NEW HAMPSHIRE BUILDING CAPACITY FOR TRANSFORMATION DEMONSTRATION WAIVER CALENDAR YEAR 2019

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

The goals of this DSRIP demonstration are: to build behavioral healthcare capacity; promote integration of physical and behavioral health care and substance use disorders across New Hampshire. 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 healthcare needs may present.

During this annual reporting period IDN's submitted semi-annual reports on January 30, 2019 and June 30, 2019, for the Jan-June and July-Dec reporting periods respectively. Of particular note is that IDN 4 achieved all the required process deliverables during the July-December 2018 reporting period while IDN 2 and IDN 5 achieved all of the process deliverables through the Jan-June 2019 reporting period. IDNs continue to have the opportunity to recoup funds for deliverables not yet achieved in the subsequent 2 reporting periods limiting achievement of process deliverables to the reporting period ending December 2019.

DHHS has continued to make interim partial payments to the IDN's based upon available funding.
Due to funding uncertainties, DHHS continues to work on alternative funding methodologies. These funding uncertainties have significantly hindered the IDNs ability for full achievement of the required deliverables or targeted performance metrics. In addition, Administrative Leads spent a significant amount of time and resources on the County funding issues. These factors resulted in IDN partners being reluctant to initiate programs and hire staff with the ongoing funding uncertainties. IDNs could not release the funds to support their partner's requests for expansion funding. In this quarter, funding for the July-Dec 2018 and the Jan-June 2019 has been issued to the IDNs. Funding uncertainties will continue to impact the IDNs ability to maintain partner engagement and full achievement of the required deliverables and performance metrics.

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.

The role of integrated behavioral health specialists (IBHC), Community Health Workers (CHW), and regional multidisciplinary care teams (RMDCT) are at the core of integration activities across provider partners. The functions assumed within these positions either facilitate or conduct the bi-directional information sharing within the teams and partner organizations. Issues relative to billing, coding and sustainability for these positions and/or job duties, have been a focus of work by a subcommittee within the Workforce Taskforce. This billing and coding subcommittee will provide recommendations to the IDN Leads to inform future sustainability and policy discussions. Post 2020 payment for integrated care and involvement of multi-disciplinary care teams including CHW, and IBHC's has not yet been determined.

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.

IDNs have completed their fourth year of the demonstration, with contracting and project plan development occurring in 2016. Development of implementation plans occurred the first half of calendar year 2017 with plans approved by October/November of 2017. Implementation, training, development of policies, procedures and protocols, began in late 2017. This schedule is important to understand as the participating providers continue to be in varying stages of implementation. At this point, at best 24 months in on some implementation activities, it is too early to determine cost savings. IDNs continue to report the onboarding of new providers with the increase of approximately 6 new partners across New Hampshire. They are also reporting the closing of practices as well.

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.

MCO's have contracted with the vendor supporting the ENS and are also receiving ADT feeds on their members. It is anticipated that this technology will continue to expand and support local care coordination partnership across the provider and payer spectrum.

IDN's continue to expand the use of Shared Care Plan (SCP), Secure Message Exchange, Event Notification Service (ENS) and reporting through the Data Aggregator. Additional hospitals have come online across the regions and are live with Event Notification and ADT feeds for the Shared Care Plan.

Some partners remain hesitant to incorporate additional technology and alter current processes due to their already overburdened staff and uncertainties regarding sustainability and ongoing funding. Regardless, IDN partners continue their commitment to improve health outcomes through whole person approach toward integrated care and have developed "toolkits" which contain sample workflows that partners can adopt or alter to suit their technologies.

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 continues to expand across IDN's. More detail on each IDN is included below in the section titled

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ACTIVITIES AND ACCOMPLISHMENTS
JUNE 2019 SEMI-ANNUAL REPORT SUMMARIES

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 2019 Q4 - Quarterly Enrollment Changes

Source: MMIS enrollment data as of 1/27/2020

IDN	IDN Attributed Population [1]	Newly Enrolled in Current Quarter [2]	Disenrolled in Current Quarter	Current Enrollees: Year to Date [3]
1	27,581	2,226	2,178	27,629
2	17,356	1,646	1,412	17,590
3	24,302	2,145	2,004	24,443
4	45,328	3,686	3,392	45,622
5	16,226	1,442	1,276	16,392
6	31,927	2,721	2,693	31,955
7	17,504	1,513	1,442	17,575
Total	**180,224**	**15,379**	**14,397**	**181,206**

Notes:
1. Attributed population includes 165,436 members from the 6/30/2019 Outcome Attribution who were attributed through claims and geography and were Medicaid Eligible on 10/1/2019, and 14,788 members newly enrolled between 10/1/2019 and 12/31/2019 who were attributed through geography only.
2. Newly Enrolled population includes members who were attributed on 6/30/2019, but were not eligible as of 10/1/2019, and became eligible later in the quarter.
3. Current population are members who were Medicaid Eligible on 12/31/2019.

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.

There are no new activities related to consumer engagement as the waiver reaches all Medicaid recipients served by provider partners working to transform their service delivery models.

As previously reported IDNs continue to hold All Partner Quarterly and Annual meetings. Additionally, information about the activities and opportunities for partners is disseminated through IDN websites, social media platforms, one-page mailings, newsletters, You Tube videos, and email. IDNs continue to engage new partners and the community by providing support to multiple community programs which address the social determinates of health. All of these activities are designed to engage partners, potential partners, as well as informing the community. Partners are also provided the opportunity to network at Myers & Stauffer Quarterly Learning Collaborative Meetings. These networking opportunities allow partners who would not normally interact with the ability to develop relationships which will inevitably impact and drive collaboration as they move through the SAMHSA Coordinated/Integrated Care Designation.

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

As previously reported concerns about ongoing availability of funding are impacted by fiscal and policy issues at the provider, state, and federal level. For example, county contributions are voted on during each county fiscal year leaving future funding for future years through the remainder of the demonstration period an unknown. County contributions were approved for 30% and 50% of the amounts IDN's were requesting for 2018 and 2019 respectively. The continued funding uncertainty from year to year, and more so in the final year of the demonstration, clearly impacts buy in at both the IDN Lead and provider partner level. Lead agencies are hesitant to contract without guaranteed funding and partners are resistant to initiate additional changes that they do not know they can sustain.

Medicaid Managed Care organizations are entering into contractually required alternative payment arrangements following the strategy that is included as an attachment to this report and titled 19-0029 - DHHS APM Strategy and Guidance Document_20191004vF.

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.

NH DHHS is working with CMS to address questions related to budget neutrality calculations.

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.
A public presentation of the demonstration activity was made to MCAC in December 2019.

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.

PLEASE REFER TO THE SECTION BELOW TITLED
EVALUATION
ANNUAL UPDATE 2019
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X. DSHP and DSRIP Expenditures

State of NH, DHHS

DSHP earn DSRIP spend

Amounts Reported By Quarter On CMS-64 DSHP Waiver Line 49

Quarter Ending	DSHP Earn: Amount - Total Computable	DSHP Earn: Amount - FFP	DSHP Earn: Cumulative - FFP	DSRIP Spend: Amount - Total Spent	DSRIP Spend: Amount - FFP	DSRIP Spend: Cumulative - FFP	GF Balance Available
3/31/2016	$0.00	$0.00	$0.00	$0	$0	$0	
6/30/2016	$12,361,921.24	$6,180,960.62	$6,180,960.62	$0	$0	$0	
9/30/2016	$574,962.71	$287,481.36	$6,468,441.98	$20,040,871.78	$10,020,435.89	$10,020,436	
12/31/2016	$3,841,698.34	$1,920,849.17	$8,389,291.15	$171,977.94	$85,988.97	$10,106,425	
3/31/2017	$15,998,211.27	$7,999,105.64	$16,388,396.78	$5,493,910.16	$2,746,955.08	$12,853,380	
6/30/2017	$6,627,039.19	$3,313,519.60	$19,701,916.38	$604,662.70	$302,331.35	$13,155,711	
9/30/2017	$1,963,083.44	$981,541.72	$20,683,458.10	$351,737.03	$175,868.51	$13,331,580	
12/31/2017	$2,803,906.49	$1,401,953.25	$22,085,411.34	$13,814,111.29	$6,907,055.65	$20,238,635	
3/31/2018	$3,765,738.38	$1,882,869.19	$23,968,280.53	$429,393.57	$214,696.78	$20,453,332	
6/30/2018	$4,612,523.86	$2,306,261.93	$26,274,542.46	$7,322,912.53	$3,661,456.26	$24,114,788	$2,159,754
9/30/2018	$0.00	$0.00	$0.00	1,949,649.45	$974,824.73	$25,089,613	
12/31/2018	$0.00	$0.00	$0.00				
Total thru 12/31/2018	**$52,549,084.92**	**$26,274,542.46**	**$150,140,699.32**	**$50,179,226.45**	**$25,089,613.22**	**$149,363,901.19**	

Matchable

Notes:
DSHP has met cap until 1/1/19.

EVALUATION
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On October 3, 2018, New Hampshire received approval from the Governor and Executive Council to enter into an agreement with the University of Southern Maine's Cutler Institute for Health and Social Policy, Muskie School of Public Service (aka, Muskie). Over the past year, NH has worked with MUSKIE to implement evaluation activities to complete the interim evaluation report due to CMS on 3/31/2020, which included:

- Publishing a *Data Analytic Plan*, which will serve as the detailed specifications for each performance measure associated with DSRIP evaluation research questions and hypothesis;
- Approval by the University of Southern Maine's Internal Review Board (IRB) to begin collecting data;
- Completion of transferring DHHS claims extracts for calculating performance measures in the evaluation;
- Completion of Member Experience of Care surveys.
- Completion of Health Information Technology and IDN Administrator semi-structured interviews.

PROJECT STATUS

MUSKIE is on target for all necessary activities needed to complete the interim evaluation report due to CMS on 3/31/2020. These activities include:

- **Primary Data Collection** (Surveys and Semi-Structured Interviews): All project surveys and semi-structured interviews are completed or are in the field as scheduled.
- **Performance Measure Calculation:** MUSKIE has completed a final analytic file and coded nine (9) HEDIS measures. Once the remaining HEDIS measures are completed, MUSKIE will complete final performance measure calculations.
- **Data Analysis:** Data analysis is near completion for completed primary data collection activities (e.g., HIT Survey, IDN Administrator Interviews). MUSKIE will commence remaining analysis once the remaining data has been collected and all performance measures have been calculated.
- **Report Writing:** MUSKIE and DHHS are working on an outline of the interim evaluation report to assure that all evaluation elements are accurately represented prior to drafting the final report.

QUANTITATIVE DATA FINDINGS

All findings listed below are preliminary and should be used with caution outside of the full interim evaluation report.

Interim Behavioral Risk Factor Surveillance System (BRFSS) findings indicate that although the differences between 2014 and 2017 were not significant:

- Fewer Medicaid respondents had between 14 and 30 "not good" physical health, mental health, and poor health days per month;

- Respondents with 14 or more "not good" mental health days per month had a decrease in alcohol consumption; and
- Fewer respondents who had 14 or more "not good" mental health days per month reported being a smoker.

CASE STUDY (QUALITATIVE DATA FINDINGS)

All findings listed below are preliminary and should be used with caution outside of the full interim evaluation report.

HIT Stakeholder Survey

While the majority of respondents believed HIT advances had a positive impact on care coordination, the vast majority of respondents had not implemented each of the HIT software systems. Barriers to implement HIT systems were identified as (1) limited resources and (2) policy concerns around information sharing.

Member Experience of Care Survey

The baseline survey indicated that in the last 12 months the majority of beneficiaries reported that they were always able to access needed care and get care quickly. In addition, most felt there was care coordination between their primary and specialty providers. While these results indicate that many beneficiaries have access to needed care, there is room for improvement. For example, 15% of respondents reported that they were only able to access needed care, tests, or treatment "some of the time."

UTILIZATION DATA

There is no utilization data available in the evaluation at this time.

POLICY AND ADMINISTRATIVE DIFFICULTIES

There were no notable policy or administrative difficulties to note in Demonstration Year 4 for completing evaluation activities.

KEY DATES FOR ACHIEVING MILESTONES OR DELIVERABLES

Deliverable	Due to DHHS	Due to CMS
OUTLINE: Draft Interim Evaluation Report	12/1/19	N/A
Draft Interim Evaluation Report	**2/1/20**	**3/30/20**
OUTLINE: Draft Final Evaluation Report	9/1/20	N/A
Draft Final Evaluation Report	**11/1/20**	**1/30/21**

LEARNING COLLABORATIVE ANNUAL UPDATE 2019 ACTIVITIES AND ACCOMPLISHMENTS

All-Partner Statewide Meetings

Four All-Partner Statewide meetings were held between October 1, 2018 and September 30, 2019. All-Partner Statewide meetings are designed as opportunities for IDNs to engage as a group in statewide forums to share best practices and exchange ideas around specific topics through facilitated activities, question and answer sessions with local and national leaders, and group work. Statewide meetings are intended to support shared learning and knowledge transfer among learning collaborative participants. The following provides a high-level summary of each event.

Title/Date	Event Description	Goals	Outcomes
"IDN Perspectives on Sustainability" November 14, 2018	This learning collaborative was designed for State leaders, IDN leads and administrators, MCOs, project managers, practice managers, quality improvement team members, billing and coding staff, regional public health network managers and community partners to facilitate the sharing of strategies and best practices to support IDN project sustainability.	– Use outcome and service utilization data to demonstrate the value of integrated care to patients, providers, and payers. – Understand the importance of maximizing revenue as a bridge to a value-based payment system. – Understand how one IDN leveraged current program investments and built partnerships to increase workforce retention, build a workforce pipeline, and provide a structure for future investment. – Describe statewide strategies from the	The learning collaborative increased attendees' understanding of the importance of partnerships, leadership, communications, policy, and other strategies in expanding and sustaining DSRIP programs and provided the occasion to network with peers to address challenges and identify opportunities in sustaining integrated care and community programs. Total registrants = 108 Total attendees = 77 Total Unique Organizations = 38

Title/Date	Event Description	Goals	Outcomes
		work plan of the Retention and Sustainability Committee of the statewide Workforce Taskforce and the strategies' potential impact on New Hampshire, including IDNs and partner organizations. – Analyze which elements are feasible to sustain integrated care and community projects in terms of policy, funding, partnerships, and networks, and develop strategies to sustain them.	
"Building the Public Will to Advance Population Health" February 11, 2019	This learning collaborative was designed to help State leaders, IDN leads and administrators, community partner administrators, public health network managers, population health administrators, community health workers/navigators/care coordinators, project managers, and practice managers to learn and apply evidence-based strategies to make the case to advance population health and health equity.	– Recognize both the challenges and the importance of building public will to address population health – Rethink how they are currently making the case for population health – Identify areas where their casemaking could be leveraged to strengthen public support using evidence-based strategies	The learning collaborative increased attendees' understanding of how data can prove it's possible to invest in population health in ways that are cost-effective, improve outcomes, and engage communities as co-producers of their own health. Moreover, attendees learned how to use data to build public support for scaling health programs, policies and investments that

Title/Date	Event Description	Goals	Outcomes
		– Describe methods of using data to build public support for population health programs and health system transformation	fundamentally transform our health ecosystems for the better. Attendees participated in a casemaking exercise to create messaging material to build the case for population health in New Hampshire. Total registrants = 155 Total attendees = 101 Total Unique Organizations = 47
"The New Normal: Enhanced Care Coordination" May 7, 2019	This learning collaborative was designed to help State leaders, IDN leads and administrators, managed care organizations, community partner administrators, public health network managers, community health workers/navigators/care coordinators/patient advocates, project managers, and practice managers to use peer sharing to develop strategies to address clinical and data challenges by comparing enhanced care coordination across IDNs.	– Identify strategies that promote the whole person approach. – Describe NH DSRIP work in enhanced care coordination in community projects and integrated care. – Describe the participation of community-based organizations and managed care in care coordination. – Analyze privacy concerns of teams working with protected health information and understand scripts and forms IDNs have used to	The learning collaborative increased attendees' understanding of e-discharge systems, the importance of collaborating with ServiceLink for referrals and local resources, leveraging Community Care Coordinators, the Zero Suicide initiative, the Columbia Risk Scale, and coordinator workflows. Total registrants = 112 Total attendees = 82 Total Unique Organizations = 40

Title/Date	Event Description	Goals	Outcomes
		obtain patient consent. – Identify opportunities for collaboration and coordination in partnership with managed care organizations.	
"New Hampshire State of Care: Local, Integrated, and Accountable" August 20, 2019	This learning collaborative was designed to share with IDNs and network partners implementation actions that sustain core DSRIP levers that achieve patient-centered, high-value care; specifically actions to adopt alternative payment models (APMs), enable data-informed treatment, and provide local care management support.	– Share the current status and plans for local care management and APMs. – Understand managed care organizations' plans for the utilization of shared care planning, event notification systems, alternative payment models, and care management as it relates to a patient use case. – Identify opportunities for collaboration and coordination in partnership with managed care organizations. – Identify common terminology for and understanding of patient risk and vulnerability, and identify key targeted subpopulations.	The learning collaborative increased attendees' understanding of key levers that support patient-centered, high-value care in New Hampshire; and MCO methods to identify, support, and provide treatment based on patient scenarios. Attendees also participated in an exercise which allowed the attendees to share what concepts, methods, etc. Total registrants = 124 Total attendees = 105 Total Unique Organizations = 51

All-IDN Administrative Lead Meeting

Nine All-IDN Administrative Lead meetings were held between October 1, 2018 and September 30, 2019. The All-IDN Administrative Lead meeting allows IDN Administrative Lead staff to engage as peers in facilitated discussions related to targeted interventions, best practices, successes, and challenges related to statewide and community projects. During each meeting, participants discuss how their interventions intersect and relate to the demonstration's integration goals. The following provides a high-level summary of each event.

Date	Goals
November 2, 2018	– Increase understanding of the importance of implementing a Closed Loop Referral (CLR) system. – Learn best practices related to a CLR system and be able to identify the seven principles of the CLR process. – Learn from peers in a facilitated panel discussion about the successes, and challenges related to developing and implementing a CLR system.
December 7, 2018	– Increase understanding of the importance of implementing a Multidisciplinary Team. – Learn best practices related to Multidisciplinary Teams. – Learn from peers in a facilitated panel discussion about the successes, and challenges related to developing and implementing a Multidisciplinary Team.
January 4, 2019	– Establish a baseline for expectations of workflows in this demonstration. New to some and a refresher for others. – Learn from peers in a facilitated panel discussion about the successes, and challenges related to developing and implementing workflows.
February 1, 2019	– Increase understanding of tools and resources available to IDNs and their partners to move metrics including Event Notification Systems (ENS) and Shared Care Plan (SCP) Platforms. – Learn from peers in a facilitated panel discussion about the successes and challenges related to implementation of ENS and SCP.
March 8, 2019	– Review IDN claims measured performance metrics. – Refresh and level-set performance measures. – Share risk-stratification approaches through a facilitated panel discussion.
April 5, 2019	– Share risk-stratification approaches through a facilitated panel discussion (continuation of March discussion)
June 7, 2019	– Identify and discuss approaches and workflows that IDN partners are using to administer the comprehensive core standardized assessment (CCSA) in their practices. – Learn from peers and in a facilitated panel discussion, strategies to address challenges when implementing the CCSA.
August 2, 2019	– Identify and discuss overlapping/intersecting initiatives between DSRIP 1115 Waiver and State Opioid Response (SOR) Grant focusing on the

	IDNs and the "Doorways" hub-and-spoke model serving individuals with substance use disorder (SUD). This included systems such as Centralized Referrals and Care Coordination.
September 6, 2019	– Understand the differences between patient assessment tools used by the MCOs and the DSRIP-required CCSA through a facilitated panel discussion with MCOs.

