EMPOWERING THE GRANITE STATE:

State Health System Innovation Plan Model Design Proposal

January 2016

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This report was prepared by:

Center for Evidence-based Policy:
Pam Curtis, MS
Duke Shepard
Kelly Ballas
Mike Bonetto, PhD
Beth Church
Cathy Gordon, MPH
Anne King, MBA
Stephanie Lyzell
Susan Stuard, MBA
Aasta Thielke, MPH

In partnership with ECONorthwest:
Carl Batten, MS
Matt Chwierut, MCP
John Tapogna, MPP

Actuarial services provided by:
Charles C. DeWeese, FSA, MAAA

Health IT consulting provided by Rise Health:
Joel Ainsworth
Kevin E. Cahill, PhD
Jeff Harner, MHA
Connie Moser, MBA
Adrienne Williams

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New Hampshire has developed a transformation plan for improving health, moving toward better care and better outcomes at lower cost. The plan was supported by a federal State Innovation Model (SIM) Design grant and this report is structured to comply with federal SIM Model Design requirements and guidelines.

New Hampshire's SIM State Health System Innovation Plan was developed through a robust and stakeholder-driven process that formed the foundation for the long-term viability of optimum health care in New Hampshire. The planning process built upon a limited initial proposal and is now a cross-sector, multi-stakeholder initiative built on a shared vision, drive for accountability, and commitment to doing the difficult work to make transformation a reality in the Granite State. As designed, New Hampshire's SIM State Health System Innovation Plan is predicted to produce cost savings of between $1.2 and $2.4 billion in its first five years of implementation across the entire health sector, public and private. A SIM Governor's Advisory Board (GAB) of stakeholders from across New Hampshire oversaw the model design process, meeting in person four times from September 2015 through January 2016 design period.

Sarah Aiken	Community Support Network, Inc.
Rich Crocker	State Committee on Aging; Community Support Network, Inc.
Lisa DiMartino	Advocate and former State Representative
Mary Beth Eldredge	Dartmouth Hitchcock Medical Center
Peggy Gilmour	Former NH State Senator; The Granite State and Beyond
Lisa Guertin	Anthem Blue Cross and Blue Shield
Ned Helms	Rudman Center Advisory Board, University of N.H. School of Law
Lucy C. Hodder	Institute for Health Policy and Practice, University of New Hampshire School of Law
Ken Jue	Ken Jue & Associates; InSHAPE Program
Cassie Keane	NH Department of Administrative Services
Mike LaChance	YMCA of Greater Nashua
Pamela Laflamme	City of Berlin
Jessie Levine	Sullivan County Manager and Sullivan County Public Health Network
Keith Loud, MD, FAAP	Children's Hospital at Dartmouth-Hitchcock
Doris Lotz, MD, MPH	NH Department of Health and Human Services
Patrick B. Miller	Pero Consulting Group LLC
Lisa Morris	Lakes Region Partnership for Public Health
Ken Norton	NAMI NH
Thomas Sherman, MD	Core Physicians and State Representative
Lori Shibinette	Merrimack County Nursing Home

Abigail Shockley	The NH Providers Association
Tim Soucy	Manchester Health Department
Jack Wozmak	Office of the Governor

The Governor's Advisory Board established a vision for guiding health transformation and New Hampshire's SIM State Health System Innovation Plan:

> *"Access to person-centered, coordinated, and comprehensive services that improve health outcomes for individuals and populations and brings rationality, intentionality, equitability, and sustainability to the Granite State (sustainability includes affordability and cost effectiveness)."*

Growing out of this vision, the Board established the following guiding principles:

- "Health" is a broad concept and should be thought of expansively, including social indicators of health.
- Transformation efforts in New Hampshire should identify what is effective and what is in place, and then connect and innovate.
- Balance innovation with the building blocks already in place.
- Imagine the possible, break loose when necessary, but have a reason to break loose.
- Sequence implementation into achievable bits.
- Acknowledge New Hampshire's changing demographics.
- Recommendations should make sense for the consumer/person and the system.

Working under this vision and guiding principles, the State health Innovation Plan for New Hampshire balances ambition with practicality. New Hampshire has a strong health sector and many health assets, but as a small state is subject to forces in the marketplace in which it has limited direct control. New Hampshire is the last of its contiguous border states to undertake statewide transformation. As regional health economics spill across state borders, New Hampshire must choose to either allow the transformation efforts in other states to drive the market and ultimately drive health outcomes and costs in New Hampshire; or establish New Hampshire-specific momentum to deliver transformation that works best for its communities. In this process New Hampshire's stakeholders and citizen leaders have purposefully chosen the latter. New Hampshire seeks to spark a cohesive, unified, and entrepreneurial action plan for health transformation that is specific and unique to the state.

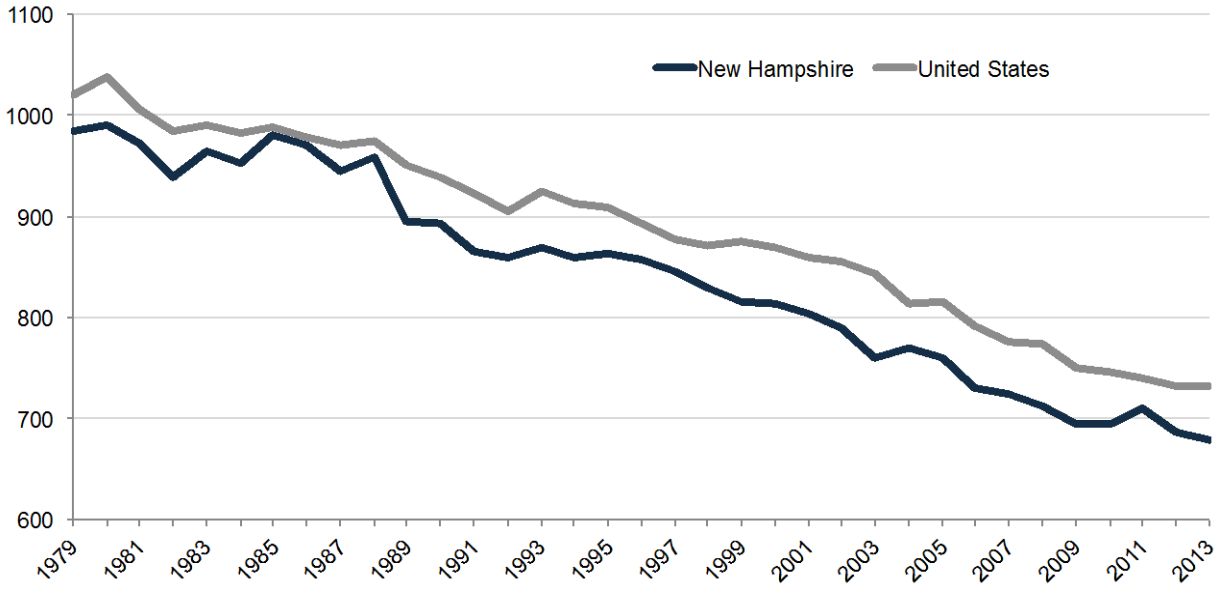
A. Description of State Health Care Environment

New Hampshire established a baseline for transformation by examining the policy environment, economics, demographics, and key policy elements intended to form the basis of the SIM State Health System Innovation Plan. Components of this baseline assessment follow; the full "State of Transformation" report is attached as Appendix I.

Health in New Hampshire

New Hampshire ranks in the top ten states with respect to lower rates of stroke deaths (9th), infant mortality (2nd), and homicides (1st), and ranks in the top 20 states with respect to heart disease deaths (10th), influenza and pneumonia deaths (18th), and percent of live births with low birth weight (15th) (Figure A.1).

Figure A.1. Mortality Rates per 100,000, New Hampshire and the United States, 1973-2013, (Adjusted for Age)



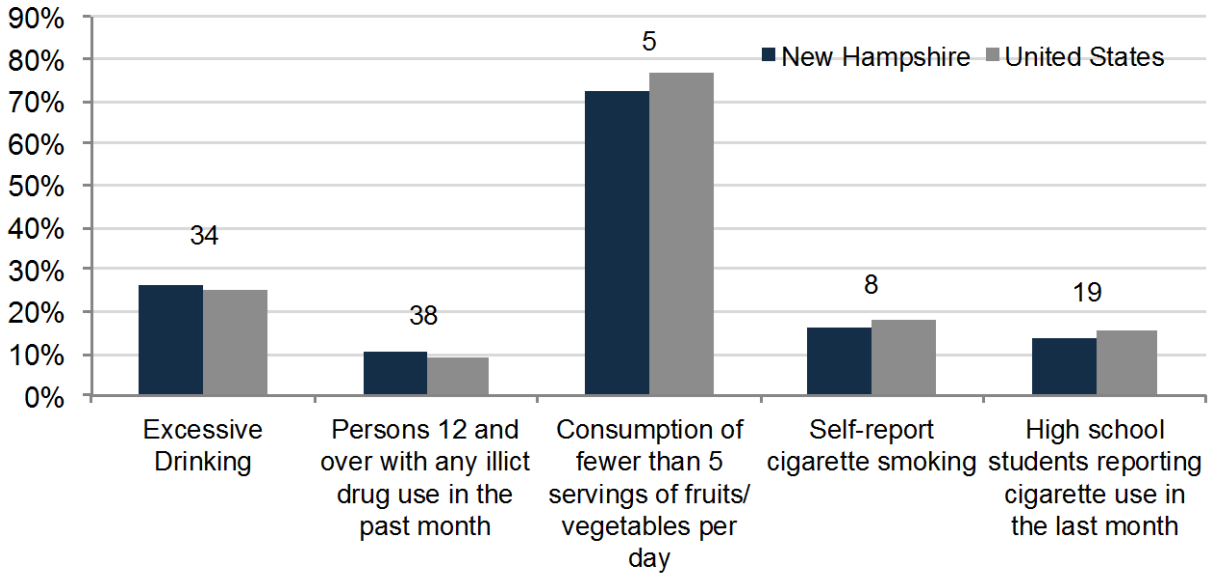
Source: Centers for Disease Control and Prevention (2013). *National Vital Statistics System.*

Among the general health outcomes and mortality rates from common causes of death, New Hampshire ranks in the top half of states (United Health Foundation, 2015). The number of occurrences of heart disease is lower than the national average (149 per 100,000 in New Hampshire compared with 170 nationally). The incidence rates in New Hampshire of two other relatively common conditions—stroke

and Alzheimer's disease—are also below that of the rest of the country. Despite this seemingly strong performance, cancer, heart disease, stroke and dementia remains among the highest causes of death and disability for the state.[1]

The story for New Hampshire is somewhat mixed when it comes to the prevalence of behavioral risk factors and chronic conditions. On the one hand, New Hampshire performs well relative to the national average with respect to high rates of vegetables comsumption and low smoking rates, both generally and specifically among high school students.These statistics mask costly (in human and fiscal terms) subpopulation facts, including that 32% of pregnant Medicaid beneficiaries utilized tobacco compared to 13.6% of the general population. (see Figure A.2)

Figure A.2. Behavioral Risk Factors with State Rank, New Hampshire and the United States, 2013



Sources: See References, Appendix

Additionally, New Hampshire has a relatively high prevalence of excessive drinking and illicit drug use. In 2011, 27% of New Hampshire's adult population reported that they had more than 15 drinks per week, compared with 25% nationally. With respect to the the national average on excessive drinking—18.4% of New Hampshire's adults reported excessive drinking (ranked 27th nationally)(United Health Foundation,

[1] NH DHHS, Leading Causes of Death, 1999-2009; Accessed at http://www.dhhs.state.nh.us/dphs/hsdm/death/documents/causes.pdf on January 20, 2016

2015). Further, 10% of the population aged 12 and older reported using illicit drugs in the last 12 months, compared to 9% of the United States overall (Office of National Drug Control Policy (2013). The relationship between substance use and mental illness is discussed in more detail below.

Generally speaking, New Hampshire ranks among the top states with respect to health outcomes and the prevalence and incidence of chronic conditions and cancer, and ranks highly with respect to health care risk factors, with the two exceptions of excessive drinking and illicit drug use. (United Health Foundation, 2015).[2]

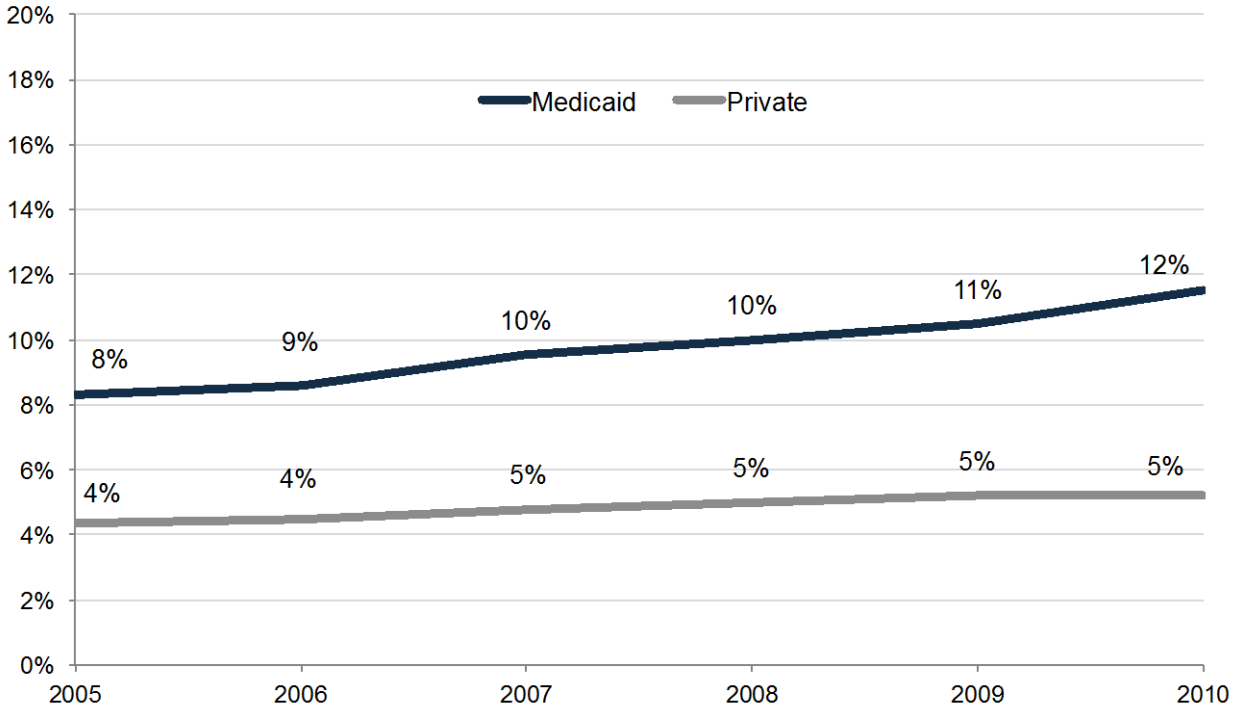
Regarding Serious Mental Illness (SMI), New Hampshire is on par with the national average, with approximately 4% of residents affected by a SMI between 2009 and 2013. During that time, the proportion of residents affected by a SMI remained relatively stable. However, this stability masks the increased need for additional services in the state. A 2013 New Hampshire Department of Health and Human Services (DHHS) study revealed that 1 in 3 patients who used the emergency department and required adult in-patient psychiatric care waited an average of 2.5 days for in patient bed availability. The study also revealed insufficient capacity to handle the demand for outpatient mental health services for patients with SMI. (Taskforce to Assess the Current Status of Publicly Funded Mental Health Services in New Hampshire, 2008).

Recent studies from the Substance Abuse and Mental Health Services Administration (SAMHSA) reveal that many patients with mental health issues also experience issues with substance abuse. Mental illness and substance abuse share the same underlying causes and often occur together. The co-occurrence of substance abuse and mental illness make it difficult to appropriately treat a patient if access to robust and integrated services are unavailable.

In State fiscal years 2011 and 2012, over 58% of adult NH Medicaid enrollees who received services presented with a mental health and or substance abuse disorder. Overall, approximately 12% of patients with Medicaid that had a mental illness also had a secondary condition of substance abuse. A smaller proportion, about 5%, of patients with private insurance had a co-occurrence of substance abuse (New Hampshire Department of Health and Human Services, 2014). (see Figure A.3).

[2] New Hampshire ranks among the top states: 7 in both cardiovascular-related deaths and stroke; 16 in diabetes; 22 in heart disease; and 26 in cancer-related deaths.

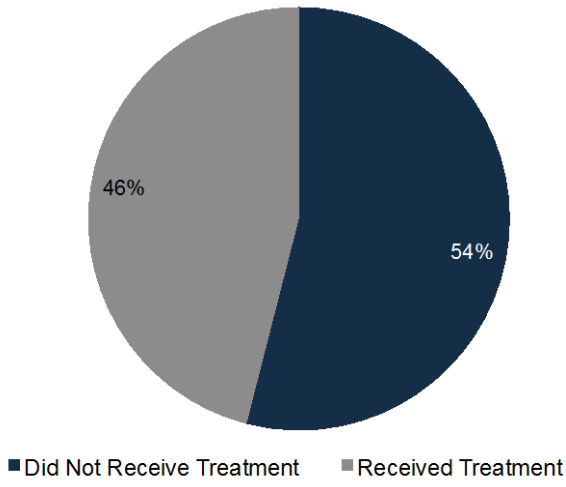
Figure A.3. Mental Illness and Co-Occurring Substance Abuse over Time, New Hampshire 2005-2010



Source: New Hampshire Center for Excellence. (2012). *State Epidemiological Profile of Mental, Emotional and Behavioral Health*.

Like many other areas of the United States, New Hampshire has struggled to keep up with the growing need for psychiatric care of its residents. Between 2009 and 2013, only 46.1% of New Hampshire residents with a mental health disorder received treatment or counseling in the year prior to being surveyed (see Figure A.4). A mental health strategy report from the New Hampshire DHHS found that declining Medicaid funding and lack of available inpatient alternatives for substance abuse and mental health were significant barriers to obtaining treatment (Taskforce to Assess the Current Status of Publicly Funded Mental Health Services in New Hampshire, 2008). As an example, despite recent increases, designated facility beds decreased from 101 beds in the early 2000s to 18 in calendar year 2014, and residential group home beds dropped to 177 (Merrimack County/6th Circuit-District Division-Concord. (n.d.). *Mental Health Court* [Brochure] Concord, NH: Merrimack County/6th Circuit-District Division-Concord).

Figure A.4. Past Year Mental Health Treatment/Counseling among Adults with Any Mental Illness (AMI), New Hampshire, 2009-2013

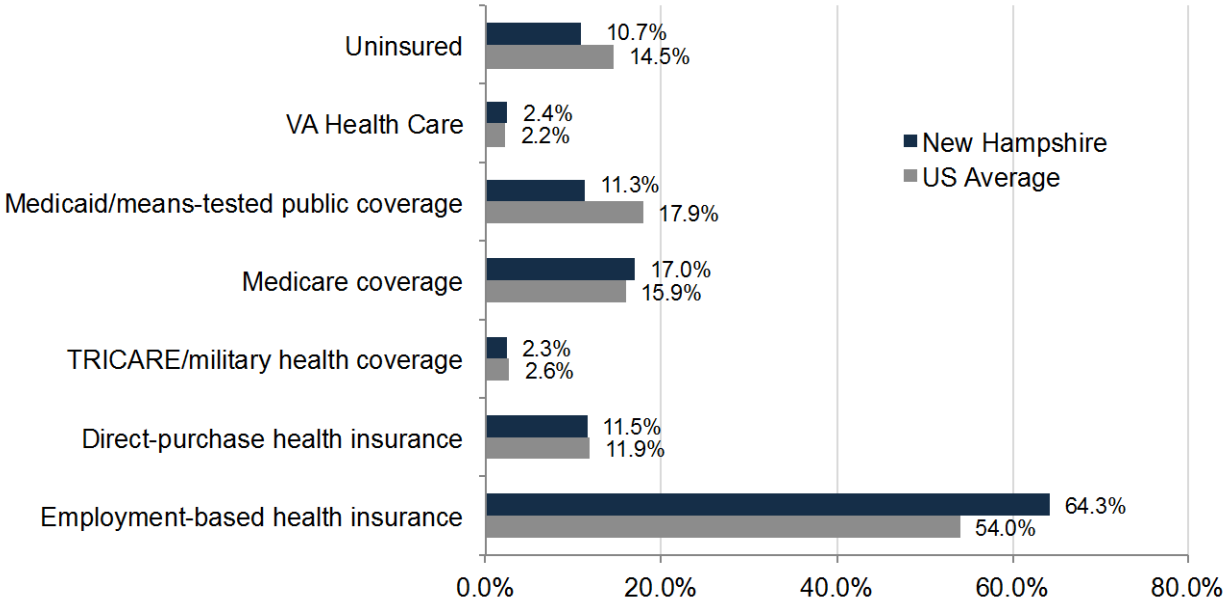


Source: Substance Abuse and Mental Health Services Administration. (2014). *Behavioral Health Barometer: New Hampshire, 2014*.

New Hampshire is in the midst of implementing changes necessary to meet the terms of a settlement of a class action lawsuit, *Amanda D, et al. v. Hassan, et al. 2014,* to expand mental health services in integrated community based settings. "The Agreement will enable a class of adults with serious mental illness to receive needed services in the community, which will foster their independence and enable them to participate more fully in community life. The expanded and enhanced community services will significantly reduce visits to hospital emergency departments and will avoid unnecessary institutionalization at State mental health facilities, including New Hampshire Hospital (the State's only psychiatric hospital) and the Glencliff Home (a State-owned and operated nursing facility for people with mental illness) (U.S. Department of Justice Civil Rights Division, 2014)."

Overall, New Hampshire enjoys an enviable situation of health insurance coverage. New Hampshire had one of the highest rates of health care insurance among the states: only 11% of the population lacked health insurance of any kind, relative to 15% across the U.S. (see Figure A.5).

Figure A.5. Health Insurance Coverage by Type, New Hampshire and US, 2013



Source: ECONorthwest (2013). Analysis of American Community Survey, 1-year Estimates, 2013.

Medicaid Expansion

In 2015, New Hampshire expanded Medicaid eligibility according to ACA guidelines allowed newly eligible individuals to enroll in Medicaid Managed Care Organizations. By May 2015, Medicaid/CHIP enrollment grew by 39% in New Hampshire, relative to 22% across the United States (The Henry J. Kaiser Family Foundation, 2015*)*. This increased enrollment of 46,000 people (as of January 2016) was more than the 34,000 originally anticipated

Prevalence & Characteristics of the Medicare Population

Almost 200,000 New Hampshire residents are enrolled in Medicare. In FY 2011, only 15% of the state's Medicare enrollees were dual-eligible for both Medicare and Medicaid, lower than the national average of 21% and one of the lowest rates among the states.[3] Eight out of ten Medicare beneficiaries are aged, in line with the national average of 81%. The remainder qualify for Medicare due to disability.

New Hampshire has one of the lowest rates of Medicare Advantage enrollment among Medicare beneficiaries: only 7% of those eligible vs. 31% across the U.S. in 2015 (The Henry J. Kaiser Family

[3] Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports.

Foundation, 2015).[4] This is in part due to the relatively low number of available plans—New Hampshire has only 10 available plans, and the unweighted average per state is 43. On average, New Hampshire Medicare beneficiaries have access to fewer *types* of plans than beneficiaries in other states, particularly Local PPO and PFFS: (57% and 31%, respectively, relative to 80% and 47% nationwide). Regional effects could exist as well: almost all New England states have a lower rate of Medicare Advantage enrollment than the national average. It is worth noting that expected Medicare Advantage enrollment in New Hampshire could arguably be *higher* than the national average (all else being equal) if older individuals in New Hampshire have (on average) higher incomes than older individuals nationally, and presumably more able to bear the additional costs of Medicare Advantage.

Prevalence & Characteristics of the Marketplace Population

As of March 31, 2015, over 45,000 New Hampshire residents were covered through marketplace exchanges, representing 3.5% of the state population, slightly higher than the national average of 3.3% (Kaiser Family Foundation, 2014).[5] This amounts to 44% of the total marketplace eligible population, which is the 8th highest participation rate among the states and higher than the 36% national average. (Kaiser Family Foundation, 2014)[6] Of those enrolling, two-thirds (66%) received financial assistance, one of the lowest rates among all the states (see Figure A.6). Premium rates do not explain this low rate: before-tax-credit premiums in 2014 were slightly higher than the national average, and while rates fell in 2015 to below the national average, they remained higher than 19 other states (Kaiser Family Foundation, 2015).[7] One explanation might be that a low portion of the population is eligible for tax credits in the first place. New Hampshire's unemployment rate is 3.1%%, vs. 5% nationwide, and the poverty rate is 8.7% vs. 15.4% nationwide.

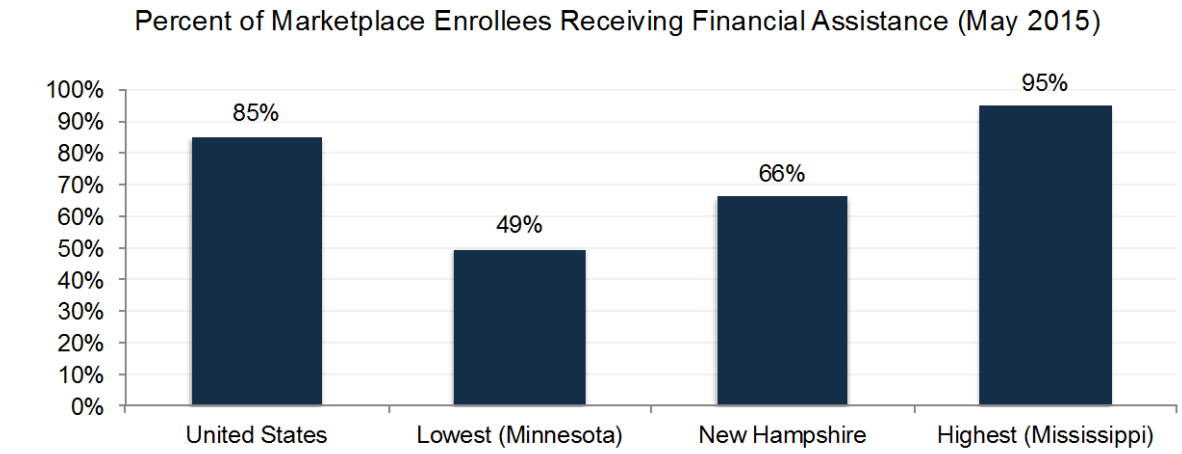
[4] Includes local HMO, local PPO, PPO Demonstration (relevant through 2005), PFFS, Regional PPO, MSA, Cost, and other demonstration contracts. Excludes HCPP, PACE, Employer-only and SNP-only contracts. U.S. territories are not included in metro, non-metro, or MSA measures.

[5] Analysis based on 2014 Medicaid eligibility levels and 2014 Current Population Survey.

[6] Includes all individuals eligible for tax credits as well as other legally-residing individuals who are uninsured or purchase non-group coverage, have incomes above Medicaid/CHIP eligibility levels, and who do not have access to employer-sponsored coverage.

[7] Based on Monthly Silver Premiums for a 40 Year Old Non-Smoker Making $30,000/Year.

Figure A.6. Percent of Marketplace Enrollees Receiving Financial Assistance, May 2015



Source: Effectuated Enrollment Snapshot, Centers for Medicare and Medicaid Services, accessed June 2, 2015 and Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels and 2015 Marketplace Plan Premiums applied to the 2014 Current Population Survey

Source: Kaiser Family Foundation (2014). *Marketplace Enrollment as a Share of the Potential Marketplace Population, April 2014*

In 2014, over half of New Hampshire's private firms offered health insurance to their employees, relative to 48% of firms nationwide. Both have declined over time, though the portion of firms offering insurance in New Hampshire fell more quickly than across the U.S. (-1.8% v -1.4% average annual change). Most of the decline in New Hampshire occurred in businesses with fewer than 50 employees, and most of that drop occurred after 2008 (Agency for Healthcare Research and Quality, 2015). However, the portion of small firms offering coverage slightly increased between 2012 and 2013. Of New Hampshire's roughly 9,700 companies with 50 employees or more, 97.8% offered health insurance to employees, more than the national average of 94.8%.

The Aging of New Hampshire's Population

While the topic of population aging has received considerable attention over the past two decades. The percentage of the population aged 65 and older remained relatively constant from 1990 to 2010, at approximately 12% (see Figure A.7). Since 2010, however, the fraction has increased to 15.3%, and is projected to increase further to 23% in the next 15 years (Norton, S., 2011).

Figure A.7. Population Growth in New Hampshire, 1995 – 2040

New Hampshire	1995	2000	2010	2020	2030	2040
Total Population	1,145,604	1,235,822	1,316,506	1,405,423	1,480,466	1,508,193
5 Year Moving Average	3.30%	7.90%	1.20%	3.30%	2.30%	0.50%
Net Migration	583	36,019	7,253	42,902	46,636	44,925
Working Age (20-64)		743,669	812,418	838,996	813,171	833,274
Change form previous year			1.52%	0.67%	-1.89%	2.18%
Share of Total Pop		60%	62%	60%	55%	55%
Seniors (65 and over)		147,980	178,278	254,912	341,992	349,622
Change from previous year			11.30%	19.30%	12.90%	-1.80%
Share of Total Pop		12%	14%	18%	23%	23%

Source: Norton, S. & Delay, D. (2012). Getting what we pay for? *Health care spending in New Hampshire. Center for Public Policy Studies.*

New Hampshire's State-federal Partnership Health Care Exchanges under the ACA

New Hampshire policymakers have generally embraced favorable attitudes toward market-based health reform since at least the early 1990s (Hackey, R.B., Olszewski, T., & Waldron, D., 2015). After the Affordable Care Act passed in 2010, Governor Lynch initially supported the acceptance of $1 million for the implementation of a state exchange the following year; however, due to concerns about the fiscal sustainability of a state-run exchange, he signed HB 1297 in June 2012, which prohibited the creation of a state-based insurance exchange (Cline, D, 2012, June 19).

In 2013, newly-elected Governor Hassan moved forward with establishing a state-federal partnership exchange (Department of Health and Human Services, 2013). Under the partnership structure, New Hampshire maintains local control for managing customer assistance and participation in the exchange, while its residents obtain coverage through the federal exchange, using HealthCare.gov. New Hampshire began enrolling residents in the federal exchange in 2013 and as of March 2015, approximately 53,000 participants enrolled (Office of the Assistant Secretary for Planning and Evaluation, 2015). New Hampshire is one of seven states with a state-federal partnership exchange.

