,860 | $ 210,721,906 | $ 221,713,686 | $ 233,276,160 | $ 246,061,757 | $ 1,111,547,369 |
| 28 | **NHHPP - Medically Frail Population** | $ 38,068,920 | $ 40,005,051 | $ 41,771,951 | $ 43,609,763 | $ 45,818,554 | $ 209,274,239 |
| 29 | **IDN Transformation Fund Expenditures** | $ 30,000,000 | $ 30,000,000 | $ 30,000,000 | $ 30,000,000 | $ 30,000,000 | $ 150,000,000 |
| 30 | | | | | | | |
| 40 | | | | | | | |
| 41 | **TOTAL** | $ 1,126,425,882 | $ 1,179,574,394 | $ 1,224,791,370 | $ 1,271,406,869 | $ 1,331,094,568 | $ 6,133,293,084 |
| 42 | | | | | | | |
| 43 | **VARIANCE** | $ (30,000,000) | $ (20,141,004) | $ 1,276,879 | $ 25,123,890 | $ 39,950,203 | $ 16,209,968 |

# ATTACHMENT B
# DEVELOPMENT OF HISTORICAL BASE DATA

**Attachment B-1**
**New Hampshire Department of Health and Human Services**
**Building Capacity for Transformation 1115 Waiver**
**Behavioral Health Population**
**FFS Base Data - Excluding Nursing Facility Services**

| | Calendar Year 2009 | | | Calendar Year 2010 | | | Calendar Year 2011 | | |
|---|---|---|---|---|---|---|---|---|---|
| **Rate Group** | **Member Months** | **Total Paid** | **PMPM** | **Member Months** | **Total Paid** | **PMPM** | **Member Months** | **Total Paid** | **PMPM** |
| **Full Duals** | | | | | | | | | |
| Low Income Children and Adults | 2,792 | $1,776,300 | $636.21 | 3,393 | $1,643,720 | $484.44 | 3,113 | $1,546,647 | $496.83 |
| Foster Care / Adoption | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 1 | 1,804 | 1,803.92 |
| Breast and Cervical Cancer Program | 18 | 27,932 | 1,551.81 | 15 | 50,427 | 3,361.82 | 39 | 19,242 | 493.38 |
| Severely Disabled Children | 24 | 77,313 | 3,221.39 | 5 | 17,398 | 3,479.60 | 0 | 0 | 0.00 |
| Disabled Adults | 41,889 | 79,703,258 | 1,902.73 | 45,048 | 89,995,222 | 1,997.76 | 44,751 | 88,659,587 | 1,981.18 |
| Old Age Assistance Program | 47,090 | 22,657,901 | 481.16 | 45,757 | 24,846,664 | 543.01 | 45,119 | 23,246,585 | 515.23 |
| Aliens | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 |
| Unknown | 1 | 112 | 112.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 |
