NH BUILDING CAPACITY FOR TRANSFORMATION SECTION 1115 WAIVER DEMONSTRATION

SECTION 1115 QUARTERLY REPORT

Demonstration/Quarterly Reporting Period: DY3Q1

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

Background and recurring submission
Widespread variability currently exists 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.

Status of key dates of approval
Semi Annual reports were submitted by all IDNs, reviewed by DHHS and received write back requests for additional information during this reporting period. Progress has been made on all projects by IDNs to varying degrees, with the majority of IDN's achieving their process milestones. Final review will be completed in 2018 Q2 as specified within the approved Terms and Conditions.

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.

All IDNs are continuing to execute implementation plans that were submitted in July. The IDNs approach to implementation include maximizing existing behavioral health workforce by developing mid-level capacities such as case managers, care coordinators, community health workers and peer coaches which may reduce no-shows and allow clinically trained providers to work at their highest licensure, making the greatest use of existing resources. Additionally, developing integrated care teams is intended to improve access to prescribing and monitoring care which may decrease barriers to care, escalation to hospitalization and residential care which continue to be strained across the state.

Development of improved care coordination should enable providers to identify emerging needs prior to requiring crisis level care supported through the use of a common shared care plan across providers.

Five of the IDNs have collaborated on training opportunities and implementation of the Critical Time Intervention Model which is the core concept of the C1 project. This collaboration provides the ability to share/reduce costs and improve viability of the programs. Similarly several of the IDNs have proceeded with engagement of NH AHEC to address

statewide training needs.

Previously reported workforce challenges continue to impact day to day implementation. IDN's continue to collaborate on efficiencies with training, recruitment, and policy development that will enhance workforce capacity and streamline administrative efficiencies.

With the implementation of the shared care plan and a common data reporting contractor across IDN's the challenges with care coordination relative to 42 CFR Part 2 become more prominent. Minimally the sharing of SUD related information is prohibited without explicit written consent for care coordination purposes, while the limits of downstream sharing impact the development of protocols for warm handoff's and closed loop referrals. The complexities for the development of workflows standardized across provider types and organizations cannot be understated. The IDNs and their partners continue to address these challenges and pilot agreed upon protocols and workflows in waves or cohorts which they will expand to the larger provider population following improvements through their rapid cycle evaluation processes.

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

No changes this reporting period

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.

IDN's are at the midpoint of the demonstration period. The participating providers and organizations are in the early stages of execution relatively speaking. Cost savings and budget neutrality are yet to be determined. Information regarding service providers and administrative lead organizations has been submitted in prior quarters and remains unchanged during this reporting period.

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.

Several of the IDNs report progress has been made with the contracting process for the Shared Care Plan, Secure Message Exchange, Event Notification, and Data Aggregator. Several hospitals have reported they are ready to go live with Event Notification Services, as well as ADT feeds for the Shared Care Plan. In addition, IDNs have begun engaging partners in submitting data feeds to the Data Aggregator.

Due to the complexity of data sharing, the implementation process has been impacted by the privacy and security issues regarding data sharing. Contractual requirements to ensure the necessary protections are in place are time consuming and involve legal, privacy, and security expertise. The emerging legal instruments and protocols for data sharing position the IDNs to implement comprehensive and meaningful integration of primary and behavioral healthcare in this demonstration. While New Hampshire recognizes that this is the foundation of our approved waiver demonstration, we have not found any other states who have successfully implemented full integration of primary and behavioral healthcare; including the sharing of 42 CFP Part 2 data with consent, at both the individual and organizational level.

The IDNs continue to be actively engaged with the identification of federal and state regulations related to sharing patient level data. Collective Medical Technologies continues to support the IDNs in identifying restrictions of data sharing. DHHS hosted a 2 day Privacy Bootcamp provided by Lucy Hodder, UNH Director of Health Law and Policy Programs to further drill down on the flow of data as it relates to 42CFR Part 2. In attendance were DHHS, the IDN leads, as well as partners, the MCOs and MAeHC, the Data Aggregator Vendor. During the breakout sessions, groups were able to map out the flow of data and discuss potential risk of sharing data.

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.

IDN 1 reports the launch of their Perinatal Medication Assisted Treatment/Intensive Outpatient Program (PATP/IOP). Through additional staff and extended hours it is expected to provide a wide variety of services to assist additional clients. The IDN has also focused on new partnerships with Sullivan County and Grafton County Department of Corrections, as well as the NH Department for Children, Youth and Families. These new partnerships are expected to provide timely referrals to the PATP/IOP which may provide additional positive outcomes for families and children within the region. Monadnock Family Services has implemented the enhancement of bidirectional integration by embedding primary care services with the support of Cheshire Medical Center Primary Care.

IDN 2 reports several successful outcomes in their PATP/MAT/IOP programs within the region. Concord Hospital Medical Group has hired 2 additional Integrated Behavioral Health Counselors within two additional primary care sites. Riverbend Community Mental Health Center continues to have significant progress through the co-location of Primary Care Services within their location. In addition, the Integrated Treatment Team, which is comprised of primary care and behavioral health providers report continued success to provide full coordination of services focused on a whole person centered planning approach.