New Hampshire has been in negotiations with insurance carriers to increase both the number of carriers and plans offered to residents. Anthem Blue Cross Blue Shield (Anthem) had been the only carrier in the state through the establishment of the state-federal partnership exchange in 2014. At that time, Anthem offered 14 plans across 16 acute care hospitals. There are five carriers currently: Anthem, Assurant Health, Community Health Options (MCHO), Harvard Pilgrim Health Care of New England, Minuteman

Health. These five carriers are expected to offer 81 plans in 2016, across 26 acute care hospitals (New Hampshire Insurance Department, 2015).

In 2013, a bipartisan nine-member commission released a report which recommended moving ahead with the expansion. In response to the report, New Hampshire passed legislation in 2014 to expand the Medicaid Managed Care program, albeit with a sunset provision that limited funding through 2016 unless policymakers agreed to reauthorize the program (The New Hampshire General Court, 2014). Enrollment in the Medicaid Managed Care program has been higher than anticipated. Early estimates suggested that 34,000 adults would enroll the first year; however, as of June 2015 almost 42,000 people entered the program (Centers for Medicare & Medicaid Services, 2015). As part of the expansion, New Hampshire submitted a waiver that would allow New Hampshire to transition the non-medically frail, expansion population from the Medicaid Managed Care model to a premium assistance model, beginning January 1, 2016 (The Henry J. Kaiser Family Foundation, 2015). This next step in the State's health care expansion allows participants in the New Hampshire Health Protection Program (NHHPP) to enroll in a Qualifying Health Plan (QHP), with fully federally funded support through December 31, 2016.

The 2016 General Court of New Hampshire will consider the continuation of Medicaid expansion beyond December 31, 2016.

Practice and Patient Care

New Hampshire exceeds the national average with respect to the number of primary care physicians per 100,000 residents (138.3 versus 134.4) and number of specialty care physicians (152.0 versus 148.3), and far exceeds the national average with respect to physician assistants per 1,000 residents (43.7 versus 30.1) and nurse practitioners (77.1 versus 47.4). These averages conceal a fairly wide variation across regions of the State. While the statewide average of primary care physicians is 1 per 1,080 residents, the ratio ranges from 1 per 537 residents in Grafton County to 1 per 1,471 residents in Belknap County.[55] In total, three counties had more than one physician per 1,000 residents: Grafton County (1:537), Merrimack County (1:839), and Coos County (1:867). Four counties had less than one physician per 1,300 residents: Strafford County (1:1,364), Sullivan County (1:1,389), Cheshire County (1:1,397), and Belknap County (1:1,471). Such regional variations are important to keep in mind as access to care appears to differ within the State.

New Hampshire also ranks high with respect to Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS) scores for whether the patient would recommend the hospital, as 75% of patients in New Hampshire said they would definitely recommend their hospital, compared with a nationwide average of 71%. Other measures of quality appear to indicate that New Hampshire's health care providers' performance is mixed with respect to several other attributes. The percentage of New

Hampshire's hospitals that received an "A" on the Hospital Safety Score—based on 28 performance measures—was 23.1% in 2015, compared with a national average of 31%. Caution should be used in interpreting this particular result, however, as the lower ranking might also reflect differences in the perceptions of New Hampshire residents relative to those in other states. New Hampshire is below the national average with respect to the average number of minutes patients spent in the ER prior to being admitted (107 minutes in New Hampshire compared with 104 minutes nationally) and the percentage of outpatients having surgery who received antibiotics at the correct time (99% in New Hampshire compared with 98% nationally).[8]

The quality of health care in New Hampshire has also benefited from several trends nationally that also come with increases in cost, as noted by the New Hampshire Center for Public Policy Studies (New Hampshire Center for Public Policy Studies, 2012). Conditions that were previously treated as terminal, such as HIV and diabetes, are now treatable with advanced drug therapies. Similarly, secondary conditions and acute conditions can now be treated, and such treatment increases the cost of health care while improving the outcomes of patients. The irony is that such treatments—and the resulting improvements in quality of care—may actually increase the size of the patient population.

B. Report on Stakeholder Engagement and Design Process Deliberations

Over 80 stakeholders designed the New Hampshire SIM Process, with additional robust input from over 1200 citizens. Stakeholders participated in one or more deliberate design opportunities including an advisory board to the Governor, five model design workgroups, interviews with key informants, online survey, all-stakeholder feedback events and community meetings.

Workgroups and Meetings

The office of Governor Maggie Hassan empaneled the SIM Governor's Advisory Board (GAB) in August, 2015. The GAB met on September 17, October 27, December 2, January 7 2016, and January 26 2016. Meetings were well attended and highly participatory. The GAB provided the vision and guiding principles, and developed ongoing guidance and feedback for each of the substantive work groups throughout the process. Surveys were sent to the Governor's Advisory GAB at the conclusion of each meeting in order to gauge their satisfaction with the process and provide improvement for each forthcoming meeting.

[8] Timely and Effective Care. (2013-4). Timely and Effective Care - State. Baltimore, MD: Center for Medicare & Medicaid Services. Retrieved from: https://data.medicare.gov/data/hospital-compare/Timely%20%26%20Effective%20Care.

An “All Stakeholder” kick-off was held on September 17, with broad attendance from work group participants and interested citizens. This kick-off meeting featured opening remarks by Governor Hassan, demonstrating the importance of this endeavor for the future of the State. The stakeholders were then provided with an overview of SIM, the goals of health transformation, baseline data on the health system and economics of New Hampshire, and the opportunity to ask questions and volunteer for involvement. The All-Stakeholder group was reconvened on January 8 2016 to review, question, and consider the emerging work product of the SIM Model Design process.

One community meeting was held in Berlin, to discuss the issues and health challenges in New Hampshire’s North Country. Stakeholders focused on substance use and behavioral health resources, the challenges presented by statewide disinvestment in treatment resources, and particularly the culture of poverty and trauma that feeds into and reinforces health status and behaviors. The lack of treatment beds in the North Country was the highest level priority.

The central component of stakeholder involvement was a workgroup structure to answer key questions and address strategic areas of the SIM Model Design. Active stakeholder participation was the foundation of each workgroup.

Practice Transformation	The workgroup focused on the core attributes and standards that determine what a practice should do under New Hampshire's regional transformation model. Considerations included access to care, accountability, continuity of care, coordination and integration, patient-centered approaches, quality assurance, and metrics to measure success.
Payment Reform	This workgroup identified advanced payment models for New Hampshire by reviewing critical data, developing economic models, and by fostering collaboration between the state, private payers, large employers, providers, consumers, and other stakeholders. Considerations included evidence of effective models, population data, financial models, benchmarking, risk adjustment, quality assurance, and metrics to measure success. This workgroup will also identified implementation considerations for payers and purchasers.
Health Information Technology (HIT)	This workgroup focused on developing a plan to expand and increase generation, exchange, and use of electronic health information through EMRs and electronic health exchange, opportunities for interoperable solutions to support and monitor success in the SIM State Health System Innovation Plan, the role of health information technology in improving population health, increasing transparency, assuring quality and metrics to measure success.
Governance	This workgroup focused it work on the proposed Regional Healthcare Cooperative Extensions (RHCEs) model and overall governance and authority issues related to state and regional transformation efforts. Considerations included communication and workflow, budgeting and incentives, relationship to other participants in the "medical neighborhood", policy requirements and levers, legal and regulatory issues, evaluation accountability, overall quality assurance for the system, and metrics to measure success. This group was particularly attentive to aligning SIM Model Design efforts with other regional structures and initiatives, notably New Hampshire's pending Medicaid 1115 waiver and existing public health networks, in order to create efficiencies, eliminate duplication, and build upon the strengths of regional partner networks and geographic regions.
Community Initiatives	This workgroup focused on regional population health improvement and identified mechanisms to build on, and align with, New Hampshire's State Health Improvement Plan. Considerations included identification of clear objectives, measurable goals and priorities, evidence-based opportunities to advance New Hampshire's 10 priority areas for improvement using the SIM State Health System Innovation Plan in development, quality assurance, and metrics to measure success.

Work groups held in person meetings in each month from September through December, supplemented with multiple webinars, conference calls, and direct communication to advance their deliberations and "cross-pollinate" their work with one another.

Key Informant Interviews

A valuable element of engagement was through key-informant interviews with stakeholders representing the range of geographic, organizational, and consumer diversity of the state. Interviews were used to gather deep, and confidential, stakeholder perspective.

Methods

In consultation with New Hampshire DHHS staff, a list of 40 targeted key informants was generated to represent the diversity of New Hampshire and stakeholder perspective. Key informants included providers, payers, professional associations, policy experts, advocates, elected officials, state agency representatives, labor representatives and purchasers from all regions of the state. The goal of the interviews was to mine stakeholder experiences and perspectives to assist the SIM Governor's Advisory Board, workgroups, and DHHS in identifying the most effective way to move Granite Staters to rapid and comprehensive system change. Figure B.1 identifies interview respondents by category of stakeholder.

Figure B.1. Demographics

Stakeholder Category	# of Respondents
Advocate/Consumer	2
Elected/Appointed Official	1
Foundation/Non-profit	4
Health/Public Policy	7
Payer	5
Professional Association	2
Provider	6
State/Regional/Local Agency	5
Total	**32**

Standard qualitative interview techniques were used within a detailed interview protocol (Appendix II), including open-ended questions with scripted and spontaneous probes. Questions were provided to key-informants in advance of interviews, along with basic introductory information regarding the purpose and process of SIM planning. Snowballing techniques were also used with key-informants to help identify other stakeholders to involve during subsequent engagement opportunities (such as stakeholder survey, all stakeholder and public dialog sessions).

A nine-question, standardized interview guide was used to focus on stakeholder experiences and perspectives of transformation efforts to date, barriers and facilitators to change, and identification of other essential stakeholder perspectives. Respondents were asked to provide feedback on key potential areas of transformation, aligned with workgroup foci:

- Background and experience
- Reflections on current and past reform efforts
- Practice transformation
- Payment reform
- HIT
- Community Initiatives
- Governance
- Additional, open-ended comment opportunity

Interviews were conducted by telephone and were digitally recorded with verbal consent. Interviews were approximately 60 minutes in length, depending on how much time and input participants had to offer.

Interview Findings

Key informants provided a rich and deep description of the healthcare landscape in New Hampshire. The section that follows summarizes themes that emerged from the interviews.

Cultural & Environmental Factors

> *"In my opinion people in New Hampshire are driven to do the right thing. They also want their organizations to survive."*

Key informants noted that Granite Staters are "good people" who want to "do the right thing" for ethical and moral reasons. Reforming healthcare for the benefit of the overall population falls under this convention. There is an overall sense of readiness for, as well as openness to, doing the work of significant delivery system and reimbursement transformation in the state of New Hampshire. As evidence of this, many regional reform efforts are already underway but to date, none span the entire state or reach all populations of patients and citizens. Fragmentation and siloes exist in all regions and across all provider types. This fragmentation is viewed as a significant barrier to previous and current statewide system change. However, many of the current regional models are showing signs of success and potentially could be scaled up for state-wide reform efforts. Partially because of the fragmented nature of the current

delivery system and serial or concurrent efforts at reform with the same list of rotating participants, key informants noted a significant level of "reform fatigue".

> *"Reform in New Hampshire is meeting after meeting and not a lot of reform. And yes it's very important to bring stakeholders at the table but they have to be used effectively, and I think people want to see results."*

Unique geographical challenges that are posed by the physical nature of the state were noted as having significant impact on the delivery system and access patterns by Granite Staters. In addition, it was noted that New Hampshire is a "small" state both geographically and in overall population numbers, and citizens are fiercely loyal to their own locality or town. This was identified as both a strength and a challenge for reform planning and implementation processes. Given the small number of powerful and active groups, stakeholders with conflicting objectives are observed to be reluctant to be as frank as may be necessary in order to bring about significant change. Individuals expressed concern about alienating potential allies who may be of crucial importance to them for future issues on the horizon. This was also a finding of the interviews themselves in that key informants requested to go 'off the record' more frequently than typically seen by the Center for Evidence-based Policy in its state focused stakeholder work. Respondents also observed that there exist enclaves of provider types and regional coalitions who compete for ever shrinking healthcare dollars during biennial budget sessions and therefore, have become entrenched in an 'us' versus 'them' mindset. This in turn makes it more difficult to view other providers or regions as allies in reform efforts.

The current crisis in behavioral and substance use treatment is perhaps the starkest example of how the fragmentation of the current system is inadequate to meet the challenges facing the state. Some key informants were hopeful that the current crisis in New Hampshire's behavioral health system could prove to be the necessary fulcrum for wide-spread progress on state-wide system transformation. Many respondents asserted that any reform effort would necessitate meaningful integration of the behavioral and physical health systems in order to impact spiraling healthcare costs. These respondents also suggested that SIM work be developed in concert with the current 1115 Medicaid waiver for Behavioral Health Integration.

Limited Government State

Respondents indicated that public resources are extremely limited due to New Hampshire's cultural identity as a "limited government state". The political structure in the state was viewed by many

respondents as thwarting health care reform efforts based on cost of programs (some reforms require up-front expenditures, even if they do realize cost savings in the long term; any new investment is a non-starter). Key informants reported that it will be critical to communicate the potential for health transformation to deliver cost reductions in real dollar terms, in order for the legislature to support transformation efforts. Limited sources of revenue (New Hampshire has no state income or sales tax) leaves the state budget vulnerable to economic downturns or crises; and because general funds are flexible by nature, competing policy priorities inevitably leave some programs without funding. Respondents stated that general fund resources, even when "dedicated" to health, can be unreliable from one budget to the next. Therefore, respondents asserted that reform efforts will need to be public-private partnerships in order to assure long-term success of comprehensive and complex system changes.

Visionary Leadership

A preponderance of respondents identified the need for consistent, united, visionary leadership in order to bring about necessary system reform. Barriers of note included short election cycles, coupled with loss of institutional knowledge of veteran employees and experience at DHHS due to budget cuts. Several respondents credited state agency efforts as commendable, even heroic, but expressed concern that DHHS does not currently have the necessary resources to sustain long-term transformation activities on their own. Key informants suggested the need for reform "champions" from all sectors in the state. These champions will be needed to carry the messages of unity in order to inspire former competitors and front-line workers to remain committed to the heavy lift of comprehensive system change.

Reform Focus Areas

Key informants were asked to provide comment on past, current and future New Hampshire reform efforts while focusing their responses on issues focused on by the five SIM work groups: practice transformation, payment reform, health information technology, community initiatives and governance.

In recognition of the fact that many key informants have concentrated areas of expertise, respondents were offered the opportunity to, but were not required to, comment on all five workgroup focus areas. Targeted sampling was employed in an iterative recruitment process to increase validity of interview findings. The descriptions of themes reported below represent the divisions between work group topic areas even though respondents wove multiple focus areas together when answering on a single topic, and many interview comments reflected the natural overlap of the five focus areas.

Practice Transformation

> *"There are efforts coming from all the different fronts, but I don't see anyone looking at a 'health system', we have been nibbling at the edges, trying to improve the health delivery components."*

There are multiple practice transformation models in various stages of implementation in New Hampshire. These include advanced primary care, patient centered medical homes, team-based care, integrated care models and others. The primary goal of practice transformation is to improve the effectiveness of health services delivery and patient outcomes and experience, as well as consider health costs. Key informants were asked to comment on their experience of practice transformation efforts in the state and offer suggestions for the most promising models going forward. Overall, respondents offered more in-depth comments on this focus area than any of the other four workgroup focus areas.

As noted above, respondents stated that there is an overall sense of readiness for transformation in New Hampshire as evidenced by multiple, regional reform efforts, which have achieved varying levels of success. Some areas or systems stood out in terms of how often they were mentioned as exemplary. These included the communities of the North Country and the efforts of the federally quality health centers (FQHC) and hospitals, Cheshire Medical Center and the community of Keene, Derry Medical Center, Manchester Public Health Network and the Dartmouth Hitchcock system.

A major gap that was identified nearly unanimously by respondents was the crisis in the behavioral health system. Key informants with historical roots in the state observed that New Hampshire was once a recognized national leader in this area of healthcare, making the current situation more distressing. Multiple factors were identified as contributing to the current state of behavioral health care in New Hampshire. Of these, insufficient funding, increasing costs of providing care, lack of infrastructure supports, and workforce and capacity shortages were identified most frequently. Key informants noted that DHHS and other stakeholders have been working to implement components of the *Ten Year Mental Health Plan* but even the ten year plan has significant gaps, including children's mental health and substance use treatment.

Respondents identified the need to transform healthcare delivery to a team-based care model. The behavioral health crisis led many to suggest that the best model for practice transformation going forward would be a fully integrated care system. Many key informants were familiar with the state's 1115 Medicaid waiver (approved January 3, 2016) focused on behavioral health integration. Some respondents noted that

unless physical health providers practiced from a population health approach, they do not recognize or understand the magnitude of impact of untreated mental health and substance use disorders. Increasing providers' understanding of this population's impact on total cost of care will be necessary to a successful and cost bending result in the Granite State.

New Hampshire has a highly concentrated healthcare delivery system and nearly all key informants mentioned this fact during their interview. A majority of primary care practices are hospital owned and specialty practices are increasingly following that path. In addition, most communities have only one hospital so natural market forces such as competition are not present to assist with cost containment. Larger systems can, however, provide the needed infrastructure for large-scale reform efforts but are less nimble and flexible than smaller groups and have fewer financial incentives to change. Informants suggested aligned payment, accessible data and meaningful support for providers undergoing transformation as necessary to bring about successful change.

Payment Reform

> *"When there is shared risk that makes people sit up and take notice. There is no need to go to full capitation to get people to change behavior."*

Alternative payment methods focus on models that move away from fee for service (volume) and begin to pay for outcomes in health and care quality (value). There are a variety of these methods in place or in exploration in New Hampshire today as cited by interview respondents. However, these alternative payment models are fragmented across the state, and without a unifying component. New payment models presently being piloted include shared savings with and without shared risk, bundled payments & episodes of care, full and partial capitation, payment penalties and others. Several variations of accountable care organizations are in place and these and other solutions continue to evolve with the changing landscape. Respondents noted that health care in New Hampshire is still predominantly reimbursed on a fee for service basis.

Key informants reported that the highly concentrated payer and provider market in New Hampshire has resulted in high healthcare prices, including costs and premiums to citizens, and provides little or no incentive for payers or providers to change their fundamental business practices. This is viewed as a very significant barrier to meaningful change in New Hampshire. Some respondents noted that this is the intersection where the Granite Stater desire to "do the right thing" shifts to an overriding concern for financial self-interest and competition for limited resources perpetuates the status quo. Other respondents

suggested that purchasers and consumers are 'taking it on the chin' as costs are shifted to them, while payers and providers engage in finger pointing. Another barrier respondents highlighted was the struggle the state has had in achieving a phased-in managed care system for Medicaid including strained relationships with contracted vendors.

Payer alignment is viewed as 'critical' to achieving overall transformation goals. Changing provider practices will require support while transition from the fee for service model is shifting to value based reimbursement in the care delivery system. Incentives need to align across sectors in order to make practice transformation feasible. Some respondents suggested that given the highly concentrated market, tighter rate regulation or global budget capitation may need to be considered to bring about a tipping point. This is an extremely sensitive topic, because for many providers cost controls translate to income reductions.

Health Information Technology (HIT)

> *"There is half an HIE that was set up for the state government, but they've really struggled, primarily due to legislative restriction on how the HIE can be used. It's hobbled them greatly."*

Respondents reported that New Hampshire enjoys a robust Health Information Technology (HIT) environment but that access and uptake are highly variable across the state and stakeholder groups. Respondents noted that robust data is available, but not accessible to many end-users. Effectively managing health information is a fundamental precept of health care reform. HIT has the potential to improve patient care and experience, increase efficiency of utilization, reduce unnecessary and redundant services, identify gaps in care, and calculate total cost of care. Key informants stated that some provider groups are much further behind in their use of HIT including electronic health record (EHR) adoption, than are some of their other colleagues; this is especially true for long term care, behavioral health, substance use disorder and social support providers.

A key theme that emerged from the interviews is that privacy concerns have blocked much progress in advancing HIT use in the state. Many respondents noted that because of legislative conerns of potential privacy breaches, the New Hampshire Health Information Organization (NHHIO) is not allowed by state law to store personal health information and can only act as a conduit for health information between payers, providers and the public. Respondents asserted that legal and regulatory barriers to accessing data will need to be addressed in implementing the SIM State Health System Innovation Plan.

A key development that occurred during the course of this project was the creation of Benevera, a new partnership between Harvard Pilgrim, Dartmouth –Hitchcock, Frisbee Memorial Hospital, and Elliot Health System to address entrenched barriers between payers, providers and plans in data sharing and system efficiencies. Data will be collected, analyzed and shared to assist in complex care management across the system in real time. The focus of this partnership is managing population health to achieve outcomes of the Triple Aim. Respondents cited this as a viable model for bringing about significant and necessary market changes including cost control.

Community Initiatives

> *"Oftentimes the social components of what's going on in someone's life is what is inhibiting them from getting the healthcare they need…for example, seniors in the community that don't have a driver's license and they don't have a spouse, the social isolation that goes along with that impacts [mental health] which impacts nutrition and it's just a rolling snowball downhill."*

With the understanding that all healthcare is delivered locally, the SIM Model Design process asked stakeholders for their assessment and evaluation of local health initiatives to improve population health. Key informants cited multiple community initiatives that could be models for the upcoming SIM work. Two that were mentioned most frequently were the work of the Citizen's Health Initiative (CHI) and the Regional Public Health Networks (RPHNs). An example of a community with strong stakeholder involvement that was offered frequently was Keene. Respondents noted that in this community there had been very strong community involvement that included healthcare providers, business leaders, government, advocacy groups, non-profits and other service providers. The North Country and Manchester were other areas cited for strong collaborative efforts. Respondents cited the importance of community initiatives focusing on social determinants of health noting that social obstacles can seriously impact health outcomes but are often overlooked in reform efforts.

Key informants suggested the hospital community benefit programs could be harnessed for community-based initiatives going forward.

Governance

"I think the idea of having regional hubs is very important but people will think, 'Oh my god, here is another regional effort and how are we going to integrate?' I would definitely have a lead agency with clear criteria such as financial stability and so forth."

The initial SIM Model Design application included the concept of regional entities that would serve as "hubs" to support health care systems engineering and provide tools to assist with implementation of transformation. Compared to other components of the project, respondents offered relatively few comments on potential governance structures for regional entities. Many respondents were unfamiliar with the elements of the SIM Model as it was presented to CMS. This lack of familiarity may have made key informants reluctant to comment even when encouraged to provide opinion only. Overall, respondents approved of a regional approach and indicated it will be necessary to transformation success as Granite Staters insist on local control of health care and resist "top down" plans originating from the state government.

However, key informants cautioned that to be effective, regional efforts will need some form of statewide oversight structure and that this should be a public-private partnership. The key theme was, "Don't reinvent the wheel". Respondents noted that much good work has already been done and that the state has limited capacity for development of yet another regional system. Key informants were particularly concerned that the SIM effort coordinate regional hubs in such a way that it does not create duplication of effort with the New Hampshire's 1115 waiver which calls for independent delivery networks for behavioral health and substance use services. Respondents identified several potential options to structure SIM regional efforts including the existing public health networks, counties and aging and disability services, and Area Health Education Centers (AHECs). These same respondents also noted that these existing entities have areas of strength and weakness. No one existing network stood out as being easily transferrable to the SIM conceptual model. In terms of demonstrating outcomes of successful transformation impacts on population health, respondents warned not to 'carve up the state into too small of chunks' as there is a need for numbers large enough to show statistically significant change.

Stakeholder Survey

New Hampshire stakeholders were invited to participate in an online survey, open to any New Hampshire citizen. The purpose of the survey was to introduce key recommendations developed during the SIM planning process and gauge the level of agreement for these elements.

Methods

The 25 question online survey was hosted on Survey Monkey®, and was open from December 21, 2015 through January 8, 2016. The survey was intended for a broad range of stakeholders, including consumers, citizens, academics, patients, advocates, clinicians, policy makers, and anyone who might have interest in health transformation efforts. Eighteen questions were closed-ended and seven were open-ended comment boxes. Sixteen questions required the respondent to choose their level of agreement with a declarative statement regarding the SIM planning process findings and recommendations. No questions required an answer to move forward in the survey, allowing respondents to only answer those questions they wished to.

During the three-week collection period 1181 individuals participated. The survey was initially distributed to 379 unique email addresses identified through DHHS listservs and professional networks. The survey link was unprotected and therefore could be forwarded to an unlimited number of additional stakeholders. Individuals and organizations were asked to share the survey information and link with their members and constituents through emails, listservs, newsletters, websites, or other forums. While this allowed for the widest distribution of the survey in the shortest period of time, it also resulted in a convenience sample that was skewed to three stakeholder categories: citizens of New Hampshire, healthcare providers including behavioral health providers, and local and state government agency personnel.

Respondents represented providers, policymakers, advocates, payers, consumers, patients, academics, community organizations, professional associations and others. Some respondents were unfamiliar with the background and technical aspects of comprehensive health reform and noted this in open-ended comments. Given the sampling methodology findings may not be representative of the state as a whole. This along with the acknowledgement by some respondents that they have limited knowledge of health reform concepts, can be considered a limitation of the survey results.

Simple descriptive statistical analysis was performed on quantitative data to determine frequencies. Qualitative responses were coded and analyzed to develop high-level themes from the data collected by open-ended text boxes. No sub-analyses were performed on either quantitative or qualitative data. Key findings from the online survey are summarized below.

Survey Findings

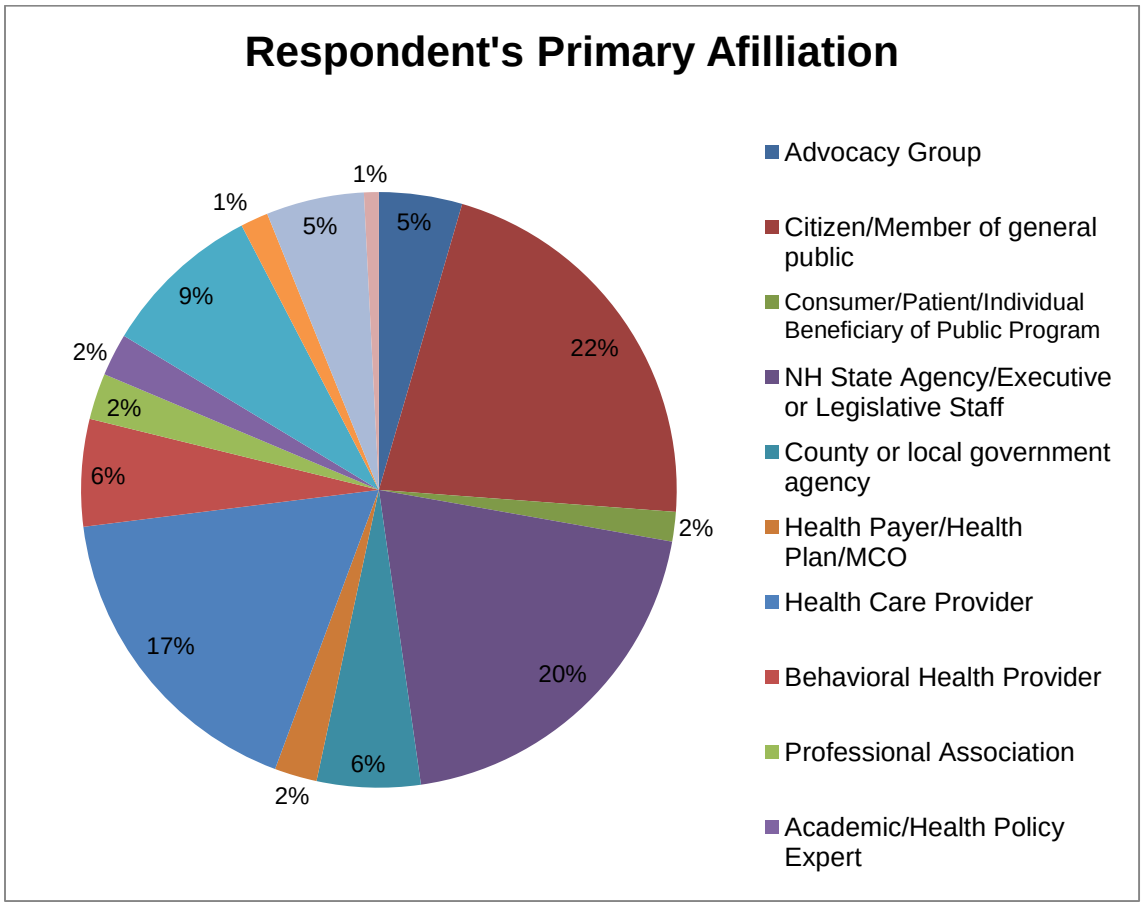
The online survey was an attempt to gather broad feedback on elements of the proposed SIM Model Design. The primary key finding of the survey is that all major components of the proposed plan received significant support from respondents. The response rate was significantly higher than expected given the

initial distribution list, time of year and limited resources for public education on comprehensive health reform. Importantly, this survey highlights that diverse citizens feel strongly about the need for health transformation and vested in the outcomes, regardless of their depth of knowledge base, and want to be involved.