| Subtotal | 91,814 | $104,242,817 | $1,135.37 | 94,218 | $116,553,432 | $1,237.06 | 93,023 | $113,473,865 | $1,219.85 |
| **Non Duals** | | | | | | | | | |
| Low Income Children and Adults | 290,388 | $153,082,527 | $527.17 | 322,751 | $168,683,972 | $522.64 | 327,969 | $173,251,108 | $528.25 |
| Foster Care / Adoption | 16,569 | 17,779,031 | 1,073.03 | 16,703 | 29,501,385 | 1,766.23 | 15,868 | 25,925,651 | 1,633.83 |
| Breast and Cervical Cancer Program | 915 | 1,323,514 | 1,446.46 | 1,064 | 1,660,449 | 1,560.57 | 1,042 | 1,800,167 | 1,727.61 |
| Severely Disabled Children | 14,781 | 34,276,929 | 2,318.99 | 15,402 | 39,677,672 | 2,576.14 | 15,574 | 39,377,856 | 2,528.44 |
| Disabled Adults | 86,871 | 154,967,134 | 1,783.88 | 94,649 | 175,684,007 | 1,856.16 | 99,764 | 181,553,688 | 1,819.83 |
| Old Age Assistance Program | 3,233 | 5,344,084 | 1,652.98 | 3,703 | 6,846,329 | 1,848.86 | 3,895 | 6,865,302 | 1,762.59 |
| Aliens | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 |
| Unknown | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 |
| Subtotal | 412,757 | $366,773,218 | $888.59 | 454,272 | $422,053,815 | $929.08 | 464,112 | $428,773,772 | $923.86 |
| **Partial Dual Eligibles** | | | | | | | | | |
| Partial Duals | 26,677 | $3,464,306 | $129.86 | 32,472 | $4,554,829 | $140.27 | 37,048 | $4,946,878 | $133.53 |
| Partial Duals - Plus | 77,536 | 103,407,172 | 1,333.67 | 83,638 | 115,533,092 | 1,381.35 | 88,837 | 121,492,150 | 1,367.59 |
| Subtotal | 104,213 | $106,871,479 | $1,025.51 | 116,110 | $120,087,921 | $1,034.26 | 125,885 | $126,439,028 | $1,004.40 |
| **Grand Total** | **608,784** | **$577,887,513** | **$949.25** | **664,600** | **$658,695,168** | **$991.12** | **683,020** | **$668,686,664** | **$979.01** |
| | | | | | **2009 to 2010** | **4.4%** | | **2010 to 2011** | **-1.2%** |
| **Excluded from Base for 1115 Waiver** | | | | | | | | | |
| Unknown | 124 | $71,476 | $576.42 | 126 | $114,355 | $907.58 | 146 | $61,601 | $421.92 |
| CHIP (Healthy Kids Silver Standalone) | 3,960 | 4,104 | 1.04 | 4,250 | 2,932 | 0.69 | 4,592 | 6,162 | 1.34 |
| Subtotal | 4,084 | $75,580 | $18.51 | 4,376 | $117,287 | $26.80 | 4,738 | $67,763 | $14.30 |