Technical Assistance/IDN Support Activities

Myers and Stauffer LC (MSLC), the NH DSRIP Learning Collaborative contractor, provides technical assistance and IDN support activities upon request by the State or IDN Administrative Leads. In addition to providing a monthly listing of state and national training opportunities relevant to IDNs and their partners, MSLC provided the following technical assistance and support activities to IDNs between October 1, 2018 and September 30, 2019.

- Examples of communications/methods of communications that IDNs are using to engage their partners.
- Research regarding community paramedicine programs, specifically a synthesis of research findings compiled into a short memo including an overview of community paramedicine generally, including national themes in staffing and program design, regulations, reimbursement models, and return on investment; an overview of New Hampshire's Mobile Integrated Health program; and a list of related resources.
- A compendium of resources, developed by the American Hospital Association and National Urban League, designed to support implementation of successful and sustainable community health worker programs.
- Research to assist with understanding the requirements for billing Health and Behavioral Assessment CPT codes specific to integration.
- Information on the effectiveness of the multidisciplinary core team in terms of patient outcomes, including evidence-based practices to support effectiveness.
- Research on programs that incorporate trauma informed care information through grants or other methods in New Hampshire (NH) and at the national level.
- A compilation of all IDN submitted protocols and workflows submitted in accordance with the December 31, 2018 semi-annual report (SAR), particularly those required in B1-8 and B1-9.
- Guidance regarding Behavioral Health Integration billing codes covered in the NH Medicaid Fee Schedule for purposes of sharing the benefits of implementing the Collaborative Care model (CoCM) to ensure sustainability of integration after the DSRIP Waiver is over.
- A summary of New Hampshire DSRIP requirements "crosswalked" with requirements for Patient-Centered Medical Homes (PCMHs) and Federally Qualified Health Centers (FQHCs). The goal of this is to support provider communications, particularly the idea that they may already be meeting DSRIP requirements through other program requirements.
- A billing and coding matrix to include Behavioral Health (BH) and Primary Care (PC) Integration billing CPT Codes, services, time/unit, description, provider types, and NH Medicaid rate. The matrix will be used as a tool to assist the Statewide Billing and Coding Workgroup in identifying which BH codes are currently active on the NH Medicaid Fee Schedule and not being billed by partners and why. It will also be used to identify barriers to

billing that partners are facing for certain BH and PC codes, why these barriers exist and what recommendations can be made to leadership to assist with breaking down those barriers.

- Guidance on requirements specific to billing Behavioral Health (BH) and Primary Care (PC) Integration CPT Codes that are turned on in the NH Medicaid Fee Schedule. Information specific to these codes that would help support IDN efforts in making a business case to their B1 partners on the benefits of using these codes to sustain integration after the DSRIP 1115 Waiver has concluded.
- Technical assistance support to identify best practices for "cross-cultural" reentry/behavioral health staff communications and how to resolve or address those differences.

WORKFORCE TASKFORCE
ANNUAL UPDATE 2019
ACTIVITIES AND ACCOMPLISHMENTS

Accomplishments

- ***Retention and Sustainability***
  - Publicly recognized and support of behavioral health workforce in ways that educate the broader community. In NH, Human Services Day was established 12/6/18 with the Governor's Proclamation. A series of editorials recognizing human service workers was released statewide. The Governor's proclamation was distributed to IDNs and their partners. The proclamation was read at the Behavioral Health Summit. **Key Date:** December 6, 2018

  - Completed Mental Health First Aid (MHFA) trainings; trained 30 new MHFA trainers, including Police and first responders across the state. Dartmouth-Hitchcock Medical Center and NAMI-NH received a grant to disseminate MHFA further.

  - Compiled information about workplace culture elements known to increase retention. A Workplace Culture presentation was provided by Bi-State (The Federally Qualified Health Center Association) Recruitment Center.

  - Partnered with Citizens Health Initiative (CHI) on billing and coding identification to improve reimbursement opportunities for Behavioral health and primary care. Identified billing codes for integration, primary care, BH intervention, and codes that would sustain the work IDNs are doing in statewide integration and local projects. Developed a Billing and Coding Group to work with DHHS, to identify codes to support and sustain integration and present justification to activate existing codes, including an estimate of the fiscal impact on Medicaid.

  - Researched opportunities to enhance telehealth/telemedicine billing for telehealth as a way of workforce accessibility. Investigated various telehealth platforms for BH and PC practices
    Legislation was passed, SB 258, which adds telehealth definitions to NH's managed care statute, RSA 415-J and clarifies the statute governing telemedicine and Medicaid coverage for telehealth services (Aligned Medicaid with private insurance requirements). **Key Date**: IDN 2 will conduct at pilot at Riverbend July 1, 2019.

- ***Education and Training***
  - Centralized statewide training catalog developed as a resource to inform partners throughout the state on effective, value based trainings as well as upcoming training opportunities. This provides cost savings and efficiency, rather than each IDN administering on regional basis.

  - Developed the IDN track for the BH Summit. Six sessions were recorded, and CEUs offered.

- Coordinated with Area Health Education Center (AHEC) on a statewide Health Careers Catalog, which now includes integrated roles. **Key Date:** The Catalog will be published in the fall of 2019.

- ***Recruitment and Hiring***
  - Advocated and succeeded in legislation to increase the State's appropriation to the State Loan Repayment Program (SLRP). **Key Date:** June 2019

  - Catalogued and distributed to IDNs information on peer organizations and career pipelines. **Key Date**: June 2019

  - Created a peer careers path document to be distributed to appropriate peer organizations within each IDN. **Key Date:** July 2019

  - Identified "Return to Work" course at NH's community colleges for workforce re-entry

  - IDN 4 developed and shared a repository of integrated jobs

  - Coordinated with AHEC on a statewide Health Careers Catalog, which now includes integrated roles. **Key Date:** The catalog will be published and distributed in the fall of 2019.

- ***Policy***
  - Addressed delays at the NH Office of Professional Licensure and Certification (OPLC) and licensing boards in application processing. Key Date: ongoing efforts to engage with OPLC Directors.

  - Advocated for the passage of legislation to improve BH workforce. **Key Dates:** bills signed by Governor. See effective dates below.
    HB 239, *Relative to requirements for supervision for licensure of certain mental health and drug counselors:* permits supervision to take place at a location mutually convenient to the supervisor and candidate for licensure. Effective September 2019.
    SB 80, *Relative to membership on the board of mental health practice, applications for licensure by mental health practitioners, and insurance credentialing of out-of-state mental health practitioners and psychologists:* Adds 2 members to the Mental Health Practice (MHP) board (CMHC, CHC); requires MHP board to adopt rules for timely action on license applications by qualified applicants; clarifies procedure for insurance credentialing of out-of-state mental health practitioners and psychologists applying for state licensure. Effective September 2019.
    SB 180, *Relative to privileged communications under the law governing mental health practice*:
    Clarifies when disclosure of privileged communications is authorized under the law governing mental health practice. Effective September 2019

SB 258, *Relative to telemedicine and telehealth* services: Adds definitions to and clarifies the statute governing telemedicine and Medicaid coverage for telehealth services. Effective 10/11/19 for Medicaid; 1/1/20 for Insurance statute
HB 127, *Relative to the board of medicine and the medical review subcommittee and relative to health care workforce survey data*: requires certain health care professionals to complete a survey collecting data on the primary care workforce. Effective July 2019.

Quantitative and Case Study Findings

- *Retention and Sustainability*
  - A statewide study of employee benefits was conducted. A map of offerings in for-profit and not-for-profit and small/large employee groups was compiled to demonstrate inequities.

Policy and Administrative Difficulties

Ongoing communication with Director of the Office of Professional Licensure and Certification. Included OPLC Director of Health Professions on the Workforce Taskforce Policy Subcommittee to enhance OPLC knowledge of administrative barriers, importance of attracting behavioral health professionals to New Hampshire, and to provide communication with professional boards which license BH, SUD and primary care professionals. **Key Date**: Ongoing.

ADMISSION DISCHARGE TRANSFER NOTIFICATION
COLLECTIVE MEDICAL
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ACTIVITIES AND ACCOMPLISHMENTS

Overview of Collective Medical - DSRIP

Accomplishments – 15 hospitals contributing ADT data, 48 non-hospital partners connected to the network, increasing trends on notifications sent, membership file numbers, patient record views, and active users (see data below). Active clinical collaboration throughout the state, and 42 CFR Part 2 information is now being shared broadly to all treating providers for patients that have given their consent to do so. While not part of the DSRIP project, all MCOs have signed an agreement with Collective Medical as well.

Project Status – Our next goal is to connect the remaining hospitals and non-hospital partners (by end of Q1 2020). All hospitals in the state are actively working toward that goal except for hospitals w/in IDN 6 who did not select Collective Medical as their vendor for this project. We are also actively training clinicians across the state on how to use the platform to better collaborate on care.

Quantitative case study and findings and utilization data – please review the subsequent slides to view our data on how the platform is being used. Non-hospital partners are receiving alerts when patients of theirs arrive in the ED. The partners are able to chose the criteria for which visits they would like to be alerted on (high-utilizer alert, travelling patient alert, custom alerts based on diagnoses etc)

Policy and administrative difficulties – Many IDNs and partners are looking forward to New Hampshire Hospital coming on the network, we hope we are assigned a contracting liaison soon! Working with IDN 6 to bring on their hospitals would be a welcomed effort and bring value to the rest of the IDN partners.

Key dates / milestones – As mentioned previously, our next milestone is completion of the network by brining on all hospitals and IDN partners by end of Q1. We are also hoping to connect to the PDMP next year, as we have done in many other states, to alert ED physicians to risk.

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Hospital Status

Hospital	IDN	Contributing ADT	Receiving Notifications
Alice Peck Day Hospital	1	✓	✓
Cheshire Medical Center	1	✓	✓
Dartmouth-Hitchcock Medical Center	1	✓	✓
Monadnock Community Hospital	1		
New London Hospital	1		
Valley Regional Hospital	1	✓	✓
Concord Hospital	2	✓	✓
Southern New Hampshire Medical Center	3	✓	✓
St. Joseph Hospital	3		
Catholic Medical Center	4	✓	✓
Elliot Hospital	4	✓	✓
Parkland Medical Center	4		
Franklin Regional Hospital	5	✓	✓
Lakes Region General Hospital	5	✓	✓
Spear Memorial Hospital	5	✓	✓
Exeter Hospital	6		
Frisbie Memorial Hospital	6		
Portsmouth Regional Hospital	6		
Wentworth Douglas Hospital	6		
Androscoggin Valley Hospital	7	✓	
Huggins Hospital	7	✓	✓
Littleton Regional Hospital	7		
Memorial Hospital	7		
Upper Connecticut Valley Hospital	7	✓	
Weeks Medical Center	7	✓	✓
Cottage Hospital	7		

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Ambulatory Partners on the Network

Ambulatory Partners	IDN
DH Heater Road	1
West Central Behavioral Health Lebanon	1
West Central Behavioral Health Claremont	1
Valley Primary Care	1
Monadnock Family Services	1
Crotched Mt. Community Health Center	1 &3
Dartmouth GIM	1
Counseling Associates	1
Concord Regional VNA	2
Riverbend Community Mental Health	2
NH Complex Care	2
Epsom Family Health (Concord OP)	2
Concord - Concord Family Medicine	2
Concord - Epsom Family Medicine	2
Concord - Family Health Center - Concord	2
Concord - Family Health Center - Hillsboro	2
Concord - Family Physicians of Pembroke	2
Concord - Internal Medicine - Horshoe Pond	2
Concord - Penacook Family Physicians	2
Concord - Pleasant Street Family Medicine	2
The Youth Council	3
Greater Nashua Mental Health Center	3
Crotched Mt. Community Health Center	3
Lamprey Health	3
Home Health and Hospice Care	3
Life Coping	3 & 4 & 7
Ascentria Care Alliance	3
Granite State Independant Living	3
The Emmaus Institute	3
NAMI NH	3

Ambulatory Partners	IDN
Center For Life Management	4
CMC Healthcare for the Homeless	4
Manchester Community Health	4
Mental Health Center of Greater Manchester	4
Fusion Health Services	4
Life Coping	3 & 4 & 7
CMC Primary Care Practices	4
Health First Family Care Center	5
Lakes Region Mental Health	5
Mid-State Health Center	5
Horizon Counseling Center	5
White Mt. Community Health Center	7
Northern Human Services	7
Coös County Family Health Services	7
Ammonoosuc Community Health Services	7
Huggins OP Facilities	7
Indian Stream Health Center	7
Life Coping	7

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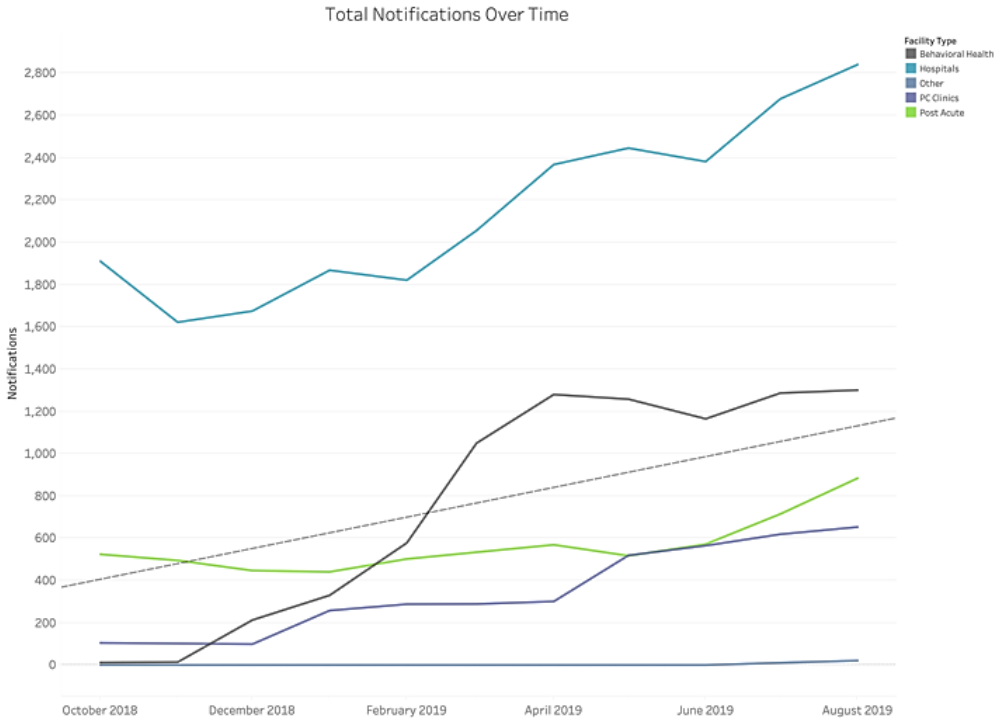

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Notification Views in the Collective Portal

Facility Type	Facility Name	Notifications	Active Users	Hours Logged In	Ratio of Notifications Viewed in 6 Hours	Ratio of Notifications Viewed in 72 Hours	Ratio of Notifications Viewed in 7 Days
Care Coordinator	Life Coping Case Management Services	21	6.0	5.2	76.20%	100.00%	100.00%
Clinic	RCMH - Children's Intervention Program (CHIP)	2	5.0	0.7	100.00%	100.00%	100.00%
	Emmaus Institute, Inc.	3	2.0	1.1	33.30%	100.00%	100.00%
	RCMH - CHOICES	27	3.0	1.5	29.60%	88.90%	88.90%
	RCMH - Franklin Adult Services	8	3.0	1.4	12.50%	75.00%	87.50%
	Crotched Mountain Community Care	148	13.0	7.0	25.00%	64.20%	69.60%
	RCMH - Community Support Program (CSP)	32	3.0	1.5	0.00%	9.40%	18.80%
	Concord - Family Health Center - Hillsboro	27	1.0	0.1	0.00%	3.70%	3.70%
Home Health Agency	Home Health & Hospice Care	299	23.0	151.6	43.10%	90.30%	93.60%
	Concord Regional VNA	548	6.0	19.5	52.20%	91.10%	92.70%
Mental Health	Mental Health Center of Greater Manchester	761	5.0	29.8	9.30%	88.30%	95.80%
	West Central Behavioral Health	55	5.0	6.8	1.80%	3.60%	7.30%
	Counseling Associates Of New London PLLC	24	2.0	0.1	0.00%	4.20%	4.20%
	Manchester Community Health Center	151	2.0	4.5	0.00%	1.30%	2.00%
Primary Care	Health First Family Care Center	11	3.0	8.0	36.40%	100.00%	100.00%
	Valley Primary Care	2	1.0	1.4	0.00%	50.00%	50.00%
Skilled Nursing Facility	Bel-Air Nursing Home and Rehab	14	2.0	2.3	78.60%	100.00%	100.00%
Substance Abuse Treatment..	Nashua Youth Council INC	1	2.0	2.9	100.00%	100.00%	100.00%

Ratio of Notifications..
1.30% 100.00%

Ratio of Notifications..
2.00% 100.00%

Ratio of Notifications..
0.00% 100.00%

Notifications
1 761

Hours Logged In
0.1 151.6

Active Users
1 23

This shows our active users who have opted to receive notifications outside of the portal (text, email, fax etc) and how quickly they are viewing the information on our portal after they have received the notification.