Demographics

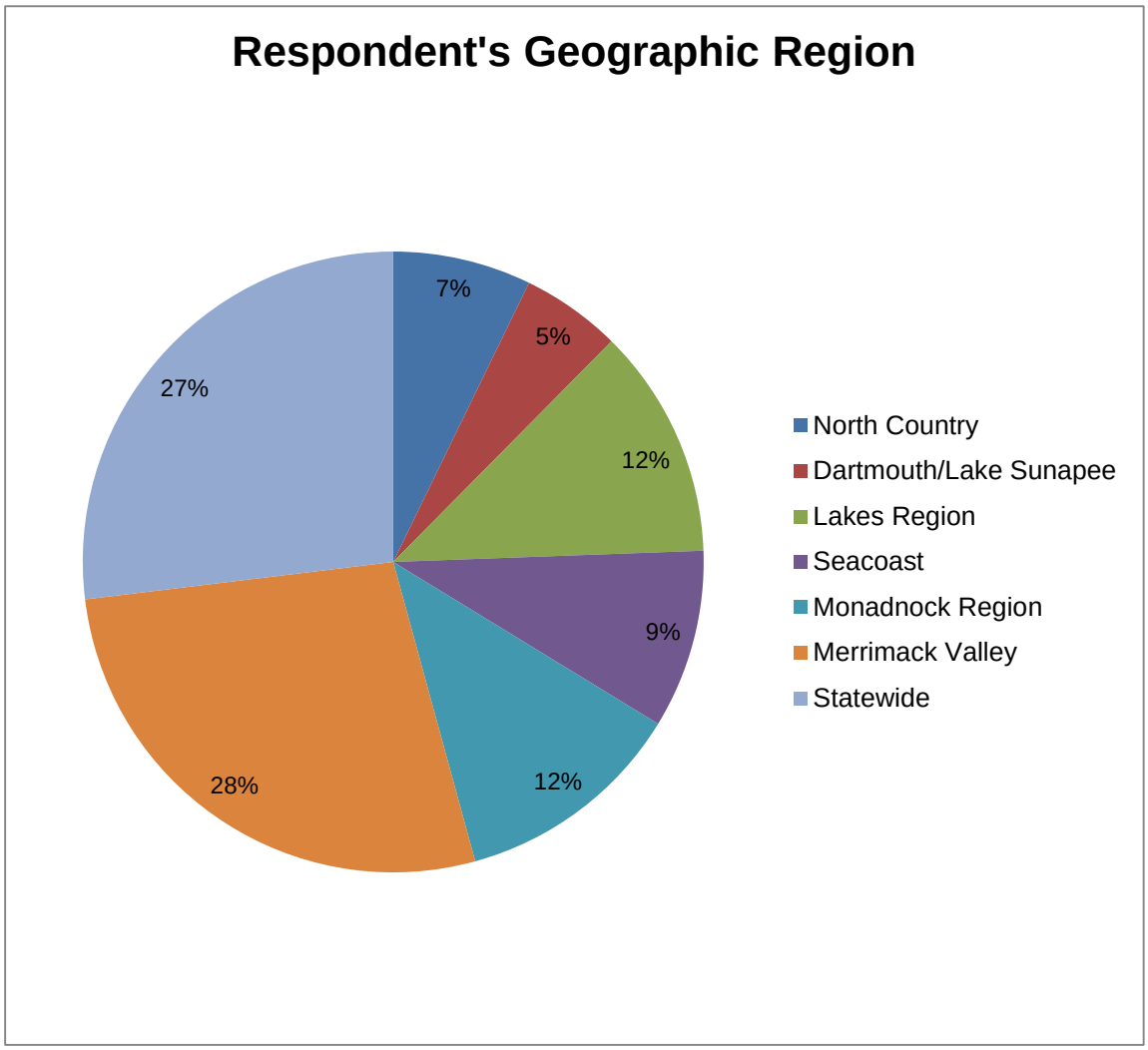
Introductory questions captured respondents' primary role in relation to SIM model planning as well as their geographic region. Initially there were 13 categories for "primary role"; these were collapsed to 11 categories for purposes of analysis. Of the 1181 respondents, 26% identified themselves as affiliated with "NH State Agency/Executive or Legislative Staff" or "County or local government agency"; 22% identified as '"Citizen/Member of general public" and 23% identified as "Health Care Provider" or "Behavioral Health Provider". Figure B.2 shows the full breakdown of survey respondent's primary roles.

Figure B.2: Respondent's Primary Affiliation



The majority of respondents were from the Merrimack Valley (28%) or represented statewide geographies (27%). Figure B.3 shows the percentage of respondents from each region of the state. No sub-analyses were completed based on respondent region.

Figure B.3: Respondent's Geographic Region

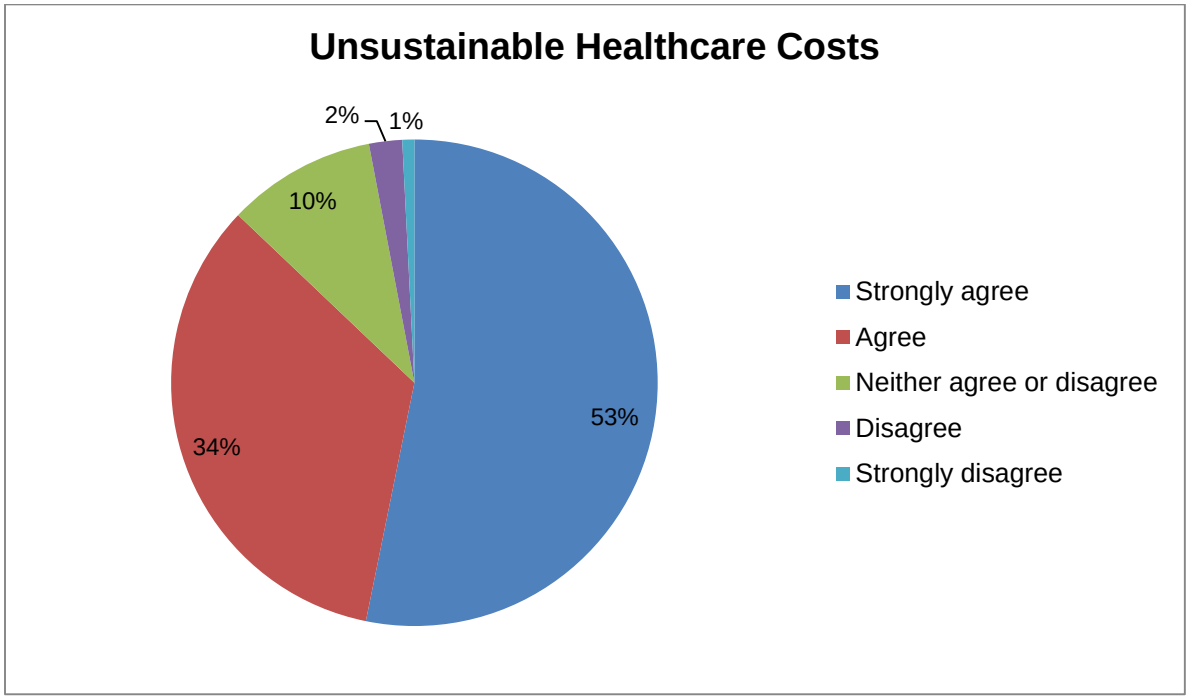


New Hampshire and Healthcare Transformation

Respondents were asked to rate their agreement with three overarching concepts related to comprehensive health care reform in New Hampshire. The first was related to health care costs, including a potential $65 million dollar budget gap for the state budget (see Appendix X for New Hampshire budget analysis). The question included a statement asserting that health care costs are too high, unsustainable and that this is a significant problem for all Granite Staters. Eighty-seven percent of respondents either

strongly agreed (53%) or agreed (34%) with this statement. Ten percent answered that they neither agreed nor disagreed and three percent either disagreed (2%) or strongly disagreed (1%).

Figure B.4: Unsustainable Healthcare Costs

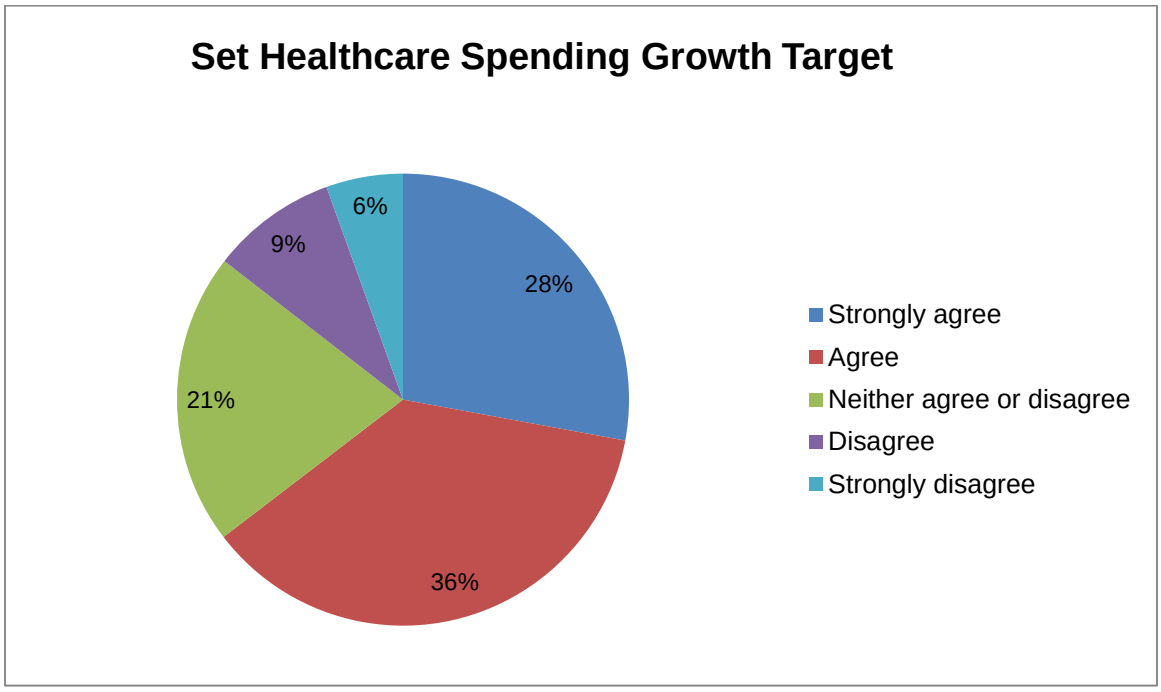


Respondents were also asked to rate their level of agreement with the following statement:

> *New Hampshire should adopt a growth target to control the rate at which health care spending is allowed to increase each year. Any targets New Hampshire adopts should include transparent public accountability for reaching those targets, including but not limited to public hearings and reporting.*

This question was designed to address the rate at which health care costs are growing and to assess whether or not respondents are in support of cost control efforts in the form of a growth target. Sixty-four percent of respondents either strongly agreed (28%) or agreed (36%) with this approach. Twenty-one percent answered that they neither agreed nor disagreed and fifteen percent either disagreed (9%) or strongly disagreed (6%). Sub-analysis revealed that providers and advocacy groups were approximately twice as likely to disagree or strongly disagree with setting growth targets for health spending. All other stakeholder groups' answers were in general accordance with the aggregate.

Figure B.5: Set Healthcare Spending Growth Target

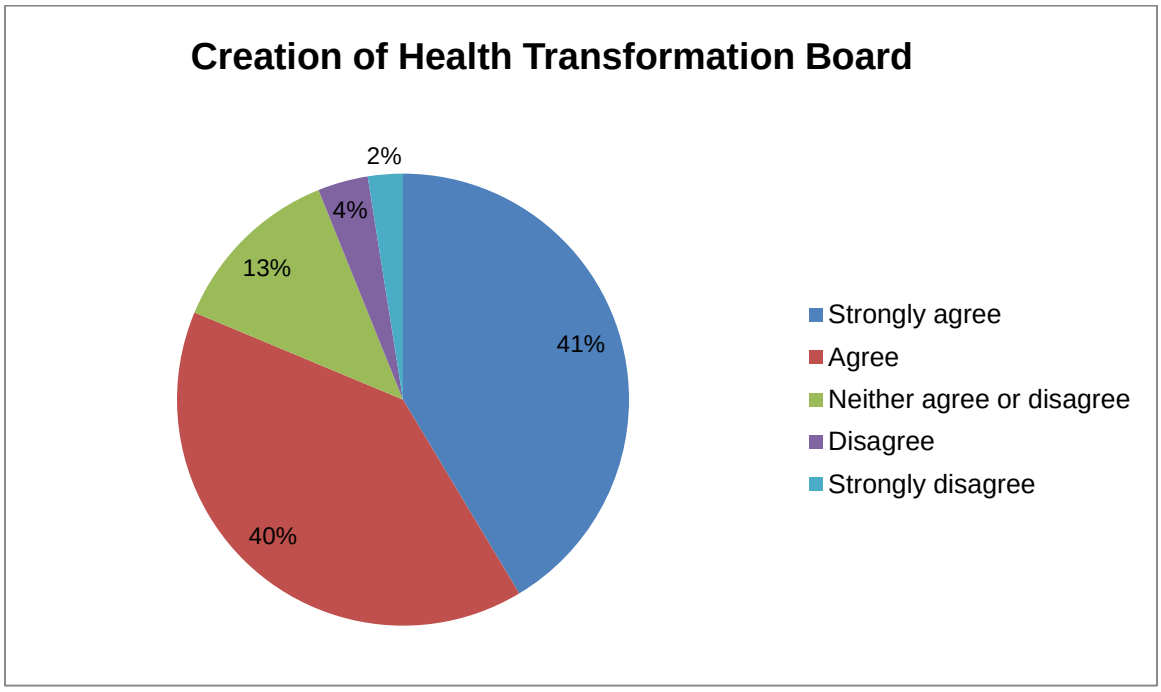


The third concept that was tested in this survey was related to visionary leadership and accountability for reform efforts. A major theme that emerged from key informant interviews early in the SIM planning process was that New Hampshire lacks a shared statewide vision and commitment to improving health and lowering health care costs. Further, participants in the planning process expressed frustration at the fragmented nature of the health care system, and that this fragmentation has led to a lack of shared accountability. This in turn inspired the GAB and workgroups to suggest an oversight board that would be dedicated to and accountable for health transformation. As a result, survey respondents were asked to rate their level of agreement with the following statement:

> *New Hampshire should create a state-wide, multi-stakeholder Health Transformation Board (to include patients, consumers, employers, providers, payers and others) to ensure consistent, high level, accountable attention to comprehensive health care transformation.*

Eighty-one percent of respondents either strongly agreed (41%) or agreed (40%) with the need for a multi-stakeholder oversight approach. Thirteen percent answered that they neither agreed nor disagreed and six percent either disagreed (4%) or strongly disagreed (2%).

Figure B.5: Creation of Health Transformation Board



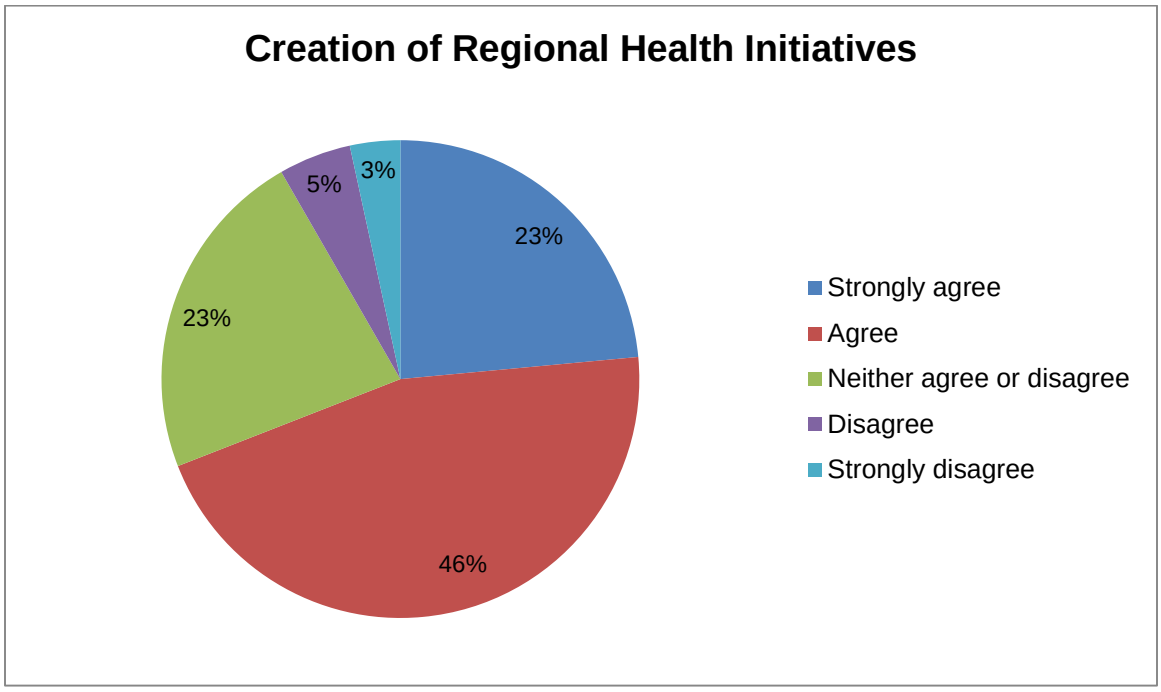
Work Group Recommendations

The subsequent sections of the survey focused on specific recommendations brought forward by the SIM Governor's Advisory Board (GAB) and their workgroups. SIM State Health System Innovation Plan recommendations were presented in the form of declarative statements to which respondents were asked to rate their level of agreement. Recommendations were offered for each of the five work groups areas of the SIM stakeholder process as described on page 15. Each focus area also provided an opportunity for open-ended comment.

Governance

The survey queried respondents on one overarching Governance workgroup recommendation. The suggested approach was for a coordinated and aligned effort related to regional initiatives (see page 48 for description of Regional Health Initiatives {RHIs}). The proposed initiatives would provide assistance in health and practice transformation, be locally driven, leverage existing structures and strengths and connect to Public Health Networks. Regional Health Initiatives will be designated through an outcome focused, competitive RFP process and will act as 'backbone' entities to foster aligned reform efforts. Sixty-nine percent of respondents either strongly agreed (23%) or agreed (46%) with this approach. Twenty-three percent answered that they neither agreed nor disagreed and eight percent either disagreed (5%) or strongly disagreed (3%).

Figure B.6: Creation of Regional Health Initiatives

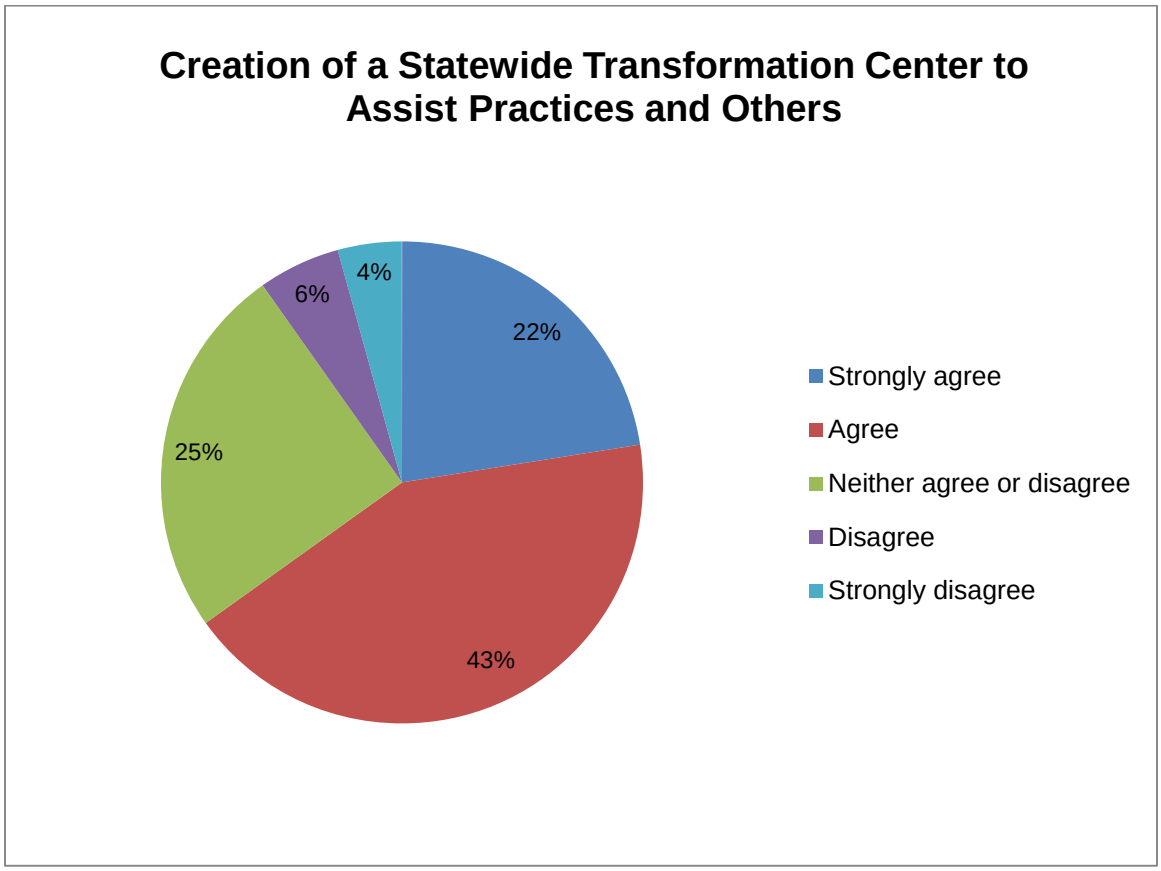


Qualitative responses showed that respondents were particularly concerned that regions be treated equitably and noted that regions are very differently resourced, in particular, respondents stated concern for the North Country.

Practice Transformation

The Practice Transformation workgroup proposed several recommendations to guide comprehensive changes to care delivery practices in the state. The first recommendation involved recognition that healthcare delivery transformation requires significant effort and resources, and that change can place a burden on health care providers. Since many providers do not have the capacity to transform with purely internal resources and support, the workgroup recommended the creation of a statewide Transformation Center to support and sustain providers during their reform efforts. The Transformation center would work with the new board described above to select Regional Health Initiatives. Sixty-five percent of respondents either strongly agreed (22%) or agreed (43%) with this approach. Twenty-five percent answered that they neither agreed nor disagreed and ten percent either disagreed (6%) or strongly disagreed (4%).

Figure B.7: Creation of Statewide Transformation Center

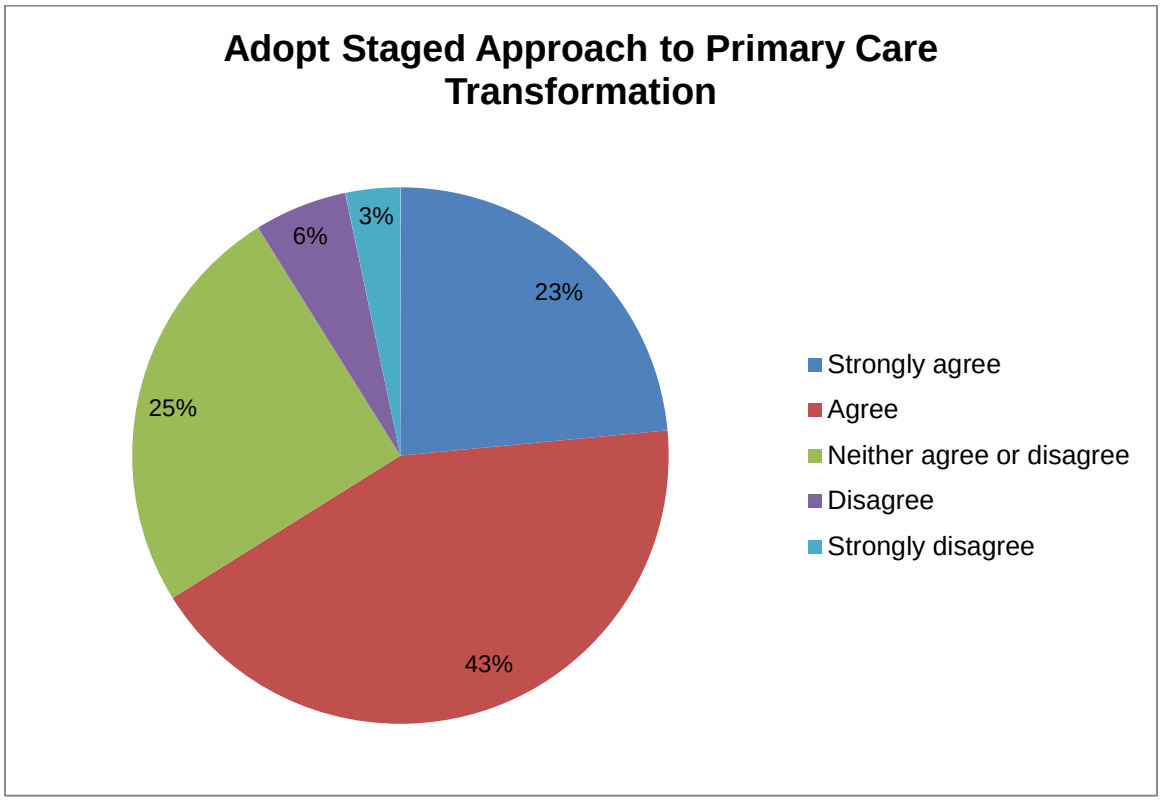


In addition to creating a Transformation Center, the workgroup also recommended taking a staged approach using a hybrid primary care transformation model with the following elements:

- Providers involved in setting their own transformation goals based on their current level of readiness;
- Technical assistance for practice to achieve specific goals including pro-active care management for patients, coordination of care during transitions, enhanced patient access, solicitation of patient feedback and ongoing efforts to measure and improve quality; and
- Practices entering agreements with their local RHI to receive support and coaching to achieve transformation goals.

Sixty-six percent of respondents either strongly agreed (23%) or agreed (43%) with this approach. Twenty-five percent answered that they neither agreed nor disagreed and nine percent either disagreed (6%) or strongly disagreed (3%).

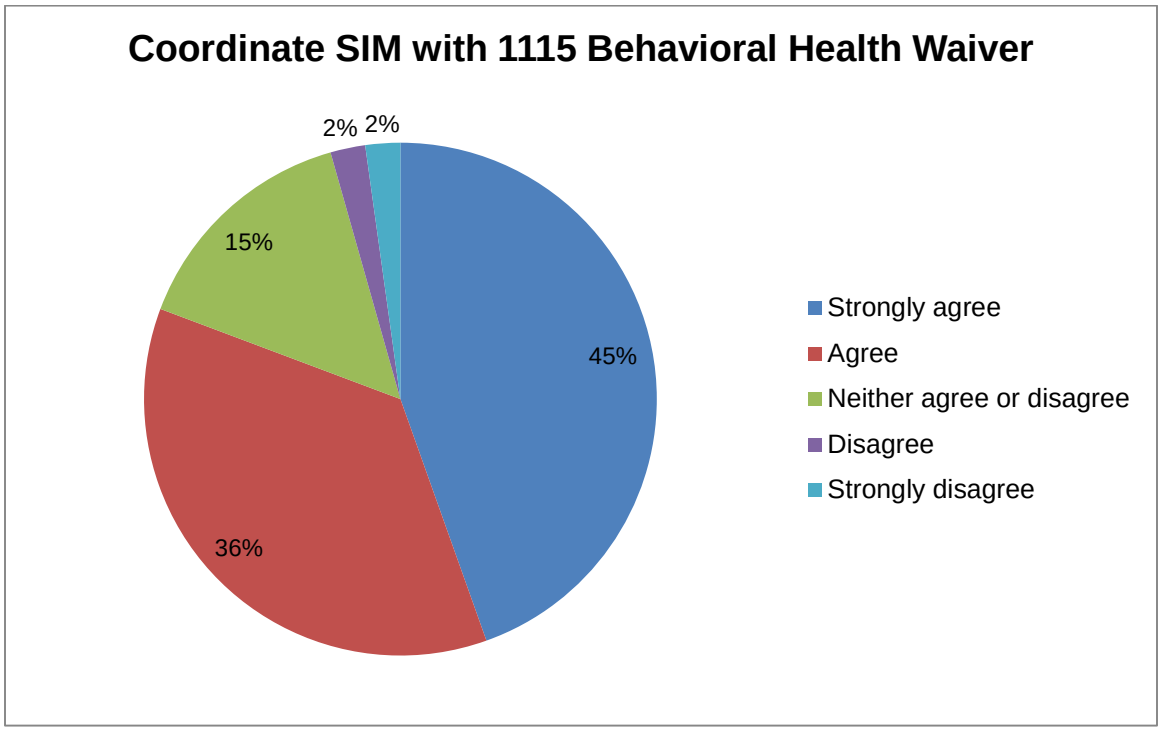
Figure B.8: Adopt Staged Approach to Primary Care Transformation



Simultaneously to applying for a SIM Model design grant, DHHS applied for and was granted a Medicaid Section 1115 waiver to assist with the integration of physical and behavioral health systems including substance use disorders. Integrated delivery networks (IDNs) are a foundational element in the 1115 waiver. IDNs include patients, clients, family members and providers all working together to create patient-centered care that is cost effective and addresses issues of delivery system fragmentation. Per the waiver, New Hampshire will adopt an Integrated Care Framework to support efforts of primary care providers and behavioral and substance use health providers to coordinate care for shared patients and integrate their services into one coordinated care team.

Eighty-one percent of respondents either strongly agreed (45%) or agreed (36%) with this approach. Fifteen percent answered that they neither agreed nor disagreed and four percent either disagreed (2%) or strongly disagreed (2%).

Figure B.9: Coordination of SIM with 1115 Behavioral Health Waiver



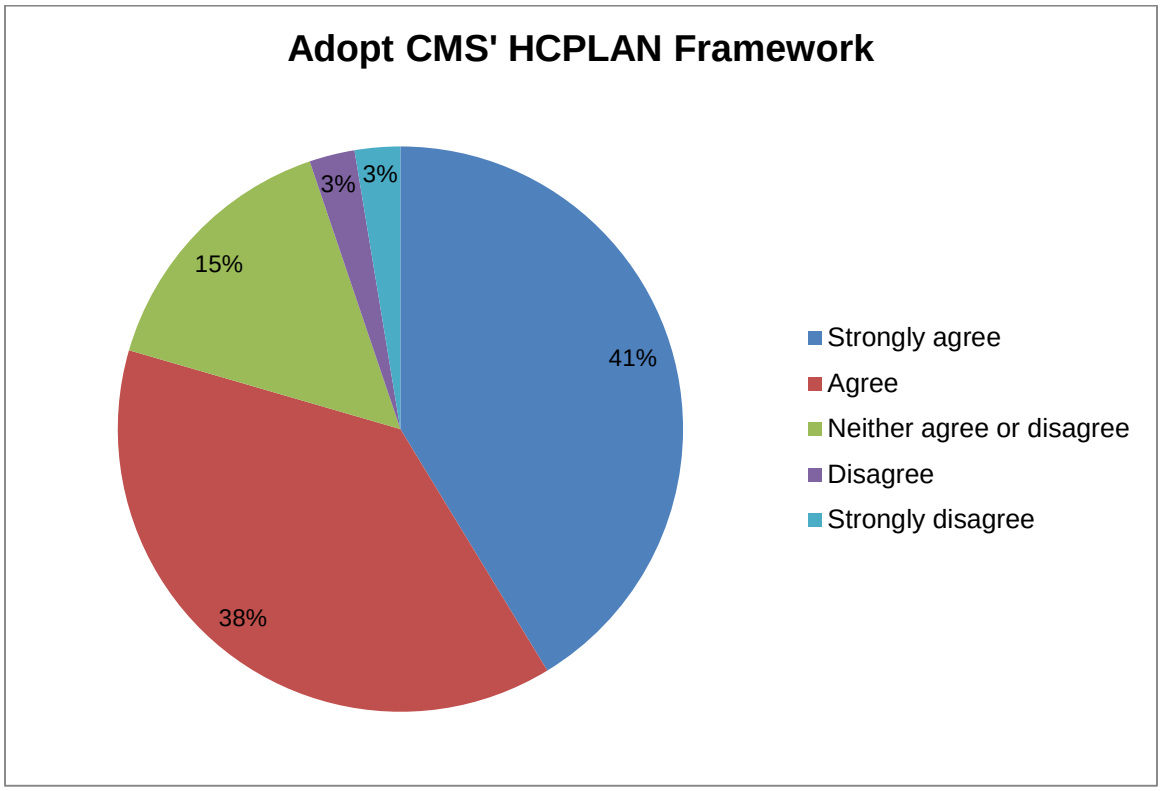
Payment Reform

There is currently no overall, broad-based effort to catalogue or coordinate payment reform in New Hampshire, share learning, or evaluate different models and approaches within the state. The goal of payment reform is to move payment models toward outcome, quality related or "value-based payments" and away from the dominant fee for service (or pay for volume) method. The Payment Reform Work Group proposed the adoption of the CMS supported Healthcare Payment Learning and Action Network (HCP LAN) Framework (Figure D.2). This framework outlines a continuum of stepped categories, which can be sequentially be implemented for progress toward value-based payments with varying levels and timeframes. Respondents were asked to rate their degree of agreement with the following statement:

> *Using the HCPLAN Framework, New Hampshire should adopt a transparent and ambitious schedule for implementation and progress that involves all payers, including Medicare.*

Sixty-nine percent of respondents either strongly agreed (41%) or agreed (38%) with this approach. Fifteen percent answered that they neither agreed nor disagreed and six percent either disagreed (3%) or strongly disagreed (3%).

