NH BUILDING CAPACITY FOR TRANSFORMATION SECTION 1115 WAIVER DEMONSTRATION

SECTION 1115 QUARTERLY REPORT

Demonstration/Quarterly Reporting Period: DY3Q2

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

New Hampshire continues to address the widespread variability in the availability and accessibility of both physical and behavioral health services which includes those for mental health and substance use disorders across New Hampshire. The goals of this DSRIP demonstration are; to build behavioral health care capacity; promote integration of physical and behavioral health care and improve care transitions that are implicated by behavioral health care needs. The demonstration seeks to achieve these goals by providing funding to providers for organizing themselves into regional networks of providers that can address the full spectrum of needs with which someone with behavioral health care needs may present.

Semi-annual reports were submitted at the close of this quarter. DHHS is currently in the review period. Progress continues to be made to varying degrees across the IDNs. DHHS Write-back requests are due mid-September.

II. Integrated Delivery Network (IDN) Attribution and Delivery System Reform Information

1: Trends and any issues related to care, quality of care, care integration and health outcomes.

As IDNs continue with the implementation of their projects submitted in 2017, many are reporting in increase integration of primary care, behavioral health and community services resulting in a comprehensive care plan for participating individuals. Through the use of a common, shared person-centered care plan combined with training and common standards regarding patient health information releases and IT solutions, communication between providers will significantly increase. With the development of improved care coordination, case management, and other mid-level staff within the integration strategies will result in; a more seamless care transition, increase in consumer satisfaction as they receive coordinated care, and increase in the ability to identify emerging needs prior to reaching crisis level.

Several of the IDNs are sharing training opportunities as well as collaborating training opportunities with neighboring regions. Sharing of resources provides a reduction in cost as well as providing uniform dissemination of information across multiple regions. IDN 2 hosted a Mental Health First Aid Train the Trainer Session which they made available to all IDN partners while IDNs 7 & 5 are coordinating to provide a 2-part session on Co-Occurring Medical Conditions. IDNs have also collaborated in engaging with NH Bureau of Drug and Alcohol Services to provide Addiction 101 trainings.

Challenges with obtaining and retaining appropriately credentialed staff continues to impact several IDNs implementation

plans. IDNs continue to share initiatives to enhance workforce capacity through their continued involvement in the Workforce Taskforce Subcommittees to address issues related to education and training, recruitment and retention and policy. These challenges continue to thwart implementation efforts in several IDNs.

Implementation of the Shared Care Plan and Event Notification System has been slow due to privacy issues surrounding the sharing of information relative to 42 CFT Part 2. SUD related information is prohibited without explicit written consent which limits care coordination. IDNs are reporting positive outcomes from partners who are piloting integrated care projects. These partners are reporting a decrease in ED visits due to appropriate care coordination for individuals who have signed informed consents. The development of standardized workflows and protocols has proven to be very challenging across regions. Partners are hesitant to incorporate additional technology to their already overburdened staff. Several of the IDNs have developed "toolkits" which contain sample workflows which partners can adopt or adapt to suit their current technology.

2: Any changes, issues or anticipated changes in population attributed to the IDNs, including changes to attribution methodologies.

IDNs report minimal changes to their attribution in this reporting period. Monthly enrollment fluctuates in some areas. However, these changes do not impact their implementation process.

3: Information about each regional IDN, including the number and type of service providers, leader provider and cost-savings realized through IDN development and maturation.

As IDNs complete the second quarter of the third year of the project which brings us to the mid point of the demonstration, most Integrated Delivery Networks and their partner providers continue to progress beyond the early stages of project execution. At this point it is too early to determine cost savings due to the need of onboarding of additional staff and resources. During this reporting period there have been no reported changes of services providers.

4: Information about the state's Health IT ecosystem, including improvements to governance, financing, policy/legal issues, business operations and bi-directional data sharing with IDNs.

IDNs are beginning to implement Shared Care Planning, Secure Message Exchange, Event Notification Service and Data Aggregation. Several hospitals are live with the Event Notification Service and ADT feeds for the Shared Care Plan. IDNs report that partners are in either the test or production phase for submitting data feeds to the Data Aggregator while one partner is completing scoping sessions for the Shared Care Plan and Event Notification Services with a separate vendor.