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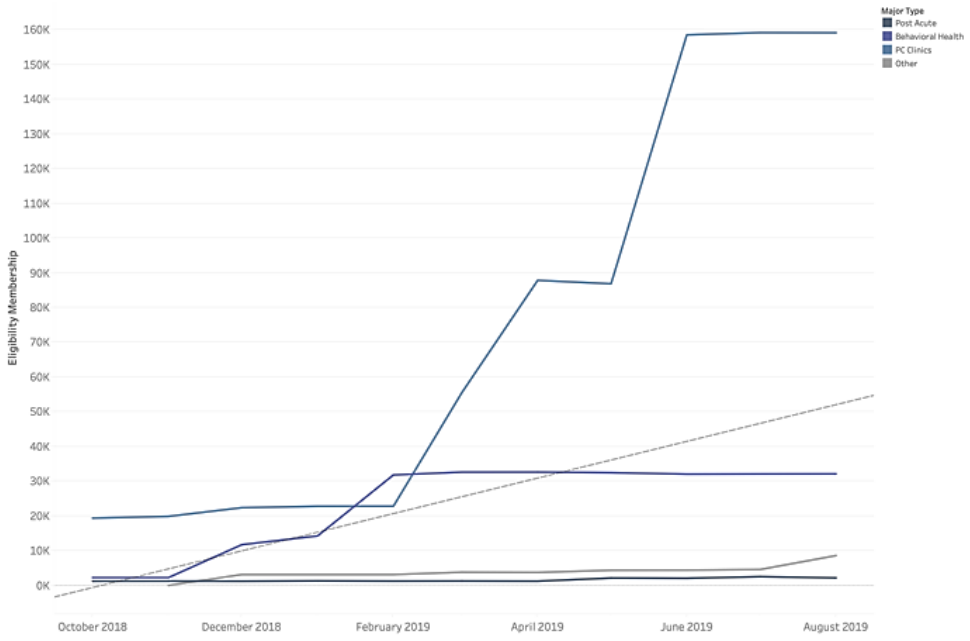
Eligibility Membership



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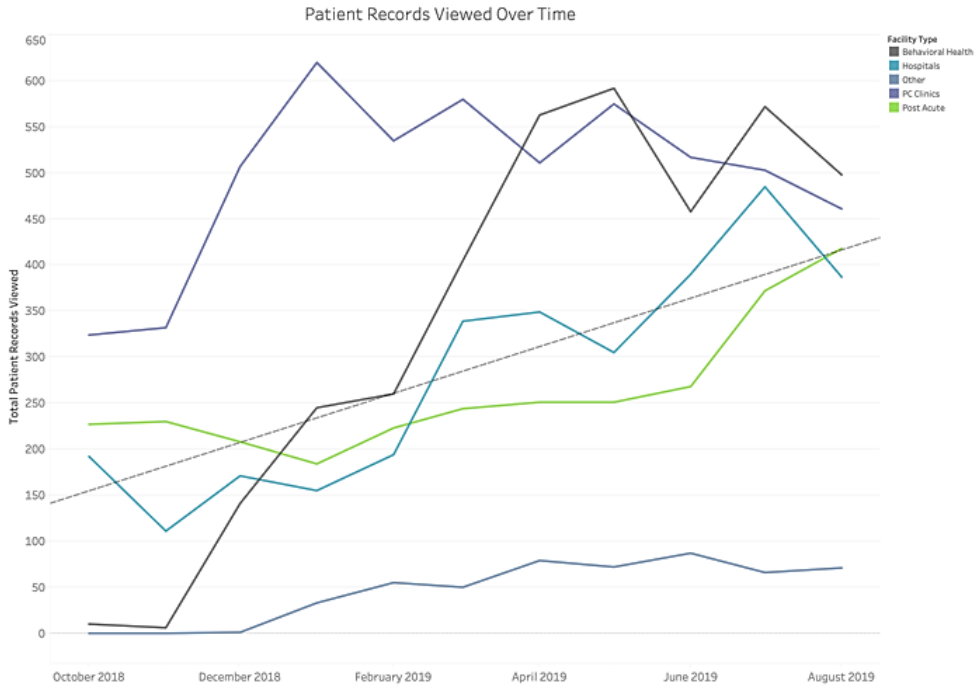
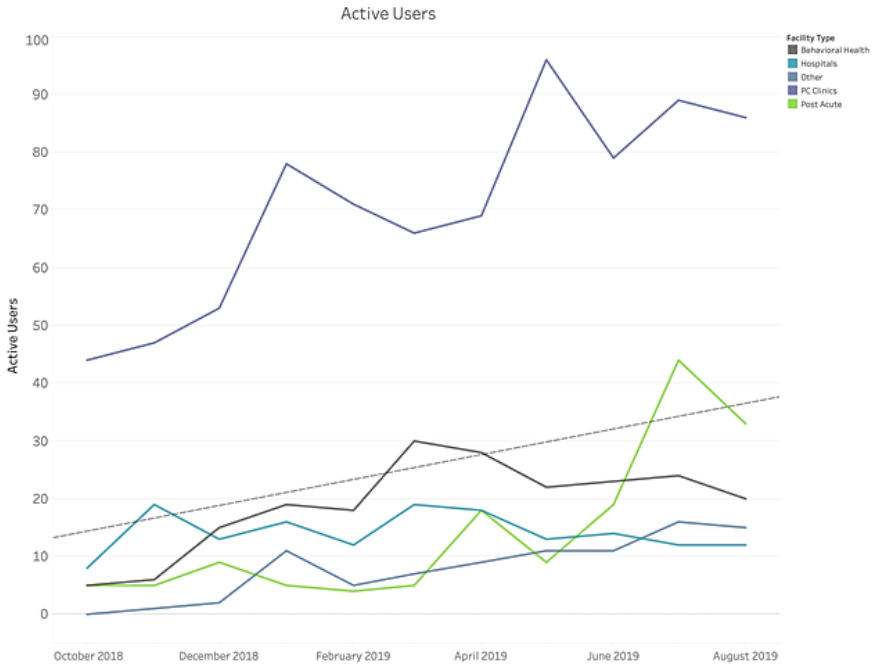




PERFORMANCE METRICS
ANNUAL UPDATE 2019
ACTIVITIES AND ACCOMPLISHMENTS

1. Accomplishments: As part of DHHS efforts to better measure and analyze data to incentivize IDNs and support future efforts for alternative payment models and quality improvement DHHS has implemented a new analytic data warehouse, within our Enterprise Business Intelligence platform. Medicaid claims and member data provides the DSRIP analytic team with ready access to data, analytic tools, and a pathway for future development of dashboards and other approaches to communicating complex information. As part of these efforts data from nine separate payers are now stored in a harmonized manner. While the project was initiated to support all Medicaid activities, the DSRIP data team was directly involved in project development to ensure that information needs for DSRIP were incorporated.

2. Project status: DHHS has calculated all performance measures for incentive payments through the end of the 2018 data period. Currently DHHS is finalizing the remainder of the baselines for measures that become performance based in 2019.

3. Policy and administrative difficulties: Currently DHHS is assessing the validity of measures to insure they are appropriate for performance payment. Of particular concern is the Timely Transmission of Transition Record After Hospital Discharge measure which has lost its National Quality Forum endorsement and the Daily Dosage of Opioids Greater Than 120mg Morphine Equivalent Dose for 15 or more days in year which has significantly changed in its meaning since the baseline period as far fewer people are prescribed high dose opioids.

4. Key dates for performance results calculations:

Measure ID	Measurement Period	Target Date for Rate Calculation
ASSESS_SCREEN.01	Jan-June 2019	11/15/19
ASSESS_SCREEN.02	Jan-June 2019	11/15/19
ASSESS_SCREEN.02	Cy 2018	11/15/19
ASSESS_SCREEN.04	Jan-June 2019	11/15/19
CARE.03-A	CY 2018	11/15/19
CARE.03-C	CY 2018	11/15/19
CARE.01	12 months ending 06/2019	12/31/19
CARE.02	12 months ending 06/2019	12/31/19
CARE.04	12 months ending 06/2019	12/31/19
CARE.05	12 months ending 06/2019	12/31/19
CMHC.02	Jan-June 2019	10/31/19
CMHC.03	Jan-June 2019	10/31/19
HOSP_ED.01	12 months ending 06/2019	12/31/19
HOSP_ED.02	12 months ending 06/2019	12/31/19
HOSP_ED.03	12 months ending 06/2019	12/31/19
HOSP_ED.04	12 months ending 06/2019	12/31/19
HOSP_INP.01	12 months ending 06/2019	12/31/19
HOSP_INP.03	12 months ending 06/2019	12/31/19
HOSP_INP.04	12 months ending 06/2019	12/31/19
OPIOIDRX.01	12 months ending 06/2019	12/31/19

ANNUAL IDN UPDATES 2019
ACTIVITIES AND ACCOMPLISHMENTS
JUNE 2019 SEMI-ANNUAL REPORT SUMMARIES

IDN 1

Workforce Capacity (A1):

Workforce Capacity Programs are live across Region 1 and include funding to support:

- Funding support for attracting, recruiting, hiring, and retaining workforce. This includes: Student Loan Repayment, Recruitment & Retention, Supervision Support, Internship Support, and Organization Capacity Support for Internships.
- Funding support to increase capacity with Community and Peer Support organizations. This includes: Housing stabilization coordinators, Sober housing specification study, Transportation and vocational training for those in recovery, Peer recovery outreach and education, Development of community referral partnerships, Cell phone technology for pregnant women and new mothers, Roving advocate to support those suffering from domestic abuse in rural areas

Current allocations by County include:

- Cheshire County: Workforce (~$441k)
- Sullivan County: Workforce (~$620k)
- Lower Grafton County: Workforce (~$379k)
- Western Hillsborough County: Workforce (~$20k)

An additional $650k has been released in June and will be distributed to Partners for July-Dec 2019 workforce support.

Health Information Technology (A2):

All Region 1 Partners have been provided access to foundational technology to support care integration and quality reporting. Current status of technology implementation is as follows:

- 10 Partners Capable of Direct Secure Messaging for care coordination
- 5 Partners Connected to Shared Care Planning Technology
- 4 Hospitals are 'Triggering' and 6 Partners are 'Receiving' event notifications of emergency department and inpatient admissions, discharges and transfers
- 11 Partners Submitting clinical quality data for quality reporting

All required IDN Partners are reporting clinical quality data to DHHS.
Current allocations for technology support is $1.9 M. This allocation is regionwide and not broken out by County.

Primary Care and Behavioral Health Integration (B1):

Primary Care and Behavioral Health Integration Programs are live across Region 1. Partners that are engaging in integration projects and that are working to meet the SAMHSA 'Coordinated Care Practice' and 'Integrated Care Practice' designations.

- Cheshire County: Cheshire Medical Center and Monadnock Family Services

- Sullivan County: Valley Regional Primary Care and Behavioral Health, Newport Health Center, and growing partnerships with West Central Behavioral Health, Counseling Associates, and Headrest
- Lower Grafton County: Alice Peck Day, Dartmouth Hitchcock, West Central Behavioral Health, Counseling Associates, and growing partnerships with Headrest
- Western Hillsborough County: Monadnock Community Hospital practices
- Western Merrimack County: New London Hospital practices

Current allocations by county for Primary Care and Behavioral Health Integration projects

- Cheshire County: ~$748k
- Sullivan County: ~$685k
- Lower Grafton County: ~1.05M
- Western Hillsborough County: ~$223k
- Western Merrimack County: ~$398k

Currently 5 organizations are meeting requirements of Coordinated Care Practice and 3 organizations are meeting requirements of Integrated Care Practice.

Care Transitions (C1)

Monadnock Family Services, Monadnock Collaborative, and Cheshire Medical Center continue to improve inter-organizational care transitions as part of their Care Transitions project.
Current allocation by County for Care Transition Community Project:

- Cheshire County: Care Transitions Community Project (~$262k)
- 2 new hires, now fully staffed.
- 28 active participants for January-March 2019, 26 active participants for April-June 2019.
- Blended funding with E5 project; January-June 2019 Expenses: $95,484.80

Increased Capacity for Substance Use Disorder Treatment (D3)

The Perinatal Addiction Treatment-Intensive Outpatient Program (PATP-IOP) project at Dartmouth Hitchcock continues to improve capacity for Mothers and Newborns.
Current allocation by County for Increased Capacity for SUD Treatment Community Project:

- Lower Grafton County: Substance Use Treatment Capacity Community Project (~$213k)
- The PATP-IOP no longer receives support from a CHI WI coach.
- 13 women served by the IOP program as of 6/30/2019
- 2.05 FTE's as of 6/10/2019
- January-June 2019 Expenses: $55,446.40

Enhanced Care Coordination (E5)

The Sullivan County community organizations continue to meet monthly. The coalition is now conducting [de-identified] multi-organizational holistic care planning meetings each month. Additionally the community organizations continue to meet to inform one another of programs and news.
Current allocation by County for Enhanced Care Coordination Community Project:

- Sullivan County: Enhanced Care Coordination Community Project (~$88k)
- 11 cases reviewed by Sullivan County Complex Community Care Team (SCCT)
- Facilitator position is open and not being recruited for, IDN administration is doing it but an organization that is part of the SCCT will need to assume the role and responsibilities

IDN 2

A-1 Workforce Taskforce

Approximately 40.35 full-time equivalent (FTE) staff are hired and trained by the IDN.
In this reporting period the IDN spent time building a network of peers who can delivery recovery support services.

- o IDN2 now has 9.25 peers, all of who are CRSW or working toward CRSW
- o 7.25 peers are hired by and based at Riverbend and 2 are contracted from NAMI NH and Youth Move to address family- and youth-focused needs.
- o A peer navigator oversees and manages peer deployment to IDN2 partner sites including:
  - Emergency room
  - Primary and specialty care practices
  - In the community

IDN2 paid for groups of direct care staff to attend approximately 32 separate trainings or conferences over a 6-month period
January-June 2019 Expenses: $151,490.

A-2 Health Information Technology

Concord Hospital Emergency Department (CHED) went live with an event notification feed to CMT on 6/18

- Riverbend, CRVNA, and 8 Concord Hospital Medical Groups (CHMG) are all receiving these event notifications
- Riverbend has entered 144 shared care plans across four of their 4 programs: Children's Intervention Program, CHOICES, Community Support Program, and Riverbend Counseling Associates.

Dartmouth Hitchcock-Concord went live with their iPad integrated CCSA at the end of April 2019.
All B1 partners are submitting data to MAeHC
All B1 partners are increasing their use of technology to identify, plan, and manage care for high need patients
January-June 2019 Expenses: $87,423.00

B1 Integration

- CCSA is in use at all Integrated Care sites and is available electronically at all sites.

- Concord ED, the B1 sites, and Concord PD and EMS are participating in a Complex Care Project to identify, plan, and manage care for consented clients who visited the CHED 3 times in 90 days
- 21.25 FTE's
- Over 200 service providers received multidisciplinary core team trainings
- Over 270 non-clinical staff received integrated care and stigma reduction training
- Weekly multidisciplinary case conferences are taking place at all B1 sites
- Closed Loop Referral processes are in place at all B1 sites
- MAT provider integrated into 7 out of 11 B1 sites; others have access and warm handoff to MAT providers at HUBS (Riverbend, CH Substance Use Services)
- All 11 partners meet the Integrated Care designation
- Began tracking IBHC activity (scheduled and unscheduled patient visits, team consults, phone check ins, and resource calls) at B1 sites in February 2019
- January-June Expenses: $ 583,129.00

C Care Transitions

- IDN 2 and Merrimack County Department of Corrections developed and submitted a grant to BJA (Bureau of Justice Assistance?) for reentry funding.
- The case manager no longer does full days at New Hampshire Department of Corrections, goes there as needed.
- IDN 2 no longer works with Sununu Youth Services, only a small percentage of youth are released to the IDN 2 region.
- 36 clients served pre-release during January-June 2019, and 39 served post-release during January-June 2019.
- 156 clients served pre-release to date (114 unduplicated), 112 served post-release to date (66 unduplicated), and 19 have completed 12 months of service.
- 12.25 FTE's.
- January-June 2019 expenses: $101,971

D Substance Use

- 14 total MAT providers
    - 5 MAT providers at HUBs
        - 4 at Riverbend
        - 1 at Concord Hospital Substance Use Services
    - 9 MAT Providers at B1 sites (who did they lose since last SAR? We had 14 on previous summary and Deb L. changed it to 15 in her edits, so maybe they did not lose someone and there is just a mistake)
        - 160 patients treated with MAT during January-June 2019, 82 were new patients
- 2 MAT Providers at OBGYN sites
    - 16 OBGYN patients treated with MAT during January-June 2019
    - 19 OBGYN patients served through wraparound during January-June 2019
- 15.95 FTE's as of 12/31/2018.

- January-June 2019 expenses: $190,827

E Care Coordination
Enhanced Care Coordinator provided ongoing, intensive wraparound services for 9 individuals aged 15-22 within a six-month period using the RENEW (Rehabilitation for Empowerment, Natural Supports, Education, and Work model. YouthMove provided peer support.
Complex Care Coordinator hired on 3/11/2019 to:

- Identify, plan for, and structure interventions for high-utilizing populations.
- Plan/facilitate regular communication to ensure mutual understanding of goals, avoid duplication of services and service silos, and ensure that clients are served in the least restrictive settings according to their needs.
- Facilitate a regular meeting to:
  - Address and respond to individuals identified as having complex care needs.
  - Improve transitions of care and communication across teams and organizations.
  - Reduce the frequency of unnecessary emergency department use.
- 15 individuals served during January-June 2019
- 9.6 FTE's total
- January-June 2019 expenses: $67,650

IDN 3

B1 Integrated Care Expansion- InteGreat Health, an IDN-funded program with expenditures of more than $600,000 since 2017, is a collaboration between Greater Nashua Mental Health and Lamprey Health Care. With their tag line of *One Body, One Mind, One You*! their goal is to assist patients with complex medical needs, especially those who require behavioral health services. To date, they have enrolled 150 unique clients who need both primary care and behavioral health services, with 90 of those not previously connected with a primary care provider.
In addition to InteGreat Health, IDN funding is supporting several multi-disciplinary core teams (MDCT) across the region's primary care provider organizations, totaling nearly $2 million. These teams each include representation from a primary care provider (PCP), behavioral health clinician, care coordinator/case manager and psychiatrist, with the IDN preparing to conduct a regional MDCT to allow for more complex cases to be evaluated and discussed on a monthly basis. Mental health and substance use disorder providers within the IDN will engage with these multi-disciplinary core teams to support shared patients with complex health care needs by engaging in monthly case management meetings and information sharing through the use of shared IT platforms, sponsored and funded by the IDN at an allocation of more than $1.5 million over the course of the demonstration.

- As of 6/30/2019, 6 of the IDN-3 partners have initiated the execution of the CCSA
- Of the 10 IDN Member Entity PCP/MH/SUD providers, 7 are reporting outcome measures to MAeHC either electronically or manually directly into their portal.
- 13 IDN Member Entity provider partners now operational with the Collective Medical Technologies' platform to enable them to receive event notifications. Infrastructure has now been built for the ability to use the platform for an electronic shared care plan (with required patient consent).
- January-June 2019 Expenses: $399,713.00

A1 Workforce Development- Due to the behavioral health workforce shortage, several IDN 3 partners are leveraging investment in their workforce via usage of IDN3 funding targeted for salaries, salary adjustments, benefits, professional dues/licensing fees and multiple workforce-related bonus types (sign-on, retention, referral, etc.) with promising results. To date, more than $20,000 has supported professional development/CMEs and staff licensing dues across provider partners, as well as more than $25,000 for sign-on and referral bonuses to incentivize recruitment/hiring. The IDN has also financially supported more than $100,000 for workforce training and education to build capacity and knowledge among providers and direct support staff.