Figure B.10: Adopt CMS' HCPLAN Framework

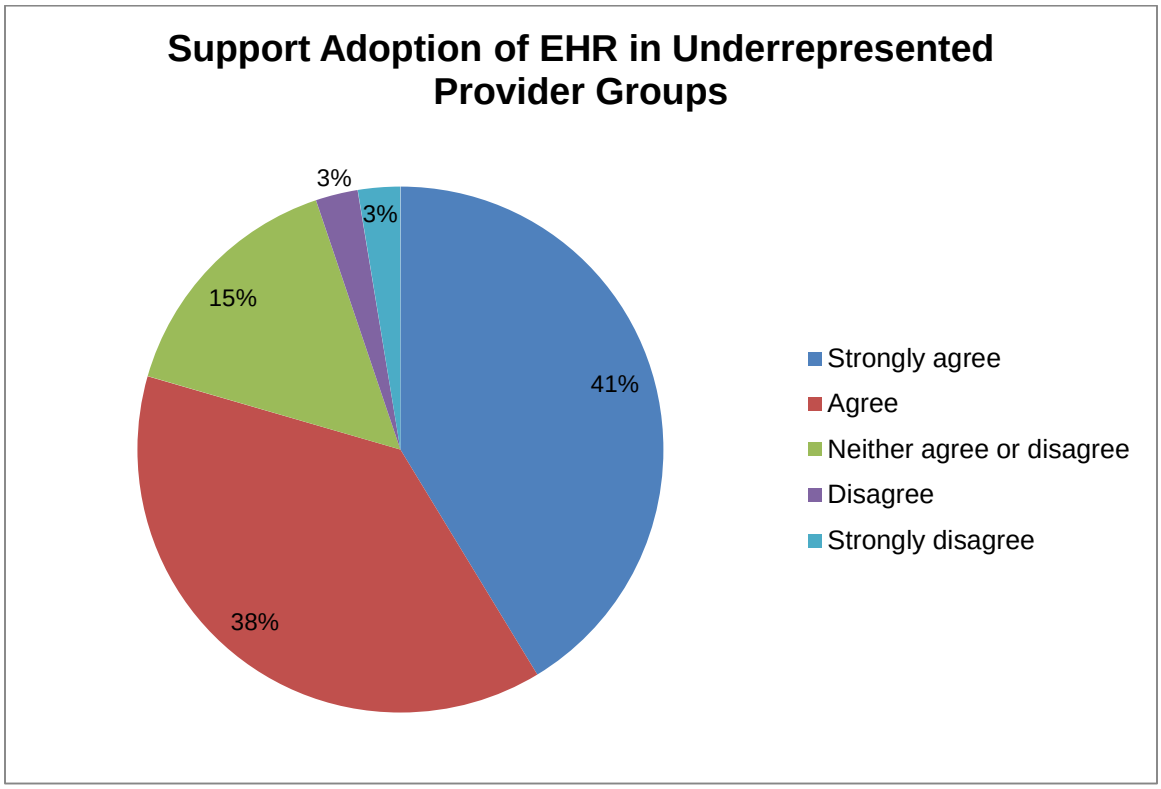


Health Information Technology

The Health Information Technology (HIT) Work Group proposed a comprehensive, phased approach for optimal use of HIT resources in New Hampshire. The survey queried stakeholders on four recommendations from the workgroup. The first recommendation acknowledged that NH has a high level of electronic health record (EHR) adoption and recommended strategies for adoption by provider groups who have been historically poorly represented. These include provider types such as behavioral health services and long-term services and supports.

Seventy-nine percent of respondents either strongly agreed (41%) or agreed (38%) with this approach. Fifteen percent answered that they neither agreed nor disagreed and six percent either disagreed (3%) or strongly disagreed (3%).

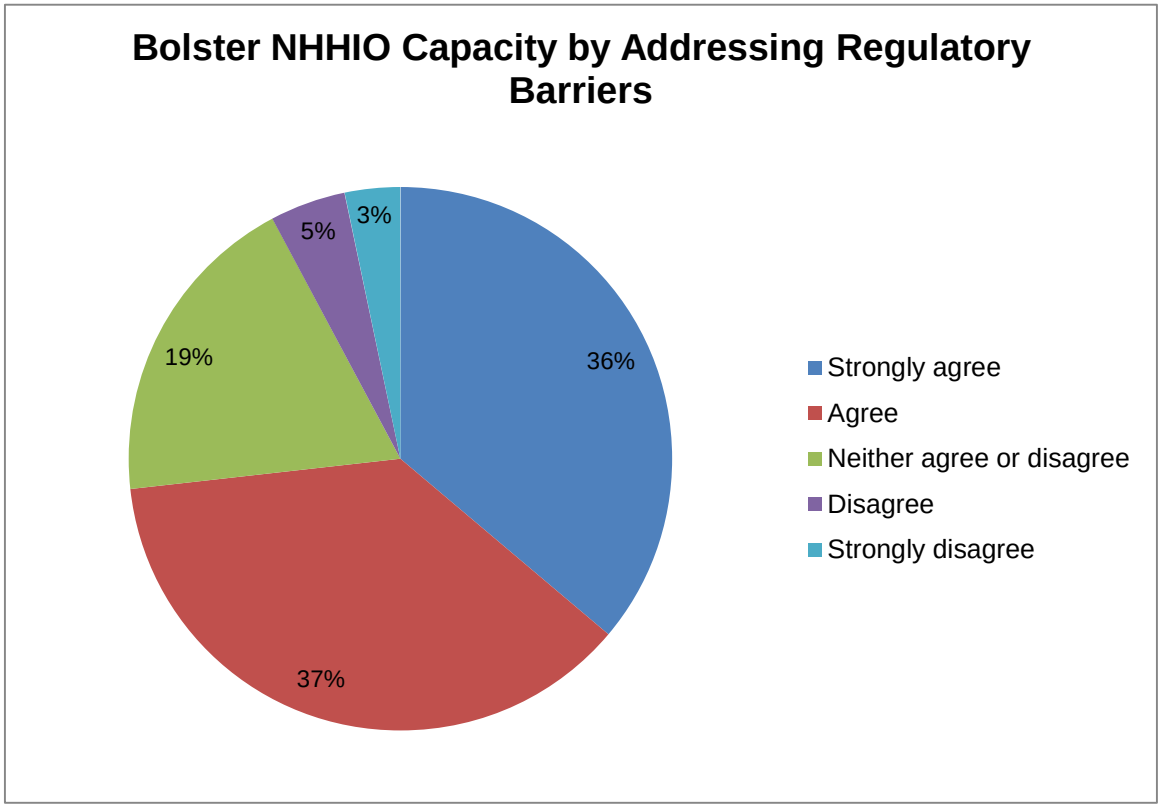
Figure B.11: Adoption of EHR in Underrepresented Provider Groups



The electronic exchange of health information in New Hampshire is fragmented. This is partly due to the state-designated health information exchange entity, the New Hampshire Health Information Organization (NHHIO), having limited ability to store and transfer health information (per regulation). Therefore, the workgroup proposed bolstering the ability of the state HIE by addressing regulatory challenges for NHHIO. Modifying restrictions on the amount and types of information that the HIE can store and transfer, and expanding the definition of the types of providers who can participate in the exchange is one step toward that outcome.

Seventy-three percent of respondents either strongly agreed (36%) or agreed (37%) with this approach. Nineteen percent answered that they neither agreed nor disagreed and eight percent either disagreed (5%) or strongly disagreed (3%).

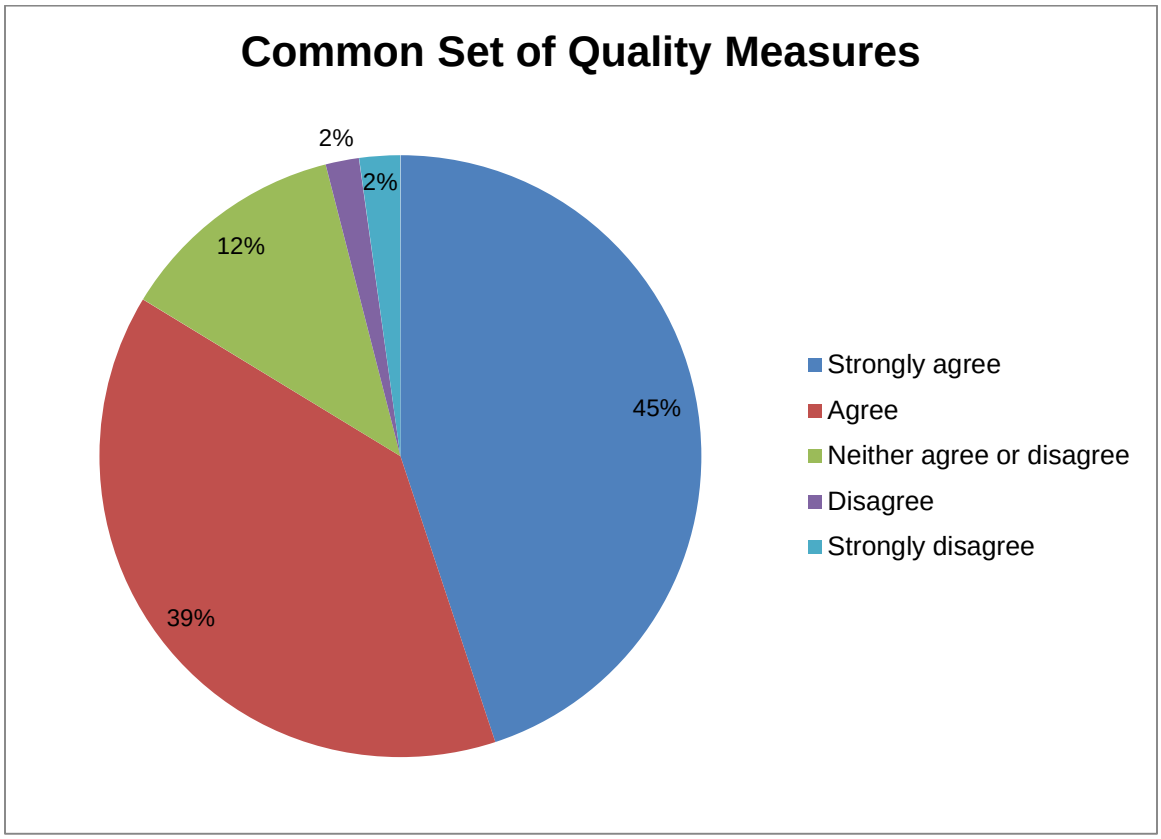
Figure B.12: Bolster NHHIO Capacity by Addressing Regulatory Barriers



In order to measure population health improvements, healthcare providers are required to report quality outcomes to multiple payers including the state, federal and commercial plans. These outcomes are currently not coordinated or aligned, which results in significant administrative burden on providers. The workgroup recommended the development of a common set of electronically reported quality measures that are aligned across payers with the caveat that these measures must not add administrative burden and should provide actionable data for those individuals providing care.

Eighty-four percent of respondents either strongly agreed (45%) or agreed (39%) with this approach. Twelve percent answered that they neither agreed nor disagreed and four percent either disagreed (2%) or strongly disagreed (2%).

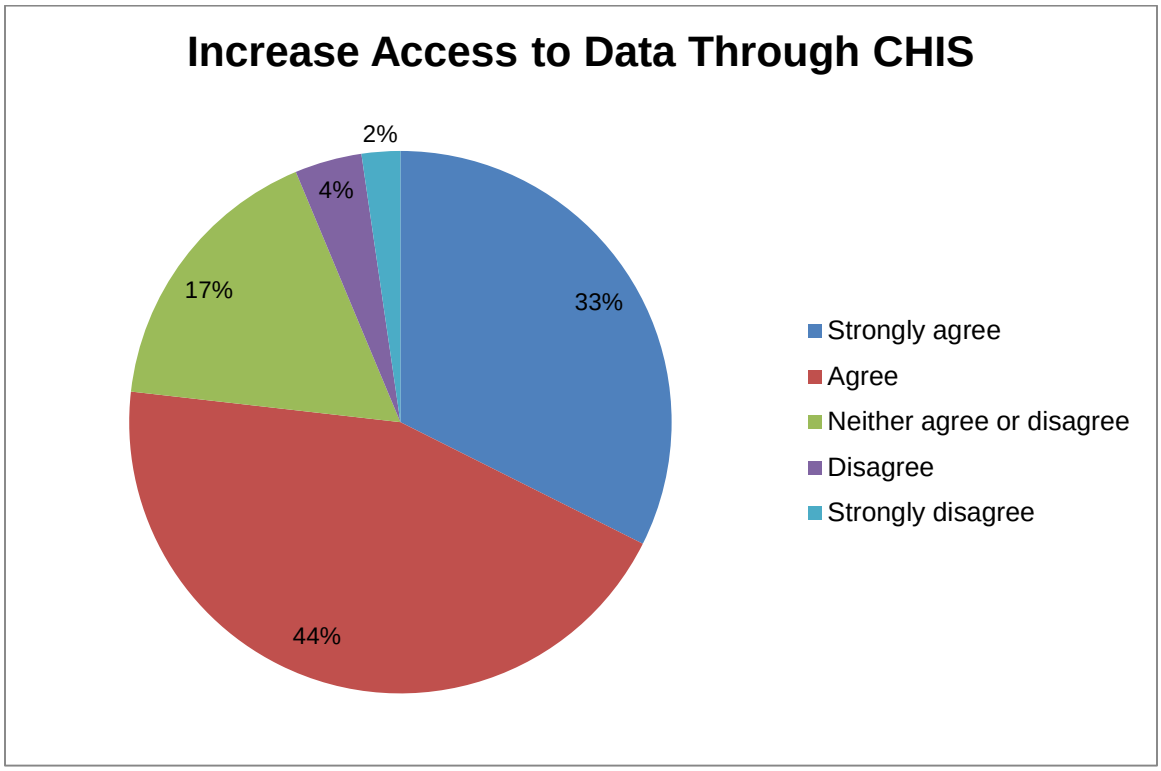
Figure B.13: Common Set of Quality Measures



Access to information is needed to drive decision-making across multiple domains, including individual and population health. While New Hampshire currently has two robust websites that provide access to population health indicators and healthcare cost, greater access to this already-public data is needed. Therefore, the workgroup proposed increasing access through the state Comprehensive Health Care Information System (CHIS) as a starting point. Eventually, other data types could be incorporated and linked including data from other sectors such as transportation and environmental registries, as appropriate.

Seventy-seven percent of respondents either strongly agreed (33%) or agreed (44%) with this approach. Seventeen percent answered that they neither agreed nor disagreed and six percent either disagreed (4%) or strongly disagreed (2%).

Figure B.14: Increase Access to Data Through CHIS



Community Initiatives

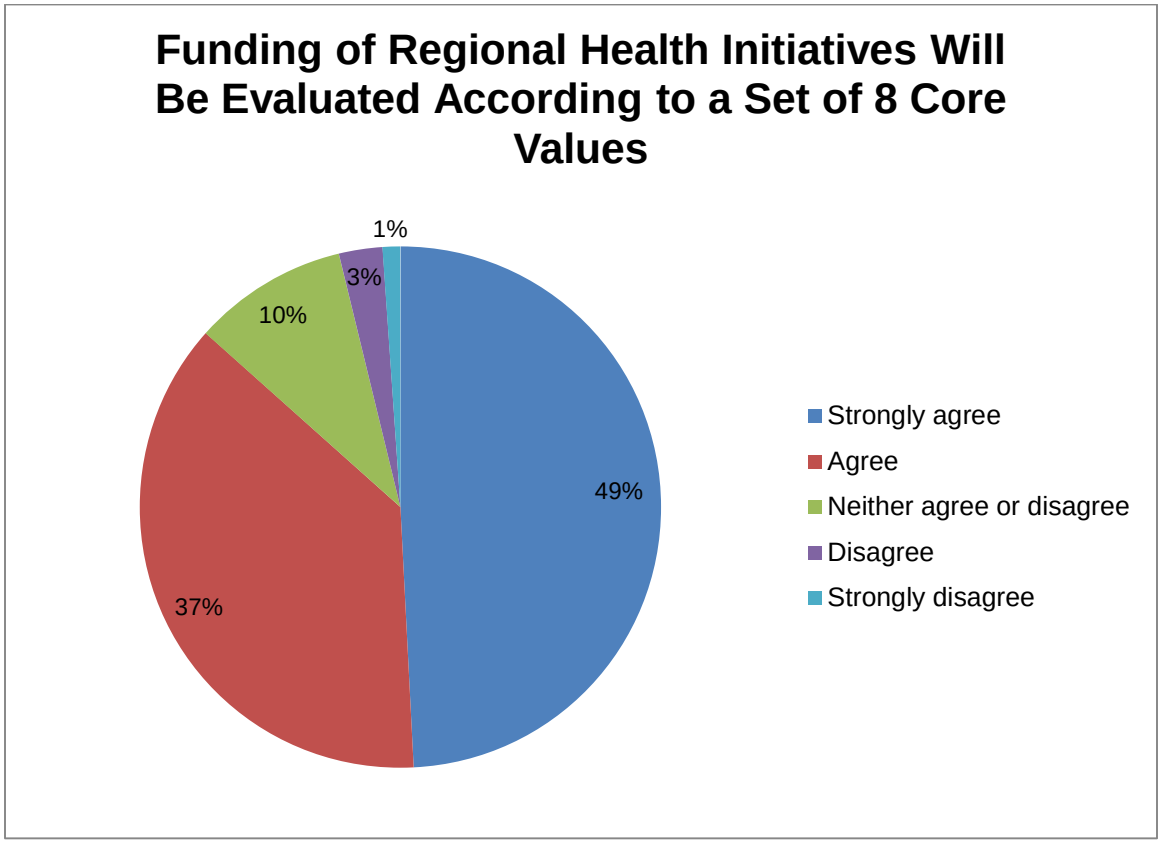
The Community Initiatives Work Group proposed several recommendations to guide community level engagement in improved health outcomes. Survey respondents were asked to rate their level of agreement with two overarching approaches to work that will be designed and implemented at the local level. Funding for community health initiatives will be available through the Regional Health Initiatives (RHIs) and will assist communities with implementation of health improvement efforts. One recommendation is that regional population health initiatives address all of the following eight core values in order to receive funding for community based health improvement efforts:

- Increase access to care
- Build on existing strengths of the community
- Promote evidence-based interventions
- Motivate and engage the community
- Make all access points the 'right' door for entry to care or services
- Focus on 'health' not just 'healthcare'
- Include 'adverse childhood experiences'

- Include all relevant stakeholders including those with lived experience of targeted conditions

Eighty-six percent of respondents either strongly agreed (49%) or agreed (37%) with this approach. Ten percent answered that they neither agreed nor disagreed and four percent either disagreed (3%) or strongly disagreed (1%).

Figure B.15: 8 Core Values

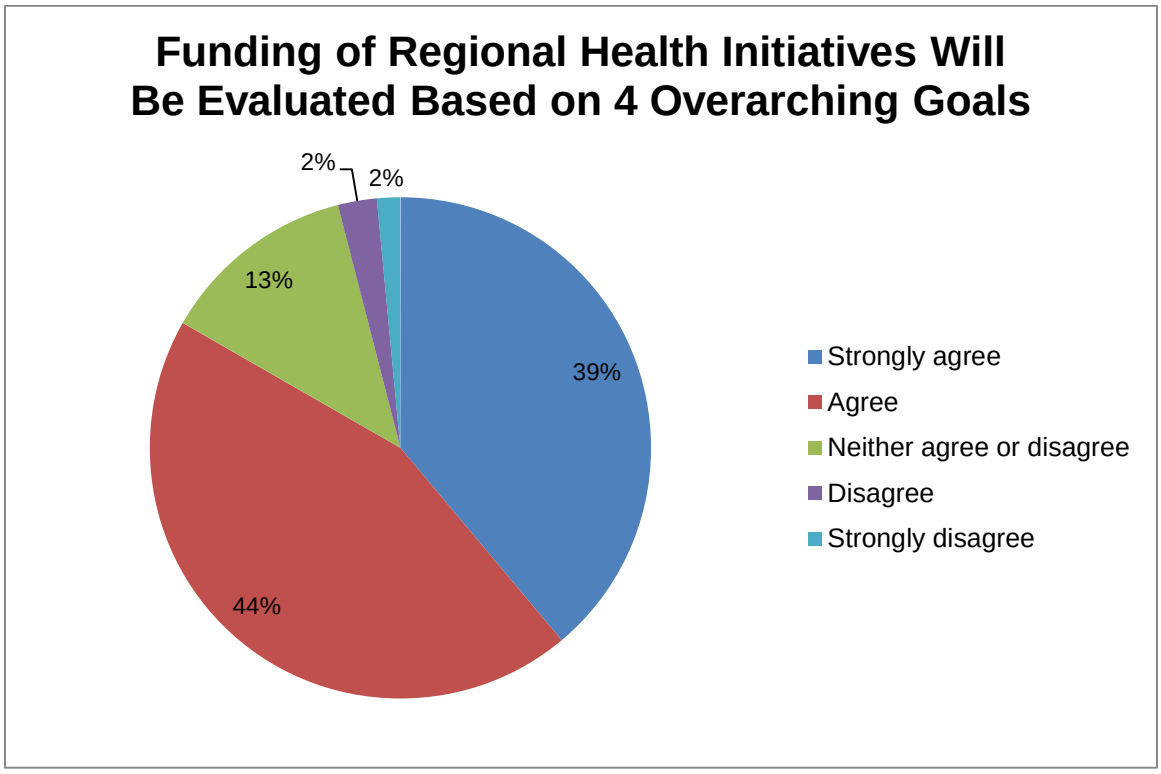


In addition to requiring adherence to eight core values, the workgroup proposed that applications for population health initiatives be evaluated based on the following goals:

- Collaboration, alignment and supportive structures for health
- Further population health goals (based on evidence, data, and local/regional priorities)
- Competent workforce for population health
- Motivating leadership - Multi-sector decision makers (including Public Health Networks and community leaders) come together and make decisions aligned with statewide plans

Eighty-three percent of respondents either strongly agreed (39%) or agreed (44%) with this approach. Thirteen percent answered that they neither agreed nor disagreed and four percent either disagreed (2%) or strongly disagreed (2%).

Figure B.16: 4 Overarching Goals

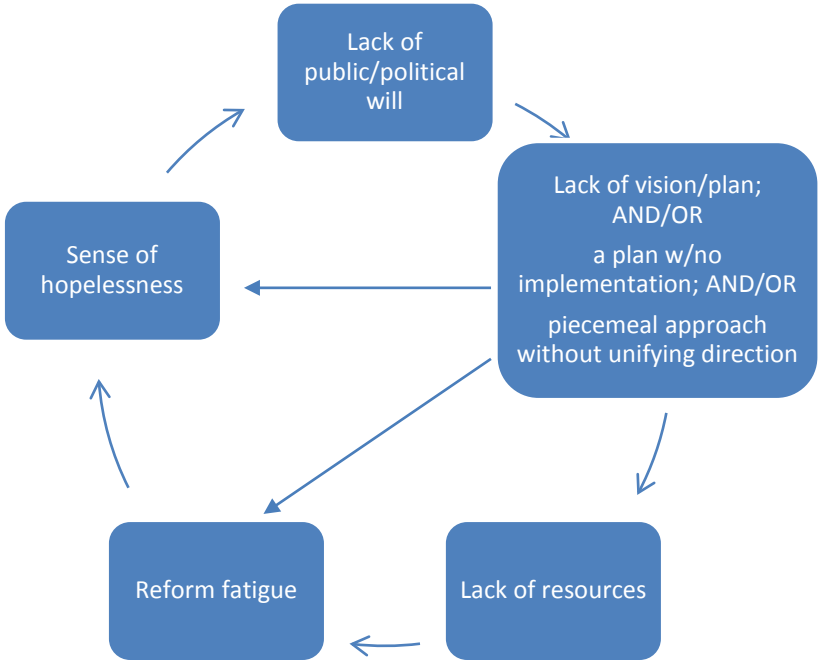


Overall, New Hampshire stakeholders are in strong support of both the overarching need for and elements of comprehensive health transformation as outlined in the SIM Model Design proposal. The aggregate majority supported all the key elements that were vetted with survey respondents. In addition, there is robust stakeholder interest for engaging in transformation efforts by the general citizenry as well as stakeholders who are already more closely involved.

C. Health System Design and Performance Objectives

A common and recurring theme throughout workgroup deliberations, in stakeholder engagement and Key Informant Interviews is the "lack of statewide vision" and "roadmap" on health. There has been no unifying set of goals or outcomes, and no clear center of gravity for health transformation with credibility, access, and leverage across all sectors. The Governor's Advisory Board expressed frustration with a repetitive cycle of problem identification and discussion with limited follow through and attention span across the state. As one advisory board member described, people participate in processes, committees, and forums and then two years later do it all over again. This was identified as a "Cycle of Inertia" (see Diagram C1). SIM will help New Hampshire break this cycle.

Figure C.1: Cycle of Inertia



Relatedly, stakeholders do not believe that the state agency, the Department of Health and Human Services (DHHS), has the authority or influence to serve as the primary leader for transformation – this is not a challenge for which a single agency is designed or equipped. Likewise, while state government has

important levers for change and leading roles to play, the broader health community must share long-term ownership and accountability for maintaining momentum and achieving transformational change. The bulk of the health sector is outside of the direct operational control of state government.

This section outlines New Hampshire's overall health system design, emphasizing governance and key components of the model. Sections D-H will provide additional detail about how the model will be operationalized.

Governance of the SIM State Health System Innovation Plan

The original New Hampshire SIM Model Design proposal called for the Governor's Advisory Board (GAB) to serve a long-term function in guiding SIM plan implementation. However, the GAB lacks formal authority beyond the SIM planning grant, exists only under the current governor (who will leave office in 2017) and is without full legislative or executive council investment in its role. The GAB was not designed with accountability or oversight authority and would need increased formalization to do so.

Stakeholders are clear that substantive leadership on broader health transformation is needed and must transcend legislative sessions and election cycles in order to achieve any sustained improvement in health outcomes and costs. They are united in recommending the creation of an overarching governance board or council to unify goals and outcomes and provide leverage and credibility in moving health transformation forward, addressing the absence of unified vision and roadmap, identified by nearly all stakeholders.

The SIM State Health System Innovation Plan calls for a governance board or council with authority vested by the state to guide transformation. A board will ultimately be created with support and authority vested by the legislature, executive council, and governor. The board will include policy makers and government leaders, but cannot be exclusively – or even majority – state government membership. Health stakeholders, experts, community leaders, local governments, payers, employers, and consumer representatives all must have a voting seat at the table. A governance board or council is needed that is not only "advisory" – but has the *authority to guide transformation in a coordinated manner by utilizing the appropriate levers the state has as a purchaser, provider, regulator and convener of health care.*

The SIM Governor's Advisory Board (GAB) framed the desired scope and characteristics of the new governance board or council as:

- Focused on delivery system reform and implementation of the SIM State Health System Innovation Plan
- High profile, but objective, empowered, and trusted enough to influence

    - Executive branch
        - Governor
        - Agencies
    - Legislative branch
    - Transformation partners
- Provides public transparency
- Accountable to deliver outcomes
- Authority to drive outcomes in delivery system reform and SIM implementation including
    - Agency coordination (across agencies) and oversight
    - Private sector providers and payers
    - Macro outcome authority
    - Influence/guide community initiatives
- Relationship and voice for Transformation Center
    - Barrier busting
    - Exercise voice/power on behalf of those 'doing' transformation

The operational plan outlines specific phases of a governance board or council – with an immediate need of creating the structure and the longer-term goal of having it legislatively approved and self-sustaining.

Stakeholders agreed on this board's establishment as an urgent priority, important both for substantive change and continued momentum. One option endorsed by several key stakeholders is the initial creation of a start-up or transition board via Executive Order, with a clear expiration date and limited scope, giving way to a truly statewide board to be created through legislative action in 2017. This board should be comprised of 9-13 members with initial representation from and expertise in:

- Health care systems
- Health policy
- Health care reimbursement/payment
- Public health
- Providers
- Health information technology
- Workforce development
- Patient advocacy
- Consumer/public
- Department of Health and Human Services
- Insurance Department

- Business
- Legislators

The board should hold meetings at which testimony is taken and community input is provided to inform their actions and priorities.

Statewide cost reduction accountability is a critical element of durable health transformation. New Hampshire is alone among its contiguous neighbor states in the lack of any target for curbing costs or restraining growth.

Figure C.2: New England Health Cost Containment Policy and Targets

Massachusetts[9]	a) Set 2013-2017 benchmark at the growth rate of potential gross state product of the Commonwealth (PGSP). b) For 2013-2015, consistent with the PGSP, the health care cost growth benchmark has been set at 3.6%.
Vermont[10]	Statutory Goal "reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised."
Maine[11,12]	Maine Health Management Coalition (a) Limit the annual increase in risk adjusted healthcare spending for all Maine residents to the Northeastern United States Consumer Price Index and, in addition, (b) Reduce total risk-adjusted per member per month health care spending by an additional 10% within six years SIM goal Reduce the total cost of care per member per year in Maine to the national average.