**Attachment B-1**
**New Hampshire Department of Health and Human Services**
**Building Capacity for Transformation 1115 Waiver**
**Behavioral Health Population**
**FFS Base Data - Excluding Nursing Facility Services**

| | Calendar Year 2012 | | | January - November 2013 | | | |
|---|---|---|---|---|---|---|---|
| Rate Group | Member Months | Total Paid | PMPM | Member Months | Total Paid | Completed Paid | PMPM |
| **Full Duals** | | | | | | | |
| Low Income Children and Adults | 2,848 | $1,395,257 | $489.86 | 2,438 | $956,628 | $966,194 | $396.34 |
| Foster Care / Adoption | 0 | 0 | 0.00 | 11 | 84,167 | 85,008 | 7,728.04 |
| Breast and Cervical Cancer Program | 1 | 0 | 0.00 | 14 | 32,012 | 32,332 | 2,270.19 |
| Severely Disabled Children | 618 | 1,514,000 | 2,449.38 | 1,323 | 3,199,215 | 3,231,207 | 2,441.80 |
| Disabled Adults | 45,529 | 90,698,439 | 1,992.08 | 43,922 | 90,399,574 | 91,303,569 | 2,078.76 |
| Old Age Assistance Program | 44,754 | 25,271,827 | 564.69 | 42,173 | 26,430,875 | 26,695,184 | 633.00 |
| Aliens | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Unknown | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Subtotal | 93,750 | $118,879,524 | $1,268.05 | 89,881 | $121,102,470 | $122,313,495 | $1,360.84 |
| **Non Duals** | | | | | | | |
| Low Income Children and Adults | 330,839 | $181,252,927 | $547.86 | 357,296 | $190,236,745 | $192,139,112 | $537.76 |
| Foster Care / Adoption | 15,242 | 24,799,493 | 1,627.08 | 14,992 | 24,026,342 | 24,266,606 | 1,618.61 |
| Breast and Cervical Cancer Program | 1,235 | 2,543,408 | 2,059.41 | 1,061 | 1,910,708 | 1,929,815 | 1,819.44 |
| Severely Disabled Children | 17,639 | 42,692,890 | 2,420.43 | 18,451 | 46,411,214 | 46,875,326 | 2,540.49 |
| Disabled Adults | 98,260 | 178,731,495 | 1,818.96 | 94,534 | 162,962,548 | 164,592,174 | 1,741.09 |
| Old Age Assistance Program | 4,325 | 7,339,431 | 1,696.85 | 5,069 | 6,948,021 | 7,017,501 | 1,384.42 |
| Aliens | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Unknown | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Subtotal | 467,540 | $437,359,644 | $935.45 | 491,403 | $432,495,578 | $436,820,534 | $888.93 |
| **Partial Dual Eligibles** | | | | | | | |
| Partial Duals | 36,073 | $4,654,954 | $129.04 | 35,145 | $5,116,484 | $5,167,649 | $147.04 |
| Partial Duals - Plus | 79,510 | 112,294,835 | 1,412.34 | 67,652 | 93,568,070 | 94,503,750 | 1,396.91 |
| Subtotal | 115,582 | $116,949,789 | $1,011.83 | 102,797 | $98,684,553 | $99,671,399 | $969.60 |
| **Grand Total** | **676,872** | **$673,188,957** | **$994.56** | **684,081** | **$652,282,601** | **$658,805,427** | **$963.05** |
| | | **2011 to 2012** | **1.6%** | | | **2012 to 2013** | **-3.2%** |
| | | | | | **Average Annual Trend 2009 - 2013** | | **0.4%** |
| **Excluded from Base for 1115 Waiver** | | | | | | | |
| Unknown | 78 | $58,461 | $749.50 | 0 | $0 | | $0.00 |
| CHIP (Healthy Kids Silver Standalone) | 7,438 | 10,730 | 1.44 | 0 | 0 | | 0.00 |
| Subtotal | 7,516 | $69,191 | $9.21 | 0 | $0 | | $0.00 |

**Attachment B-2**
**New Hampshire Department of Health and Human Services**
**Building Capacity for Transformation 1115 Waiver**
**All Other Population**
**FFS Base Data - Excluding Nursing Facility Services**