- Continuous training offering of >60 training opportunities over 6 months to partner members.
- Biweekly training matrix, delivered via email to the Full IDN membership (~175), highlighted the available training opportunities of which most were available to any/all members and their staff, which resulted in >300 unique, general IDN/community members participated in the broad offering of training topics, including:
    - Mental Health Awareness, Mental Health First Aid and Youth Mental Health First Aid training opportunities to non-clinical staff, IDN-3 sponsored 4 full-day trainings which drew >100 attendees.
    - Twelve cultural competency trainings, attracting over 200 attendees.
- January-June Expenses: $548,201.00

A2 Health Information Technology- All IDN 3 partners are being financially supported by the IDN through staffing allocations (more than $35,000 to date) and sponsorship of technology platforms (more than $375,000 to date) to work toward interoperability across the region, including engagement in receiving notifications of emergency department admissions, discharges and transfers for attributed Medicaid beneficiaries, as well as reporting against the DSRIP outcome measure targets. These funding allocations are supporting care coordination and have the goal of reducing gaps in care and preventing unnecessary emergency department and inpatient care visits. To date, IDN 3 providers (primary care, mental health and substance use disorder) have completed and submitted reporting to the IDN 3 quality data center (QDC) database, including:

- completion of Comprehensive Core Standardized Assessments (CCSAs): 1,307
- positive depression screening and follow-up: 627
- positive substance use disorder screening and follow-up: 207
- positive tobacco screening and follow-up: 992.

Based upon claims data for the period ending June 30, 2018, the IDN reduced frequent and potentially avoidable emergency department visits from its 2015 baseline:

- reduced frequent emergency department use (4+ visits per year) from 8.4% in 2015 to 6.39%
- reduced potentially avoidable emergency department visits from 15.07% in 2015 to 11.65%.

January-June 2019 Expenses: $139,348.00

Care Transitions- Greater Nashua Mental Health is supporting the Critical Time Intervention (CTI) program for IDN 3, receiving nearly $250,000 to date to support case managers and field

coordinators to implement this evidence-based program. CTI receives referrals from emergency departments, designated receiving facilities (DRFs) and inpatient facilities (NH Hospital and Southern NH Medical Center Behavioral Health Unit) to support patients prior to or at discharge with developing relationships with mental health and SUD treatment as well as their primary care providers to support their medical/behavioral health needs. As part of the patient's goals, they are connected with other IDN 3 community-based social service support providers to address barriers to their healthcare needs. This includes housing instability, lack of food access, employment, and transportation needs. As of July 2019, more than 70 individuals have been served by this intensive case management program, with case management meetings being held with Gateways Community Services, The Emmaus Institute and The Front Door Agency who share patients with GNMH. The IDN 3 CTI team is collaborating with the other 4 CTI teams around the state in monthly Community of Practice (CoP) meetings and trainings.

- 3.15 FTE's as of 6/30/19
- Expenses for January-June 2019: $140,541

Expansion in SUD Treatment Options- Behavioral health (mental health and substance use disorder) services have been enhanced for young adults in the greater Nashua region through IDN funding to support expanded individual therapy and case management that was previously not immediately available for this age group. Parents have overwhelmingly provided their consent for these services through referrals from the Integrated Middle School Project Providing Assessment & Collaboration Together (IMPACT) program.

- 77 youth supported by The Youth Council's IMPACT project
- 56 people participated in spirituality based support provided by The Emmaus Institute
- Greater Nashua Mental Health Center withdrew from plan to develop a substance use disorder group, IDN decided not to pursue alternate completion of this strategy.
- 4.53 FTE's as of 6/30/19
- Expenses for January-June 2019: $69,570

Integrated Treatment of Co-Occurring Disorders- Greater Nashua Mental Health is supporting the Integrated Dual Diagnosis Treatment (IDDT) program for IDN 3, receiving more than $350,000 to date. From January 2018 to present, nearly 100 individuals with co-occurring mental health and substance use disorders have been engaged in this evidence-based intervention, receiving a team case management approach that includes individual mental health and substance use treatment as well as housing assistance, and family & peer support. Several of the patients did not have relationships with a primary care provider, so they were referred to the IDN's co-located practice InteGreat Health for services.

- 5.8 FTE's as of 6/30/19
- Expenses for January-June 2019: $213,950

IDN 4

A1 Workforce Taskforce

- Behavioral Health Scholars Program – Manchester Community College – Since inception in August 2018, 20 Network4Health Behavioral Health Scholarships totaling $34,000 have been awarded. Behavioral Health Scholars Program – Granite State College – Since

inception in September of 2018, 28Network4Health Behavioral Health Scholarships totaling $27,500 have been awarded.

- Essentials of Project Management Program – Granite State College - Classes were held for 3 days over the month of June 2019 for a total of 18 hours. Recruitment wasn't as strong as predicted, so Network4Heath was also happy to partner with IDN 2 to offer slots to that region as well. 4 people participated from IDN 2. A total of 20 participants started the program and all 20 completed the program.
- Fundamentals of Leadership Program – Granite State College – This program began in March 2019 and ran for 2 months until April 2019. Thirty participant employees were in class for 4 sessions over 2 months, and had approximately 2 hours of online work to do per week between sessions. Network4Health's Workforce Development Director partnered with Southern New Hampshire Area
- Health Education Center and hosted two Behavioral Health Educational Round Tables on February 8, 2019 and on April 22, 2019
- Explored the design of a HealthCare Career Ladder program for non-native English speakers.
- Contemplating funding for Mental Health First Aid for students attending the LNA course at the American Red Cross.
- Supported 123 trainings across all projects and funding for 343 individuals most of which provide CEU credits
- UNH Occupational Therapy Intern at Center for Life Management (CLM). The internship was such a success CLM has reached out to request another intern. N4H promoted OTs as a care enhancer at CMHC's.
- Catholic Medical Center (CMC) and Health Care for the Homeless (HCH) are exploring the Behavioral Health Physician Assistant model
- Successfully recruited 20 of 37 positions
- Prescriber Recruitment and Retention Initiative – reimburse 50% of allowable recruitment/retention costs up to $10,000 to any partners who hire or retain MAT prescriber (MD, DO or APRN). Committed $100,000 to this.
- Scholarship Program for Training CRSWs in partnership with the Mental Health Center of Greater Manchester – committed $2,550 – 20 graduates
- 53 partners with 20 B1 partners engaged

A2 Health Information Technology

- As of June 30, 2019, 22 practices are live with shared care planning.
- 41 practices are using the Event Notifications services.
- 43 practices are now using secure direct messaging technologies.

B1 Integration

Manchester Community Health Center and Healthcare for the Homeless achieved Integrated Care Practice Designation

FQHC - Healthcare for the Homeless

- Expansion of integrated PC/BH team model, to include Manchester Recovery and Treatment Center

- Implementation of MAT program; recently completed MAT planning grant
- Implement Institute for Clinical Systems Improvement (ICSI) shared decision making model to treat mild to moderate depression
- BH provider(s) to attain ADA Diabetes Recognition (would be 1st in NH to have this designation)

FQHC – Manchester Community Health Center

- Expansion of current integrated PC/BH team model (Cherokee model) to all 4 practice sites
- Shift from current treatment of mild to moderate depression to another evidence-based model to further enhance capabilities, e.g., Improving Mood: Providing Access to Collaborative Treatment (IMPACT) or Institute for Clinical Systems Improvement (ICSI) shared decision making model to treat mild to moderate depression
- Expand collaborative efforts with several social service agencies to support vulnerable populations

CMHC - Center for Life Management

- Implement enhanced care management team model that includes a Nurse Care Manager targeting clients with co-occurring mental illness and chronic medical condition(s)
- Develop an automated registry for high risk clients with identified co-morbidities

CMHC - Mental Health Center of Greater Manchester

- Implement Intensive Transition Team (ITT) to support the identification, assessment and transition of high-risk individuals in the ED & PC settings (based on Oregon ITT model)
- Implement BH clinician in 4 Manchester middle schools
- Development of joint workflows with PC & SUD partners

PC & BH - Catholic Medical Center

- Expand multidisciplinary team to include Behavioral Health Patient Navigators at 3 practices and an in-practice therapist at one practice
- Increase SUD capacity; implement SBIRT; potentially implement MAT in 2019
- Psychiatric consultation for primary care
- Development of joint workflows w/MHCGM for closed loop referral and shared care planning

PC - Dartmouth-Hitchcock -Adult / Pediatric

- Introduce integrated onsite Primary Care/Behavioral Health teams at 2 adult and 1 pediatric DH practice sites including Behavioral Health Consultants and Family Support Specialists/Social Workers
- Collaboration for mental health services w/MHCGM and for MAT with Fusion

Elliot Health Pediatrics Manchester (IEP Accepted, SOW Pending)

- Implementing integrated behavioral health in primary care, utilizing a BH Consultant and psychiatric consultation

Partial Hospitalization Program and Drug Court

- PHP/ Enhanced care management model addressing co-occurring disorders including increasing and enhancing integrated coordination with primary care providers.

Fusion Health Services MAT and Primary Care Services

- Support PCP & CMHC practices expanding MAT capabilities through education, coaching, suboxone inductions, and vivitrol administration
- Start-up of new integrated primary care & behavioral health practice for complex patients, specializing in SUD, chronic pain, and neurologically impaired patients

Families in Transition (FIT) - New Horizons Willows Treatment Program

- Enhanced internal integration between Willows Treatment Program and other FIT-NH services (workflows, enhanced coordination and communication, enabling HIT)
- Enhanced coordination and documented workflows with community partners, particularly those within the new Manchester Recovery and Treatment Center
- Expand SUD treatment services to include men who are homeless or at risk of homelessness

Easterseals NH Farnum Center (IEP Accepted, SOW Pending)

- Expand care coordination capacity, targeting individuals being discharged from the Farnum Center.
- Collaborating with EHS and Healthcare for the Homeless to improve referral and joint workflows.

C Care Transitions

- As of June 2019 serving 62 clients out of 294 referrals (87 total served to date).
- 30 participants graduated from the program as of June 2019
- Expenses for January-June 2019: $134,046

D Substance Use

- 185 individuals have been referred to the PHP as of June 2019
- 109 individuals have been evaluated and admitted to the program as of June 2019
- As of June 2019 50% have successfully completed the program
- Expenses for January-June 2019: $704,004

E Care Coordination

- Two new Dual Diagnosis Capability assessments were completed; Families in Transition Open Doors Program and Elliot Partial Hospitalization Program
- 1,636 Medicaid clients served from July 2018-June 2019 in integrated treatment programs
- Expenses for January-June 2019: $141,636

Dual Diagnosis Capability Assessments and Quality Improvement Plans

- **Center for Life Management Adult Services**
  - Trained both clinical and supervisory staff in numerous interventions for co-occurring disorders. Related changes within the EMR to support training and increase capability to track patient progress and use of interventions. On site CRSW, and ongoing supervision for LADC/MLADC licensure efforts.

- **Families in Transition- New Horizons (FIT-NH) Willows Program**
  - Trained both clinical and supervisory staff in numerous interventions for co-occurring disorders, including the use of PCL-5, PHQ-9 and GAD7. Ongoing supervision for mental health and substance use related licensure efforts. Started Relapse Prevention Group for individuals waiting to transition to treatment.

- **The Mental Health Center of Greater Manchester (MHCGM) Cypress Center, Emergency and Interim Services and CTT**

  - Increased training for supervisory staff in supervising Motivational Interviewing and Stages of Change interventions. Related changes within the EMR to support training and increase capability to track patient progress and use of interventions, including The University of Rhode Island Change Assessment Scale (URICA). Increased substance use related licensure efforts to support staff. Provided CRSW Academy(s).

- **Pastoral Counseling Services (PCS) Outpatient Therapy**
  - Increased individual and group supervision for individuals pursuing MLADC licensure, as well as staff looking to increase skills and knowledge. Treatment group on COD offered to interested patients. Increased training efforts for staff regarding SUD, MH and COD.

- **Parkland Medical Center- Partial Hospitalization Program and Acute Behavioral Health Unit (QIP in Process)**

Integrated Treatment for Co-Occurring Disorders (ITCOD) Training and Support for Primary Care and Community Based Organizations

- Numerous in person and webinar trainings offered to all partner agencies including (but not limited to): Mental Health First Aid, Motivational Interviewing, Stages of Change, COD, Condition specific identification and diagnosing (MH and SUD), and ASAM.

- Monthly electronic and hard copy mailing provided to all partner agencies in related COD topics including assessment and screening tools, best practices, general education on identification and referral, etc.

- **Recommended Protocols**
  - The Network4Health Co-Occurring Disorders Clinical Director completed Network4Health recommended protocols for patient assessment, treatment,

management and referrals for the co-occurring disorders population and distributed to all partner agencies.

IDN 5

A1

CHSN's training contract with NHADACA successfully trained 712 individuals since inception in April 2018
State loan repayment matching funds dispersed to 5 individuals at $7,500 each; 15 "matches" remain available.
The community projects projected a total of 26.2 FTEs to operationalize the three projects. To date all projects are fully staffed with the exception of 1 FTE for the D3 project MLADC to run the Plymouth IOP.

CHSN's current retention rate is 100% with a current vacancy rate of 2.6%. CHSN-IDN5 has offered all partners incentives through an Employee Retention Incentive Plan (ERIP).

A2

- 14 IDN providers achieving minimum HIT standards
- Every organization now has its own CCSA that has been implemented.
- Implementation of shared-care planning software (Collective Medical) at every B1 practice was completed as of June 30, 2019.
- January-June 2019 Expenses: $65,633.61

B

- 100% of PC/BH partners adopting standardized assessment tools and procedures
- 71% of practices adopting use of a common Shared Care Plan
- 100% of practices/providers with multidisciplinary teams and case conferences for complex or high risk patients
- 71% of practices with co-location of primary care, mental health staff and/or substance use treatment
- The average University of NH/Citizens Health Initiative Site Self-Assessment score has improved about 18% since the baseline was taken in the second half of 2017.
- CHSN-IDN5 developed all required B1 protocols in December 2018 and shared with B1 partners to assist and direct them in their work. Additionally, this "Protocol Guidance" document was reviewed and discussed with B1 partners at the January 17, 2019 B1 meeting to offer any clarification if needed.

C

- 71 individuals served as of 6/30/19
- 100% of referred clients had a completed assessment and continuing care plan development while in correctional facility prior to release
- Expenses for January-June 2019: $118,992.62

D

- To date, the IOP expansion has decreased the wait for IOP services from what was three to four weeks to no more than three to four days.
- Expanding IOP level of care to Plymouth area has been unsuccessful to date
- 60 clients were served from January-June 2019
- Expenses for January-June 2019: $128,072.87

E

- Two Enhanced Community Care Coordination rack cards were developed – one for clients and one for providers
- 2038 client encounters and 930 clients served
- First care coordination team contact is within 3 days for all referrals
- New data reporting for percent of clients with a housing need that were given a referral for housing; 74.6% as of June 2019
- Expenses for January-June 2019: $315,167.20

IDN 6

A1 Workforce Development

- Initiation of a new Community Care Team meeting series to a third site at Exeter Hospital, where area partner agency representatives now come together monthly.
- To reduce transportation barriers, one mental health peer support agency partner was able to distribute 200 bus tickets to Medicaid enrolled or eligible clients for transport to medical appointments, many of which were SUD partners for methadone and/or suboxone treatment.
- 406 partner agency staff have received IDN sponsored training as of 6/30/19

A2 Health Information Technology

- 100% of B1 partners have signed a Data Sharing Agreement/Business Associate Agreement as of this reporting period.
- 17 partners reporting access to a shared care plan solution

B1 Integration

- As of 6/30/19, Region 6 has ***six Coordinated Care practices*** and ***four Integrated Care Practices***.
- All regional B1 partners have identified Multi-Disciplinary Core Teams
- As of 12/31/2018 1,113 Medicaid beneficiaries received the CCSA
- Approximately 20 trainings were held in the 6 month reporting period of January-June 2019

C Project – Critical Time Intervention Care Transitions Team

- 278 clients referred to and screened by care transitions team as of 6/30/19, 68 were new for the January-June 2019 period
- 5.8 FTE' as of 6/30/19

- Expenses for January-June 2019: $237,960

D Project

- Southeastern New Hampshire Services (SENHS) re-assigned all their residential beds to ASAM Level 3.1 Low Intensity Treatment. This functionally eliminated all capacity of ASAM Level 3.5 High Intensity Treatment beds (28-Day program) in the region, except for the eight Level 3.5 beds at Hope on Haven Hill, which are only for pregnant and post-partum women.
- In March 2019, internal changes at SENHS led to a discussion of SENHS ability to continue to manage the embedded D3 program and staff. After multiple discussions, the contract was not renewed and ended 4/30/2019. In preparation for this change, the IDN 6 Operations team surveyed partners to find a new option to house the MLADC and CRSW for community-based assessments. There was not a regional partner prepared to host this team.
- Over 78 patients engaged with the MLADC Navigator
- 30 clients completed a defined treatment program
- 2 FTE's as of 6/30/2019
- Expenses for January-June 2019: $152,395

E Project – Enhanced Care Coordination Project

- 41 individuals served as of 6/30/2019
- 68% of clients have met their self-generated achievable goals
- 85% of clients have improved functional status
- 2.2 FTE's as of 6/30/2019

Expenses for January-June 2019: $81,764

IDN 7

A1 Workforce

- 9 mental health professional students completed the Live, Learn Play program in northern NH as of 6/30/19
- 3 new preceptor sites accepting mental health professional students as of 6/30/2019
- January-June 2019 Expenses: $152,736

A2 Health Information Technology

- The region was able to report fully on a measure (ASSESS_SCREEN.01) for the first time ever.
- 10 practices have the shared care plan tool and closed loop referral
- 7 practices have event notification services
- January-June 2019 Expenses: $186,550

B1 Integration

- All thirteen partners have some version of a CCSA underway as of 6/30/2019.
- Six partners have successfully implemented a MDCT at their individual sites

- January-June 2019 Expenses: $243,530

C Project – Critical Time Intervention Care Transitions Team

- During the reporting period of January-June 2019 Carrol County Department of Corrections (CCDoC) served 84 TRUST candidates using the CTI model.
- CCDoC shared that their TRUST program has driven down their recidivism rates to almost a quarter of the national average. They have also identified that completion of the program is a compelling factor when requests are made of the courts to shorten probation sentences, further decreasing the burden of corrections expense on the county.
- Family Resource Center reported serving 37 new clients during the reporting period of January-June 2019.
- Tri-County Community Action Program (TCCAP) reported that the shelter's average length of stay has decreased from over 12 months per guest to 4.5 month increasing access to shelter for others in crisis.
- The NH CTI Community of Practice met monthly during this reporting period, including two in-person gatherings in January and April.
- The Region 7 IDN team coordinated a statewide CTI Supervisor training on May 6 for CTI partners from Regions 3, 4 and 7.
- Region 7 IDN worked with CACTI consultant Kim Livingstone to convene a facilitated call on May 29 with stakeholders from State of NH DHHS, CACTI, IDN Team Leads from the five regions implementing the CTI model and representatives from several CTI programs. Discussion focused on determining the value of CTI activities and coordinating coverage of CTI as a reimbursable service under Alternative Payment Models in general and by the NH Medicaid Managed Care Organizations specifically.
- 344 individuals served by CTI as of 6/30/2019

D Project – Expansion in Intensive Substance Use Disorder (SUD) Treatment Options

- 5 New MAT services have been added to the region
- 211 clients have been served by the new MAT services
- 189 clients have been served by intensive outpatient services
- 88 peer recovery coaches have been trained, 35 of these individuals are actively employed by Region 7 IDN partners.
- 480 clients have been served by the peer recovery coaches

E Project – Enhanced Care Coordination for the High Needs Population

- Huggins Hospital reports that they hired two staff members for their enhanced care coordination program during this reporting period, filling all seven budgeted positions which include three care coordinators, three PCP's and a social worker. Huggins Hospital also added another fifty patients to the enhanced care coordination program during this reporting period, bringing their overall total of individuals served by their team during the DSRIP period to 124.
- The North Country Health Consortium (NCHC)'s Ways 2 Wellness Connect CHWs have served 24 NH Medicaid beneficiaries with enhanced care coordination services at the request of Region 7 IDN partners during the DSRIP demonstration.