IDN 4 reported that the implementation of the IOP/PHP Program with Serenity Place was severely affected by Serenity Place being placed into receivership. Due to the severe impact on the community with the loss of these services, community partners stepped up to address the issue. Through a collaboration of IDN partners, Families in Transition, Elliott Hospital, Easter Seals Farnum Center and Granite United Way worked develop a plan to continue to provide services to the community.

IDN 7 reports Northern Human Services has partnered with Coos County Family Health Services in Berlin by creating a primary care office within the Berlin location of Northern Human Services to provide services to treat patients with SMI, SPMI and dually diagnosed patients. In addition, Huggins Hospital, Northern Human Services and White Mountain Community Health Center are collaborating to provide a Regional Care Coordination Program. Ammonoosuc Community Health Services is providing a Psychiatric Nurse Practitioner and a Physician Assistant at Friendship House Substance Abuse Treatment Center to treat individuals with dual diagnoses and address the screening and treatment of chronic disease

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 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

DSRIP CY 2018 Q1 - Quarterly Enrollment Changes

Source: MMIS enrollment data as of 4/20/2018

IDN	IDN Attributed Population[1]	Newly Enrolled in Current Quarter[2]	Disenrolled in Current Quarter	Current Enrollees: Year to Date[3]
1	29,010	1,818	2,540	28,288
2	18,938	1,381	1,653	18,666
3	25,008	1,867	2,245	24,630
4	48,501	3,268	4,206	47,563
5	17,524	1,266	1,548	17,242
6	32,435	2,165	2,975	31,625
7	19,132	1,194	1,682	18,644
Total	**190,548**	**12,959**	**16,849**	**186,658**

Notes:
1. Attributed population includes 164,316 members from the 6/30/2017 Outcome Attribution
who were attributed through claims and geography and were Medicaid Eligible
on 1/1/2018, and 26,232 members newly enrolled between 7/1/2017 and 1/1/2018 who
were attributed through geography only.
2. Newly Enrolled population includes members who were attributed on 6/30/2017, but were not eligible
as of 1/1/2018, and became eligible later in the quarter.
3. Current population are members who were Medicaid Eligible on 3/31/2018.

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.

As previously reported a variety of outreach activities directly targeted to outreach and information exchange have continued within each IDN. Initiatives include: hosting a Behavioral Health Conference, connecting through various social media platforms, continued participation in the Children's Behavioral Health Collaborative, participation in the Medication Innovation Accelerator program, publishing monthly newsletters, attending public health and substance misuse prevention meetings, as well as conducting regional meetings. Several of the IDNs have launched region specific websites which provides information on current initiatives, employment opportunities and calendar of events. These websites are designed to engage partners, potential partners and the community.

IDNs completed presentations to their partner lead agencies on their B1 Integration approach in the monthly learning collaborative sessions. Promising practices and lessons learned were shared amongst the lead agencies including approaches to contracting, workforce enhancement, Information Technology, data reporting, and partner engagement. The leads have decided to expand the monthly learning collaborative sessions to include partner agencies as they move from planning and partial implementation to full execution. Partners convened for the quarterly learning collaborative focused on Relational Coordination. 124 participants from 69 partner agencies participated.

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.

No change noted. As previously reported:

The IDNs continue to formalize operating structures, policy and procedures as well as focusing on data needs for the Shared Care Plan and Data Aggregator. IDNs continue to move forward with contracting for the Shared Care Plan, Secure Message Exchange, Event Notification, and Data Aggregator. Due to the complexity of data sharing, the process of contracting is inevitably impacted by the privacy and security issues regarding data sharing. DHHS, MCOs and the IDNs have continued bi-weekly data meetings to discuss privacy issues and develop potential plans to move forward.

Concerns about ongoing availability of federal funding are impacted by fiscal and policy issues at the provider, state, and federal level. For example, New Hampshire's pending CPE approval and the December 2017 SMD letter regarding DSHP and DSRIP programs, have the understandable impact of provider organizations contemplating their ongoing level of participation in certain projects. Other examples are the viability of providers and programs with limited funding and the impact on the delivery system when they don't succeed. In short, 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.

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.

DHHS continues to work with CMS on the CPE reporting and funding methodology. At this point in time ongoing payments are contingent upon the approval of new funding methodology.

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.

No complaints or problems have been identified. Several IDNs reported the need to implement a process for collecting this information moving forward as well as the development of a process for reviewing and responding to complaints or problems. Consumers identified the need for supportive housing through engagement via advisory groups, surveys, and

focus groups.

VIII. Quality Assurance/Monitoring Activity

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

IDNs continue to have open dialogue with one another on current screening tools used to monitor quality assurance. One IDN's Quality Assurance efforts include spot audits of partner collected data against claims/utilization data which have proven ineffective due to the age of the data. Once the Shared Care Plan and Data Aggregator have been initiated, report generated from real-time data will be an effective tool for monitoring and quality assurance. DHHS and the IDNs have begun open dialogue with the Medicaid MCOs surrounding data. This collaboration will drive decisions regarding data collection as well as quality assurance and monitoring activities.

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.

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) NH Medicaid DSRIP MM 2016 Q1-2018 Q1 as of 2018-04-20
b) CY18 Q1 IDN Quarterly Enrollment Changes

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***

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