| | Calendar Year 2009 | | | Calendar Year 2010 | | | Calendar Year 2011 | | |
|---|---|---|---|---|---|---|---|---|---|
| **Rate Group** | **Member Months** | **Total Paid** | **PMPM** | **Member Months** | **Total Paid** | **PMPM** | **Member Months** | **Total Paid** | **PMPM** |
| **Full Duals** | | | | | | | | | |
| Low Income Children and Adults | 1,058 | $337,628 | $319.12 | 1,059 | $592,204 | $559.21 | 1,099 | $465,285 | $423.37 |
| Foster Care / Adoption | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 |
| Breast and Cervical Cancer Program | 5 | 887 | 177.31 | 15 | 9,002 | 600.14 | 2 | 76 | 38.09 |
| Severely Disabled Children | 0 | 0 | 0.00 | 3 | 15,681 | 5,226.93 | 3 | 2,091 | 696.99 |
| Disabled Adults | 8,127 | 7,274,010 | 895.04 | 8,939 | 9,747,719 | 1,090.47 | 8,756 | 10,325,979 | 1,179.30 |
| Old Age Assistance Program | 19,314 | 6,576,552 | 340.51 | 19,878 | 8,092,429 | 407.10 | 18,657 | 8,005,074 | 429.07 |
| Aliens | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 |
| Unknown | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 |
| Subtotal | 28,504 | $14,189,076 | $497.79 | 29,894 | $18,457,034 | $617.42 | 28,517 | $18,798,504 | $659.20 |
| **Non Duals** | | | | | | | | | |
| Low Income Children and Adults | 765,819 | $99,405,085 | $129.80 | 792,676 | $101,725,554 | $128.33 | 799,777 | $105,661,102 | $132.11 |
| Foster Care / Adoption | 9,869 | 3,225,129 | 326.79 | 8,820 | 3,413,478 | 387.02 | 8,730 | 3,038,383 | 348.04 |
| Breast and Cervical Cancer Program | 1,354 | 710,254 | 524.56 | 1,420 | 1,119,830 | 788.61 | 1,674 | 1,322,308 | 789.91 |
| Severely Disabled Children | 5,764 | 7,811,818 | 1,355.28 | 5,476 | 8,374,257 | 1,529.27 | 5,318 | 7,377,032 | 1,387.18 |
| Disabled Adults | 27,996 | 21,639,258 | 772.94 | 29,059 | 24,883,188 | 856.30 | 30,633 | 22,692,027 | 740.77 |
| Old Age Assistance Program | 6,168 | 3,321,235 | 538.46 | 6,126 | 3,679,427 | 600.62 | 6,598 | 4,438,487 | 672.70 |
| Aliens | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 |
| Unknown | 0 | 0 | 0.00 | 1 | 0 | 0.00 | 0 | 0 | 0.00 |
| Subtotal | 816,970 | $136,112,778 | $166.61 | 843,578 | $143,195,735 | $169.75 | 852,730 | $144,529,338 | $169.49 |
| **Partial Dual Eligibles** | | | | | | | | | |
| Partial Duals | 61,277 | $1,227,895 | $20.04 | 68,763 | $1,206,673 | $17.55 | 78,862 | $1,564,645 | $19.84 |
| Partial Duals - Plus | 23,244 | 10,612,452 | 456.57 | 22,984 | 11,550,696 | 502.55 | 23,987 | 11,264,472 | 469.61 |
| Subtotal | 84,521 | $11,840,346 | $140.09 | 91,747 | $12,757,369 | $139.05 | 102,849 | $12,829,116 | $124.74 |
| **Grand Total** | **929,995** | **$162,142,201** | **$174.35** | **965,219** | **$174,410,138** | **$180.69** | **984,096** | **$176,156,959** | **$179.00** |
| | | | | | **2009 to 2010** | **3.6%** | | **2010 to 2011** | **-0.9%** |
| **Excluded from Base for 1115 Waiver** | | | | | | | | | |
| Unknown | 58 | $10,350 | $178.45 | 36 | $8,394 | $233.17 | 90 | $8,205 | $91.16 |
| CHIP (Healthy Kids Silver Standalone) | 89,981 | 27,461 | 0.31 | 95,263 | 27,736 | 0.29 | 99,674 | 47,859 | 0.48 |
| Subtotal | 90,039 | $37,811 | $0.42 | 95,299 | $36,129 | $0.38 | 99,764 | $56,063 | $0.56 |

**Attachment B-2**
**New Hampshire Department of Health and Human Services**
**Building Capacity for Transformation 1115 Waiver**
**All Other Population**
**FFS Base Data - Excluding Nursing Facility Services**