Due to the ongoing complexity of data sharing, the implementation process for the Shared Care Plan continues to be impacted by the privacy and security issues surrounding 42 CFR Part 2. IDNs have participated in multiple learning sessions regarding data sharing requirements. Several IDNs have also contracted with legal teams to provide guidance. Collective Medical Technologies, the Shared Care Vendor to 6 of the IDNs, has been actively engaged with their legal team to ensure compliance with federal and state regulations surrounding privacy. Safeguards are being developed directly into the Shared Care Plan Platform to ensure compliance which alleviates many of the partners concerns in the contracting process.

IDN1, 2, and 5 have completed the contracting process for the Data Aggregator for all participating partners, many of whom are in the final test phase for ADT feeds submissions. These partners are at varying stages of the scoping sessions for the Shared Care Plan. Currently two partners from IDN1 are piloting full use of the Shared Care Plan with approximately 20 shared patients who have signed informed consents. These partners indicate they continue to work through issues surrounding co-located care coordination but are already seeing improvement with these clients. It is too early in this pilot to report any clear findings. However, the use of the Shared Care Plan at this level is an integral step in the implementation process.

5: Information about integration and coordination between service providers, including bi-directional integrated delivery of physical, behavioral health services, SUD services, transitional care and alignment of care.

Integration and Coordination between service providers continues to develop. The use of a Closed Loop Referral process to address the needs of the client is the building block of coordination between service providers. As the providers continue to work through privacy issues, bi-directional integrated care of physical, behavioral health and SUD services continues to be impacted.

Three of the IDNs have co-located Primary Care Services within their Behavioral Health facilities. These IDNs are beginning to see the positive impact of the co-located services, while some are beginning to use the Shared Care Plan to develop a more comprehensive care plan for their shared clients.

IDN 2 is beginning to integrate IBHCs into their primary care offices. With the integration of behavioral health services, physicians are finding patients are more open to behavioral health services within a familiar setting. IBHCs are also being imbedded within the EDs to provide a more intensive assessment of behavioral health services in order to properly refer for additional services. This approach may reduce the waitlist for IEAs to New Hampshire Hospital.

IDN4 reports success with individuals engaged in the Critical Time Intervention (CTI) transitional care program. This 9-month program is designed to support high need clients as they transition. During the transitions the CTI Case Manager is coordinating care through connections with multiple providers to support the person centered transition plan. One individual that completed the CTI reported that it was the first time he was involved with development of his transition plan which he feels was the key to his success.

Due to the lack of qualified candidates and licensing requirements, SUD services have been slowly expanding across the state. This expansion is beginning to reduce wait time for access to services. The IDNs and the Department are coordinating efforts to address licensing requirements with legislature.

IDNs are also collaborating to address training needs which reduces the financial impact. Several trainings are being made available on-line to reduce the loss of productivity.

6: Information about specific SUD-related health outcomes including opioid and other SUD-dependency rates, opioid and other SUD-related overdoses and death – and trend rates related to Hepatitis C and HIV acquisition.

No changes this reporting period.

III. Attribution Counts for Quarter and Year to Date

PLEASE NOTE: **TO BE COMPLETED BY NH DHHS STAFF**

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

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

IDN	IDN Attributed Population[1]	Newly Enrolled in Current Quarter[2]	Disenrolled in Current Quarter	Current Enrollees: Year to Date[3]
1	28,659	1,767	2,129	28,297
2	18,597	1,336	1,549	18,384
3	24,967	1,807	2,174	24,600
4	48,114	3,135	3,990	47,259
5	17,146	1,128	1,480	16,794
6	32,133	2,074	2,699	31,508
7	18,855	1,022	1,487	18,390
Total	**188,471**	**12,269**	**15,508**	**185,232**

Notes:
1. Attributed population includes 175,486 members from the 12/31/2017 Outcome Attribution who were attributed through claims and geography and were Medicaid Eligible on 4/1/2018, and 12,985 members newly enrolled between 1/1/2018 and 4/1/2018 who were attributed through geography only.
2. Newly Enrolled population includes members who were attributed on 12/31/2017, but were not eligible as of 4/1/2018, and became eligible later in the quarter.
3. Current population are members who were Medicaid Eligible on 6/30/2018.

IV. Outreach/Innovation Activities to Assure Access

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

IDNs continue to hold All Partner Quarterly Meetings. In addition, information is disseminated through IDN websites, Facebook, one-page mailings, monthly newsletters, You Tube videos, on-line trainings and multiple training opportunities. IDNs continue to engage the community by providing support to several community programs which address the social determinates of health. All of these activities are designed to engage partners, potential partners and inform the

community. In addition, partners are provided the opportunity to network at Myers & Stauffer Quarterly Meetings. These networking opportunities allow partner who would not normally interact the ability to develop communications which will drive collaboration as they move through the SAMHSA Coordinated/Integrated Care Designation.