In many ways, this positions New Hampshire as the profit center for multi-state payers in the region. As costs are restrained nearby, the gap can be at least partially made up by New Hampshire. This is certainly not beneficial to New Hampshire consumers. Moreover, the long-term financial impact of unrestrained growth is significant – a projected $65M deficit alone for the state budget in 2017. This dynamic also creates reform challenges -- as some organizations in the system experience high profit margins, while other stakeholders experience large cost increases. Stakeholders overwhelmingly agreed that the state

[9] http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/

[10] http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf
[11] http://www.maine.gov/dhhs/sim/documents/4-%20PROPOSAL%20NARRATIVE%20_Sept%2024_.pdf
[12] http://www.maine.gov/dhhs/sim/resources/sim-application.shtml

must have a goal – ideally in statute - of lowering health care costs. Stakeholders were not able to agree on what a benchmark should be. However, examples that were considered, and that should remain on the table for policy maker consideration, include holding cost growth down to an annual percentage below annual projected trend; or restraining cost growth to the same or lower levels than general fund revenue growth; or another meaningful, easily measurable fiscal benchmark such as gross state product. The governance board or council described previously should be charged with cost containment oversight, and publicly holding the whole health sector accountable for achieving it through, at the very least, the power of public scrutiny. The board should hold regular (monthly or bi-monthly) meetings to track health transformation efforts toward the fiscal and health outcomes established by the state, with an annual public meeting dedicated to addressing the state's achievement in meeting these goals.

Without a target for cost containment or cost reduction, and public accountability in the form of transparency and consistent attention aligned with policy and regulatory levers, New Hampshire will not achieve meaningful health transformation.

The governance board or council will initially be supported through the state DHHS; this will transition to a newly established "Transformation Center".

Key Components of the Plan

Transformation Center

The practice transformation work group first identified the conceptual need for a "Center of Excellence" to support practice change across the state. However, stakeholder feedback also revealed that this concept is necessary and applicable across the transformation endeavor. A central hub with a mix of leadership and technical assistance is crucial to providing a day-to-day backbone for broader health transformation, and merging this need with the requirements of the 1115 waiver (which establishes a centralized resource for technical support) provides leverage and efficiency. While Regional Health Initiatives will take the lead on the ground in communities, the size of the state and the efficiency in centralizing some components make a "transformation center" a necessary component to achieve change at scale without redundant infrastructure at the state and local levels. Such a center would establish a critical, central and singular focus on transformation. However, this Center should not be a new layer of management or hierarchy. It must provide support, have direct access at the highest levels (Commissioner and Governor's office) for purposes of accountability and cross-agency and cross-sector legitimacy, and report to the newly established governance board or council; but it should not be in a position of being hierarchically "in charge" of the regional initiatives nor should it be a regulatory agency.

This concept reaffirms the fact that transformation activities can be difficult and require technical assistance and support for on-the-ground organizations to successfully achieve goals.

Participating stakeholders unanimously agreed that the Center will not be within state government. It will be created through open and competitive solicitation through a public RFP process and awarded to an organization(s) with the necessary infrastructure to support the Center's critical activities. Partnership will be encouraged given the size of the state and the multiple centers of research and potential assistance currently available within the state.

To be most effective and efficient, the Transformation Center will:

- Report to the governance board or council, and receive direction and oversight from the board;
- Support practice transformation and health IT integration and coordination across the state. Such support will be in the form of technical assistance, coaching, learning forums, and other highly effective methods (see also Section E for description of practice transformation functions of Transformation Center);
- Coordinate the state's multi-payer activities involving payment reform strategies, stakeholder engagement, strategic planning and implementation;
- Supervise the administration of the Request for Proposals for health transformation by the Regional Health Initiatives. RFPs would be aligned with the Governance board or council's vision and goals and include a combination of practice transformation, health IT and population health improvement projects. The Governance board or council will provide final approval of applications for financial support; and
- Closely align and leverage the transformation activities and resources already underway and available in some regions across New Hampshire.
- Act as the Health Information Technology coordinator within the state, providing support and technical assistance, and convening a HIT committee to oversee and align HIT efforts and accelerate implementation of strategies.

The Transformation Center will have core competencies in practice, payment, and HIT enabling it to provide a blended array of direst services, coordination, convening assistance, resources and guidance. While it will function as the central hub for transformation, the mix of direct service vs, guidance and support to regionals will vary based on the strength and readiness of the local or regional service systems, and the pace and strength of development of Regional Health Initiatives.

Regional Health Initiatives

The initial New Hampshire SIM proposal aspired to create "Regional Healthcare Cooperative Extensions" as a structure to provide local convening, leadership, resources, and support for all components of health systems engineering, integration of social determinants of health, Health IT, and broader transformation. While the concept of locally led convening and coordination remains valid (indeed prioritized), stakeholders recommended that the existing Public Health Networks be integrated into New Hampshire's work and also ensure that resources were used for on-the-ground programs and services and not for additional administration. Thus, the concept of Regional Health Initiatives (RHIs) has developed to fulfill the priorities of local ownership and leadership in a more flexible, outcome driven manner.

There was consensus for allowing Regional Health Initiatives to develop organically within parameters while allowing for maximum flexibility in achieving those outcomes (as opposed to creating strict structural and regulatory requirements or criteria and designation). Based on guidance from the governance board or council, the Transformation Center will create an RFP process that will allow the state to identify the appropriate criteria for the RHIs. Organizations interested in pursuing the development of a Regional Health Initiative through the Transformation Center could be existing regional collaborative or entities that demonstrate strong collaboration between regional stakeholders.

Organizations pursing the RHI designation should be able to demonstrate proficiency in seven governance criteria that will be included in the RFP for Regional Health Initiatives:

- Operating Entity
- Board Make-up
- Accountability
- Structure
- Financial Oversight
- Clinical Oversight
- IT/Data Oversight
- Community Engagement

Operating Entity

A Regional Health Initiative should build upon the strengths of existing organizations within a region and could vary by region. Below are three possible (though not the only possible) models:

1. *Collaborative Contracting*: In some regions, there may be a lead organization – or a Lead Entity - where the contractual arrangements between regional partners stipulate roles and responsibilities. However, the Lead Entity would retain decision-making authority and would contract directly

with the Transformation Center. Partners could be represented in an Executive Committee whose role is limited to coordination and oversight of operational activities.

2. *Delegated Model*: With this model, partners join together (often through a jointly owned LLC) and delegate key responsibilities for governance to a newly created legal entity. The governance process directly oversees all aspects of operational governance with accountability to an Executive Committee representative of the partners.
3. *Fully Incorporated Model*: In this model, the regional partners have combined into a single legal entity with full ownership of the care delivery system. With this model there is close integration of the care delivery processes, unified governance in a corporate structure, and a single management team to drive performance.

Board Make-up

All regional efforts will need to determine how all partners and constituencies have an appropriate and proportionate voice in the governance process of a Regional Health Initiative. Any regional governance model must recognize each organization's autonomy without impeding effective and timely decision-making.

To the extent that there will be capital contributions made toward the Regional Health Initiative, the form of those contributions may impact participation - such as having a proportionate voice based on the size of the contribution. For example, a community should include a majority of stakeholders consisting of the major components of the delivery system as well as the community at large, to ensure that the RHI's decision-making is consistent with the values of the members and the community.

Ultimately, regions must demonstrate that membership will support a sustainable and successful Regional Health Initiative that can deliver the greatest possible benefit within available resources.

Accountability Structure

Objective outcome measures and benchmarks will be a required component for any Regional Health Initiative. Measures would need to be consistent with existing state and national measures, and demonstrated to make progress toward the Triple Aim.

Such measures could be embedded into the contracts of regional partners to hold the organizations accountable for overall performance. In addition, each Regional Health Initiative will develop a process for disputes involving its partners.

Financial Oversight

Regional Health Initiatives will need to have partnering entities with accounting and financial systems that can manage the distribution of payments, other grants and incentives and must be able to provide timely and accurate accounts payable and service reimbursements in a transparent and well-organized business process and the use of best practices in the management of finances and contracts.

Clinical Quality Assurance

Regional Health Initiatives will demonstrate that they have the necessary buy-in from regional partners to champion effective clinical care management processes, including the use of evidence based pathways and compliance with care standards. Clinical oversight includes the following functions:

- Prioritizing the creation, implementation, oversight and continuous improvement of best evidence based medical practices that will most contribute to closing identified clinical performance gaps. Addressing social determinants, and improving clinical and financial results.
- Employing rapid-cycle improvement processes for quality improvement and reinforcing feedback loops for accountability to system improvements, better communication, and sustainability of transformation efforts
- Ensuring the availability of high quality technical assistance support infrastructure, including well-trained practice transformation coaching in collaboration with the Transformation Center
- Facilitating learning collaborations as needed and offering a sustained coaching resource to support practice transformation (See Section E)

IT/Data Oversight

Similar to clinical oversight, Regional Health Initiatives will need to demonstrate that they have the necessary buy-in from regional partners to oversee health IT integration and coordination. IT oversight includes:

- Ensuring the interoperability of regional partner platforms in order to share data
- Consistent with the governance board or council, prioritizing allocation of IT resources and joint IT investments
- Consistent with the governance board or council, recommending the selection of applications and IT approaches
- Support providers in implementation/effective use of, Health IT (EHR's, etc.)

Community Engagement

Each Regional Health Initiative will demonstrate how community members are actively engaged in the design and implementation of the initiative. Regional Health Initiatives will need to work with cross-sector partners at the community level to achieve integration across the health care delivery system, public health and community resources; and improve population health through engaged participation in and commitment to a collective impact approach at the community level. Regional Health Initiatives will include in their regional plans specific strategies to address the needs of the aging population and align them with Medicare and LTSS efforts.

Public Health Networks

A recurring theme from members in SIM workgroups has been the need to integrate the existing Public Health Networks (PHNs) into New Hampshire's transformation work. New Hampshire's PHNs were created to 1) facilitate improvements in the delivery of the 10 Essential Public Health Services including preparedness-related services; and 2) continue the implementation of the Strategic Prevention Framework, substance misuse prevention and related health promotion activities as appropriate to the region. Regional public health priorities have been established based on assessments of community health. The PHNs look to implement programs, practices and policies that are evidence-based and meet improved health outcomes and also advance the coordination of services among partners.

A Regional Health Initiative must demonstrate how they are partnering with Public Health Network expertise in a meaningful way; the role and engagement of the PHN will be further determined through the RFP. As the strength and capacity of the PHNs is uneven throughout the state, their function within the Regional Health Initiatives will vary accordingly.

Diagram C.2

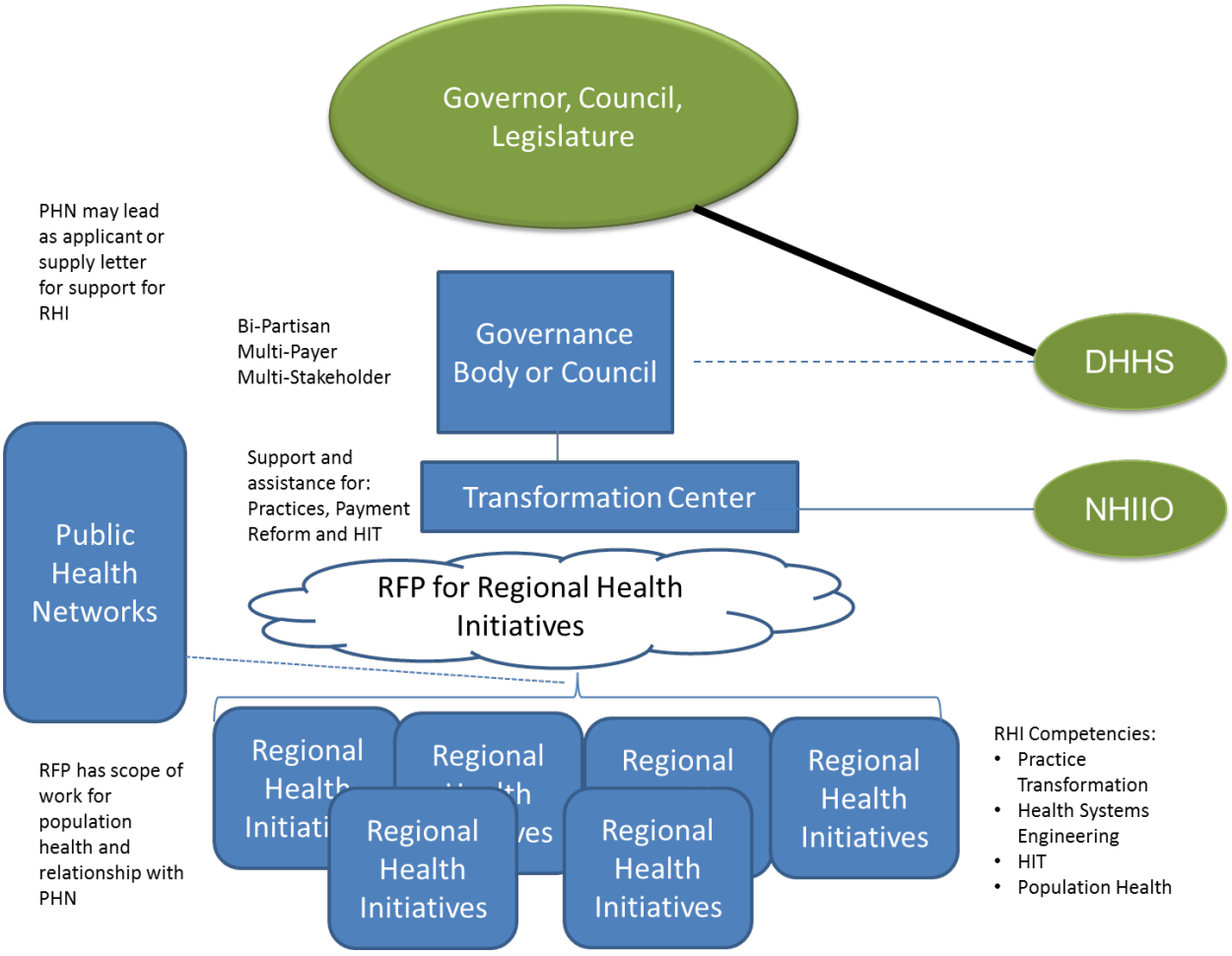


Diagram C.2 illustrates how the components that will govern New Hampshire's SIM model fit together into a comprehensive and accountable approach to transforming the existing system and delivering on the objectives of the Triple Aim.

D. Value-Based Payment

Current State of Payment

From 1991-2009, New Hampshire's growth rate in per capita health spending was 4th in the country at 6.6% per annum, compared to 5.3% nationally (Highland et al., 2015). Additionally, New Hampshire's per capita spending exceeded that of the nation in four areas: hospital ($2,980 versus $2,475), physician and clinical services ($1,863 versus $1,650), other professional services ($248 versus $218) and other services ($2,478 versus $2,211) (SHADAC, 2015). Similarly, consumer out of pocket costs in the private sector have increased. From 2009-2014, consumers faced an average premium increases of 31% (from $13,882 to $18,126) (Agency for Healthcare Research and Quality, 2015).

Coupled with increasing health care expenditures, New Hampshire has a highly concentrated provider and health insurance market that has resulted in limited market competition. Insurers have entered and left the market due to the limited membership supply. Smaller membership pools are inherently unstable and carry high risk for carriers. The NH Certificate of Need (CON) requirement exists to document medical necessity and therefore influences potential expansion of healthcare services. The CON requirement sunsets June 2016, and if not replaced the lack of competition could be impacted.

Currently, New Hampshire carriers rely heavily on a charge-based or fee-for-service payment system in which a provider is paid a fee for rendering a specific service. A large volume of claims expense is also paid to hospitals in the form of DRG payments for inpatient services and APCs for outpatient services. Fee-for-service payment systems create incentives for delivering services, regardless of their impact on health outcomes. The Institute of Medicine (IOM) estimates that 30% of services provided to patients are unnecessary or inappropriate (IOM, 2005). This estimate of waste and inefficiency further increases the costs of health care.

Paying for value is the alternative to paying for volume through fee-for-service payments. Paying for value often includes payment reform as well as delivery system reform. While each can be approached separately, they are inextricably linked, and reform goals will be most effectively met when they are synchronized. Payment reform entails purchasing health services through new payment models that motivate and reward providers for delivering care consistent with scientific findings about what works, rewards improved health status and incentivizes providers to spend health benefit purchaser dollars wisely (Bailit & Burns, 2012). Payment models –including global payments, bundled payment, and shared savings – also give providers incentives to incorporate social interventions into their clinical models. The goal of delivery system reform is to move from a system where individual providers care for patients in silos to a more coordinated and evidence-based approach where providers collaborate on the patient's

behalf to provide care that is known to improve the health status of a patient (Bailit & Burns,2012). In order for payment models to yield maximum benefit, providers must be able to refer patients to the most appropriate source of care, based on cost, access, and quality. Many communities, provider employment arrangements, and/or carrier networks are not yet synchronized to effectively employ this approach.

Delivery system reform models, such as patient-centered medical home, require that providers integrate social and community supports into their care models. Incorporation of social interventions into the care model help providers achieve quality metrics and earn higher levels of reimbursement because the patient's health needs are being addressed in a holistic manner. Connecting medical patients with community interventions enhances whole person outcomes and should be incorporated into payment reform efforts.

Medicare payment reforms have started to push providers towards value-based payment methodologies and transformation of care delivery. It is expected that the proportion of Medicare payments tied to quality or value will increase to 85% by 2016 and 90% by 2018 (Anderson, Davis & Guterman, 2015). The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) supports Medicare's movement toward value based payment: it provides 5 percent fee increases to physicians who receive a significant portion of their revenue from an alternative payment model (ibid.).

New Hampshire's Approach

Medicare payment and practice transformation initiatives will provide guideposts for New Hampshire's transformation model. New Hampshire will use a graduated set of steps to move towards value-based purchasing, and to achieve Triple Aim goals of reducing inappropriate or unnecessary care, improving health outcomes, and reducing costs. The State will focus its work in four areas, forwarded by the Payment Reform Workgroup, but echoed in other stakeholder settings:

1. Leverage the State's role as purchaser, convener and regulator to support payment reform, including the integration of Section 1115 Waiver with other payment and delivery system reforms.
2. Move providers along a continuum of value based payments through a progressive "ladder" of assessments and goals.
3. Align payment reform models and outcomes with Medicare initiatives and State commercial market initiatives to ensure success and sustainability across payment sources; and ensure payment models incorporate community services, support medical neighborhoods, address social determinates of health and address the patient's whole person needs along the continuum of care.

4. Develop a "Transformation Center" to support providers in accelerating transformation towards comprehensive population-based payment and delivery models.

Each of these areas is further outlined below.

1. Leverage the State's role as purchaser, convener and regulator

The State can provide leadership in the effort to transform payment to models that improve the value of the services, while helping providers move towards innovative delivery models that meet the needs of the communities they serve.

In July 2014, New Hampshire expanded Medicaid eligibility and by May 2015 enrollment grew by 39% -- an increased enrollment of 42,000. Starting in 2016, New Hampshire will provide premium assistance to Medicaid beneficiaries to purchase coverage through the State's insurance exchange (Centers for Medicare and Medicaid Services, 2015). New Hampshire is also considering linking insurer participation to payment reform by placing providers at risk.

In 2016, the New Hampshire legislature will consider reauthorizing the Medicaid expansion past 2016 when the 100% federal match ends. If it elects to not continue the expansion, low-income individuals that do not make enough to qualify for tax credits will be left without insurance coverage -- leading to increases in uncompensated care. In addition, New Hampshire would forego an estimated $1.5 billion in federal health care revenue over the period between 2017 and 2020 (The Lewin Group, 2012). Though New Hampshire would have to assume some of the costs for the Medicaid expansion after 2016, the federal dollars flowing into the State improve the economy and flow downstream beyond the health care sector.

New Hampshire's state-federal partnership exchange allows the State to retain its role as the primary regulator of insurance while using the healthcare.gov exchange platform. Enrollment in the exchange is increasing and there are approximately 53,000 participants enrolled. Under Affordable Care Act requirements, Qualified Health Plans are accountable for performance across a set of metrics (Quality Rating System). With legislative changes, New Hampshire could augment these measures with a set of performance indicators that support transformation priorities (e.g., affordability, behavioral health/substance use service integration, coordinated care). Additionally, New Hampshire could require carriers to develop quality improvement strategy (QIS) plans that expand market-based incentives to align with New Hampshire transformation priorities (e.g., medical home adoption, pay for performance incentives).

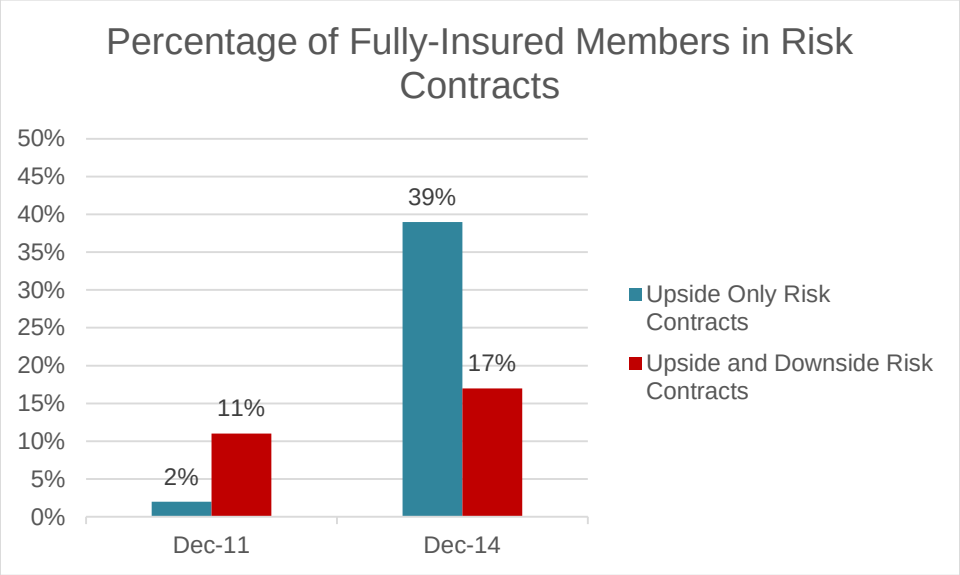
By providing leadership in its own purchasing and requiring innovative payment methods, the State will begin to move other payers and purchasers towards innovative payment methods that will impact the commercial market as well.

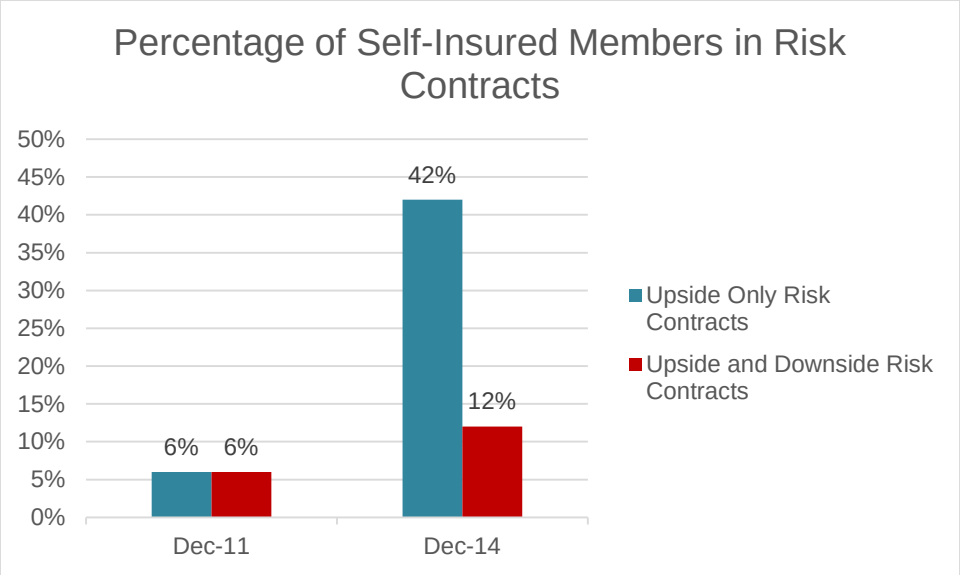
Using the convening and oversight authority of the new governance board or council, a public/private all payer table will be convened to strengthen and support practice transformation through collaboration among public and private health care payers. This payer collaborative will work together to coordinate resources and support for practices that are transforming care as described in Section E. The payer collaborative will operate in compliance with federal and State antitrust laws, and will align support and payment methodologies (See Section E) for practices that successfully improve the health of their patients and population health, while reducing costs.

2. Move providers along a continuum of value based reforms

In 2011, carriers primarily relied on traditional fee-for-service payment methods. They reported that 12% of total payments made to Accountable Care Organizations used global payment methods (with downside risk); only 0.1% of all payments (acute conditions) used bundled payment arrangements; and 20% used pay-for-reporting incentives (Grenier et al., 2013).

Figure D.1: New Hampshire Insurance Department Report on VBP





As part of the SIM model design process, the Payment Reform Workgroup interviewed ten (10) New Hampshire carriers with self-funded or fully insured accounts across all segments of the market. The interview questions were designed to assess the level of activity in value-based payment, the future plans of the carriers to implement new and more advanced payment models, the basic nature and structure of alternative payment models (APMs) utilized, the incentives and/or penalties employed, metrics used and measurable impact on quality and efficiency.

The results of the interviews were aggregated and several relevant themes were identified across carriers:

- Value-Based Payment (VBP) is part of each carrier's payment reform strategies.
- The percentage of payer/provider contracts in VBP models varies from zero to 80% of primary care providers. The difference is newer entrants with lower membership are not well positioned to negotiate value-based contracts with providers.
- All carriers plan for systematic increases in the number and nature of APMs over the next three to five years.
- Carriers believe VBP increases quality, and improves both efficiency and patient satisfaction.
- Positive results are reported on quality measures when VBP has been in place for a reporting period. Utilization may be reduced and there is some strong evidence of cost of care reduction from developed models, but mostly slowing of the upward trend.
- Carriers use risk adjustment models to determine appropriate levels of per member per month (pmpm) coordination fees.

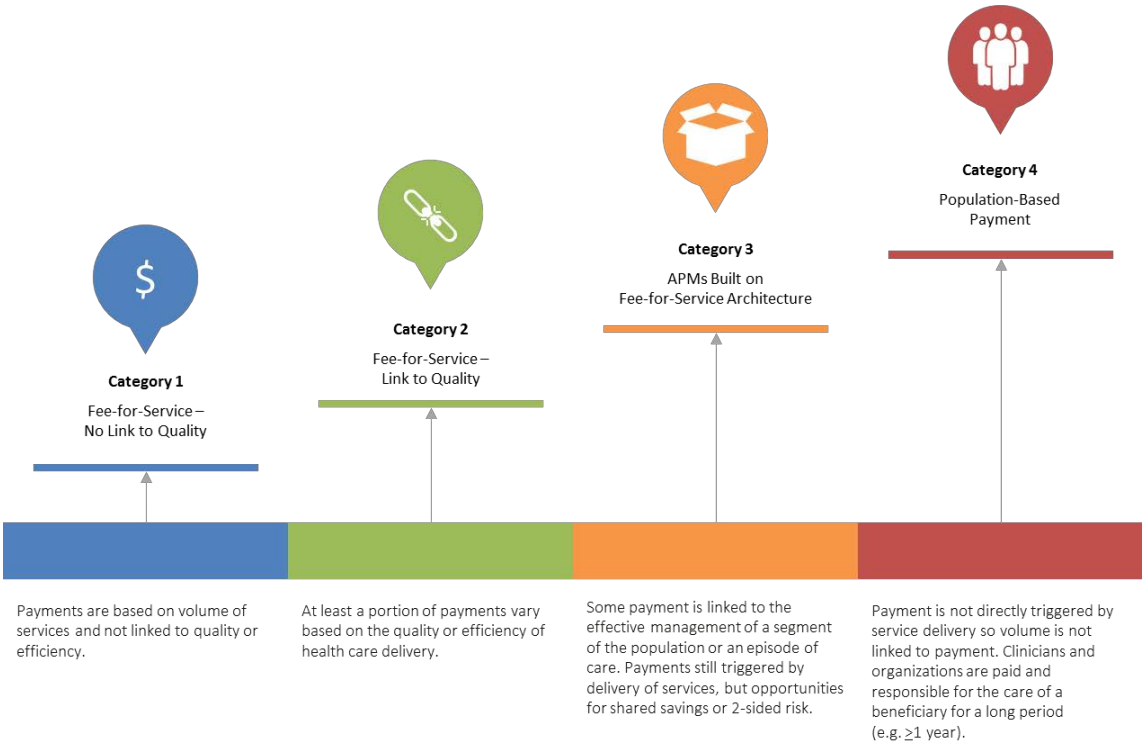
- Data and analytic support for practices varies greatly because carriers with large membership have invested in developing these capabilities over time. Providers are wary of downside risk due to past experiences.
- VBP models are used across each carrier's service area – they are used less in the north, and less with new entrants. They are used more with larger and certified PCMH, and with health systems as more practices are acquired by hospitals.
- Most existing VBP models are built on a fee-for-service structure with reconciliation to a cost target.
- Some models make specialists and hospitals accountable for costs and quality, but most do not.

Overall, there was a high degree of interest among carriers in aligning with Medicare payment models. In particular, there is interest in building on existing VBP models and adding strategies to accelerate change using Medicare innovations and timelines. In addition, physicians and practices are often not well informed about VBP models, nor do they understand incentives currently in place. As a result, carriers expressed interest in starting with practices "where they are", including efforts to increase value, quality and metrics to measure progress. Given practice and payer variability, carriers overall supported identifying a minimum set of predefined metrics to measure progress individually and across the State.

These findings, coupled with stakeholder feedback and deliberations of the Payment Reform Workgroup, resulted in agreement on the need for a system-wide shift to drive payers, purchasers, and providers towards contracting models that emphasize value-based payment, quality, and coordinated, integrated systems of care. The transformation governance board or council (see Section C) will develop transparent goals for moving the health care sector up the "ladder" of alternative payment methods described below, recommending legislation, if necessary, to alter the system to meet goals.

New Hampshire will use the CMS Health Care Payment Learning and Action Network (HCPLAN) as the "ladder" of alternative payments described above. The HCPLAN framework will be used to help New Hampshire meet or exceed Medicare goals for value-based payments and alternative payment models. As illustrated in Figure D2, the HCPLAN is a continuum of payment approaches divided into four categories – FFS (no link to quality), FFS (link to quality), APMs built on FFS architecture, and population based payments (Health Care Payment Learning and Action Network, 2015).

Figure D.2: HCPLAN Payment Framework



Working with the governance board, the Transformation Center described in Section C of this report will provide tools and supports to assist both payers and providers in advancing along the continuum of payment approaches. New Hampshire will track payer and provider progress up the ladder of payment approaches using measures for quality, cost effectiveness, and patient engagement.