| | Calendar Year 2012 | | | January - November 2013 | | | |
|---|---|---|---|---|---|---|---|
| Rate Group | Member Months | Total Paid | PMPM | Member Months | Total Paid | Completed Paid | PMPM |
| **Full Duals** | | | | | | | |
| Low Income Children and Adults | 1,149 | $503,959 | $438.76 | 661 | $141,227 | $142,639 | $215.86 |
| Foster Care / Adoption | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Breast and Cervical Cancer Program | 9 | 1,360 | 151.06 | 26 | 10,068 | 10,169 | 396.43 |
| Severely Disabled Children | 202 | 110,605 | 548.55 | 407 | 383,057 | 386,887 | 951.50 |
| Disabled Adults | 10,297 | 11,946,739 | 1,160.20 | 9,181 | 10,163,623 | 10,265,259 | 1,118.10 |
| Old Age Assistance Program | 20,586 | 9,849,271 | 478.44 | 17,082 | 8,750,067 | 8,837,568 | 517.38 |
| Aliens | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Unknown | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Subtotal | 32,243 | $22,411,934 | $695.10 | 27,356 | $19,448,042 | $19,642,522 | $718.04 |
| **Non Duals** | | | | | | | |
| Low Income Children and Adults | 833,285 | $104,983,013 | $125.99 | 741,698 | $90,067,691 | $90,968,368 | $122.65 |
| Foster Care / Adoption | 8,966 | 2,746,998 | 306.37 | 6,961 | 1,623,925 | 1,640,164 | 235.63 |
| Breast and Cervical Cancer Program | 1,632 | 1,408,170 | 863.05 | 1,411 | 1,359,591 | 1,373,187 | 972.90 |
| Severely Disabled Children | 4,214 | 4,786,225 | 1,135.83 | 1,852 | 2,496,485 | 2,521,450 | 1,361.22 |
| Disabled Adults | 33,361 | 24,250,686 | 726.91 | 27,777 | 22,167,258 | 22,388,931 | 806.04 |
| Old Age Assistance Program | 6,742 | 4,274,349 | 633.95 | 7,003 | 4,278,398 | 4,321,182 | 617.02 |
| Aliens | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Unknown | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Subtotal | 888,200 | $142,449,440 | $160.38 | 786,702 | $121,993,348 | $123,213,282 | $156.62 |
| **Partial Dual Eligibles** | | | | | | | |
| Partial Duals | 60,393 | $1,760,371 | $29.15 | 31,448 | $1,829,683 | $1,847,980 | $58.76 |
| Partial Duals - Plus | 25,488 | 10,770,250 | 422.56 | 21,761 | 8,502,481 | 8,587,506 | 394.63 |
| Subtotal | 85,881 | $12,530,621 | $145.91 | 53,209 | $10,332,164 | $10,435,486 | $196.12 |
| **Grand Total** | **1,006,324** | **$177,391,995** | **$176.28** | **867,267** | **$151,773,554** | **$153,291,290** | **$176.75** |
| | | **2011 to 2012** | **-1.5%** | | | **2012 to 2013** | **0.3%** |
| | | | | | **Average Annual Trend 2009 - 2013** | | **0.3%** |
| **Excluded from Base for 1115 Waiver** | | | | | | | |
| Unknown | 61 | $14,695 | $240.90 | 0 | $0 | | $0.00 |
| CHIP (Healthy Kids Silver Standalone) | 44,186 | 36,207 | 0.82 | 0 | 0 | | 0.00 |
| Subtotal | 44,247 | $50,902 | $1.15 | 0 | $0 | | $0.00 |

**Attachment B-3**
**New Hampshire Department of Health and Human Services**
**Building Capacity for Transformation 1115 Waiver**
**Total Population**
**FFS Base Data - Excluding Nursing Facility Services**