- Weeks Medical Center, Ammonoosuc Community Health Services and Northern Human Services, reported having served 275, 380 and 120 individuals respectively with enhanced care coordination since the start of the Region 7 IDN implementation plan on July 1, 2017.
- Saco River Medical Group (SRMG) reports that they have hired a new MAT waivered Nurse Practitioner during this reporting period.
- 21 trained care advocates

Expenses across all C, D, and E projects for January-June 2019: $50,680

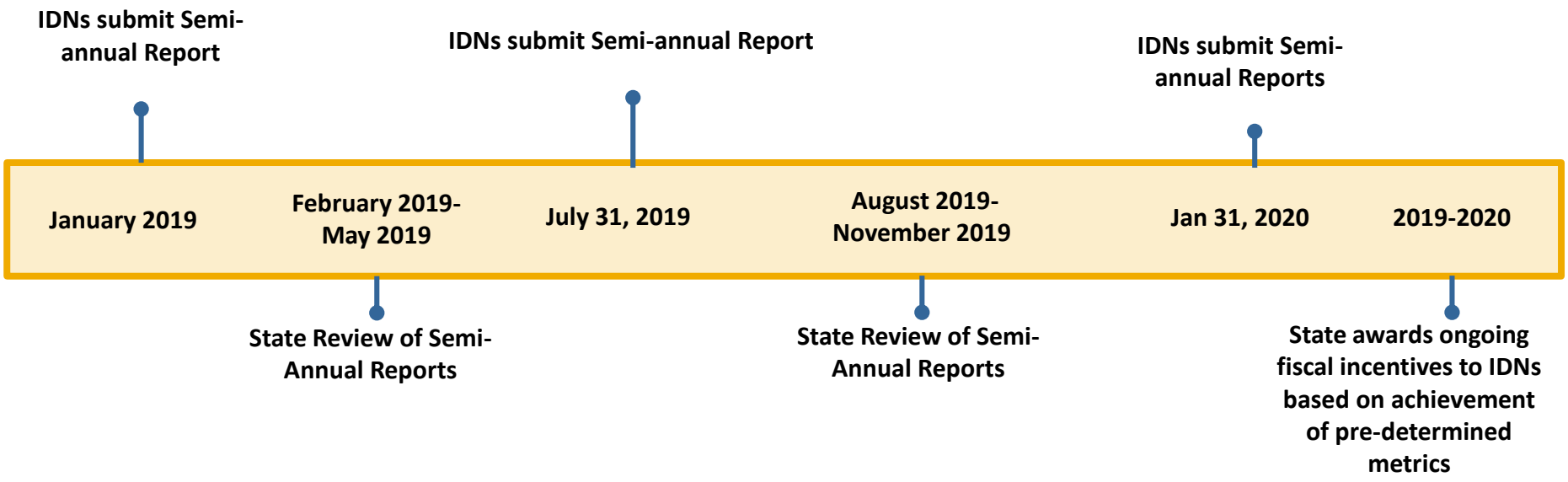
DSRIP Annual Update

December 9, 2019

Integrated Delivery Network Timeline Year 4

- Detailed DSRIP Project Plans approved January 2017
- Distribution of project incentive funds January 2017
- Semi-Annual Report Submissions 2x per year in July and January
- Earned incentive payments no longer tied to process as of January 2019
- Earned incentive payments are solely tied to performance as of January 2019

Implementation Timeline



Overview

- Each IDN is participating in two statewide projects; one mandatory core competency project: and three community-driven projects selected from a DHHS-defined menu.
- All payments are based on progress towards and achievement of, identified deliverables.
- Deliverables for which payment can be earned include both process and performance over the demonstration period.
- Process payments are tied to achievement of project deliverables.
- Achievement of all process deliverables was targeted through December of 2018.
- Achievement of performance deliverables is through 2020.
- Percent of funding tied to process and performance shifts over the demo period. As of calendar year 2019, 100% of incentive payments are tied to outcomes metrics.

Project Selection

Each IDN is participating in two statewide projects; one mandatory core competency project: and three community-driven projects selected from a DHHS-defined menu.

Statewide

Strengthen mental health and SUD workforce

Mandatory

Core Competency: Integrating Behavioral Health and Primary Care

Statewide

Develop health information technology infrastructure to support integration

COMMUNITY DRIVEN PROJECTS

Care Transitions:

Support beneficiaries with transitions from institutional settings to the community

- Care Transition Teams
- Community Reentry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Healthy Issues

Capacity Building:

Supplement existing workforce with additional staff and training

- Medication Assisted Therapy of Substance Use Disorders
- Expansion in intensive SUD Treatment Options, including partial hospital and residential care

Integration:

Promote collaboration between primary care and behavioral health care

- Integrated Treatment for Co-Occurring Disorders
- Enhanced Care Coordination for High –Need Populations

Process Achievements

Health Information Technology

- Implementation of a real time event notification system;
- Implementation of an electronic shared care plan;
- Statewide direct and secure messaging;
- Data reporting.

Workforce

- Legislative updates that support integration such as licensing and telemedicine.
- Recruitment, staffing, training.

Integration of primary and behavioral health

- Standardize protocols across multidisciplinary providers for comprehensive assessment, timely exchange of information, closed loop referrals, multidisciplinary care teams.

Process Achievements cont'd

- Three IDN's have achieved 100% of their process deliverables. (IDN's 2, 4 and 5)
- Four IDN's are in varying degree's of achievement with December 30, 2019 being the final period for recovering previously not met incentive payments tied to process.
  - IDN's can recover previously unmet incentive payments for 2 subsequent reporting periods, or over the 12 month period following the target date.
- Final reporting period to recover previously unearned process incentive payments is December 2019.

Overview of Event Notification

Accomplishments – 15 hospitals contributing ADT data, 48 non-hospital partners connected to the network, increasing trends on notifications sent, membership file numbers, patient record views, and active users (see data below). Active clinical collaboration throughout the state, and 42 CFR Part 2 information is now being shared broadly to all treating providers for patients that have given their consent to do so. While not part of the DSRIP project, all MCOs have signed an agreement with Collective Medical as well.

Project Status – Our next goal is to connect the remaining hospitals and non-hospital partners (by end of Q1 2020). All hospitals in IDNs 1,2,3,4,5,7 are actively working toward that goal. IDN 6 is working on an alternate solution. CMT is also actively training clinicians across the state on how to use the platform to better collaborate on care.

Quantitative case study and findings and utilization data –Non-hospital partners are receiving alerts when patients of theirs arrive in the ED. The partners are able to chose the criteria for which visits they would like to be alerted on (high-utilizer alert, travelling patient alert, custom alerts based on diagnoses etc)

Policy and administrative difficulties – Many IDNs and partners are looking forward to New Hampshire Hospital coming on the network. Integrating the IDN 6 solution would be a welcomed effort and bring value to the rest of the IDN partners.

Key dates / milestones – The next milestone is completion of the network by brining on all hospitals and IDN partners by end of Q1. CMT is also hoping to connect to the PDMP next year, as we have done in many other states, to alert ED physicians to risk.

Data Reporting

Accomplishments: As part of DHHS efforts to better measure and analyze data to incentivize IDNs and support future efforts for alternative payment models and quality improvement DHHS has implemented a **new analytic data warehouse**, as part of DHHS's Enterprise Business Intelligence platform, for Medicaid claims and member data **that provides the DSRIP analytic team with ready access to data**, new tools to more easily analyze data, and a path forward to allow future development of dashboards and other approaches to communicating complex information. As part of these efforts we have brought together data from nine separate payers that are for the first time stored in a harmonized manner. While the project was initiated to support all Medicaid activities, the DSRIP data team was directly involved in project development to ensure that information needs for DSRIP were incorporated.;

Project Status: DHHS has calculated all performance measures for incentive payments through the end of the 2018 data period. Currently DHHS is finalizing the remainder of the baselines for measures that become performance based in 2019.

Policy and Administrative Challenges: Currently DHHS is assessing the validity of measures to insure they are appropriate for performance payment. Of particular concern is the Timely Transmission of Transition Record After Hospital Discharge measure which has lost its National Quality Forum endorsement and the Daily Dosage of Opioids Greater Than 120mg Morphine Equivalent Dose for 15 or more days in year which has significantly changed in its meaning since the baseline period as far fewer people are prescribed high dose opioids.

Funding Distribution

Based upon

- Regional member attribution
- Process versus performance measures
- Statewide versus community based projects
- Identified metrics

Workforce Capacity

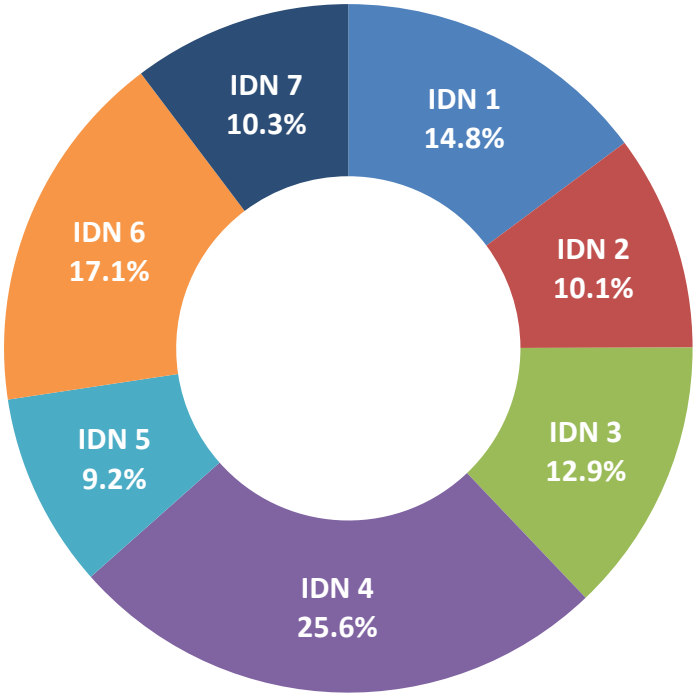
	FTE's BY IDN
IDN1	25.95
IDN2	40.35
IDN3	64.8
IDN4	49
IDN5	19.3
IDN6	33.48
IDN7	170*
Total	392.88

*IDN 7 reports the number of positions working on the integration of primary and behavioral healthcare within their region regardless of the funding source.

Note: FTE's are representative of the sum of full time equivalents with actual count of individuals filling positions higher due to part time positions.

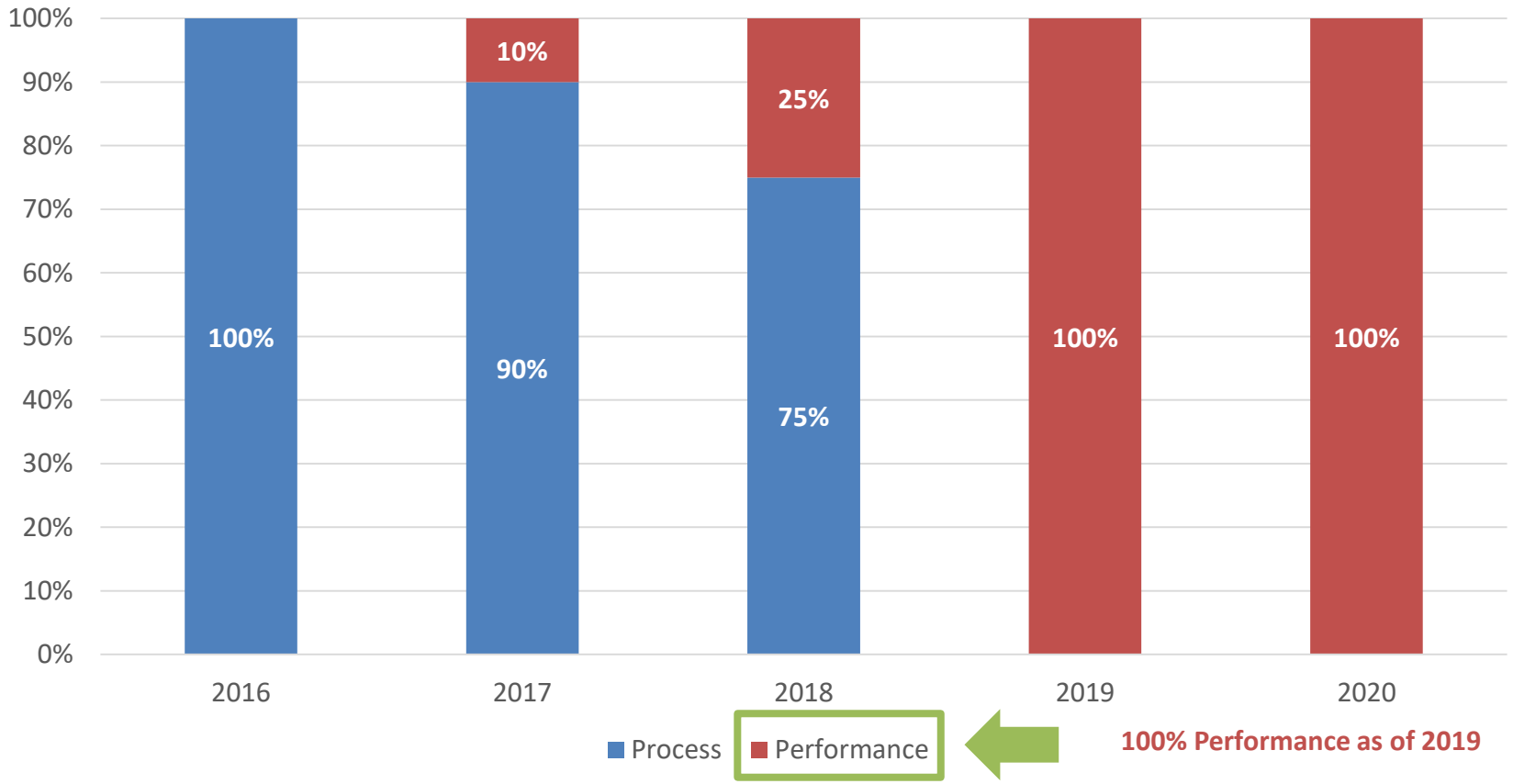
Achievable Payment Distribution Between IDNs

- Percent of funding is based on each IDNs attributed Medicaid population as a share of total Medicaid population as of 11/30/16



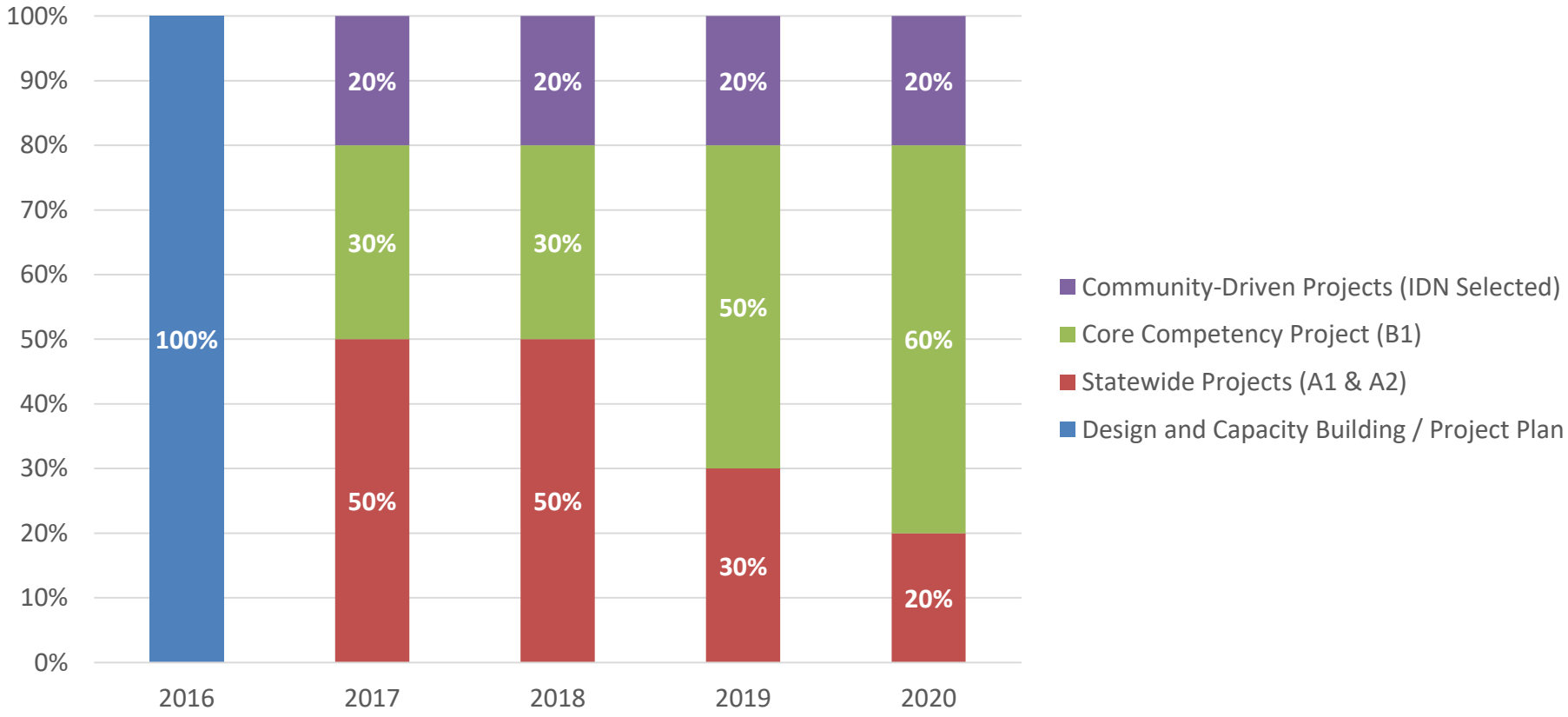
Achievable Payment Distribution Between Process and Performance

- Incentive payments shift from process to performance; same for all IDNs



Achievable Payment Distribution Between Types of Projects

- Funding tied to specific projects shifts over the demonstration period



2019 dates for achieving milestones or deliverables:

Measure ID	Measurement Period	Target Date for Rate Calculation
ASSESS_SCREEN.01	Jan-June 2019	11/15/19
ASSESS_SCREEN.02	Jan-June 2019	11/15/19
ASSESS_SCREEN.02	Cy 2018	11/15/19
ASSESS_SCREEN.04	Jan-June 2019	11/15/19
CARE.03-A	CY 2018	11/15/19
CARE.03-C	CY 2018	11/15/19
CARE.01	12 months ending 06/2019	12/31/19
CARE.02	12 months ending 06/2019	12/31/19
CARE.04	12 months ending 06/2019	12/31/19
CARE.05	12 months ending 06/2019	12/31/19
CMHC.02	Jan-June 2019	10/31/19
CMHC.03	Jan-June 2019	10/31/19
HOSP_ED.01	12 months ending 06/2019	12/31/19
HOSP_ED.02	12 months ending 06/2019	12/31/19
HOSP_ED.03	12 months ending 06/2019	12/31/19
HOSP_ED.04	12 months ending 06/2019	12/31/19
HOSP_INP.01	12 months ending 06/2019	12/31/19

WHERE WE ARE NOW

IDNs have completed the third quarter of the fourth year of the demonstration reporting a total of 377 participating partners.