3. Align payment reform models and outcomes with Medicare and other State initiatives to ensure whole person care

A significant number of New Hampshire providers have transformed their practice to a Patient Centered Medical Home (PCMH) approach, and commercial carriers are working to support these efforts. Payers, such as Anthem Blue Cross Blue Shield and Harvard Pilgrim, have mature programs in place that promote practice transformation. In addition, New Hampshire has several Accountable Care Organizations (ACOs) – Dartmouth-Hitchcock Health, the Granite Health Network, North Country ACO, and NH Accountable Care Partners. With a focus on health promotion and disease prevention, payment reform, and medical homes, the New Hampshire Citizens Health Initiative (CHI) has brought together an array of public, business, and provider stakeholders to improve systems that finance and provide health care in New Hampshire. New Hampshire's SIM State Health System Innovation Plan

leverages these efforts to move other providers and payers towards similar delivery system and payment models. The alternative payment framework described above will be enhanced by practice transformation, including patient-centered integrated models of care delivery, and the regional health networks that will support population health improvements (See Sections C and E).

Roughly 231,000 New Hampshire residents are enrolled in Medicare (Henry J. Kaiser Family Foundation, 2012). Medicare enrollment is expected to increase significantly as the population continues to age at a high rate. As the population ages, it will be critical to integrate long term services and supports (LTSS) with primary care to ensure population needs are addressed. The demographic shift in the population will place a greater burden on the health care system and it will be increasingly important to transform payment and delivery systems. The Transformation Center described in Section C as well as the Regional Health Initiatives will include in their regional plans specific strategies to address the needs of the aging population and align them with Medicare and LTSS efforts.

Medicare has supported several ACO demonstrations across New Hampshire, including the North Country ACO, NH Accountable Care Partners ACO, The Accountable Care Project, Dartmouth-Hitchcock ACO, and Advanced Investment Model ACO. Medicare is leading the way in payment and delivery system innovation and offers New Hampshire a foundation for additional reform efforts. New Hampshire will seek to build on Medicare reform efforts using the HCPLAN payment ladder. New Hampshire will align with Medicare and also will continue to allow providers and carriers the flexibility to innovate and improve existing initiatives. One specific way New Hampshire will leverage existing Medicare initiatives, is to develop a "Model Contract" that will serve as a template for carriers, purchasers, and delivery systems interested in payment reform and cost containment goals.

New Hampshire's Medicaid Section 1115 Waiver, "Building Capacity for Transformation", includes a pay-for-performance component that provides enhanced payment to support development of pilot programs and capacity for mental health, substance use disorder, and maternal dental and tobacco cessation services. New Hampshire will adopt the SAMHSA-HRSA Integrated Care Framework as the goal for primary care and behavioral health and substance use service providers. The adoption of the payment ladder described above will promote movement towards integrated care delivery models by providing physicians with payer supported financial incentives.

Section E further describes how whole person care will be implemented in New Hampshire's SIM State Health System Innovation Plan.

4. Use "transformation center" to accelerate movement toward population-based payment and delivery models

Using the Transformation Center described in Section C, New Hampshire will support movement through the ladder of alternative payment models through several strategies:

- Learning collaboratives will educate stakeholders and offer a forum to share best practices.
- The Transformation Center will provide assistance with review of value based concepts, proposed contract language, and supporting documentation in order to support value based arrangements such as global or shared savings methodologies (category 3 and 4), care coordination requirements, quality and performance measures, monitoring for compliance, and grievance and appeals processes.
- Pilot projects and special initiatives may be funded through the Transformation Center to test innovation and/or to support regional and statewide needs (e.g., rural health issues, health information exchange) and further population health goals. Rural communities are confronted with special health needs. According to the New Hampshire Office of Rural Health nearly half the population of the State lives in rural communities. The rural population faces demographic and socioeconomic challenges, compounded by greater distances to services, lower provider availability, and an older provider base.
- HCPLAN Participation by the Transformation Center and other interested stakeholders could include serving on workgroups, attending webinars or conference calls to keep abreast of progress. The Transformation Center will coordinate and disseminate information from the HCPLAN work to assist payers and providers interested in adopting value-based payment approaches.

In addition, the Transformation Center will work to promote specific implementation strategies, identified through the SIM model design process, which will impact the adoption of VBP models. First, providers, especially small and rural practices, are leery of entering into risk arrangements with payers. The Transformation Center will develop mechanisms to mitigate provider risk. One option under consideration is a small practice risk pool that aggregates and assumes risk for small practices –allowing them to enter into risk arrangements with carriers. The New Hampshire Insurance Department (NHID) could also consider formalizing regulations that move providers toward adoption of alternative payment models. With additional statutory authority, the NHID could collect data on the use of alternative payment methods and the State could make these data available to the legislature and the public to monitor and evaluate the impact of provider risk bearing requirements in the promotion of transformation goals.

Second, New Hampshire has a robust all payer all claims database but there is currently no efficient process to match clinical and claims data in real time. The ability to do so will be critical to progress towards payment methods that support the Triple Aim. Various health information technology initiatives exist across the State that supports individual providers, but there is a lack of interoperability between providers making it difficult to exchange personal health information to support care coordination. To minimize provider administrative burden, the New Hampshire's SIM State Health System Innovation Plan implementation includes the development of an online, multi-payer provider portal where providers can report on a defined and simplified set of quality measures. Providers will also be able to use the portal to view their total gains/losses related to alternative payment methodologies in place and identify high-cost patients requiring more intensive care management. Similar to the provider portal, New Hampshire will also develop a single patient portal that can be used to view health care information across providers and payment types. Consumers will have the ability to view quality, cost, and value of services available to the patient resulting in increased transparency. Please see Section G for additional detail.

E. Plan for Health Care Delivery System Transformation: Support for Change in Practice

The Granite State has tangible experience to leverage for delivery system transformation. With limited resources and a collaborative mindset, provider organizations and non-profits within the State have self-organized to create a foundation for transformation. Nearly a third of the State's primary care providers have already achieved NCQA recognition at the highest level for Patient Centered Medical Home (PCMH). Approximately 30% of the State's Medicare FFS beneficiaries are attributed to a Medicare ACO model. The NH Citizen's Health Initiative has initiated behavioral health integration collaborative to build upon work done by providers around the State to implement integrated care.

Goals, Barriers, and Drivers for Practice Transformation

Leveraging these accomplishments, the goal of New Hampshire's practice transformation plan is to accelerate change and bring transformation to the remaining two-thirds of the State's providers.

New Hampshire aspires to create patient-centered care and increased satisfaction of healthcare workers by focusing on seven objectives:

1. *Bring care to the patient by changing* the concept of patient access by bringing care to patients in different settings, including primary care, behavioral health (including substance use disorders), and community-based settings. Expand patient access with care outside of business hours, asynchronous communication, or telemedicine.
2. *Create team-based care* that values contributions by all members. Create a collaborative construct for patient care that values providers of all types, seeks to utilize staff to top of their ability, and views community based services as part of the care team.
3. *Focus on care for the whole person* by supporting the efforts of clinical care providers to address the social determinants that affect a person's health outcomes. Engage patients in their health outcomes and work collaboratively with them to set goals.
4. *Stratify approaches to achieve transformation by tiering* practices according to readiness so practice transformation support can be more efficient and successful. Encourage practices to use clinical risk stratification so care management and supports can be offered to patients where most needed.
5. *Address burnout among health care workers*. Health care workers experience fatigue with ongoing transformation and systems that reward volume over value. Create health system transformation that enables valuable interactions between health care workers and their patients.

6. *Recognize diversity and best practices within NH* by adapting practice transformation models to fit urban, suburban and rural geographies.
7. *Provide a roadmap and supports for transformation* through the provision of tools and supports to enable transformation. Create alternate payment models that allow providers to shift away from volume-driven practice (See Section D).

Pragmatically, it is important to acknowledge barriers that hamper achievement of the goal to bring transformation to the remaining two-thirds of the State's providers. These barriers include:

- Payment, sustainability and lack of time. New Hampshire lacks funding and payment models to sustain transformation and also lacks time to pursue transformation. There is a need for a multi-payer model to support transformation.
- An aging population of patients and an aging health care workforce.
- Readiness for change at scale. Concerns about readiness for change, change fatigue, and ability to foster leadership needed for practice transformation echoed in stakeholder voices throughout the SIM model planning process. A call also reverberated to move from isolated pilots to transformation at scale.
- There are silos between behavioral health, substance use services, and primary care that need to be addressed, perpetuating and stigma for substance abuse patients.
- Marshaling and training the workforce for new models of care.
- Ability to impact the social determinants and stressors that affect patients, including income, employment, childcare, transportation, and housing.
- Lack of support for transformation, and a call for a neutral transformation and improvement entity to support regional efforts, disseminate best practices, and provide sustained technical support.

The Transformation Center and its partners, the Regional Health Initiatives, (described in Section C) will be key agents to address these barriers in support of reaching practice transformation goals and objectives.

Drivers and Models for Practice Transformation

Drivers of Practice Transformation

Based on the goals and barriers described above the following drivers were used to identify and select models to spur and sustain transformation practice within the New Hampshire:

- Primary Care as Building Block. A base of transformed primary care is a critical driver of change within the whole system; Medicare and commercial payers are asking for primary care transformation.
- Innovative Programs. Look for opportunities to leverage learning and funding from the Primary and Behavioral Health Care Integration grant awards from SAMHSA and the Practice Transformation Network (PTN) award from CMMI.
- Measures to Address NH's Goals. The model must incorporate measures that help track progress on the goals identified, including patient and family engagement, expanded access and continuity for patients, risk stratified care management, and care coordination/engagement with community resources.
- Competitive Concerns. Through the Transformation Center, create a "no wrong door" for interested providers to participate in transformation model.
- Medicaid Section 1115 Waiver. The practice transformation model must integrate with the State's 1115 Waiver and its focus on behavioral health and substance use disorder care, as well as the possibility of a NH Health Homes program.

Transformation Models: Primary and Integrated Care

Knowing that overall system transformation requires a high-performing primary care system, NH has adopted two models of transformation for statewide use: 1) an advanced primary care model; and 2) an integrated care model to bring together primary and behavioral (including substance use) health care.

Advanced Primary Care

NH's advanced primary care model draws elements from both CMS's Comprehensive Primary Care (CPC) initiative and NCQA's Patient Centered Medical Home (PCMH) models. This hybrid model emphasizes both the hard lifting required to achieve process and structure change in practice as well as the outcome measures necessary both for the State to track improvement and for payers to enable value-based payment models.

New Hampshire's advanced primary care model is based on seven core competencies: 1) empanelment; 2) risk stratification; 3) care management: 4) care coordination with health neighborhood; 5) patient access; 6) patient experience; and 7) quality improvement. As illustrated in Appendix IV, the model identifies specific measures for these seven competencies and maps them to three stages of transformation: Stage 1: process and structure transformation; Stage 2: beginner/intermediate outcome reporting; and Stage 3: advanced outcome reporting.

Supported by the Transformation Center and Regional Health Initiatives described in Section C, Stage 1 will commence with a practice's formal engagement with the transformation process as measured by entering into a Transformation MOU. Following a practice's engagement, the Regional Health Initiative will conduct a practice readiness assessment and then create a tailored practice learning plan to address gaps in the seven core advanced primary care competencies. A practice may be deemed to have met the Stage 1 requirements by virtue of current PCMH recognition at the highest level, Level III, or active engagement with the New Hampshire Practice Transformation Network (PTN) grant. Following this initial transformation stage, the Regional Health Initiatives will move practices into Stage 2 and Stage 3 outcome reporting to enable these practices to enter into value-base reimbursement models with commercial health plans and government payers. Development and implementation of these payment models will be supported by the multi-payer workgroup affiliated with New Hampshire's governance board (See Sections C & D).

Integrated Care

Transformed providers, once stabilized in new value-based payment models, will want to adopt integrated care as the natural progression of their effort to become patient-centered. For integrated care, NH has elected to adopt the SAMHSA-HRSA Integrated Care Framework (see Appendix IV) as the transformation goal for those primary care and behavioral health/substance use providers ready to embrace an integrated care model for their patients. The Framework adapts well for New Hampshire, as it acknowledges that different levels of integration are appropriate for specific provider organizations and patient panels. In addition, the Framework is site agnostic, enabling either a behavioral health provider or a primary care provider to be the physical location where the integrated team is built.

While fully integrated care teams with both physical and behavioral health providers may be ideal, this approach may not be the most practical model for all patient populations and geographies within the Granite State. New Hampshire therefore breaks implementation of the Integrated Care Framework into two categories, each accompanied by measures of implementation. In the first category are primary care and behavioral health practices that are implementing enhanced communication and coordinated care for their shared patients (Level 2 of the Integrated Care Framework). In the second category are behavioral health and primary care providers that are either co-locating or creating fully integrated care teams (Levels 3-6 of the Integrated Care Framework). All levels will be assessed by measures of patient experience, care coordination with the health neighborhood, and ongoing assessment of and quality improvement. See Appendix V for integrated care categories and measure descriptions.

Supporting Implementation of Practice Transformation Models

It is New Hampshire's goal to provide transformation supports to primary and behavioral health practices such that they are able to practice more efficiently, address care for the whole person, and improve quality of care over time. As noted in Section C, momentum for practice transformation will be generated and sustained by the Regional Health Initiatives with support from the state-level Transformation Center. As transformation progresses, it is envisioned that the Regional Health Initiatives and the Transformation Center will be able to expand their efforts beyond primary care and behavioral health to include other types of providers: specialists, long term care, home care, and others.

The Regional Health Initiatives will play a critical role in regional practice transformation. As they are established, Regional Health Initiatives will need to gain buy-in from local partners on the need for transformation, transparent reporting and community efforts to improve care, including local resources for practice transformation coaching.

Collaborating with and coordinated through the Transformation Center, these coaches will be trained in principles of health systems engineering, use of data to drive transformation, and creation of role-base workflows. Coaches will be familiar with local community resources and help practices connect to these resources through development of care compacts and implementation of role-based workflows. Specific coaching activities may include: 1) one-on-one coaching with practice clinical and administrative leads for both quality improvement and leadership capabilities, 2) group discussion with office/care team to discuss progress and challenges encountered during transformation, and 3) targeted training for knowledge, leadership or care team gaps identified.

Knowing that transformation activities can be difficult and require and support for on-the-ground organizations to successfully achieve the State's goals, practice related functions of the proposed Transformation Center include:

- Convening stakeholders to ensure regional input, bi-directional communication between providers and NH's governance board or council, and deployment of resources from regional, State and national entities;
- Oversight and project management for State transformation efforts, including support for Regional Health Initiatives
- Developing a transformation curriculum, best practices, and library of transformation resources;
- Providing tools and training for health system engineering and quality improvement;
- Data gathering and reporting to track the state of transformation and individual provider efforts;
- Serving as a State funding vehicle and distributing funding to regional efforts;

- Communicating with providers and recruiting them for transformation efforts; and
- Coordinating with other State and regional initiatives, both public and private.

As described in Section C, it is envisioned that the Transformation Center will be identified and selected through a competitive RFP process. Once a successful vendor(s) has been chosen, key elements of their scope of work elated to practice transformation will include:

A. *Risk Stratified Care Management and Care Coordination*:

- Empanelment: Transformation Center should review common empanelment methodologies (i.e., HRSA requirements, MassHealth Consensus Attribution Standards) and make a best practice recommendation for empanelment for NH primary care providers.
- Risk Stratification: Transformation Center should review risk stratification methodologies (i.e., AAFP Algorithm for Risk Stratification, Mercy Adult and Pediatric Risk Stratification Tools, etc.) and make recommendations regarding best practice methodologies for NH primary care providers. The Transformation Center should adapt the best practice model for special populations. Adoption of best practice is strongly recommended.
- Care Coordination: Transformation Center shall develop tools and best practice guidance to assist integrated and primary care practices with incorporating community resources into their care management workflows. This work shall also include efforts to support close-loop referrals between clinical care and social services.

B. *Health System Engineering, Quality Improvement and Workforce*:

- Health System Engineering: Transformation Center and Regional Health Initiatives should provide or coordinate (possibly with Regional Health Initiatives) training and on-site coaching to practices about the principles and application of health system engineering. Goal of this training and coaching is to enable practices to deploy health systems engineering principles, establish effective role-based workflows, and maximize efficiency of practice.
- Quality Improvement: Transformation Center and Regional Health Initiatives should train or coordinate the training of practices about quality improvement methods (PDSA cycles, run charts, quality improvement plans).
- Assessment of Implementation Progress for Integrated Care. Transformation Center and Regional Health Initiatives should recommend that practices conduct the integrated care self-assessment semi-annually during the first year of transformation.

- Workforce, Leadership and Team-Based Care. The Transformation Center shall coordinate with the NH Area Health Education Center (AHEC) or similar organizations to support efforts to recruit primary care workforce and train current workforce for new care team roles. With the NH AHEC or similar organization, the Transformation Center shall provide training, assessment, and planning resources to support both the RHIs and practices themselves in efforts to create team-based care and strong practice leadership.

C. *Patient, Family and Caregiver Engagement*:

- Patient-Family Advisory Council: Transformation Center may deem FQHCs as meeting the patient family advisory council standard since patients comprise 50% of an FQHC board of directors. The Transformation Center may deem other practice committees with substantial patient involvement as meeting patient family advisory council standard on a case-by-case review.
- Patient Experience: Transformation Center should identify evidence-based tools for patient experience in behavioral health and support their use. Transformation Center should also seek to align with State and Federal reporting requirements, as applicable.

D. *Curriculum, Communication and Engagement*:

- Curriculum: Transformation Center shall develop a model transformation curriculum that RHIs, practices and other organizations can use and adapt. Suggested modules for that curriculum are included in Appendix VI and suggested modalities for delivery of transformation supports included in Appendix VII.
- Practice Communication and Engagement: The Transformation Center should develop communication materials that both it and the Regional Health Initiatives will use to explain the case for practice transformation and recruit practices to participate. These materials shall include the business case for transformation including information about commercial and government payers that use value base reimbursement for transformed practices.
- Formal Engagement with Transformation: The Transformation Center will develop a memorandum of understanding for use by the RHIs and practices to make explicit the transformation supports offered to the practice. MOU will outline practice actions that demonstrate engagement and participation with State process to share knowledge, tools and expertise between and among practices. Data sharing with the applicable RHI and the Transformation Center will be required.

E. *Data, Tracking and Reporting*:

- Data Transparency: Practices that have entered into an MOU for transformation support will be required to share quality improvement and self-assessment results with both the Transformation Center and the applicable Regional Health Initiative.
- Data Tracking and Reporting: The Transformation Center shall gather data electronically from participating practices and RHIs to assess the progress of transformation. These reports shall be shared with the governance board or council and back with the practices and RHIs themselves.

F. *Funding and Collaboration*:

- Secure Additional Funding for Transformation: The Transformation Center shall seek out additional funding to support statewide transformation projects. Example of possible funding include:
    - the $100 million earmarked for practice technical assistance in the Medicare Access and CHIP Reauthorization Act (MACRA);
    - engaging Medicare to participate as a payer in NH's multi-payer advanced primary care model under the auspices of CMMI's November 2015 guidance for SIM states; and
    - transformation funds budgeted within the pending 1115 Waiver.

G. *Coordination with Other State Initiatives*:

The Transformation Center must coordinate with existing efforts within the State to spur and accelerate transformation. Specific examples include, but are not limited to, CMMI's Practice Transformation Network (PTN) grant, the NH Citizen Health Initiative Behavioral Health Collaborative, and the NH Area Health Education Center.

F. Plan for Improving Population Health

Generally, the health care conversation in the United States has emphasized the treatment of people once they become ill – ignoring that the health of a population is essential to economic security and success along many measures. Improving population health can be used as a focal point to bring together health care providers, including behavioral, substance use, and social service providers, public health agencies, employers, local leaders and others to improve outcomes across their communities. In addition, population health issues such as tobacco, obesity, substance use and diabetes become substantial cost drivers over time within the traditional health system, and across other societal and public services through their relationship to other health conditions, behaviors and outcomes. The SIM State Health System Innovation Plan offers an opportunity for New Hampshire to test innovative payment and delivery system models focused on improving overall outcomes and population health.

New Hampshire has several building blocks in place that will be used as a foundation for the collective effort necessary to improve population health. For example, New Hampshire DHHS undertook a stakeholder-driven planning process to establish population health goals across the State for the period 2013-2020. This process resulted in the *New Hampshire State Health Improvement Plan "Charting a Course to Improve the Health of New Hampshire"* (SHIP). Many of the State's building blocks are cataloged in this document. The SHIP also informed both the SIM Model Design application and the State's Section 1115 Medicaid Waiver application. Appendix VIII outlines the goals of New Hampshire's SHIP.

While it is robust, community focused, and data driven, the SHIP lacks cross sector ownership and integration, connections to payment, financial resources, and accountability outside traditional public health settings. And, historically the building blocks it represents have been largely disconnected from other New Hampshire health transformation efforts.

Regional Integration, Plans and Priorities

The SIM State Health System Innovation Plan offers a powerful and unprecedented opportunity to integrate population health efforts (outlined in New Hampshire's SHIP), behavioral health/substance use focus (outlined in New Hampshire's 1115 Waiver application and approval) and primary care transformation (outlined in Section E of this document). These integration efforts will coalesce through the work of the Regional Health Initiatives (see Section C).

Regional Health Initiatives (referred to as Regional Health Care Extensions in the SIM Model Design application) will bring together stakeholders and plans from public health networks, behavioral and social services, healthcare, citizens and others to develop integrated and community based approaches to improve the health of their population. Initial statewide priorities, with regionally specific plans, will

emphasize behavioral health/substance use integration (1115 Waiver) and SIM priorities of tobacco cessation, obesity and diabetes.

Plans will be developed and/or evaluated according to five characteristics: 1) local solutions development and implementation; 2) statewide guidance; 3) Transformation Center support; 3) data-driven and evidence-based; and 5) outcome measures.

1. **Plans will be developed locally** to leverage local interest, priorities, strengths and capacity as well as feedback and buy-in from the community.
2. **Statewide guidance** will be used to set overall goals, and to ensure consistency and accountability. In addition, funding for prioritized efforts (see below) will follow common criteria across the State, under the oversight of the governance board or council.
3. **The Transformation Center** (see Section C) will provide support and technical assistance as needed.
4. **Data-driven and evidence-based strategies** will be included in Regional Health Initiative plans to ensure investments support strategies that have a strong likelihood to successfully improve the health of entire populations. Approaches will be based on best evidence or promising practices that have demonstrated a measurable impact. Emphasis will be placed on projects that have a likely return on investment within a reasonable time frame.
5. **Outcome measures** will be used to ensure accountability and continuous improvement. Objective outcome measures and benchmarks, consistent with existing State and national metrics, will be used to gauge progress toward State population health goals and the Triple Aim. Measures will be embedded into the contracts of regional partners to ensure accountability for overall performance.

As outlined above, Regional Health Initiatives will demonstrate how they are partnering with and leveraging their Public Health Network expertise in a meaningful way. It is anticipated that specific methods will vary across the State, adding value and providing connections, but without creating new additional silos or bureaucracy.

Prioritized Efforts

The discussions and deliberations of the SIM Model Design process identified five high priority areas for initial focus or investment. Investments may come through sustained effort, resource allocation, technical assistance, transformation strategies or local grants. High priority areas include: 1) behavioral health and primary care integration; 2) de-siloing traditionally separate structures and approaches; 3) access to data across community settings; 4) E-referrals among clinics and community settings; and 5) community-based health workers.

1. **Behavioral health, substance use, and primary care integration:** Focus on, and investments in, projects and approaches that integrate behavioral health, substance use service, and primary care in order to increase whole-person, patient-centered approaches that identify and address all the health needs of a patient -- no matter where they seek care.
2. **De-siloing**: Focus on, and investments in, projects and efforts aimed at coordinating care across traditionally siloed health sectors and strategies including behavioral health, substance use, primary care, public health, long-term care services and supports, and school based health.
3. **Access to data across community settings:** Focus on, and investments in, projects or efforts that enable secure data sharing across systems in order to improve whole-person care through care coordination and cross system strategies.
4. **E-referrals:** Focus on, and investments in, the rapid development or improvement of capability for e-referrals across organizations, including both clinic and community agencies to address the social determinants of health and patient portals for direct access by the consumer.
5. **Community-based Health Workers:** Focus on, and investments in, efforts that support training of a non-traditional workforce, including those with lived experience, in order to accelerate the alignment of local community and clinical resources in a consumer-centered, responsive and cost effective manner.

G. Health Information Technology Plan

New Hampshire is strongly positioned to increase the use of health information technology (HIT) to support health system transformation. This transformation plan includes targeted investments in HIT infrastructure that leverage well-established, and nationally recognized, existing HIT systems in the State.

While New Hampshire has a relatively high adoption rate of HIT among providers compared to national averages, fragmentation and gaps in HIT use persist across the State, particularly among behavioral health, long-term care, and home care providers. Investments in needed infrastructure will enable all provider types to meaningfully participate in the collection, exchange, and use of data to improve health at the individual and population level, while reducing costs, provider administrative burden and driving improvement across the healthcare system. The use of HIT is incorporated throughout this innovation plan. The specific elements outlined below create a support structure for essential components of health transformation (i.e., practice transformation, payment reform, and population health initiatives). New Hampshire has prioritized five focus areas for greater infrastructure development:

1. Electronic health record adoption and optimization
2. State HIE system
3. Quality measurement, reporting, and feedback system
4. Patient engagement tools
5. Public data reporting expansion

Several of these focus areas incorporate short-term (within the next 12 months) and long-term (within three to five years) goals (see Section K, Operational Plan), some of which will require substantial public support and legislative changes. Sustained stakeholder engagement throughout the implementation period will be required to maintain momentum and to ensure that health transformation reflects the goals and addresses the needs of stakeholders across the State. These HIT focus areas concentrate on the local level through supporting the actions set forth in Practice Transformation Section E, as well as additional initiatives that create greater connectivity and access to data across the State.

In order to coordinate with existing State and private entity efforts related to HIT adoption and use, the Transformation Center described in Section C will act as the HIT coordinator within the State. In addition, the Transformation Center will convene a HIT committee that will meet monthly during HIT Implementation Phase 1 (Design and Planning), and then continue to meet quarterly during Phase 2 (Implementation). Additional project-specific subgroups will be created and meet as necessary.

As noted above, there are ongoing efforts to increase the use of HIT and create better access to public data in New Hampshire. Transformation leadership will work in conjunction with current initiatives to complement and add to ongoing work. Each focus area below outlines the synergistic relationships with

ongoing projects, as well as where SIM investments will add innovative HIT strategies for New Hampshire.

1. Electronic Health Record Adoption and Optimization

The primary strategies related to Electronic Health Record (EHR) optimization are:

- Establish a grant program for EHR adoption and optimization; and
- Establish a HIT Committee within the Transformation Center to develop strategies to address nuances in data reporting

New Hampshire is among the states leading the nation in electronic health record (EHR) adoption. As of April 2015, 78% of New Hampshire physicians participating in CMS EHR incentive programs have demonstrated meaningful use and/or adopted, implemented or upgraded an EHR (Office of the National Coordinator for Health IT [ONC], 2015a). There are similar EHR adoption and use rates among New Hampshire hospitals participating in federal EHR incentive programs with 88% of all eligible and critical access hospitals having demonstrated meaningful use by April 2015 (ONC, 2015b).

While these are older estimates of EHR adoption rate across New Hampshire, the true number of providers who have adopted HIT and EHR systems is not well known. Anecdotal estimates place the EHR adoption rate at roughly 90%, although this has not been verified through a standard metric. Regardless, there remains a portion of the provider population that has not yet integrated the use of HIT into clinical workflows, and there are concerns that EHR adoption does not directly equate to using HIT in a meaningful way.

New Hampshire's SIM State Health System Innovation Plan addresses these challenges through a multi-part strategy. First, the Transformation Center (See Section C) will coordinate with existing efforts on measuring EHR adoption and use, with ongoing EHR outreach and support. Currently, the New Hampshire Department of Health and Human Services (NH DHHS) has contracted the University of New Hampshire (UNH) Survey Center to evaluate the use of EHRs and health information exchange (HIE) across providers in New Hampshire in spring 2016. The survey is intended to reach a diverse set of provider types, including acute care hospitals (critical access and non-critical access), rehabilitation hospitals, primary care physicians (including private practices, rural health clinics, and federally qualified health centers), community mental health centers, homecare/home health/hospice, skilled nursing facilities/nursing homes (public and private), and specialty physician practices (e.g., radiologists, orthopedics)(personal communication, P. Miller, January 4, 2016). The Transformation Center will coordinate with NH DHHS in using the upcoming survey as baseline EHR adoption and use data. Future surveys may draw on pre-established measurement tools, such as the Ambulatory and Hospital EMR Adoption Models℠ from HiMSS Analytics (HiMSS Analytics, 2015; n.d.) (see Figure G.1 and G.2)to provide additional information on EHR adoption/use along the referenced continuum.

In addition to the DHHS EHR survey, the Transformation Center will work with NHHIO to document other technical assistance resources being used by providers (e.g., CMS incentive programs, CIOs, NH REC, NHHIO) as to not duplicate future efforts.

Figure G.1: Ambulatory EMR Adoption Model[SM]

Stage	Cumulative Capabilities
Stage 0	Paper chart based system
Stage 1	Desktop access to clinical information, unstructured data, multiple data sources, intra-office/informal messaging
Stage 2	Beginning of a clinical data repository with orders and results, computers may be at point-of-care, access to results from outside facilities
Stage 3	Electronic messaging, computers have replace the paper chart, clinical documentation and clinical decision support
Stage 4	Computerized physician order entry, use of structured data for accessibility in EMR, internal and external data sharing
Stage 5	Personal health record, online tethered patient portal
Stage 6	Advanced clinical decision support, proactive care management, structured messaging
Stage 7	HIE capability, sharing of data between EHR and community-based EHR, business and clinical intelligence

Adapted from HiMSS Analytics (2015).

Figure G.2: Hospital EMR Adoption Model[SM]

Stage	Cumulative Capabilities
Stage 0	All three ancillary clinical systems not installed
Stage 1	Ancillary clinical systems all installed – laboratory, radiology, pharmacy
Stage 2	Clinical data repository receives feeds from ancillary systems, controlled medical vocabulary, clinical decision support/rules engine (CDSS), may have document imaging, HIE capable
Stage 3	Nursing/clinical documentation (flow sheets), CDSS (error checking), picture archive and communication system (PACS) available outside radiology, electronic medication administration record application implemented
Stage 4	Computerized practitioner order entry, CDSS (clinical protocols)
Stage 5	Closed loop medication administration
Stage 6	Physician documentation (structured templates)), full CDSS (variance & compliance), full R-PACS
Stage 7	Complete EMR, continuity of care document transactions to share data, data warehousing, data continuity with emergency department, ambulatory, and outpatient

Adapted from HiMSS Analytics (n.d.)