IDNs 1, 4 and 6 collaborated to provide a 1.5-day Cherokee Integrated Care Training Academy. Over 120 partners from all three regions joined the course to understand the Cherokee model of integrated care and discuss how to enhance and sustain integration in New Hampshire. Attendees reported a feeling of "hope and enthusiasm" following the training. One attendee said, "Behavioral Health plans are best driven through primary care." While another said, "Don't be afraid to go where the grass is brown. Baby steps can achieve much over time." In addition, the training allowed attendees to discuss billing, legislative and regulatory issues. These issues were presented to the Statewide Workforce Taskforce who will be taking the lead on driving change in New Hampshire.

V. Operational/Policy/Systems/Fiscal Developments/Issues

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

The IDNs continue to formalize and refine operating structures, policies, procedures, protocols, and workflows for all required aspects of the demonstration deliverables.

IDNs continue to move forward with contracting and implementation of the Shared Care Plan, Secure Message Exchange, Event Notification, and Data Aggregator in both a test and live environment.

DHHS, MCOs, and the IDNs have continued regular data meetings to address privacy issues and develop potential plans to meet the collaborative goals of the demonstration.

Concerns about ongoing availability of federal funding continue to impact fiscal and policy issues at the provider, state, and federal level. County Delegations are meeting over the second and third calendar quarter and voting on whether to provide county contributions for the continued DSRIP funding through the demonstration period.

As always the day to day operational issues, balancing of competing priorities, and the need for adequate funding, do not disappear in a demonstration environment. Rather these issues require a heightened level of awareness within the IDN, a partnership across the provider organizations, recognition by all participants that we need to be adaptable if we want to keep these providers at the table.

This quarter began recurring monthly learning collaborative meetings that expanded attendance from IDN administrative leads only to administrative leads and all partners.

Also this quarter, multi series stakeholder meetings were held to inform of APM development for managed care reprocurement.

The recurring monthly meeting schedule for DSRIP is as follows:

Every 2nd Monday: Learning Collaborative(Myers and Stauffer)/DHHS update meeting

1st Friday of the month – B1 Integration Leads Learning Collaborative

Data Meeting

3rd Tuesday of the month – DSRIP Executive team updates

3rd Wednesday of the month – DSRIP Finance round table discussion

3rd Friday of the month – NHDHHS/ IDN lead meeting

VI. Financial/Budget Neutrality Development/Issues

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

No issues reported in this quarter assuming that CMS regional office recognizes the email communication indicating that the member months and CMS expense reports will be used by CMS to calculate budget neutrality.

VII. Consumer Issues

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

There have been no reported consumer issues during this reporting period.

VIII. Quality Assurance/Monitoring Activity

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

Oversight committees which monitor progress and outcomes indicate it is too early to determine trends in quality of care. No issues were reported in this quarter.

IX. Demonstration Evaluation

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

The DSRIP Evaluation Design was approved by CMS in September. A Request for Proposal has been released to secure a vendor to provide quantitative and qualitative measurement, including secondary administrative and electronic health data, stakeholder interviews, and surveys as well as document review. A vendor has been selected and contract negotiations continue. It is the expectation that the contract will begin to be implemented in the first quarter of 2019.

X. Enclosures/Attachments

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

a) Summary of quarterly expenditures;
b) Summary of all public engagement activities, including, but not limited to the activities required by CMS; **Include a list of all meetings, meeting agenda's and attendee's.**

Additional Information

STC Quarterly Operational Reports

c) Summary of quarterly expenditures;
d) Summary of all public engagement activities, including, but not limited to the activities required by CMS; **Include a list of all meetings, meeting agenda's and attendee's.**
e) Summary of activities associated with IDN's, DSRIP Project plans, and the IDN Funds. This shall include, but is not limited to, reporting requirements in STC 41 and the DSRIP Planning Protocol (Attachment C);
f) Summary of provider progress towards the pre-defined set of activities and associated milestones that collectively aim towards addressing the state's goals;
g) Summary of transformation and clinical improvement milestones that have been achieved.

XI. State Contacts

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

PLEASE NOTE: ***TO BE COMPLETED BY NH DHHS STAFF***

NAME	TITLE	PHONE NUMBER	FAX NUMBER	MAILING ADDRESS
Kelley Capuchino	Senior Policy Analyst	603-271-9096	603-271-4912	129 Pleasant Street Concord, NH 03301