Of those partners;
125 practice sites are working towards integration,

52 partners engaged in care transition or reentry projects,

130 partners engaged in enhanced care coordination and co-occurring disorder treatment and

75 partners are working to expand access to substance use disorder services.

What's next?

- Financing
- Sustainability
- Performance metrics

New Hampshire Department of Health and Human Services
DHHS Medicaid APM Strategy
Guidance No. 1

Contents

NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CARE MANAGEMENT PROGRAM

Reference Number	19-0029
Authorized by	Henry Lipman, Medicaid Director
Division/Office/Bureau	Division of Medicaid Services
Publication Date	October 4, 2019
Effective Date	September 1, 2019
Subject	**DHHS Medicaid APM Strategy, Guidance Document No. 1**
Description	Summary of key guidance for MCOs in meeting requirements for the development, implementation and reporting on Alternative Payment Models consistent with MCM Contract (RFP-2019-OMS-02-MANAG-02) approved by the Governor and Executive Council in March 2019. (Excerpted contract terms included below)

Introduction

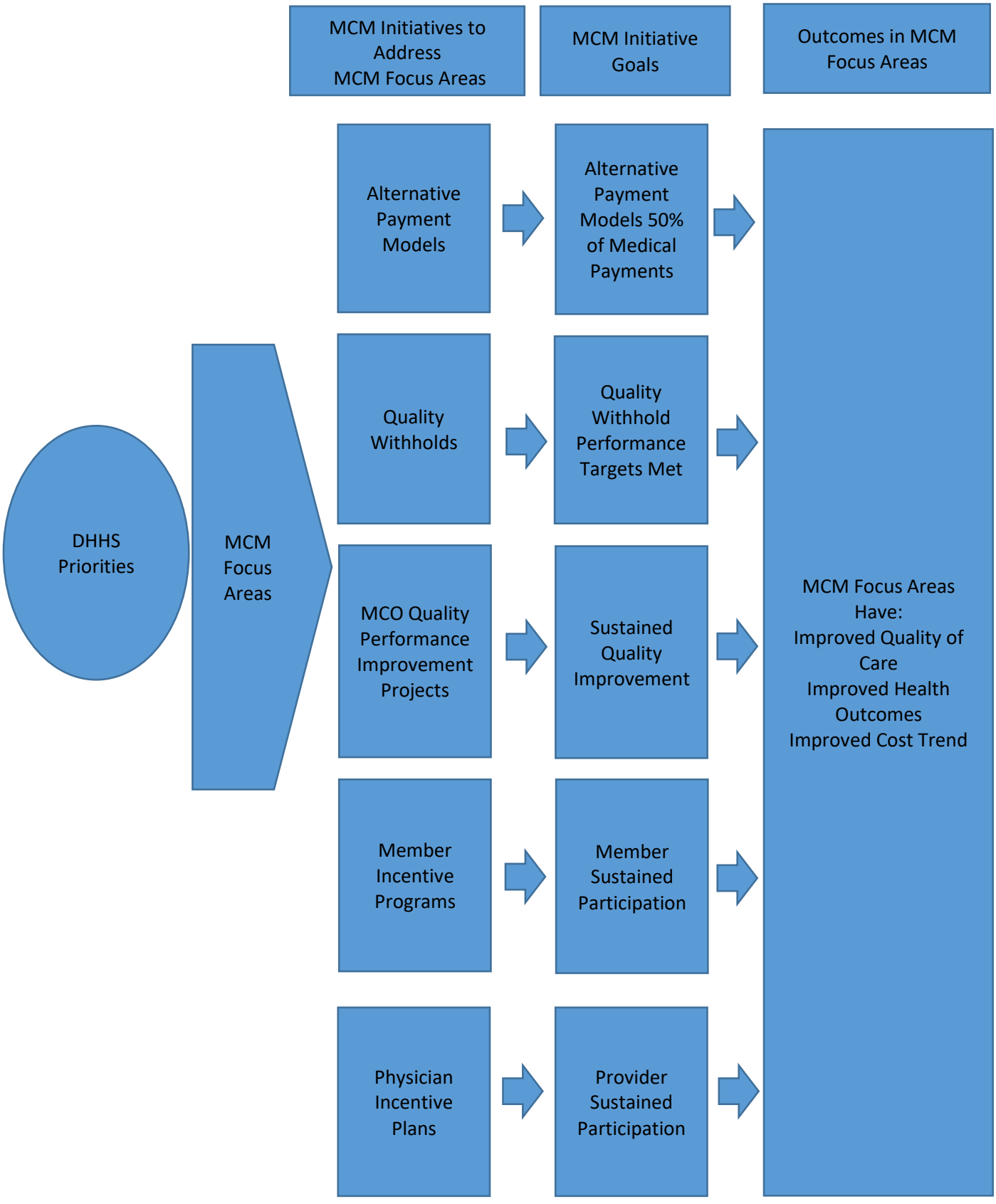
As required by the special terms and conditions of the NH Building Capacity for Transformation waiver, NH is implementing a strategy to expand use of Alternative Payment Models (APM) that promote the goals of the Medicaid program to provide the right care at the right time, and in the right place through the delivery of high-quality, cost-effective care for the whole person, and in a manner that is transparent to the Department of Health and Human Services (DHHS), providers, and the stakeholder community. Including APMs into Medicaid Care Management (MCM) is one of many Medicaid program components that, taken together, will lead to 3 major goals:

- Improved Quality of Care
- Improved Health Outcomes
- Improved Cost Trend

DHHS Priorities and Incentives Alignment

It is DHHS's intent for each MCO to build and implement a Medicaid APM Plan that helps achieve the state's priorities for the health and wellbeing of its beneficiaries and aligns with the MCO's Quality Assessment and Performance Improvement Program, Performance Improvement Projects, Beneficiary Incentives, Provider Incentives, NH Medicaid Quality Strategy and other programs and initiatives. See Graphic below.

DHHS Priority & MCM Initiative Alignment Graphic



This DHHS Medicaid APM Strategy ("DHHS APM Strategy"), Guidance No. 1, is intended to provide MCOs further guidance regarding expectations for the MCOs as they engage in APM planning and implementation pursuant to the terms and conditions of the Medicaid Care Management Services Contracts effective September 1, 2019 (the "MCO Contracts"). The DHHS APM Strategy is not intended to conflict with the terms of the MCO Contracts but to offer further guidance regarding certain terms and conditions as promised therein, including:

1. Guidance for MCOs regarding DHHS's Medicaid APM Strategy
2. Updated summary of the State's Priorities in RSA 126-AA
3. Timeline summary of key dates regarding APM implementation
4. Instructions for the MCO APM Implementation Plan contents

The DHHS APM Strategy may be supplemented with additional guidance, templates, worksheets and other materials from time to time.

Guidance Number 1

Timeline

What	**First Due Date**	**Reporting Period** (If applicable)	**Ongoing Due Date** (If applicable)
MCO APM Implementation Plan (APM.01)	October 15, 2019	3/1/2020 – 6/30/2020	May 1
DHHS Review Complete	December 1, 2019	N/A	
APMs Begin	March 1, 2020	N/A	APMs should be in place consistent with MCO APM Implementation Plan
First Partial Quarter Report (APM.02)	7/31/2020	3/1/2020 – 3/31/2020	4 months after the end of the quarter
Second Quarterly Report (APM.02)	10/31/2020	4/1/2020 – 6/30/2020	4 months after the end of the quarter
HCP-LAN Assessment Due[1] (APM.03)	10/31/2020	3/1/2020 – 6/30/2020	October 31st
50% Expenditures in Qualifying APMs (4.14.7.1)	6/30/2021 (As reported in APM.03 due on 11/30/2021)	7/1/2020 – 6/30/2021 (WS & NHHF) 1/1/2020 – 6/30/2021 (ACNH)	
Capitated Payment Arrangements with CMHCs (4.11.5.2.2)	No later than 90 days after the effective date		

Fifty Percent Payment Goal (4.14.7.1)

DHHS intends to achieve the goal of moving 50% of provider payments to APMs and expects the MCOs to undertake key activities as set forth in the MCO Contracts towards this goal.

[1] https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf

Each MCO shall ensure through its APM Implementation Plan that fifty percent (50%) of all MCO medical expenditures are in Qualifying APMs, as defined by DHHS, within the timeline set forth above.

State Priorities and Evolving Public Health Matters (4.14.12.3)

New Hampshire has identified by statute, RSA 126-AA, key state priorities for its Medicaid program.

The MCO's APM Implementation Plan shall explain how its APM plan will address the following state priorities and any additional evolving public health matters identified by DHHS, and in each quarterly report on the Standard Template for Quarterly Results, the MCO shall update DHHS on how its APMs are impacting the following state priorities:

- Opportunities to decrease unnecessary service utilization, particularly as related to use of the hospital Emergency Department (ED), especially for Members with behavioral health needs and among low-income children;
- Reduce preventable admissions and thirty (30)-day hospital readmissions for all causes;
- Improve the timeliness of prenatal care and other efforts that support the reduction of births of babies affected by prenatal drug or fetal alcohol exposure (including Neonatal Abstinence Syndrome);
- Better integrate physical and behavioral health, particularly efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission; and efforts aligned to support and collaborate with Integrated Delivery Networks (IDNs) to advance the goals of the Building Capacity for Transformation waiver;
- Better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts to promote effective utilization, particularly reducing potential harm from polypharmacy, as described in Section 4.2.5 (Medication Management) of the MCO Contracts;
- Enhance access to and the effectiveness of Substance Use Disorder treatment (further addressed in Section 4.11.6.5 (Payment to Substance Use Disorder Providers) of the MCO Contracts);
- Address social determinants of health;
- Address the needs of patients who are boarded in hospital emergency departments waiting for placements or services and reduce "ED boarding"; and
- Address emerging public health trends identified by DHHS.

Qualifying APMs: Defined

The MCO shall have flexibility to design Qualifying APMs consistent with this DHHS Medicaid APM Strategy and in conformance with CMS guidance.

In developing and refining its APM strategy, DHHS relies on the framework established by the Health Care Payment Learning and Action Network APM framework (or the "HCP-LAN APM framework") in order to develop a common understanding of qualifying categories, encourage

alignment with other payer APMs, and provide a framework for monitoring. DHHS's APM Strategy is also based on Qualifying APMs that promote stakeholder and beneficiary engagement, and result in outcomes that further the state's public health priorities.

Consistent with the MCO contracts, "Qualifying APMs" developed and implemented by MCOs must meet the following standards:

- **HCP-LAN APM Framework**: Meet the requirements of the HCP-LAN APM Framework Category 2C, 3A, 3B, 4A-C, based on the refreshed 2017 framework released on July 11, 2017 and all subsequent revisions (the "Framework");[2] (*see below*)
- **State Priorities**: Align with state priorities and address the social determinants of health; (*see above*)
- **Community Mental Health**: Include capitated payment arrangements with Community Mental Health Programs to deliver Community Mental Health Services as specified from time to time by DHHS (4.11.5.2.1);
- **Improve Health**: Include outcomes that improve health for Members consistent with state priorities and ensure that delivery of services are provided at the appropriate intensity and duration (4.11.1.12.2);
- **All Payer Alignment**: Align, where practical and possible, with current and emerging APMs being deployed with area providers by other health benefit payers in order to enhance provider engagement and outcomes that improve quality, outcomes and cost-effective care;
- **Transparency:** Meet DHHS's goals for transparency and data sharing with providers as set forth more fully in the MCO Contracts;
- **Provider Engagement:** Meet DHHS's goals for provider engagement as set forth in the MCO Contracts;
- **Quality Measures:** Take quality into account if payment methodology takes cost of care into account, in other words, if payment is related to cost thresholds or benchmarks, payment must also be related to quality thresholds or benchmarks;
- **Compliance**: Comply with 42 CFR 438.6(c)(1)(i) or (ii)(4.14.6); and
- **DHHS Discretion**: Meet any qualifying requirements approved by DHHS and publicized to MCOs consistent with the objectives of this DHHS APM Strategy.

When developing Qualifying APMs with large providers and provider systems, DHHS expects the Qualifying APM to adopt a total cost of care model with shared savings to the maximum extent feasible. As highlighted above, such total cost of care model must include quality thresholds or benchmarks as part of the APM. When developing Qualifying APMs for small providers, DHHS expects the Qualifying APM to take into consideration the capacity of the small provider, and incorporate collaborative care models, pay-for-performance bonus incentives and/or per member per month payments related to a provider's success in meeting actuarially-relevant cost and quality targets.

[2] http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

The MCO shall ensure that all member incentives adopted pursuant to a Member Incentive Program have a linkage to the APMs (4.9.4). Physician Incentive Plans that have a linkage to APMs shall be included in the MCO's APM Implementation Plan.

Mandatory Qualifying APMs To Be Negotiated by MCOs with Certain Providers

MCOs shall include and implement Qualifying APMs in the following provider categories:

- Capitated payment arrangements negotiated with Community Mental Health Programs that support the delivery and coordination of behavioral health services and supports for children, youth and transition-aged youth/young adults and adults, ensure economic sustainability of the Community Mental Health Program, allow for flexibility in the delivery of care, enhance meaningful integrated primary care/behavioral health, reduce ER utilization and provide appropriate incentives to improve the quality of care.[3] (4.11.5.2.1);
- APMs negotiated with FQHCs, RHCs and/or other health or family planning clinics or their designated contracting organizations to enhance state priorities, address social determinants of health, and meaningfully integrate behavioral health interventions in clinic settings (4.15.3);
- At least one APM should increase access to MAT for Substance Use Disorder combined with enhanced reimbursement for MAT reflecting the number of MAT patient members on the providers panel and evidence-based outcomes consistent with SAMHSA quality measures approved by DHHS (4.11.6; 4.11.6.5.7; 4.14.12.4.1.2);
- At least one APM should support evidence-based care and treatment of babies born affected by prenatal drug or fetal alcohol exposure, including the eat, sleep and console methods, and support the development of Plans of Safe/Supported Care (4.11.6.5.7; 4.14.12.4.1.1);
- The MCO shall incorporate APM design elements into its Qualifying APMs that permit Participating Providers to attest to participation in an "Other Payer Advanced APM" (including but not limited to a Medicaid Medical Home Model) under the requirements of the Quality Payment Program as set forth by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (4.14.8.10.2)

HCP-LAN Framework and Categories

As set forth above, only APMs that are reported to meet the HCP-LAN Framework and do meet the HCP-LAN Framework according to DHHS are Qualifying APMs. The following descriptions of the HCP-LAN Framework are taken from the MCO Contracts and Framework in order to assist the MCOs in the categorization of APMs. DHHS shall determine whether the MCO's APMs are aligned with an HCP-LAN Category (and which category it aligns with) using the Standardized Assessment of APM Usage (4.14.10.2).

MCOs are permitted to engage providers in payments reflected by Category 2B, providing

[3] The timeline for engaging in good faith negotiations between the MCOs and the Community Mental Health Programs regarding the Qualifying APMs for clients in the Medicaid program shall be July 1, 2019, and for Granite Advantage Health Care Program clients on July 1, 2020.

positive or negative incentives for reporting data, however, such APMs are not considered "qualifying" for purposes of meeting the 50% target.

Category 2C is met if the payment arrangement between the MCO and Participating Provider(s) rewards Participating Providers that perform well on quality metrics and/or penalizes Participating Providers that do not perform well on those metrics.

As described in the APM Framework:

> Payments are placed into **Category 2C** if they reward providers that perform well on quality metrics and/or penalize providers that do not perform well, thus providing a significant linkage between payment and quality. For example, providers may receive higher or lower updates to their FFS baseline, or they may receive a percent reduction or increase on all claims paid, depending on whether they meet quality goals. In some instances, these programs have an extensive set of performance measures that assess clinical outcomes, such as a reduction in emergency room visits for individuals with chronic illnesses or a reduction in hospital-acquired infections. Payments in this subcategory are not subject to rewards or penalties for provider performance against aggregate cost targets but may account for performance on a more limited set of utilization measures.[4]

HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C shall all also be considered Qualifying APMs, and the MCO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the DHHS Medicaid APM Strategy.

The following explanations from the APM Framework should provide guidance to the MCOs in developing and reporting on their APMs in Category 3.