| | Calendar Year 2009 | | | Calendar Year 2010 | | | Calendar Year 2011 | | |
|---|---|---|---|---|---|---|---|---|---|
| **Rate Group** | **Member Months** | **Total Paid** | **PMPM** | **Member Months** | **Total Paid** | **PMPM** | **Member Months** | **Total Paid** | **PMPM** |
| **Full Duals** | | | | | | | | | |
| Low Income Children and Adults | 3,850 | $2,113,928 | $549.07 | 4,452 | $2,235,924 | $502.23 | 4,212 | $2,011,932 | $477.67 |
| Foster Care / Adoption | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 1 | 1,804 | 1,803.92 |
| Breast and Cervical Cancer Program | 23 | 28,819 | 1,253.00 | 30 | 59,429 | 1,980.98 | 41 | 19,318 | 471.17 |
| Severely Disabled Children | 24 | 77,313 | 3,221.39 | 8 | 33,079 | 4,134.85 | 3 | 2,091 | 696.99 |
| Disabled Adults | 50,016 | 86,977,268 | 1,738.99 | 53,987 | 99,742,941 | 1,847.54 | 53,507 | 98,985,566 | 1,849.96 |
| Old Age Assistance Program | 66,404 | 29,234,453 | 440.25 | 65,635 | 32,939,093 | 501.85 | 63,776 | 31,251,659 | 490.02 |
| Aliens | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 |
| Unknown | 1 | 112 | 112.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 |
| Subtotal | 120,318 | $118,431,893 | $984.32 | 124,112 | $135,010,466 | $1,087.81 | 121,540 | $132,272,369 | $1,088.30 |
| **Non Duals** | | | | | | | | | |
| Low Income Children and Adults | 1,056,207 | $252,487,612 | $239.05 | 1,115,427 | $270,409,526 | $242.43 | 1,127,746 | $278,912,210 | $247.32 |
| Foster Care / Adoption | 26,438 | 21,004,160 | 794.47 | 25,523 | 32,914,863 | 1,289.62 | 24,598 | 28,964,033 | 1,177.50 |
| Breast and Cervical Cancer Program | 2,269 | 2,033,768 | 896.33 | 2,484 | 2,780,279 | 1,119.27 | 2,716 | 3,122,475 | 1,149.66 |
| Severely Disabled Children | 20,545 | 42,088,746 | 2,048.61 | 20,878 | 48,051,929 | 2,301.56 | 20,892 | 46,754,889 | 2,237.93 |
| Disabled Adults | 114,867 | 176,606,392 | 1,537.49 | 123,708 | 200,567,195 | 1,621.30 | 130,397 | 204,245,715 | 1,566.34 |
| Old Age Assistance Program | 9,401 | 8,665,319 | 921.74 | 9,829 | 10,525,756 | 1,070.89 | 10,493 | 11,303,789 | 1,077.27 |
| Aliens | 0 | 0 | 0.00 | 0 | 0 | 0.00 | 0 | 0 | 0.00 |
| Unknown | 0 | 0 | 0.00 | 1 | 0 | 0.00 | 0 | 0 | 0.00 |
| Subtotal | 1,229,727 | $502,885,996 | $408.94 | 1,297,850 | $565,249,550 | $435.53 | 1,316,842 | $573,303,110 | $435.36 |
| **Partial Dual Eligibles** | | | | | | | | | |
| Partial Duals | 87,954 | $4,692,201 | $53.35 | 101,235 | $5,761,502 | $56.91 | 115,910 | $6,511,523 | $56.18 |
| Partial Duals - Plus | 100,780 | 114,019,624 | 1,131.37 | 106,622 | 127,083,788 | 1,191.91 | 112,824 | 132,756,621 | 1,176.67 |
| Subtotal | 188,734 | $118,711,825 | $628.99 | 207,857 | $132,845,290 | $639.12 | 228,734 | $139,268,144 | $608.87 |
| **Grand Total** | **1,538,779** | **$740,029,714** | **$480.92** | **1,629,819** | **$833,105,306** | **$511.16** | **1,667,116** | **$844,843,624** | **$506.77** |
| | | | | | **2009 to 2010** | **6.3%** | | **2010 to 2011** | **-0.9%** |
| **Excluded from Base for 1115 Waiver** | | | | | | | | | |
| Unknown | 182 | $81,826 | $449.60 | 162 | $122,749 | $757.71 | 236 | $69,805 | $295.78 |
| CHIP (Healthy Kids Silver Standalone) | 93,941 | 31,565 | 0.34 | 99,513 | 30,668 | 0.31 | 104,266 | 54,021 | 0.52 |
| Subtotal | 94,123 | $113,391 | $1.20 | 99,675 | $153,416 | $1.54 | 104,502 | $123,826 | $1.18 |