In conjunction with existing efforts, and informed by the survey described above, the Transformation Center (with oversight from the governance board or council) will create a grant program targeted towards providers who have not yet adopted an EHR system and providers who could benefit from technical assistance in optimizing their use of current EHR systems. The grant program could be part of the Regional Health Initiative (RHI) RFP process, and/or be available to providers independent of the RHIs.

Encouraging providers to make better use of an EHR system can be challenging, and it will be critical that Regional Health Initiatives identify local EHR champions to promote and lead IT change. The local champions should work closely with Transformation Center staff and be cognizant of other ongoing technical assistance programs as to not duplicate efforts.

Along with EHR adoption and use, there is a need to address how data is being reported across providers to facilitate more efficient data analytics and reporting. To this end, the Transformation Center's HIT Committee will explore strategies to encourage organizations to follow national standards for collecting and reporting data, and develop methods for normalizing the nuances in how data is reported and captured through EHR systems.

2. State Health Information Exchange System

The primary strategies related to statewide Health Information Exchange (HIE) include:

- Adapt NHHIO regulation to allow for greater exchange of information across providers;
- Establish grant program to support the first year of NHHIO membership;
- Establish an e-Referral program to create bi-directional communication between providers and community-based organizations; and
- Develop reference list of community-based provider organizations.

The electronic exchange of information is a major conduit for health system transformation. A recent systematic review from the Agency for Healthcare Research and Quality found that the use of health information exchange (HIE) has the potential to lower costs by reducing duplicative laboratory and radiology testing, lowering emergency department costs, reducing hospital admissions, as well as improving public health reporting, increasing the quality of ambulatory care, and improving disability claims processing (Hersh et al., 2015). However, effective use of HIE is not without barriers. The AHRQ systematic review noted that insufficient workflow, market competition, and lack of a business case for HIE were common barriers.

Similar benefits and barriers are apparent in New Hampshire's state HIE. While poised to expand its value as a public good by enhancing the types of services provided, New Hampshire's HIE is limited under current State regulations. Legislation governing the state-designated HIE limits the type and volume of patient information that can be stored and transferred by NHHIO.Section 322-I: of theNew Hampshire

Revised Statute designates NHHIO as the state provider of health information exchange services and stipulates the respective powers and duties of the organization. Section 332-I:10 outlines the six data points that NHHIO may retain (patient name, address, date of birth, gender, and medical record number and location). Outside of this data, NHHIO may only act "solely as a conduit for […] electronic exchange [of data] and shall neither access nor retain, in any database or otherwise, the clinical content of any medical record." Under these regulations NHHIO may offer a limited set of services including direct messaging services between providers, transmittal of Summary of Care records between providers, transmittal of public health information to the State, a comprehensive provider directory, and support for the adoption and use of EHRs. However, NHHIO cannot store meaningful amounts of demographic and health information that would enable greater value, such as providing EHR translation services between providers. In addition, several private EHR vendors offer a similar set of HIE services as NHHIO. However, as the New Hampshire statute regarding HIE specifically applies to NHHIO, private HIE vendors are not regulated under the same legislative restrictions regarding the transfer and storage of data to which NHHIO must adhere. The result is a fragmented HIE system that is difficult and resource intensive to use, especially for smaller practices and specific provider types, such as behavioral health, long-term care, or home health providers.

The exchange of health information is not limited to communication between health care providers. The use of HIE can connect providers to the larger health neighborhood, such as through an e-referral system. An e-referral system can create a connection between health care and community-based organizations that address many social determinants of health. Under the current New Hampshire system, there is no structured mechanism that facilitates communication between health care providers and the broader community-based organizations. To address this deficit, the Transformation Center will collaborate with NHHIO to add community-based providers to the electronic master provider index currently in development for the State. In addition, the Transformation Center will develop an e-Referral program that electronically connects health care providers with community-based organizations through a bi-directional feedback loop. The e-Referral program creates a mechanism by which providers can send an electronic referral to a community-based organization through the State HIE, the community-based organization follows up with the patient to provide services, and finally the community-based organization sends feedback to the provider on outreach efforts with the patient and reports on utilization of services. The e-Referral program could build on efforts similar to those of the existing Tobacco Quit Line program (Quitworks NH, 2015) and glean lessons learned from the Massachusetts e-Referral program pilot underway.

To support transformation across the health neighborhood, a more robust State HIE is needed to permit greater communication and information sharing across all provider types in order to provide better quality care and reduce unnecessary and duplicative services. To achieve this goal, the legislation regarding NHHIO will need to be adapted to allow the State HIE to perform robust query and retrieves

that will support real-time access to clinical information at the point of care. To this end, the governance board or council and Transformation Center will provide education on State HIE value and build support for legislative changes that allow for increased functionality in the state while maintaining NHHIO alignment with national standards regarding the secure transfer of information (i.e., Health Insurance Portability and Accountability Act of 1996). To facilitate the participation of community-based organizations in the State HIE, the definition of entities that are permitted to participate will need to be expanded. As part of this process, the Transformation Center will convene a multi-stakeholder workgroup to draft HIE-specific legislation for the 2017 (and 2018 if necessary) legislative session.

Finally, the State HIE operates under a self-sustaining model where organizations pay dues to use HIE services. The upfront cost of joining NHHIO may present a burden for some providers with limited resources. Similar to the EHR grant program described above, the governance board or council will create an HIE incentive grant program that covers the first year of NHHIO membership to allow non-participating providers a chance to experience the value in HIE without taking on the additional initial resource burden.

The conversation regarding the use and transfer of personal health information within New Hampshire is important and has significant implications for each individual citizen. Health transformation requires greater connectivity and communication across all parties involved in health and health care, and cannot happen without enhanced use of HIE. As New Hampshire moves forward with transformation, all parties involved need to continue the discussion of HIE and find balance with historic privacy and security concerns.

3. Quality Measurement, Reporting and Feedback System

The primary strategies related to quality measurement and reporting are:

- Establish multi-stakeholder workgroup to select a coordinated set of electronic clinical quality measures for New Hampshire; and
- Develop a quality reporting portal for providers to report eCQMs and receive timely feedback on quality performance.

Under existing reporting and payment structures, providers across New Hampshire are required to provide data on upwards of hundreds of clinical quality measures. The reporting of data is administratively burdensome and there is little alignment across payers and federal reporting requirements. To streamline processes and reduce the necessary resources required to meet disparate reporting requirements, the Transformation Center will convene a multi-stakeholder workgroup with multi-payer and regional representation to develop a coordinated set of clinical quality measures that can be reported electronically. The multi-stakeholder workgroup should recognize the efforts currently

underway by the ONC and CMS on electronic clinical quality measure (eCQM) development and use, and align measures where possible.

Once established, providers will electronically submit the coordinated clinical quality measure set to the Transformation Center on a timely basis, striving for quarterly reporting. The Transformation Center will compile and use the eCQM data to provide timely feedback to providers in the form of a common Score Card that provides appropriate comparisons for providers.

4. Patient and Provider Engagement Tools

The primary strategy related to patient and provider engagement tools is the development of a single access patient portal to simplify patient access to personal health information across providers.

Through the SIM process, stakeholders strongly and consistently expressed an urgent need to reduce the barriers for individuals to access their personal health information. A commonly used example is that a patient with complex health care needs may have upwards of five or six provider portals that require separate logins to access information. Through this project, the Transformation Center will facilitate the development of a single patient access portal in collaboration with a multi-stakeholder workgroup. The patient portal will require a single login, and then provide access to individual provider portals, similar to the Washington State OneHealthPort design where providers can use a single login to access portals of local health plans and hospitals (OneHealthPort, 2015). At this point, New Hampshire does not have the ability to link clinical data across EHR systems in a master patient index. However, creating better access for individuals to view and use their personal health information may help drive support for enhanced data access and use.

In advanced alternative payment models, the ability to link clinical data across EHR systems, and to incorporate other data sets such as claims data, becomes fundamental as practices move through the differing levels of value-based payment (*see Payment Reform section*). Given that the majority of practices are in the nascent stage of using value-based payment models, there is little immediate need for creating a repository of clinical and claims data for New Hampshire. However, for transformation efforts to advance beyond initial stages, the concept of linking clinical and claims data will need to be addressed at the state-level.

5. Public Data Reporting Expansion

The SIM State Health System Innovation Plan will establish a platform for the public to view aggregate Comprehensive Health Care Information System (CHIS), and have access to de-identified granular data. This platform will have the flexibility to incorporate other data sets over time.

New Hampshire strives towards providing greater transparency and access to data across State agencies. In the area of health care services costs, New Hampshire leads the nation in providing information on the price of medical services by insurance plan and by procedure through the NH Health Cost website (New

Hampshire Insurance Department, 2015). Similarly for population health, New Hampshire provides robust access to public health data including environmental and occupation health, injury prevention, substance and alcohol misuse, and several other State health improvement priorities through the WISDOM (Web-based Interactive System for Direction and Outcome Measures) website (New Hampshire Division of Public Health Services, 2015). These tools lay the foundation for building greater access to state-wide data, but do not provide sufficient information for determining health outcomes at a population level.

Stakeholders expressed the need for greater public reporting of data in order to inform decision-making on population health. The Comprehensive Health Care Information System (CHIS), the State all-payer claims database, contains a wealth of information related to the health and utilization of health care services across New Hampshire. However, in its current state, the CHIS data is difficult to access and many community agencies and providers do not have the resources required for comprehensive data analytics of the CHIS data. To address this need, the Transformation Center will facilitate the development of a new public data reporting website that uses the CHIS data as the initial foundational information set. CHIS data can then be utilized to create regional and state-level reports using aggregate, granular, and readily available data, similar to the Community Connections, Web-based Interactive System for Direction and Outcome Measures (WISDOM) , or similar dynamic, web-based systems, that could be used by Regional Health Initiatives and other entities for planning and program development. In addition, the website would provide access to de-identified CHIS data at the granular level to create the opportunity for researchers and decision-makers to use data to address specific questions of interest.

Any public reporting application must be flexible to meet multiple value propositions, create linkages between data sets, reduce administrative burden, and be easy to use. In developing the new website, the Transformation Center will coordinate with existing State public reporting efforts to provide user-friendly linkages between websites. The Transformation Center will use stakeholder input to drive the ongoing development of the new website, the incorporation of other existing public datasets (e.g., transportation data, criminal justice data), and the focus of aggregated data reports. Stakeholders will be encouraged to suggest program improvements and ongoing data need solutions.

H. Workforce Development Strategy

New Hampshire is a largely rural state, with many communities lacking enough physicians, ARNPs, substance use and behavioral health providers to meet needs and optimally deliver care. Moreover, critical shortages in critical workforce services for children and adults with physical and developmental disabilities persist throughout the state. Across professions, an aging workforce and "churn" as young professional enter and quickly leave health and related services contribute to these ongoing workforce challenges. Communities need healthcare providers in order to maintain and improve health where people live, work, learn, and play. In order to improve these conditions, New Hampshire will focus and expand its health workforce, as well as leverage the use of twenty-first century technology to support these efforts.

Workforce training and support needs to transition and modernize in conjunction with payment reform efforts and practice transformation strategies focused on patient-centered, team-based care that supports care coordination and a better patient experience. Health IT can also enable diversified approaches that provide more personalized treatment to patients. These changes require a broader range of health professionals to meet new demands, including the use of non-traditional workers. New Hampshire is committed to developing a robust health workforce that can meet future healthcare demands. Building a strong, statewide health workforce will require involvement of the State's colleges and universities, hospitals, large healthcare providers, faculty practice plans, policy organizations, nonprofits, recovery groups, and foundations.

New Hampshire's workforce development strategy is built on three mutually reinforcing components: multi-skilled behavioral health professionals including substance abuse disorder (SUD) providers; acceleration of skills necessary for primary care practice transformation to team-based, patient-centered, population health approaches; alignment of these efforts with community services to affect community-based population health improvement through the use of a new community based workforce; and use of electronic technology for continuous improvement.

Multi-skilled Professionals

First, resources will be utilized to address the critical and urgent needs for multi-skilled behavioral health and substance abuse professionals across the State. New Hampshire faces an urgent and unrelenting opioid abuse crisis, and at the same time is proactively working to recover from years of disinvestment in critical behavioral health systems, including implementation of a settlement in the Amanda D., et al. v. Hassan, et al.; United States v. New Hampshire . The State's recently approved Section 1115 Waiver (Appendix XII) is built on the twin, overlapping needs of behavioral health and substance abuse and provides a tremendous opportunity for accelerated results in human, system, and financial terms.

In complementary alignment with this groundbreaking waiver, New Hampshire proposes to prioritize behavioral and substance abuse workforce training within the initial round of RFPs envisioned for Integrated Delivery Network, which share attributes of the Regional Health Initiatives. Transformation Center Resources will also provide a unified coordination and technical assistance resource for providers, communities, and hospitals that seek immediate investment and assistance in this critical area of skills shortage. SIM State Health Innovation Plan implementation resources will form an initial investment pool for behavioral and substance abuse workforce training in every area of the State. As Regional Health Initiatives are launched and approved, applicants will be required to demonstrate a clear understanding of specific skill needs in their community that can result in rapid impact on substance abuse and mental health service challenges. Beyond the current crisis, such workforce investments can create a long lasting base of skilled workers, embedded in the community and connected to multiple clinical and non-clinical support services that will be vital to building a long lasting culture of proactive attention to these issues so that intervention, treatment, and healing happen sooner and more systematically.

Prioritized components for workforce investments will include but not be limited to:

- Crisis intervention
- Crisis stabilization
- Prescription drug abuse
- Emergency Departments and related continuum of care
- Related mental health co-occurring disorders
- Neonatal abstinence syndrome (NAS)
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Substances misuse and abuse trends
- Navigating the SUD provider network
- Alcohol abuse
- Adolescent use of marijuana

Accelerating Practice Transformation Skills

The second component of the State's health workforce investment strategy lies within the State's significant focus on aggressively accelerating practice transformation. The Transformation Center described in Section C will coordinate with New Hampshire's Area Health Education Center (AHEC), or similar organization, to support efforts to recruit primary care workforce and train current workforce for new care team roles. With the NH AHEC, or similar organization, the Transformation Center will provide training, assessment, and planning resources to support both the Regional Health Initiatives and practices themselves in efforts to create team-based care and strong practice leadership.

Community-based Health Workers

Third, alignment of population health improvement efforts with the formal health care sector, and the community-based service infrastructure that wrestles with the day to day realities of the culture of deprivation, generational poverty, unhealthy lifestyles, and unmet health needs requires investments in a flexible, locally defined and multi-skilled workforce of Community Health Workers. Community-based health workers can play a unique role in bridging and aligning local community and clinical resources in consumer centered, responsive and cost effective manner. Community health workers, (also known as patient navigators, promotores, and those with lived experience) have demonstrated leadership, and provided education, support, and resources to empower individuals to actively engage in their health. Community-based health worker models have shown to be particularly effective in minority and underserved populations to lower health risks, help manage chronic conditions, improve health outcomes, and reduce costs, as well as with achieving and sustaining recovery in populations with behavioral health conditions.

Investments in a community-based health worker approach will align with or complement workforce investments addressing substance abuse and behavioral health and practice transformation; the investments may be the same in some communities. The State intends this third area of focus as an opportunity to meet local needs in bridging community and clinical resources and improving referral and navigation to achieve population health outcomes. Community-based health workers, as an approach, must be demand driven, well researched, evidence-based, and cost effective; this is not intended to simply create another layer or level of health workforce throughout the State across the existing inefficient system. Creating a corps of community-based health workers cannot be viewed as an outcome – it is a means to the end of improving care, costs, and health. Community-based health workers or navigator models are intended to target health transformation efforts in a manner that accelerates progress and recovery in each community, and connects patients to services across payment sectors and service streams (Medicare, Medicaid, private insurance market, and behavioral and social services).

Use of Electronic Technology

The Transformation Center (with oversight from the governance board or council) will create a grant program intended to increase the skills of providers who have not yet adopted an EHR system, and providers who could benefit from technical assistance in optimizing their use of current EHR systems. Encouraging providers to make better use of an EHR system can be challenging, and it will be critical that Regional Health Initiatives identify local EHR champions to promote and lead workforce support strategies in this area.

I. Financial Analysis

New Hampshire's SIM State Health System Innovation Plan is predicted to produce cost savings of in the range of $1.2 and $2.4 billion over its first five years of implementation. These estimates are based on data about the size of the New Hampshire health insurance market using available information about Medicaid, Commercial and Medicare populations and reasonable actuarial assumptions about population growth, provider payment increases, utilization changes and payment and practice reform initiatives. There is relatively higher confidence in savings estimates for the programs over which the State has the most influence: Medicaid and the portion of Commercial sector that is Public Employee Benefits (PEB). These programs illustrate the potential value of the plan's proposed strategies to transform the practice of primary-care medicine, integrate physical and behavioral health care delivery systems, and reform payment for health care services. Once NH SIM State Health Innovation Plan interventions are fully implemented across all market sectors, savings are projected to range from $400 million to over $800 million per year.

If the SIM State Health System Innovation Plan costs $30 million over the first five years of implementation, the return on investment would be expected to range from 3.0:1 to 6.1:1 in Medicaid expenditure savings alone.

Background

This section describes the analytic approach, including data assumptions, basis of the assumptions, and methodologies underpinning the financial analysis.

We have modeled the expected savings effects in New Hampshire from implementation of a number of payment and practice reforms. We expect that these reforms could be implemented gradually over a five-year period beginning approximately July 1, 2016

The populations addressed in the analysis include State Medicaid beneficiaries, members of the PEB, commercially insured State residents, and Medicare beneficiaries. The intent of the analysis is to estimate, to the extent possible, the impact of the SIM State Health System Innovation Plan across New Hampshire's health care systems, and its propensity to impact the health and health care of the State as a whole. For each population, the analysis addresses: 1) the population's projected total medical and other service costs absent the SIM State Health System Innovation Plan; and 2) anticipated cost savings resulting from specific outcomes expected to result from SIM State Health System Innovation Plan interventions. We developed data about the size of the New Hampshire health insurance market using available information about Medicaid, Commercial and Medicare populations, including membership and claims information for both primary payers and for payments made by consumers through cost sharing provisions under Commercial and Medicare coverage, and including payments made by Medicare Supplement insurers. We projected the data forward using reasonable assumptions about population

growth, provider payment increases and utilization changes. We created a model that calculated savings by type of business (Medicaid, Commercial, Medicare), by type of service, by primary payers and by consumers, and by year.

Our data and projections separated claims by type of service provided, with specific projection assumptions that were used for hospital, physician and prescription drug services.

Estimates of the costs necessary to implement the SIM State Health System Innovation Plan are considered in total (not specific to population segments) and compared to total estimated savings across all population segments. This allows estimation of potential return on investment over the first years of implementation. Investment costs represent only the initial funds required to implement the SIM State Health System Innovation Plan. They do not duplicate other State investments already contemplated as a normal course of business, such as costs to administer the Medicaid and PEB programs or those funded through Section 1115 Waiver.

Definition of Savings

For the purpose of this analysis, "savings" is defined as the difference between expenditures necessary to provide current levels of health care services in the absence of the proposed innovations, and what is expected to be spent including proposed innovations. While it is possible to spend less money by providing less health care, that is not the primary mechanism by which the proposed innovations produce savings, especially in the near term. The improved health of New Hampshire's population may, over time, result in less consumption of health care services than would occur without the innovations, but the primary effects of the innovations are:

- More efficient delivery of health care services, especially primary care and including behavioral and substance use disorder care, through practice transformation;
- More efficient use of health care resources through payment reform and health information exchange; and
- Reduced unit costs for some services through payment reform and transparency.

The proposed innovations intend to produce at least as much health for at least as many people while spending less in total.

The estimated savings presented here are relative to what would need to be spent to provide current levels of health care services in the future without the proposed innovations, which for Medicaid is more than current State revenue sources could fund without significant cuts to other programs. These savings, if realized, would bring the New Hampshire state budget closer to breaking even, but would not produce surpluses that could fund other initiatives.

We assumed that the proposed payment reform initiatives are not now commonly in use in New Hampshire, and made appropriate offset in our projections to reflect the extent to which those payment methods currently are in use. We also assumed the payment reform initiatives would and could be implemented gradually over a 5-year period.

Analytic Approach

The SIM State Health System Innovation Plan envisions far-reaching and cross-cutting changes to the ways in which New Hampshire organizes and purchases health services, and how providers are reimbursed under state-purchased health benefits programs. For many of the proposed innovations, the State's successful execution of the proposed strategies is expected to lead to subsequent adoption by other purchasers and payers, or to indirectly affect care delivery for all participants in New Hampshire's health care system and thus result in additional savings from commercial and Medicare programs. In other cases, innovations pioneered by commercial carriers or Medicare would be incorporated into New Hampshire's Medicaid programs in order to realize the savings.

However, the SIM State Health System Innovation Plan is deliberately flexible and not overly prescriptive in operational details or tactics. The SIM State Health System Innovation Plan itself is the supporting infrastructure to achieve the specific objectives described in the proposed model. Calculating detailed, specific savings estimates for individual components of the Plan is therefore not useful. As a consequence, all savings estimates are presented as ranges within which actual savings are likely to fall.

This financial analysis addresses the components of the Plan that are quantifiable and are expected to directly affect medical expenditures in the near term. This analysis does not attempt to quantify potential sources of longer-run savings or the value to New Hampshire residents of improved health. This analysis does serve to demonstrate that the SIM State Health System Innovation Plan would generate a positive return on investment in a short period of time, well before all of the benefits have been realized.

The estimates presented here combine analysis of other studies and implementations, reliance on actuarial experience and judgment, high-level estimation methods, and an understanding of New Hampshire's health insurance markets. They do not reflect detailed models, simulations or micro-simulations.

The estimates presented here capture both the potential savings from implementing the proposed Plan and the challenges in capturing those savings. Estimates of savings and return on investment are presented as ranges and embody significant potential uncertainty. Sources of uncertainty include execution risk; competing initiatives at federal, state, local, carrier, and provider levels; perceived level of industry and political support; and difficulties associated with shepherding multiple, significant, and fundamental changes concurrently, with implications beyond the health care system in many cases.

Direct Impacts on Health Care Costs

As described above, the financial analysis focuses on certain specific objectives of the SIM State Health System Innovation Plan that are reasonably expected to have direct and meaningful impact on the cost of health care in New Hampshire. Based on our model, we calculated an expected total 5-year savings on a best-estimate basis of approximately $1.8 billion, and we are presenting it as an estimate range of $1.2 to $2.4 billion in recognition of the uncertainty associated with the estimate assumptions. While we have modeled separately the savings for primary payers and consumers, the results in total are more reliable than the separate pieces. For example, savings to consumers who have to pay fixed deductibles may be relatively lower than for primary payers. The range of outcomes included in the analysis is summarized in the following tables:

Table I.1: High and Low Estimates of Savings Attributable to Proposed Innovations

Low Savings Estimate	Medicaid	Commercial	Commercial Members	Medicare	Medicare Members	All Payers
Year 1	5,333,000	34,939,000	6,451,000	17,955,000	3,495,000	68,173,000
Year 2	11,281,000	74,365,000	13,690,000	39,268,000	7,623,000	146,227,000
Year 3	17,705,000	117,556,000	21,575,000	62,515,000	12,104,000	231,455,000
Year 4	24,702,000	165,207,000	30,229,000	88,477,000	17,087,000	325,702,000
Year 5	32,313,000	217,694,000	39,711,000	117,410,000	22,616,000	429,744,000

High Savings Estimate	Medicaid	Commercial	Commercial Members	Medicare	Medicare Members	All Payers
Year 1	10,665,000	69,879,000	12,902,000	35,911,000	6,990,000	136,347,000
Year 2	22,561,000	148,730,000	27,379,000	78,536,000	15,247,000	292,453,000
Year 3	35,410,000	235,111,000	43,151,000	125,030,000	24,209,000	462,911,000
Year 4	49,405,000	330,414,000	60,458,000	176,954,000	34,174,000	651,405,000
Year 5	64,627,000	435,388,000	79,422,000	234,820,000	45,232,000	859,489,000

Table I.2: High and Low Estimates of Savings as Percent of Expenditures

Low Savings as Percent	Medicaid	Commercial	Commercial Members	Medicare	Medicare Members	All Payers
Year 1	0.4%	0.9%	0.9%	0.9%	0.9%	0.8%
Year 2	0.7%	1.7%	1.8%	1.7%	1.8%	1.6%
Year 3	1.1%	2.6%	2.7%	2.6%	2.7%	2.3%
Year 4	1.4%	3.4%	3.6%	3.5%	3.6%	3.1%
Year 5	1.8%	4.3%	4.5%	4.3%	4.5%	3.9%

High Savings as Percent	Medicaid	Commercial	Commercial Members	Medicare	Medicare Members	All Payers
Year 1	0.7%	1.7%	1.8%	1.7%	1.8%	1.6%
Year 2	1.4%	3.4%	3.6%	3.5%	3.6%	3.1%
Year 3	2.2%	5.1%	5.4%	5.2%	5.4%	4.7%
Year 4	2.9%	6.8%	7.3%	6.9%	7.2%	6.3%
Year 5	3.6%	8.5%	9.0%	8.7%	9.0%	7.8%

Table I3: Predicted Expenditure Growth Rates With and Without Innovation

Expenditure Growth Rate	Medicaid	Commercial	Commercial Members	Medicare	Medicare Members	All Payers
Base Case	5.0%	5.7%	5.4%	6.9%	6.6%	5.9%
Low Savings	4.6%	4.8%	4.4%	6.0%	5.7%	5.1%
High Savings	4.2%	3.9%	3.5%	5.0%	4.7%	4.2%

While our calculations accurately reflect the data and assumptions used, to the extent actual events do not correspond to those assumptions, actual results may vary.

In Tables I.1-I.3, the columns labeled "Commercial Members" and "Medicare Members" represent savings in deductibles, co-payments, and co-insurance paid by insured members.

We have relatively higher confidence in savings estimates for Medicaid and the state employee benefits program part of Commercial because of the degree of state control over benefits administration. Estimates for Medicaid and the PEB portion of Commercial savings were developed from relevant studies of experience from similar interventions in other geographies. Commercial and Medicare ranges represent the potential for "spill-over" effects resulting from the State acting as a "first mover" in the marketplace. Because current Medicaid reimbursements are substantially lower than those from commercial carriers in New Hampshire and because Medicaid has less market power than the largest commercial carriers, commercial carriers are expected to have the best opportunity to experience substantial long-run savings from payment reform.

Basis for Savings Assumptions

Because of the fundamental nature of structural changes proposed by the SIM State Health System Innovation Plan, savings are not quantified for individual innovations; instead outcomes are anticipated and savings in direct health care costs estimated through successful implementation of the Plan in its entirety. For example, concepts such as value-based contracting, value- based benefits, and bi-directional integration of physical and behavioral health care are required infrastructure for achieving real savings in acute and chronic illness, and in preventing costs related to obesity, excess maternity costs, uncoordinated/fragmented health care, etc. The complementarity of innovations in practice transformation and in payment reform results in greater savings from their combination than the sum of their effects in isolation.

While the SIM State Health System Innovation Plan as a whole is considered a prerequisite to the estimates, there are particular components for which critical assumptions are made. These include:

- The amount expected to be spent over the next five years, by combination of provider and payer, in the absence of Plan interventions;
- The estimated savings to be realized through the implementation of New Hampshire's Section 1115 Waiver, which are incorporated into the baseline from which the savings are estimated;
- The extent to which alternative payment models are already in use by different combinations of payer and provider categories;
- The pace at which providers and payers will move up the ladder to higher categories of payment models;
- The percent cost reductions, by provider category, associated with each step on the ladder of payment models;
- The extent to which advanced primary care models are already in use by different payer categories;
- The pace at which providers will engage and advance up the ladder to higher stages of advanced primary care and integrated care; and
- The percent cost reductions, by provider category, associated with each step up the ladder of practice transformation.

The categories of payment models used in this analysis follow from the HCPLAN Payment Models Framework (See Section D). They are:

- Category 1: Traditional fee for service with no link to quality
- Category 2: Fee for service with link to quality
    - Category 2A: Payments for infrastructure and operations
    - Category 2B: Pay for reporting

    - Category 2C: Rewards for performance
    - Category 2D: Rewards and penalties for performance
- Category 3: Advanced models built of fee for service architecture
    - Category 3A: With upside risk
    - Category 3B: With upside and downside risk
- Category 4: Population-based payment
    - Category 4A: Limited
    - Category 4B: Comprehensive

Practice transformation in New Hampshire will be measured in seven dimensions (See Section E): empanelment, risk stratification, care management, care coordination, patient access, patient experience, and quality improvement. The stages of practice transformation are:

- Stage 1: Process and structure transformation
- Stage 2: Outcome reporting
- Stage 3: Advanced outcome reporting

The stages of care integration are:

1. Minimal collaboration
2. Basic collaboration
3. Co-located with basic collaboration
4. Co-located with close collaboration
5. Integrated with close collaboration
6. Integrated with full collaboration

Baseline Spending Assumptions

Tables I.4-I.6 show the assumptions underlying the estimates of spending in the absence of Plan Interventions. Base year expenditures are for the 12-month period ending June 30, 2015.

Table I.4: Estimated Base Year Expenditures by Payer Category

Payer Category	Amount
Medicaid	1,234,435,000
Commercial	3,820,402,000
Commercial Members	666,366,000

Medicare	1,876,100,000
Medicare Members	352,900,000
Total	7,950,203,000

Table I.5: Estimated Member Populations by Payer Category

Year	Medicaid	Commercial	Medicare
Base Year	160,000	697,000	255,000
Year 1	183,000	704,000	263,000
Year 2	185,000	711,000	271,000
Year 3	187,000	718,000	280,000
Year 4	189,000	725,000	289,000
Year 5	191,000	732,000	298,000

The size of each market was estimated separately. The size of the commercial market was estimated based on the number of member months in the New Hampshire CHIS claims database, the size of the Medicare and Medicaid markets in the base year were based on CMS numbers as reported on the kff.org website, and the Medicaid expansion-driven increase between the base year and Year 1 was based on NH DHHS reports.

Table I.6: Expected Growth Rates for Per-Member Expenditures in the Absence of Innovation

Hospitals	6.7%
Professionals	4.8%
Drugs	4.9%
Other	4.4%

Cost Savings Assumptions

Tables I.7-I.9 show shows the assumptions about the financial effects of SIM State Health System Innovation Plan interventions that were employed in this analysis. Table I.7 shows the estimated extent of current adoption for each payment reform level for each payer category in New Hampshire.