> Payment models classified in Category 3 are based on an FFS architecture, while providing mechanisms for the effective management of a set of procedures, an episode of care, or all health services provided for individuals. To accomplish this, Category 3 payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. Additionally, payments in Category 3 are structured to encourage providers to deliver effective and efficient care. Episode-based and other types of bundled payments encourage care coordination because they cover a complete set of related services for a procedure that may be delivered by multiple providers. Clinical episode payments fall into Category 3 if they are tied to specific procedures.
>
> All Category 3 payments evaluate providers against financial benchmarks and, occasionally, utilization targets. The Category is further subdivided as follows:
> • In **Category 3A**, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets

[4] APM Framework, Refreshed 2017 http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

are met. However, providers do not need to compensate payers for a portion of the losses that result when cost or utilization targets are not met.
• In **Category 3B**, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. Additionally, payers recoup from providers a portion of the losses that result when cost or utilization targets are not met.[5]

The most important distinction between Category 3 and Category 4 payments is that the latter involve a single, predominantly prospective payment that encompasses a broad array of services, whereas providers participating in Category 3 models continue to be paid on an FFS basis with retrospective reconciliation after the period of performance. Additional conditions must be met before a payment model can be placed into Category 4. Specifically, Category 4 payments reflect the TCOC for treating a primary (typically chronic) condition (e.g., diabetes or cancer), a more limited set of specialty services (e.g., primary care or behavioral health), or comprehensive care for an entire population.[6]

Category 4 is subdivided into subcategories A, B, and C, as outlined below:
• **Category 4A** includes bundled payments for the comprehensive treatment of specific conditions. For example, bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering, for example, only chemotherapy payments. Additionally, prospective payments are classified in Category 4A if they are prospective and population-based, and also cover all care delivered by particular types of clinicians (e.g., primary care and orthopedics).
• Payments in **Category 4B** are prospective and population-based, and they cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct.
• Payments in **Category 4C** also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, while in other cases they consist of delivery systems that offer their own insurance products. To be effective, the finance and delivery arms will need to work in tandem to ensure that effective delivery investments are being made and that incentives and strategies within the organization are properly aligned. Additionally, it is important to note that when integrated lines of business comprise a portion of a company's portfolio, only the integrated payments count toward Category 4C.[7]

[5] Id. at 26-27
[6] Id. at 27.
[7] Id. at 28.

Transparency and Data Sharing

In order to engage providers and meet this DHHS APM Strategy, MCOs must provide necessary data and information to providers, including those providers who are not yet engaging, are in negotiations regarding or are participating in Qualifying APMs, to ensure providers' ability to successfully understand, assess, implement and meet the performance, quality and financial expectations included in the APM. MCOs shall make such data and information available to providers on a regular basis, in a consistent format, and as is reasonably requested. All information made available the providers shall be meaningful and actionable.

The MCO Contracts include detailed expectations to ensure MCOs are transparent with providers around data and information regarding APMs both during negotiations and during implementation. Such transparency includes providing meaningful, actionable and timely information about, but not limited to, the following:

- Member attribution model and methodology, including the process for changing attribution of members during the APM time period. In addition, if retroactive attribution is used, information clarifying how the APM considers the provider's inability to impact members that were not known to the provider until the retroactive attribution occurred;
- Detailed methodology for cost and/or utilization benchmarks or targets;
- Detailed methodology for setting quality measures, targets and/or benchmarks, including the process for changing the same during the agreement;
- Assessment of the potential rewards/penalties/risks associated with the APM;
- Outcomes or results associated with members who are attributed to the provider, including frequent updates to ensure the provider understands who he or she is accountable for and why;
- Risk adjustment methodology of the population as connected to the provider responsibilities in meeting the goals of the APM; and
- Regular, prospective gaps in care reporting to include utilization and triggered risk of members with potential impact to the provider meeting goals of the APM.

DHHS will actively ensure as part of its review of whether MCOs are "qualifying" as well as whether Exhibit O, APM 01, 02 and 03 are successfully complete, whether the MCO has meet its transparency and provider engagement obligations. Such obligations are a mandatory part of the MCO's APM Implementation Plan and implementation. (*see below*)

Reporting Requirements and Templates

APM Quarterly Reporting. MCOs must submit completed and updated APM Quarterly Updates to DHHS on a standard template showing the quarterly results of the APMs four months after the end of each quarter according to the Timeline set forth in this Guidance No. 1, on the MCO APM Quarterly Reporting Template provided by DHHS. DHHS reserves the right to ask questions and be provided timely responses regarding such template detail. (Exhibit O, APM.02)

APM Financial Reporting. MCOs must complete the APM HCP-LAN Assessment consistent with Exhibit O (APM.03). The MCO is responsible for accurately completing and submitting the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable) in a timely manner consistent with the Timeline set forth in this Guidance No. 1.

Penalties

Any penalties, liquidated damages, or other assessment based on the violation or non-compliance with the APM requirements set forth in Exhibit O as described herein shall be consistent with Exhibit N, and their assessment is in the sole discretion of DHHS.

APM Implementation Plan

Each MCO shall submit to DHHS for review and approval an APM Implementation Plan in accordance with Exhibit O. Such APM Implementation Plan shall include all elements identified in, and full and complete responses to, the APM Implementation Plan Template provided by DHHS.. (Exhibit O, APM.01)

DHHS expects that each MCO's APM Implementation Plan supports and reinforces other key MCO activities, including Quality Performance Targets, Quality Improvement Projects, Member Incentive Programs, and Provider Incentive Programs.

MCOs shall comply with the MCO Contract terms and 42 CFR 438.6(c)(1)(i) or (ii) in its APM strategy and implementation activities.

The APM Implementation Plan shall describe how MCOs expect to advance use of APMs over time (4.14.11) and shall include a plan to advance the capitated payment arrangements with CMHCs to include quality outcomes and flexibility by CMHCs to address social determinants of health.

If DHHS adds or modifies priorities or guidance after the Program Start Date, the MCO shall incorporate plans for addressing the new or modified priorities in the next regularly-scheduled submission of it APM Implementation Plan.

DHHS shall review APM Implementation Plans, respond to MCOs with questions and either approve or request further information.

Revision History

Activity Date	Version	Description of Activity	Author	Approved By
7/3/2019	053119_2	Draft release for comment	H. Lipman	H. Lipman
10/4/2019	20191004vF	Timeline updates; struck references to attachments available separately.	H. Lipman	H. Lipman

MCO Contracts -Excerpts
May 21, 2019

Alternative Payment Models (APM)

Compiled key excerpts from the 2019 Medicaid Care Management Services Contract
https://www.dhhs.nh.gov/business/rfp/documents/rfp-2019-oms-02-manag-exhibits.pdf
file:///C:/Users/lfl1008/Downloads/009%20GC%20Agenda%20041719.pdf

2. DEFINITIONS AND ACRONYMS

2.1 Definitions

2.1.65 MCO Alternative Payment Model (APM) Implementation Plan

2.1.65.1 "MCO Alternative Payment Model (APM) Implementation Plan" means the MCO's plan for meeting the APM requirements described in this Agreement. The MCO APM Implementation Plan shall be reviewed and approved by DHHS.

2.1.108 Qualifying APM

2.1.108.1 "Qualifying APM" means an APM approved by DHHS as consistent with the standards specified in this Agreement and in any subsequent DHHS guidance, including the DHHS Medicaid APM Strategy.

3. GENERAL TERMS AND CONDITIONS

3.7 CMS Approval of Agreement and Any Amendments

3.7.4 DHHS shall also submit to CMS for review and approval any Alternative Payment arrangements or other Provider payment arrangement initiatives based on DHHS's description of the initiatives submitted and approved outside of the Agreement. [42 CFR 438.6(c)]

3.15 Staffing

3.15.1 Key Personnel

3.15.1.1.4 Quality Improvement Director: Individual shall be responsible for all QAPI program activities.

3.15.1.1.4.1. Individual shall have relevant experience in quality management for physical and/or behavioral health care and shall participate in regular Quality Improvement meetings with DHHS and the other MCOs to review quality related initiatives and how those initiatives can be coordinated across the MCOs.

3.15.2 Other MCO Required Staff

3.15.2.2 Behavioral Health Clinical Providers to Minimize Psychiatric Boarding: The MCO shall supply a sufficient number of hospital-credentialed Providers in order to provide assessments and treatment for Members who are subject to, or at risk for, Psychiatric Boarding.

3.15.2.2.1 The number of such hospital-credentialed Providers shall be sufficient to provide initial on-site assistance within twelve (12) hours of a Member arriving at an ED and within twenty-four (24) hours of a Member being placed on observation or inpatient status to await an inpatient psychiatric bed.

3.15.2.2.2 The initial on-site assistance provided within these required timelines shall include a beneficiary-specific plan for discharge, treatment, admittance or transfer to New Hampshire Hospital, or another Designated Receiving Facility.

3.15.2.2.3 Each such hospital-credentialed Provider shall have the clinical expertise to reduce Psychiatric Boarding and possess or be trained on the resources, including local community resources, that can be deployed to discharge the Member safely to the community or to a step down facility when an inpatient stay is not clinically required.

3.15.2.3 Staff for Members at New Hampshire Hospital: The MCO shall designate an on-site liaison with privileges at New Hampshire Hospital to continue the Member's Care Management, and assist in facilitating a coordinated discharge planning process for Members admitted to New Hampshire Hospital.

4. PROGRAM REQUIREMENTS

4.1 Covered Populations and Services

4.1.7 Value-Added Services

4.1.7.1 The MCO may elect to offer Value-Added Services that are not covered in the Medicaid State Plan or under this Agreement in order to improve health outcomes, the quality of care, or reduce costs, in compliance with 42 CFR 438.3(e)(i).

4.1.7.2 Value-Added Services are services that are not currently provided under the Medicaid State Plan. The MCO may elect to add Value-Added Services not specified in the Agreement at the MCO's discretion, but the cost of these Value-Added Services shall not be included in Capitation Payment calculations. The MCO shall submit to DHHS an annual list of the Value-Added Services being provided.

4.9 Member Education and Incentives

4.9.4 Member Incentive Programs

4.9.4.1 The MCO shall develop at least one (1) Member Healthy Behavior Incentive Program and at least one (1) Reference-Based Pricing Incentive Program, as further described within this Section 4.9.4 (Member Incentive Programs) of the Agreement. The MCO shall ensure that all incentives deployed are cost-effective and have a linkage to the APM initiatives of the MCOs and Providers described in Section 4.14 (Alternative Payment Models) of this Agreement as appropriate.

4.9.4.6 Healthy Behavior Incentive Programs

4.9.4.6.1 The MCO shall develop and implement at least one (1) Member

Healthy Behavior Incentive Program designed to:

. . . .

4.9.4.6.1.2. Increase the timeliness of prenatal care, particularly for Members at risk of having a child with NAS;

4.11 Behavioral Health

4.11.1 General Coordination Requirements

4.11.1.12 Collaboration with DHHS

. . . .

4.11.1.12.2 To improve health outcomes for Members and ensure that delivery of services are provided at the appropriate intensity and duration, the MCO shall meet with behavioral health programs and DHHS at least four (4) times per year to discuss quality assurance activities conducted by the MCO, such as PIPs and APMs, and to review quality improvement plans and outstanding needs.

4.11.5 Mental Health

4.11.5.2 Payment to Community Mental Health Programs and Community Mental Health Providers

4.11.5.2.1 The MCO is required to enter into a capitated payment arrangement with CMH Programs to deliver Community Mental Health Services, providing for reimbursement on terms specified by DHHS in guidance.

4.11.5.2.2 The MCO shall reach agreements and enter into contracts with all CMH Programs that meet the terms specified by DHHS no later than ninety (90) calendar days after Agreement execution.

4.11.5.2.2.1. For the purposes of this paragraph, Agreement execution means that the Agreement has been signed by the MCO and the State, and approved by all required State authorities and is generally expected to occur in January 2019.

4.11.5.6 Mental Health Performance Improvement Project

4.11.5.6.1 As outlined in Section 4.12.3.7 (Performance Improvement Projects), the MCO shall engage in at least one (1) mental health PIP. The MCO shall satisfy this requirement by implementing a PIP designed to reduce Psychiatric Boarding in the ED.

4.11.6 Substance Use Disorder

4.11.6.5 Payment to Substance Use Disorder Providers

4.11.6.5.1 The MCO shall reimburse Substance Use Disorder Providers in accordance with rates that are no less than the equivalent DHHS FFS rates.

4.11.6.5.2 The MCO need not pay using DHHS's FFS mechanism where the MCO's contract with the Provider meets the following requirements:

4.11.6.5.2.1. Is subject to enhanced reimbursement for MAT, as described in as outlined in this section; or

4.11.6.5.2.2. Falls under a DHHS-approved APM, the standards and requirements for obtaining DHHS approval are further described in Section 4.14 (Alternative Payment Models).

4.11.6.5.3 DHHS shall provide the MCO with sixty (60) calendar days' advance notice prior to any change to reimbursement.

4.11.6.5.4 In accordance with Exhibit O, the MCO shall develop and submit to DHHS, a payment plan for offering enhanced reimbursement to qualified physicians who are SAMHSA certified to dispense or prescribe MAT.

4.11.6.5.5 The plan shall indicate at least two (2) tiers of enhanced payments that the MCO shall make to qualified Providers based on whether Providers are certified and providing MAT to up to thirty (30) Members per quarter (i.e., tier one (1) Providers) or certified and providing MAT to up to one hundred (100) Members per quarter (i.e., tier two (2) Providers).

4.11.6.5.6 The tier determinations that qualify Providers for the MCO's enhanced reimbursement policy shall reflect the number of Members to whom the Provider is providing MAT treatment services, not the number of patients the Provider is certified to provide MAT treatment to.

4.11.6.5.7 The MCO shall develop at least one (1) APM designed to increase access to MAT for Substance Use Disorder and one (1) APM (such as a bundled payment) for the treatment of babies born with NAS.

4.12 Quality Management

4.12.3 Quality Assessment and Performance Improvement Program

4.12.3.7 Performance Improvement Projects

4.12.3.7.2 Annually, the MCO shall conduct at least three (3) clinical PIPs that meet the following criteria [42 CFR 438.330(d)(1)]:

4.12.3.7.2.1. At least one (1) clinical PIP shall have a focus on reducing Psychiatric Boarding in the ED for Medicaid enrollees (regardless of whether they are Medicaid-Medicare dual individuals), as defined in Section 4.11.5 (Mental Health);

4.12.3.7.2.2. At least one (1) clinical PIP shall have a focus on Substance Use Disorder, as defined in Section 4.11.6 (Substance Use Disorder);

4.12.3.7.2.3. At least (1) clinical PIP shall focus on improving quality performance in an area that the MCO performed lower than the fiftieth

(50th) percentile nationally, as documented in the most recent EQRO technical report or as otherwise indicated by DHHS.

4.12.3.7.3 Annually, the MCO shall conduct at least one (1) nonclinical PIP, which shall be related to one (1) of the following topic areas and approved by DHHS:

4.12.3.7.3.1. Addressing social determinants of health;

4.12.3.7.3.2. Integrating physical and behavioral health.

4.13 Network Management

4.13.5 Provider Contract Requirements

4.13.5.1 General Provisions

. . . .

4.13.5.1.10 The MCO shall include in Provider contracts a requirement securing cooperation with the QAPI program, and shall align the QAPI program to other MCO Provider initiatives, including Advanced Payment Models (APMs), further described in Section 4.14 (Alternative Payment Models).

4.13.5.12 Payment Models

4.13.5.12.1 The MCO shall negotiate rates with Providers in accordance with Section 4.14 (Alternative Payment Models) and Section 4.15 (Provider Payments) of this Agreement, unless otherwise specified by DHHS (e.g., for Substance Use Disorder Provider rates).

4.14 Alternative Payment Models

4.14.1 As required by the special terms and conditions of The NH Building Capacity for Transformation waiver, NH is implementing a strategy to expand use of APMs that promote the goals of the Medicaid program to provide the right care at the right time, and in the right place through the delivery of high-quality, cost-effective care for the whole person, and in a manner that is transparent to DHHS, Providers, and the stakeholder community.

4.14.2 In developing and refining its APM strategy, DHHS relies on the framework established by the Health Care Payment Learning and Action Network APM framework (or the "HCP-LAN APM framework") in order to:

4.14.2.1 Clearly and effectively communicate DHHS requirements through use of the defined categories established by HCP-LAN;
4.14.2.2 Encourage the MCO to align MCM APM offerings to other payers' APM initiatives to minimize Provider burden; and
4.14.2.3 Provide an established framework for monitoring MCO performance on APMs.

4.14.3 Prior to and/or over the course of the Term of this Agreement, DHHS shall develop the

DHHS Medicaid APM Strategy, which may result in additional guidance, templates, worksheets and other materials that elucidate the requirements to which the MCO is subject under this Agreement.

4.14.4 Within the guidance parameters established and issued by DHHS and subject to DHHS approval, the MCO shall have flexibility to design Qualifying APMs (as defined in Section 4.14 of this Agreement) consistent with the DHHS Medicaid APM strategy and in conformance with CMS guidance.

4.14.5 The MCO shall support DHHS in developing the DHHS Medicaid APM Strategy through participation in stakeholder meetings and planning efforts, providing all required and otherwise requested information related to APMs, sharing data and analysis, and other activities as specified by DHHS.

4.14.6 For any APMs that direct the MCO's expenditures under 42 CFR 438.6(c)(1)(i) or (ii), the MCO and DHHS shall ensure that it:

4.14.6.1 Makes participation in the APM available, using the same terms of performance, to a class of Providers providing services under the contract related to the reform or improvement initiative;

4.14.6.2 Uses a common set of performance measures across all the Providers;

4.14.6.3 Does not set the amount or frequency of the expenditures; and

4.14.6.4 Does not permit DHHS to recoup any unspent funds allocated for these arrangements from the MCO. [42 CFR 438.6(c)]

4.14.7 Required Use of Alternative Payment Models Consistent with the New Hampshire Building Capacity for Transformation Waiver

4.14.7.1 Consistent with the requirements set forth in the special terms and conditions of NH's Building Capacity for Transformation waiver, the MCO shall ensure through its APM Implementation Plan (as described in Section 4.14) that fifty percent (50%) of all MCO medical expenditures are in Qualifying APMs, as defined by DHHS, within the first twelve (12) months of this Agreement, subject to the following exceptions:

4.14.7.1.1 If the MCO is newly participating in the MCM program as of the Program Start Date, the MCO shall have eighteen (18) months to meet this requirement; and

4.14.7.1.2 If the MCO determines that circumstances materially inhibit its ability to meet the APM implementation requirement, the MCO shall detail to DHHS in its proposed APM Implementation Plan an extension request: the reasons for its inability to meet the requirements of this section and any additional information required by DHHS.

4.14.7.1.2.1. If approved by DHHS, the MCO may use its alternative approach, but only for the period of time requested and approved by DHHS, which is not to exceed an additional six (6) months after the initial 18 month period.

4.14.7.1.2.2. For failure to meet this requirement, DHHS reserves to right to issue remedies as described in Section 5.5.2 (Liquidated Damages) and Exhibit N, Section 3.2 (Liquidated Damages Matrix).