Attachment B-3
New Hampshire Department of Health and Human Services
Building Capacity for Transformation 1115 Waiver
Total Population
FFS Base Data - Excluding Nursing Facility Services

| | Calendar Year 2012 | | | January - November 2013 | | | |
|---|---|---|---|---|---|---|---|
| **Rate Group** | **Member Months** | **Total Paid** | **PMPM** | **Member Months** | **Total Paid** | **Completed Paid** | **PMPM** |
| **Full Duals** | | | | | | | |
| Low Income Children and Adults | 3,997 | $1,899,216 | $475.18 | 3,099 | $1,097,854 | $1,108,833 | $357.85 |
| Foster Care / Adoption | 0 | 0 | 0.00 | 11 | 84,167 | 85,008 | 7,728.04 |
| Breast and Cervical Cancer Program | 10 | 1,360 | 138.26 | 40 | 42,080 | 42,501 | 1,065.36 |
| Severely Disabled Children | 820 | 1,624,605 | 1,981.84 | 1,730 | 3,582,271 | 3,618,094 | 2,091.51 |
| Disabled Adults | 55,827 | 102,645,178 | 1,838.64 | 53,103 | 100,563,197 | 101,568,829 | 1,912.67 |
| Old Age Assistance Program | 65,340 | 35,121,098 | 537.51 | 59,254 | 35,180,942 | 35,532,752 | 599.67 |
| Aliens | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Unknown | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Subtotal | 125,993 | $141,291,458 | $1,121.42 | 117,237 | $140,550,511 | $141,956,016 | $1,210.85 |
| **Non Duals** | | | | | | | |
| Low Income Children and Adults | 1,164,123 | $286,235,940 | $245.88 | 1,098,993 | $280,304,436 | $283,107,480 | $257.61 |
| Foster Care / Adoption | 24,208 | 27,546,491 | 1,137.91 | 21,953 | 25,650,267 | 25,906,770 | 1,180.10 |
| Breast and Cervical Cancer Program | 2,867 | 3,951,577 | 1,378.47 | 2,472 | 3,270,299 | 3,303,001 | 1,336.11 |
| Severely Disabled Children | 21,852 | 47,479,115 | 2,172.71 | 20,304 | 48,907,699 | 49,396,776 | 2,432.90 |
| Disabled Adults | 131,622 | 202,982,180 | 1,542.16 | 122,311 | 185,129,806 | 186,981,104 | 1,528.74 |
| Old Age Assistance Program | 11,068 | 11,613,779 | 1,049.33 | 12,072 | 11,226,419 | 11,338,683 | 939.24 |
| Aliens | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Unknown | 0 | 0 | 0.00 | 0 | 0 | 0 | 0.00 |
| Subtotal | 1,355,740 | $579,809,083 | $427.67 | 1,278,105 | $554,488,926 | $560,033,815 | $438.18 |
| **Partial Dual Eligibles** | | | | | | | |
| Partial Duals | 96,465 | $6,415,325 | $66.50 | 66,593 | $6,946,167 | $7,015,629 | $105.35 |
| Partial Duals - Plus | 104,998 | 123,065,085 | 1,172.07 | 89,413 | 102,070,550 | 103,091,256 | 1,152.98 |
| Subtotal | 201,463 | $129,480,411 | $642.70 | 156,006 | $109,016,718 | $110,106,885 | $705.79 |
| **Grand Total** | **1,683,196** | **$850,580,952** | **$505.34** | **1,551,347** | **$804,056,155** | **$812,096,717** | **$523.48** |
| | | **2011 to 2012** | **-0.3%** | | | **2012 to 2013** | **3.6%** |
| | | | | | **Average Annual Trend 2009 - 2013** | | **2.1%** |
| **Excluded from Base for 1115 Waiver** | | | | | | | |
| Unknown | 139 | $73,156 | $526.30 | 0 | $0 | | $0.00 |
| CHIP (Healthy Kids Silver Standalone) | 51,624 | 46,938 | 0.91 | 0 | 0 | | 0.00 |
| Subtotal | 51,763 | $120,093 | $2.32 | 0 | $0 | | $0.00 |