Table I.7: Estimated Current Level of Adoption of Payment Reforms

	Payment Models	Medicaid	Commercial	Medicare
1	Fee for service only	95%	45%	0%
2A	Pay for infrastructure	5%	0%	0%
2B	Pay for reporting	0%	0%	0%
2C	Rewards for performance	0%	0%	0%
2D	Rewards and penalties	0%	0%	100%
3A	Advanced model with upside risk	0%	40%	0%
3B	With upside and downside risk	0%	15%	0%
4A	Limited population-based payment	0%	0%	0%
4B	Comprehensive population-based	0%	0%	0%

Table I.8 shows the expected adoption after five years of Plan implementation for each payment reform level for each payer category.

Table I.8: Estimated Adoption of Payment Reforms after Five Years

	Payment Models	Medicaid	Commercial	Medicare
1	Fee for service only	15%	15%	0%
2A	Pay for infrastructure	0%	0%	0%
2B	Pay for reporting	0%	0%	0%
2C	Rewards for performance	30%	0%	0%
2D	Rewards and penalties	10%	0%	20%
3A	Advanced model with upside risk	25%	15%	20%
3B	With upside and downside risk	20%	50%	30%

	Payment Models	Medicaid	Commercial	Medicare
4A	Limited population-based payment	0%	10%	10%
4B	Comprehensive population-based	0%	20%	20%

Table I.9 shows the expected effect size, measured as percent reduction in expenditure from the level expected with fee-for-service only, for each combination of payment reform level and provider category.

Table I.9: Expected Effect Sizes

	Payment Reform Level	Hospital	Primary	Specialty	Other
1	Fee for service only	0.0%	0.0%	0.0%	0.0%
2A	Pay for infrastructure	0.0%	0.0%	0.0%	0.0%
2B	Pay for reporting	0.0%	0.0%	0.0%	0.0%
2C	Rewards for performance	0.0%	3.0%	0.0%	0.0%
2D	Rewards and penalties	0.0%	3.0%	0.0%	0.0%
3A	Advanced model with upside risk	2.0%	7.0%	5.0%	2.5%
3B	With upside and downside risk	5.0%	12.0%	10.0%	5.0%
4A	Limited population-based payment	10.0%	16.0%	15.0%	7.5%
4B	Comprehensive population-based	15.0%	26.0%	20.0%	10.0%

Potential Sources of Savings Not Addressed

This financial analysis does not attempt to address every potential source of savings that may follow from the successful implementation of the Plan. In particular, it does not quantify savings outside the realm of health care, such as:

- Reduced State and carrier administrative expenses through the shift to population-based payments;
- Reduction in social service and public safety expenditures resulting from more effective integration of physical and behavioral health care; or
- Reduction in sick leave and disability costs along with increased productivity from public and private employees as a result of improved individual and family health status.

J. Monitoring and Evaluation Plan

Public Transparency

For the first time, New Hampshire will have a public governance board or council empowered to guide transformation and pursue accountability for outcomes. This new body will regularly evaluate progress in health transformation in full view of policy makers and all stakeholders; notably consumers and taxpayers. High profile, public monitoring and discussion of progress, success, and failure provides significant motivation for performance, and an extremely valuable forum for maintaining focus and attention on achievement of New Hampshire's transformation goals.

The governance board or council will establish, through the Transformation Center, an online "dashboard" for public reporting and monitoring of progress on transformation process goals and outcomes.

In addition, a new public data reporting website will be developed (See Section H) to enable regional and state-level reports on progress toward key transformation indicators. Data will also be used for planning, program development and continuous improvement.

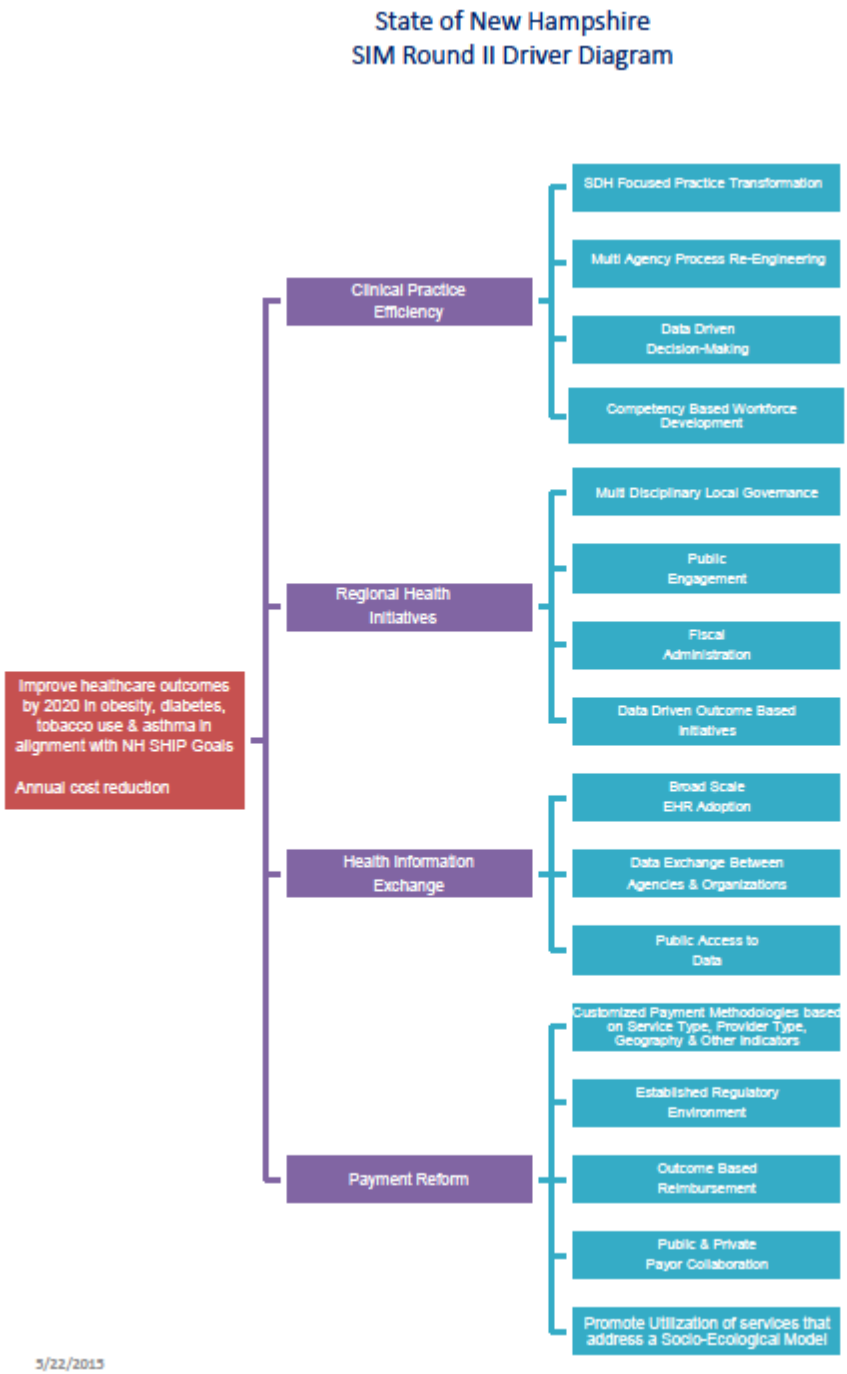
Progress Toward Reaching Goals & Objectives

New Hampshire, through the new Governing board's authority, will create an oversight process to examine progress toward outcomes at the following levels:

1. *Statewide pace of progress* on near terms process goals within the operational plan (i.e. start-up of the transformation center, establishment of Regional Health Initiatives, launch of practice transformation, convening of an All-Payer Group on alternative payment adoption). The Operational Plan below details goals by year and by quarter.
2. *Local and regional pace of progress* on development of regional priorities and approaches: progress in implementing and supporting practice transformation efforts, workforce investment, population health priorities. Local initiatives will be expected to determine outcome measures for investments, consistent with the SIM State Health System Innovation Plan.
3. Bottom line *progress toward cost reduction* for the public sector (state and federal) and private sector (payer and consumer) based on the financial modeling within this Innovation Plan. The annual statewide health sector goal for cost reduction will be finalized by either the legislature or the new governance board or council.
4. External assessment on the State's *progress on population health metrics* contained in the State Health Improvement Plan aligned with key health outcomes in the Medicaid Section 1115 Waiver.

The governance board or council, at its discretion may consider utilizing an RFP process to engage external evaluators who are not connected to New Hampshire's health market or transformation activities to procure a contractor via an RFP to perform some or all of the oversight functions, in Q1 of Year 2.

K. New Hampshire Operational Plan



<table>
<tr><td>Phase 1</td><td>Year 1</td><td>Qtr 1</td><td colspan="3">Governor’s Executive Order
• Will report to the Governor
• Will be established as a public/private partnership (with DHHS support)
• Will be time limited to serve as a start-up body only until the legislature creates a permanent body
• Will be responsible for overseeing the criteria and selection process of the Transformation Center
• Will be responsible for setting overarching State goals and coordinating healthcare transformation activities within:
-SIM, Medicaid, Medicare and commercial health insurance markets
• Will work closely with the primary care workforce commission
• Proposed membership:
-Health care
-Health policy
-Payment knowledge & expertise
-Public health
-Provider
-HIT
-Workforce development
-Patient advocate
-Consumer/public member
-Department of Health and Human Service
-Department of Insurance
-Business
-Legislators
• 9 – 13 people
• Will convene Multi-payer table
• Appointed individuals for Phase 1 will have buy-in from the Legislature and Executive Council</td><td colspan="2">Payment Reform
• Multi-payer workgroup to include representatives from commercial, Medicare and Medicaid payers in New Hampshire
• Agree on a common understanding of alignment with Medicare
• Review and discuss Health Care Payment Learning and Action Network (HCPLAN) White Paper on Alternative Payment Models (APM)
• Adopt Health Care Payment HCPLAN APM Framework to guide payment reform</td></tr>
<tr><td></td><td></td><td>Qtr 2</td><td>Workgroup</td><td>Activity</td><td>Engagement Target</td><td>Assumptions</td><td>Risks</td></tr>
</table>

			HIT 1.1.1: EHR Survey and Baseline Assessment	Transformation Center conducts survey to establish baseline EHR adoption and use rates across the State	Not applicable	Transformation Center staff will coordinate with NHHIO, NH REC, and CIOs to reach out to providers not being reached through existing technical assistance efforts. Transformation Center will evaluate EHR adoption through a standard tool, such as the Ambulatory EMR Adoption Model℠	Survey implementation and response collection may take longer than anticipated. Providers currently not accessing existing technical assistance may be hard to reach
			HIT 2.1.1: Governing Body HIE Education and Outreach for Legislative Action	Governing Body initiates outreach and education on HIE. To continue through Year 3, as necessary	Legislative action to adapt NHHIO legislation during 2016 or 2017 legislative sessions	There is public support for the continuation of a State HIE system in New Hampshire. The Governing Body can develop a multi-focused engagement and legislative strategy to reignite conversation on HIE value balanced with privacy and security concerns	Not all necessary stakeholder support communicated to legislators. Key stakeholders with strong privacy and security concerns regarding personal health information not included in outreach and education and public discourse on HIE.
			HIT 2.2.1: Community-based Organization List	Transformation Center to compile list of available community-based organizations and coordinate with NHHIO to incorporate list into master provider index	Not applicable	The Transformation Center develops a working relationship with NHHIO to provide technical assistance support and HIT expertise Risks: Transformation Center does not have necessary funding for	

						outreach and mapping of community-based organizations to develop list	
			HIT 3.1.1: Multi-stakeholder Workgroup to Select Coordinated eCQMs	Transformation Center to establish a multi-stakeholder workgroup to select a coordinated starter set of clinical quality measures that can be reported on electronically and applied across payers and federal reporting entities. Continue through the end of Year 1, as needed	Not applicable	Selected measures should align with measures in development by ONC and CMS where applicable/possible	Stakeholders cannot come to agreement on selected measures, coordinated measure set is too large so that administrative burden is still high, coordinated measure set not meaningful across providers and payers
			Practice Transformation	Transformation Center selected and contract executed	Not applicable	DHHS and Oversight body is able to select the Transformation Center entity and contract for services in a timely fashion	State of New Hampshire and Oversight Body are not able to identify start-up funding for Transformation Center or complete selection and/or contracting in quarter 2
			Payment Reform	• Identify current status of Value-Based Payment (VBP) based on HCPLAN APM Framework • Establish statewide goals for increasing VBP • Describe the pathway to comprehensive population based payment			

		Qtr 3	**HIT 2.1.2:** Draft Legislation for HIE Regulation Change	Governing body will establish a workgroup to draft legislations adapting the HIE regulations to allow for the greater transfer of information between providers	Legislation is introduced for the 2017 legislative session	The Governing Body and HIT legislation workgroup has sufficient time and resources to draft legislation prior to 2017 legislative session filing deadlines	Proposed HIE legislation many result in no action by the legislature or resulting legislation that is unsuccessful in changing the regulations on the State HIE. In the event that this occurs, the Governing Body will need to establish an alternative plan to address the need for expanded HIE in the State
			HIT 3.2.1: eCQM Provider Portal - Design and Implementation Plan, RFP Development and Release (if applicable)	Transformation Center develops detailed design and implementation plan for eCQM portal. Develop RFP (if necessary) for portal development	Not applicable	eCQMs will be reported through a provider portal	Timeline delays due to the RFP process
			HIT 3.2.2: eCQM Provider Portal – Data Analytics Plan and Reporting Design	Transformation Center develops detailed eCQM analytics plan and design for provider Score Card	Not applicable	The Transformation Center will analyze the data and provide quarterly feedback to providers through a common Score Card	Transformation Center does not have capacity to analyze data and create provider reports on a quarterly (or more frequent) basis

			HIT 5.1.1: Public Data Reporting Website – Design and Implementation Plan	Transformation Center develops detailed design plan for new public data reporting website that uses the CHIS as an initial and foundational dataset. Implementation plan determined. If implementation through RFP process, RFP drafted, released and awarded. To continue through Y1, Q4, as necessary	Not applicable	Public reporting initiative will be designed to be flexible enough to allow for aggregate and granular data access, and to incorporate other datasets	Transformation Center does not have capacity to engage stakeholders and develop detailed plan
			Practice Transformation	Transformation Center develops/adapts transformation curriculum for advanced primary care and integrated care using curriculum outline from SIM plan, CMMI's PTN and CPC initiatives, SAMHSA-HRSA Integrated Care Framework and other sources. This activity extends through the end of Year 1, Quarter 4	Not applicable	Transformation Center will primarily draw on transformation curriculum materials available from national and State resources including CMMI, NCQA, SAMHSA-HRSA, medical society, State and local collaboratives, etc.	Transformation Center is not able to deploy staff quickly enough to complete task
			Practice Transformation	Transformation Center develops a preliminary communication plan and materials to support recruitment	Not applicable	In its communication plan, the Transformation Center includes the to-be-selected Regional Health Initiatives as	Transformation Center is not able to deploy staff quickly enough to complete task

				and engagement of practices in transformation		regional communication and recruitment hubs	
			Payment Reform	• Adopt progress tracking mechanism based on HCPLAN approach • Report quarterly to Board			
		Qtr 4	**HIT 1.2.1:** EHR Adoption and Optimization Grant Program – RFP Development and Release	Transformation Center will develop EHR adoption and optimization support grant program	Not applicable	Available through RFP process, RFP will target provider types and/or geographic regions that have low EHR adoption and use as identified through the baseline survey (see 1.1.1), may be incorporated into Regional Health Initiative applications to Transformation Center, but not a requirement. RFP should request information about participation in other technical assistance programs as to not duplicate efforts. Transformation Center should coordinate with NH REC and NHHIO about potential focus areas	Available funding may limit the scope and number of awardees possible through the grant process

			HIT 2.2.2: e-Referral Program – Design and Implementation Plan	Transformation Center will convene a multi-stakeholder workgroup to create detailed design and implementation plan for a bi-directional e-Referral system that connects health care providers and community-based organizations	Not applicable	The e-Referral system may build off the New Hampshire Tobacco Quit line program, and use lessons learned from the existing Massachusetts e-Referral program. The implantation design will include significant support for incorporation of e-Referral system into health care and community-based organization workflow	This is dependent on the outcome of the HIE legislation change efforts, and clinics and community-based organization capacity to adopt e-referral system into workflow
			HIT 2.3.1: HIE Participation Support Program – RFP Development and Release	Transformation Center will develop an HIE adoption and support grant to assist providers interested in participating in the State HIE	Not applicable	The grant will support the first year of NHHIO membership fees in order to give providers an opportunity to experience value in HIE participation. Transformation Center should coordinate with NHHIO in creating provider focus areas for grant program	General perception about State HIE value may reduce the number of applicants. This is dependent on the education and outreach of the transformation efforts, led by the Governing Body. Actual resources available for grant program unknown
			HIT 3.2.3: eCQM Provider Portal – Contract Awarded, Portal Development	Transformation Center selects vendor to develop eCQM portal. Portal developed	Not applicable	The Transformation Center will use a vendor to develop and support the technology solution that aligns with the eCQM Plan (3.2.1)	

			HIT 4.1.1: Single Access Patient Portal – Design and Implementation Plan	Transformation Center will convene multi-stakeholder workgroup to create detailed design and implementation plan for single access patient portal. If implementation plan includes RFP, RRP drafted, released and awarded. To continue through Y2, Q1, as necessary	Not applicable	This project creates an IT solution to consolidate log-ins across existing patient portals. Provider organizations agree on value in creating a single access point for patients	Limited participation by provider organizations could reduce value and use by patients
			Practice Transformation	Transformation Center develops health systems engineering capabilities and a plan for disseminating tools and training about health systems engineering to the RHIs and practices	Not applicable	Development health system engineering expertise within the Transformation Center will extend into Year 2	Difficulty identifying personnel resources with the necessary health systems engineering expertise to support the activity
			Practice Transformation	Transformation Center drafts a memorandum of understanding to be used by practices and the Regional Health Initiatives to formally engage practices in the transformation supports process	Not applicable	This MOU will have required elements that RHIs must use. RHIs may adapt non-required aspects of the document	Transformation Center is not able to deploy staff quickly enough to complete task

			Practice Transformation	Transformation Center begins provider awareness communication program to lay groundwork for practice engagement in transformation	50% of primary care and behavioral health providers are reached in this awareness campaign via in person meetings, webinars and written communications/newsletters	Transformation Center is able to collaborate with State medical societies, provider groups and other to support dissemination of the communication campaign	
			Payment Reform	• Engage in HCPLAN national workgroups and activities			
Phase 2	**Year 2**	**Qtr 1**	**Governance (Year 2 & 3)** The overarching goal in Phase 2 is to pass legislation in 2017 that (1) solidifies the Governance Body and provides it with the necessary authority to enact transformational change and (2) allows NHHIO to store patient data. Below is an initial list of Governance Body oversight activities: • Standards and performance outcomes • Rate review process • Workforce capacity • Disproportionate share hospital funding • State healthcare purchasing • Identification and removal of regulatory barriers			**Payment Reform (Year 2 & 3)** • Establish Multi-Payer Collaborative to foster collaboration between payers to accelerate payment reform objectives • Provide technical assistance, tools and incentives through Transformation Center • Offer learning collaboratives on Alternative Payment Models • Develop model contract exhibit templates for Alternative Payment Models in each of the HCPLAN categories • Develop RFP template as a reference for health purchasers intend to include value-based payment criteria in contracts • Create legislative agenda to support payment reform interests • Develop provider risk mitigation strategies, education on payment reform and data analytics tools • Address synergy with 1115 Waiver, “Building Capacity for Transformation” • Develop payment strategies that address special rural health issues, support community services and social determinants of health	
			Workgroup	**Activity**	**Engagement Target**	**Assumptions**	**Risks**

			HIT 1.2.2: EHR Adoption and Optimization Grant Program – First Round Awarded	The Transformation Center will award the first set of grants for EHR adoption and optimization	Funding and request size and scope dependent	The Transformation Center will review applications for EHR support and focus on providers who have not received previous EHR-related federal technical assistance	Funding sources, requests largely outnumber available funds, poor response rate
			HIT 2.2.3: e-Referral Program – Development	The Transformation Center will work with a multi-stakeholder group to establish guidelines for e-Referral Program, and work with a preliminary set of providers and community-based organizations to create initial participation the e-Referral Program	Not applicable	The Transformation Center may build off of the New Hampshire Tobacco Quit line success and use lessons learned from the Massachusetts e-Referral program to guide development	Limited provider and community-based organization capacity for additional training and work flow change
			HIT 2.3.2: HIE Participation Support Program – First Round Awarded	The Transformation Center will award the first set of grants for HIE participation	Funding and request size and scope dependent	The Transformation Center will review applications for EHR support and focus on providers who have not received previous EHR-related federal technical assistance	Funding sources, requests largely outnumber available funds, poor response rate
			HIT 3.2.4: eCQM Provider Portal – Soft Launch (Providers Can Report eCQMs)	Soft launch of the eCQM portal	One provider can report on coordinated set of eCQMs through portal	The Transformation Center has the capacity to monitor and accept eCQM data receive through eCQM portal. The eCQM portal is easy to use and does not create additional	The portal development does not follow timeline. The portal is cumbersome to use

						administrative burden for providers	
			HIT 5.1.2: Public Data Reporting – Development	Transformation Center develops public reporting website using CHIS data	Not applicable	The data application will be flexible enough to incorporate different data sets, and produce reports of aggregate data. The website will also create access granular level data	Development costs could be higher than budget, restrictions of CHIS data access could slow down process
			Practice Transformation	Transformation Center, with input from the RHIs and practices, develops the process, workflows and modalities by with the practices and RHIs will share data implementation and outcomes of the advanced primary care and integrated care models	All RHIs will have input on the model	This process will leverage the eCQM portal and the Transformation Center's eCQM reporting workgroup. The shared data will be used both to track the state of transformation and the intermediate outcomes of transformation	There are difficulties standing up the process and/or technology by which this reporting will occur
			Practice Transformation	Transformation Center implements plan to disseminate training and deployment of health systems engineering tools to RHIs and practices	All engaged practices will receive training and support in use of these tools within six months of engagement with the transformation process	Transformation Center will work with RHIs in a train-the-trainer model	Some practice may not be ready to learn about or utilize these tools by six months into the transformation process

		Qtr 2	**HIT 2.2.4:** e-Referral Program – Soft Launch	Soft launch of e-Referral program	At least one provider can transmit an e-referral to a community-based organization. The community-based organization can interpret the referral data and successfully send feedback to the provider	The e-referral program will be launched with a small group of select provider and community-based organizations. The program will grow across the State using lessons learned from initial set of e-referral partners	This may be dependent on HIE regulations
			HIT 4.1.2: Single Access Patient Portal - Development	Transformation Center and multi-stakeholder workgroup will work with vendor to guide development of single access patient portal	Not applicable	Providers across the State will work with Transformation Center to grant access to single login technology solution	Provider organizations will not see value in reducing administrative burden for patients or collaborating with other organizations across the State
			Practice Transformation	Transformation Center makes first report to Oversight Body about state of practice transformation. These reports shall continue on a semi-annual basis	All engaged practices and RHIs provide data for the report	Data reported shall include recruitment statistics, levels of transformation achieved, and any outcome measures	Data reporting system is not operational
			Payment Reform				
			Payment Reform				

		Qtr 3	**HIT 3.2.5**: eCQM Provider Portal – Score Card (Providers Receive Feedback)	eCQM Provider Portal – Provider Feedback	At least one provider receives Score Card with first set of eCQM reporting data	Providers will submit eCQM on a quarterly basis. Transformation Center has staffing capacity to turn Scorecard reports on a timely manner	Providers do not consistently provide eCQM data, or submit data late, nuanced reporting differences between eCQM make it resource intensive to analyze, Transformation Center does not have capacity to conduct analytics and reporting feature
			HIT 4.1.3: Single Access Patient Portal – Soft Launch	Patient portal – soft launch	At least one patient is able to use a single login to gain access to all their associated provider portals	Providers across the State will work with Transformation Center to grant access to single login technology solution	Slow/non-response in providers joining to provide access through single portal, cost could exceed budget
			HIT 5.1.3: Public Data Reporting – Soft Launch	New public reporting website using CHIS data – soft launch	At least one user can create and view online data reports from aggregated data. At least one user can download de-identified granular data for analysis. Website will include hyperlinks to other State data websites (e.g., NH Health Cost, WIDSOM) and encourage users to suggest other types of data sets to include and aggregated data report topics	CHIS data can be de-identified and still provide meaningful information. The Transformation Center will guide the development of the public reporting website and be actively seeking out partners across other State departments	Website is not user-friendly, aggregated data reports do not provide value, cannot provide sufficient level of de-identified granular data to be useful to researchers
			Payment Reform				

			Payment Reform				
		Qtr 4	**HIT 3.2.6:** eCQM Provider Portal – Evaluation and Improvement	eCQM Provider Portal – Evaluation and Improvement. To continue through Year 3	At least 50% of providers submitting data and receiving quarterly feedback score cards by end of Year 2	Providers have education and training on how to report eCQMs and how to interpret and use common Score Card feedback	eCQM creates additional administrative burden for providers, providers don't see value in eCQM and Score Card reports
			Practice Transformation	Transformation Center makes second report to Oversight Body about state of practice transformation. These reports shall continue on a semi-annual basis	All engaged practices and RHIs provide data for the report	Data reported shall include recruitment statistics, levels of transformation achieved, and any outcome measures	Data reporting system is not operational
			Payment Reform				
			Payment Reform				
		Qtr 1-4	**Practice Transformation**	RHIs, with support from Transformation Center, commence communication and recruitment activities to engage primary care practices in the advanced primary care transformation model. This activity will continue throughout Year 2.	By the end of Year 2, 50% of NH's primary care providers will have either signed MOUs to begin the transformation process or will have been deemed to meet the Stage 1 criteria for advance primary care by the Transformation Center. This engagement goal is 12.5% of NH's primary care providers per quarter in Year 2	RHIs have been selected and have executed contracts	RHIs are not ready to operationalize recruitment efforts. The business case for practice participation is not adequate due to poor payer support

			Practice Transformation	Reporting by Stage 2 and Stage 3 advanced primary care practices for transformation metrics	By the end of Year 2, 25% of NH's primary care providers have commenced reporting either Stage 2 and/or Stage 3 measures for advanced primary care	Transformation Center has a reporting process established	Reporting process is unclear for practices and RHIs. Recruitment of advanced primary care practices is not successful
			Practice Transformation	RHIs, with support from Transformation Center, commence communication and recruitment activities to engage behavioral health and primary care providers in the integrated care model. This activity will continue throughout Year 2	By the end of Year 2, 50% of NH's behavioral health providers and 25% of NH's primary care providers (right target?) will have commenced implementation of the integrated care model as measured by submission of self-assessment results on the Maine Health Access Foundation tool. These engagement targets shall be broken down on a quarterly basis	RHIs have been selected and have executed contracts	RHIs are not ready to operationalize recruitment efforts. Reimbursement models do not support integrated care for primary care and behavioral health providers
	Year 3		**Workgroup**	**Activity**	**Engagement Target**	**Assumptions**	**Risks**
			HIT 5.1.4: Public Data Reporting – Incorporation of Other Datasets	Transformation Center will incorporate other data sets into public reporting website. Data set selection driven by user suggestions and demand	At least two other health-related and one non-health datasets are added to the site	Datasets are used to create aggregate data reports (e.g., charts, graphs) and provide access to granular de-identified data, Transformation Center will coordinate and communicate with non-health sector departments to prioritize data made available through website	Data are not kept up-to-date by department owners, low user volume (may be due to low perceived value, lack of knowledge about the site, etc)

		Practice Transformation	RHIs, with support from Transformation Center, continue communication and recruitment activities to engage primary care practices in the advanced primary care transformation model. This activity will continue throughout Year 3	By the end of Year 3, an additional 25% of NH's primary care providers (for a total of 75%) will have either signed MOUs to begin the transformation process or will have been deemed to meet the Stage 1 criteria for advance primary care by the Transformation Center	RHIs are stable and able to continue recruitment and transformation support efforts	Reimbursement models do not support advanced primary care transformation
		Practice Transformation	Reporting by Stage 2 and Stage 3 advanced primary care practices for transformation metrics	By the end of Year 2, 50% of NH's primary care providers have commenced reporting either Stage 2 and/or Stage 3 measures for advanced primary care	Transformation Center has a reporting process established	Reporting process is unclear for practices and RHIs. Recruitment of advanced primary care practices is not successful
		Practice Transformation	RHIs, with support from Transformation Center, will continue communication and recruitment activities to engage behavioral health and primary care providers in the integrated care model. This activity will continue throughout Year 3	By the end of Year 2, 75% of NH's behavioral health providers and 50% of NH's primary care providers will have commenced implementation of the integrated care model as measured by submission of self-assessment results on the Maine Health Access Foundation tool.	Integrated care model continues to be a good building block for both SIM and the 1115 Waiver. The integrated care model is adapted to specific needs for NH's patient population and provider organizations	Reimbursement models do not support integrated care for primary care and behavioral health providers
		Practice Transformation	Transformation Center makes semi-annual reports to Oversight Body about state of practice transformation	All engaged practices and RHIs provide data for the report	Data reported shall include recruitment statistics, levels of transformation achieved, and any outcome measures	Data reporting system is not operational

		Practice Transformation	Transformation Center and Oversight Body reviews both transformation targets and models, and makes adjustments as needed to ensure successful implementation for NH	Not applicable	Transformation Center and Oversight Body use available data and secure feedback from a larger group of NH health care stakeholders during review and adjustment process	Transformation Center and Oversight Body do not secure stakeholder input
Phase 3	**Year 4**	**Governance (Year 4 & 5)** • Assist in developing provider and patient portals for health information exchange and decision support				
		Workgroup	**Activity**	**Engagement Target**	**Assumptions**	**Risks**
		Practice Transformation	Transformation Center makes semi-annual reports to Oversight Body about state of practice transformation	All engaged practices and RHIs provide data for the report	Data reported shall include recruitment statistics, levels of transformation achieved, and any outcome measures	Data reporting system is not operational

Conclusion

The SIM Model Design Process and the resulting State Health System Innovation Plan position New Hampshire to move swiftly and aggressively, but deliberately forward with health transformation, bringing order to a fractured and chaotic range of health and fiscal challenges and opportunities. The Plan, as modeled, will result in cross sector reduction in health expenditures for all payers. The Plan directly addresses gaps identified by a broad cross-section of stakeholders with solutions identified and supported by those stakeholders; these stakeholders share a deep desire for widespread and integrated transformation across the State. The time is right for New Hampshire to capitalize on this demand and the energy that is waiting to be tapped within a defined, focused, and well organized Health System Innovation Plan focused on shared outcomes and accountability.

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