4.14.7.2 MCO Incentives and Penalties for APM Implementation

4.14.7.2.1 Consistent with RSA 126-AA, the MCO shall include, through APMs and other means, Provider alignment incentives to leverage the combined DHHS, MCO, and providers to achieve the purpose of the incentives.

4.14.7.2.2 MCOs shall be subject to incentives, at DHHS' sole discretion, and/or penalties to achieve improved performance, including preferential auto-assignment of new members, use of the MCM Withhold and Incentive Program (including the shared incentive pool), and other incentives.

4.14.8 Qualifying Alternative Payment Models

4.14.8.1 A Qualifying APM is a payment approach approved by DHHS as consistent with the standards specified in this Section (Qualifying Alternative Payment Models) and the DHHS Medicaid APM Strategy.

4.14.8.2 At minimum, a Qualifying APM shall meet the requirements of the HCP-LAN APM framework Category 2C, based on the refreshed 2017 framework released on July 11, 2017 and all subsequent revisions.

4.14.8.3 As indicated in the HCP-LAN APM framework white paper, Category 2C is met if the payment arrangement between the MCO and Participating Provider(s) rewards Participating Providers that perform well on quality metrics and/or penalizes Participating Providers that do not perform well on those metrics.

4.14.8.4 HCP-LAN Categories 3A, 3B, 4A, 4B, and 4C shall all also be considered Qualifying APMs, and the MCO shall increasingly adopt such APMs over time in accordance with its APM Implementation Plan and the DHHS Medicaid APM Strategy.

4.14.8.5 DHHS shall determine, on the basis of the Standardized Assessment of APM Usage described in Section 4.14.10.2 (Standardized Assessment of Alternative Payment Model Usage) below and the additional information available to DHHS, the HCP-LAN Category to which the MCO's APM(s) is/are aligned.

4.14.8.6 Under no circumstances shall DHHS consider a payment methodology that takes cost of care into account without also considering quality a Qualifying APM.

4.14.8.7 Standards for Large Providers and Provider Systems

4.14.8.7.1 The MCO shall predominantly adopt a total cost of care model with shared savings for large Provider systems to the maximum extent feasible, and as further defined by the DHHS Medicaid APM Strategy.

4.14.8.8 Treatment of Payments to Community Mental Health Programs

4.14.8.8.1 The CMH Program payment model prescribed by DHHS in Section

4.11.5.1 (Contracting for Community Mental Health Services) shall be deemed to meet the definition of a Qualifying APM under this Agreement.

4.14.8.8.2 At the sole discretion of DHHS, additional payment models specifically required by and defined as an APM by DHHS shall also be deemed to meet the definition of a Qualifying APM under this Agreement.

4.14.8.9 Accommodations for Small Providers

4.14.8.9.1 The MCO shall develop Qualifying APM models appropriate for small Providers, as further defined by the DHHS Medicaid APM Strategy.

4.14.8.9.2 For example, the MCO may propose to DHHS models that incorporate pay-for-performance bonus incentives and/or per Member per month payments related to Providers' success in meeting actuarially-relevant cost and quality targets.

4.14.8.10 Alignment with Existing Alternative Payment Models and Promotion of Integration with Behavioral Health

4.14.8.10.1 The MCO shall align APM offerings to current and emerging APMs in NH, both within Medicaid and across other payers (e.g., Medicare and commercial shared savings arrangements) to reduce Provider burden and promote the integration of Behavioral Health.

4.14.8.10.2 The MCO shall incorporate APM design elements into its Qualifying APMs that permit Participating Providers to attest to participation in an "Other Payer Advanced APM" (including but not limited to a Medicaid Medical Home Model) under the requirements of the Quality Payment Program as set forth by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

4.14.9 MCO Alternative Payment Model Implementation Plan

4.14.9.1 The MCO shall submit to DHHS for review and approval an APM Implementation Plan in accordance with Exhibit O.

4.14.9.2 The APM Implementation Plan shall meet the requirements of this section and of any subsequent guidance issued as part of the DHHS Medicaid APM Strategy.

4.14.9.3 Additional details on the timing, format, and required contents of the MCO APM Implementation Plan shall be specified by DHHS in Exhibit O and/or through additional guidance.

4.14.9.4 Alternative Payment Model Transparency

4.14.9.4.1 The MCO shall describe in its APM Implementation Plan, for each APM offering and as is applicable, the actuarial and public health basis for the MCO's methodology, as well as the basis for developing and assessing Participating Provider performance in the APM, as described in Section 4.14.10 (Alternative Payment Model Transparency and Reporting Requirements). The APM Implementation Plan shall also outline how integration is promoted by the

model among the MCO, Providers, and Members.

4.14.9.5 Provider Engagement and Support

4.14.9.5.1 The APM Implementation Plan shall describe a logical and reasonably achievable approach to implementing APMs, supported by an understanding of NH Medicaid Providers' readiness for participation in APMs, and the strategies the MCO shall use to assess and advance such readiness over time.

4.14.9.5.2 The APM Implementation Plan shall outline in detail what strategies the MCO plans to use, such as, meetings with Providers and IDNs, as appropriate, and the frequency of such meetings, the provision of technical support, and a data sharing strategy for Providers reflecting the transparency, reporting and data sharing obligations herein and in the DHHS Medicaid APM Strategy.

4.14.9.5.3 The MCO APM Implementation Plan shall ensure Providers and IDNs, as appropriate, are supported by data sharing and performance analytic feedback systems and tools that make actuarially sound and actionable provider level and system level clinical, cost, and performance data available to Providers in a timely manner for purposes of developing APMs and analyzing performance and payments pursuant to APMs.

4.14.9.5.4 MCO shall provide the financial support for the Provider infrastructure necessary to develop and implement APM arrangements that increase in sophistication over time.

4.14.9.6 Implementation Approach

4.14.9.6.1 The MCO shall include in the APM Implementation Plan a detailed description of the steps the MCO shall take to advance its APM Implementation Plan:

4.14.9.6.1.1. In advance of the Program Start Date;

4.14.9.6.1.2. During the first year of this Agreement; and

4.14.9.6.1.3. Into the second year and beyond, clearly articulating its long-term vision and goals for the advancement of APMs over time.

4.14.9.6.2 The APM Implementation Plan shall include the MCO's plan for providing the necessary data and information to participating APM Providers to ensure Providers' ability to successfully implement and meet the performance expectations included in the APM, including how the MCO shall ensure that the information received by Participating Providers is meaningful and actionable.

4.14.9.6.3 The MCO shall provide data to Providers and IDNs, as appropriate, that describe the retrospective cost and utilization patterns for Members, which shall inform the strategy and design of APMs.

4.14.9.6.4 For each APM entered into, the MCO shall provide timely and

actionable cost, quality and utilization information to Providers participating in the APM that enables and tracks performance under the APM.

4.14.9.6.5 In addition, the MCO shall provide Member and Provider level data (e.g., encounter and claims information) for concurrent real time utilization and care management interventions.

4.14.9.6.6 The APM Implementation Plan shall describe in example form to DHHS the level of information that shall be given to Providers that enter into APM Agreements with the MCO, including if the level of information shall vary based on the Category and/or type of APM the Provider enters.

4.14.9.6.7 The information provided shall be consistent with the requirements outlined under Section 4.14.10 (Alternative Payment Model Transparency and Reporting Requirements). The MCOs shall utilize all applicable and appropriate agreements as required under State and federal law to maintain confidentiality of protected health information.

4.14.10 Alternative Payment Model Transparency and Reporting Requirements

4.14.10.1 Transparency

4.14.10.1.1 In the MCO APM Implementation Plan, the MCO shall provide to DHHS for each APM, as applicable, the following information at a minimum:

4.14.10.1.1.1. The methodology for determining Member attribution, and sharing information on Member attribution with Providers participating in the corresponding APM;

4.14.10.1.1.2. The mechanisms used to determine cost benchmarks and Provider performance, including cost target calculations, the attachment points for cost targets, and risk adjustment methodology;

4.14.10.1.1.3. The approach to determining quality benchmarks and evaluating Provider performance, including advance communication of the specific measures that shall be used to determine quality performance, the methodology for calculating and assessing Provider performance, and any quality gating criteria that may be included in the APM design; and

4.14.10.1.1.4. The frequency at which the MCO shall regularly report cost and quality data related to APM performance to Providers, and the information that shall be included in each report.

4.14.10.1.2 Additional information may be required by DHHS in supplemental guidance. All information provided to DHHS shall be made available to Providers eligible to participate in or already participating in the APM unless the MCO requests and receives DHHS approval for specified information not to be made available.

4.14.10.2 Standardized Assessment of Alternative Payment Model Usage

4.14.11 Development Period for MCO Implementation

4.14.11.1 Consistent with the requirements for new MCOs, outlined in Section 4.14.8 (Qualifying Alternative Payment Models) above, DHHS acknowledges that MCOs may require time to advance their MCO Implementation Plan. DHHS shall provide additional detail, in its Medicaid APM Strategy, that describes how MCOs should expect to advance use of ADPMs over time.

4.14.12 Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters

4.14.12.1 The MCO's APM Implementation Plan shall indicate the quantitative, measurable clinical outcomes the MCO seeks to improve through its APM initiative(s).

4.14.12.2 At a minimum, the MCO shall address the priorities identified in this Section 4.14.12 (Alternative Payment Model Alignment with State Priorities and Evolving Public Health Matters) and all additional priorities identified by DHHS in the DHHS Medicaid APM Strategy.

4.14.12.3 State Priorities in RSA 126-AA

4.14.12.3.1 The MCO's APM Implementation Plan shall address the following priorities:

4.14.12.3.1.1. Opportunities to decrease unnecessary service utilization, particularly as related to use of the ED, especially for Members with behavioral health needs and among low-income children;

4.14.12.3.1.2. Opportunities to reduce preventable admissions and thirty (30)-day hospital readmission for all causes;

4.14.12.3.1.3. Opportunities to improve the timeliness of prenatal care and other efforts that support the reduction of NAS births;

4.14.12.3.1.4. Opportunities to better integrate physical and behavioral health, particularly efforts to increase the timeliness of follow-up after a mental illness or Substance Use Disorder admission; and efforts aligned to support and collaborate with IDNs to advance the goals of the Building Capacity for Transformation waiver;

4.14.12.3.1.5. Opportunities to better manage pharmacy utilization, including through Participating Provider incentive arrangements focused on efforts such as increasing generic prescribing and efforts aligned to the MCO's Medication Management program aimed at reducing polypharmacy, as described in Section 4.2.5 (Medication Management);

4.14.12.3.1.6. Opportunities to enhance access to and the effectiveness of Substance Use Disorder treatment (further addressed in Section 4.11.6.5 (Payment to Substance Use Disorder Providers) of this Agreement); and

4.14.12.3.1.7. Opportunities to address social determinants of health (further addressed in Section 4.10.10 (Coordination and Integration with Social Services and Community Care) of this Agreement), and in particular to address "ED boarding," in which Members that would be best treated in the community remain in the ED.

4.14.12.4 Alternative Payment Models for Substance Use Disorder Treatment

4.14.12.4.1 As is further described in Section 4.11.6.5 (Payment to Substance Use Disorder Providers), the MCO shall include in its APM Implementation Plan:

4.14.12.4.1.1. At least one (1) APM that promotes the coordinated and cost-effective delivery of high-quality care to infants born with NAS; and

4.14.12.4.1.2. At least one (1) APM that promotes greater use of Medication-Assisted Treatment.

4.14.12.5 Emerging State Medicaid and Public Health Priorities

4.14.12.5.1 The MCO shall address any additional priorities identified by DHHS in the Medicaid APM Plan or related guidance.

4.14.12.5.2 If DHHS adds or modifies priorities after the Program Start Date, the MCO shall incorporate plans for addressing the new or modified priorities in the next regularly-scheduled submission of it APM Implementation Plan.

4.14.13 Physician Incentive Plans

4.14.13.1 The MCO shall submit all Physician Incentive Plans to DHHS for review as part of its APM Implementation Plan or upon development of Physician Incentive Plans that are separate from the MCO's APM Implementation Plan.

4.14.13.2 The MCO shall not implement Physician Incentive Plans until they have been reviewed and approved by DHHS.

4.14.13.3 Any Physician Incentive Plan, including those detailed within the MCO's APM Implementation Plan, shall be in compliance with the requirements set forth in 42 CFR 422.208 and 42 CFR 422.210, in which references to "MA organization," "CMS," and "Medicare beneficiaries" should be read as references to "MCO," "DHHS," and "Members," respectively. These include that:

4.14.13.3.1 The MCO may only operate a Physician Incentive Plan if no specific payment can be made directly or indirectly under a Physician Incentive Plan to a physician or Physician Group as an incentive to reduce or limit Medically Necessary Services to a Member [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR 422.208(c)(1)-(2); 42 CFR 438.3(i)]; and

4.14.13.3.2 If the MCO puts a physician or Physician Group at substantial financial risk for services not provided by the physician or Physician Group, the MCO shall ensure that the physician or Physician Group has adequate stop-loss protection. [Section 1903(m)(2)(A)(x) of the Social Security Act; 42 CFR

422.208(c)(2); 42 CFR 438.3(i)]

4.14.13.4 The MCO shall submit to DHHS annually, at the time of its annual HCP-LAN assessment, a detailed written report of any implemented (and previously reviewed) Physician Incentive Plans, as described in Exhibit O.

4.14.13.5 Annual Physician Incentive Plan reports shall provide assurance satisfactory to DHHS that the requirements of 42 CFR 438.208 are met. The MCO shall, upon request, provide additional detail in response to any DHHS request to understand the terms of Provider payment arrangements.

4.14.13.6 The MCO shall provide to Members upon request the following information:

4.14.13.6.1 Whether the MCO uses a Physician Incentive Plan that affects the use of referral services;

4.14.13.6.2 The type of incentive arrangement; and

4.14.13.6.3 Whether stop-loss protection is provided. [42 CFR 438.3(i)]

4.15 Provider Payments

4.15.3 Federally Qualified Health Centers and Rural Health Clinics

4.15.3.1 FQHCs and RHCs shall be paid at minimum the encounter rate paid by DHHS at the time of service, and shall also be paid for DHHS-specified CPT codes outside of the encounter rates.

4.15.3.2 The MCO shall not provide payment to an FQHC or RHC that is less than the level and amount of payment which the MCO would make for the services if the services were furnished by a Provider which is not an FQHC or RHC. [Section 1903(m)(2)(A)(ix) of the Social Security Act]

4.15.3.3 The MCO shall enter into Alternative Payment Models with FQHCs, RHCs, and/or other health or family planning clinics or their designated contracting organizations as negotiated and agreed upon with DHHS in the MCO's APM Implementation Plan and as described by DHHS in the Medicaid APM Strategy.

EXHIBIT N – Liquidated Damages Matrix

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
3. LEVEL 3 MCO action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program.	3.2 Failure to submit to DHHS within the specified timeframes all required plans, documentation, and reporting related to the implementation of Alternative Payment Model requirements	$10,000 per week of violation

NH Medicaid DSRIP Member Months of Eligibility for Quarters 2016 Q1 - 2019 Q4

Source: MMIS data as of 1/28/2020

2016 Q1: 1/1/16 - 3/31/16

Year	Month	Eligibility Days	Days in Month	Member Months
2016	1*	3,276,469	27	121,351
2016	2	3,516,262	29	121,250
2016	3	3,756,815	31	121,188
2016 Q1 Total				**363,789**

2016 Q2: 4/1/16 - 6/30/16

Year	Month	Eligibility Days	Days in Month	Member Months
2016	4	3,625,073	30	120,836
2016	5	3,722,979	31	120,096
2016	6	3,589,200	30	119,640
2016 Q2 Total				**360,572**

2016 Q3: 7/1/16 - 9/30/16

Year	Month	Eligibility Days	Days in Month	Member Months
2016	7	3,678,159	31	118,650
2016	8	3,663,996	31	118,193
2016	9	3,536,109	30	117,870
2016 Q3 Total				**354,714**

2016 Q4: 10/1/16 - 12/31/16

Year	Month	Eligibility Days	Days in Month	Member Months
2016	10	3,676,376	31	118,593
2016	11	3,534,450	30	117,815
2016	12	3,605,578	31	116,309
2016 Q4 Total				**352,717**

2017 Q1: 1/1/17 - 3/31/17

Year	Month	Eligibility Days	Days in Month	Member Months
2017	1	3,590,576	31	115,825
2017	2	3,240,251	28	115,723
2017	3	3,589,893	31	115,803
2017 Q1 Total				**347,351**

2017 Q2: 4/1/17 - 6/30/17

Year	Month	Eligibility Days	Days in Month	Member Months
2017	4	3,465,673	30	115,522
2017	5	3,570,134	31	115,166
2017	6	3,449,608	30	114,987
2017 Q2 Total				**345,675**

2017 Q3: 7/1/17 - 9/30/17

Year	Month	Eligibility Days	Days in Month	Member Months
2017	7	3,549,878	31	114,512
2017	8	3,546,693	31	114,409
2017	9	3,425,796	30	114,193
2017 Q3 Total				**343,115**

2017 Q4: 10/1/17 - 12/31/17

Year	Month	Eligibility Days	Days in Month	Member Months
2017	10	3,531,684	31	113,925
2017	11	3,407,371	30	113,579
2017	12	3,516,300	31	113,429
2017 Q4 Total				**340,933**

2018 Q1: 1/1/18 - 3/31/18

Year	Month	Eligibility Days	Days in Month	Member Months
2018	1	3,526,203	31	113,748
2018	2	3,180,702	28	113,597
2018	3	3,513,531	31	113,340
2018 Q1 Total				**340,685**

NH Medicaid DSRIP Member Months of Eligibility for Quarters 2016 Q1 - 2019 Q4

Source: MMIS data as of 1/28/2020

2018 Q2: 4/1/18 - 6/30/18

Year	Month	Eligibility Days	Days in Month	Member Months
2018	4	3,390,093	30	113,003
2018	5	3,490,419	31	112,594
2018	6	3,359,135	30	111,971
2018 Q2 Total				**337,568**

2018 Q3: 7/1/18 - 9/30/18

Year	Month	Eligibility Days	Days in Month	Member Months
2018	7	3,460,352	31	111,624
2018	8	3,443,727	31	111,088
2018	9	3,314,355	30	110,479
2018 Q3 Total				**333,191**

2018 Q4: 10/1/18 - 12/31/18 (updated from prior report)

Year	Month	Eligibility Days	Days in Month	Member Months
2018	10**	3,332,722	31	107,507
2018	11	3,214,855	30	107,162
2018	12	3,316,711	31	106,991
2018 Q4 Total				**321,660**

2019 Q1: 1/1/19 - 3/31/19 (updated from prior report)

Year	Month		Days in Month	Member Months
2019	1	3,304,959	31	106,612
2019	2	2,974,737	28	106,241
2019	3	3,301,173	31	106,489
2019 Q1 Total				**319,342**

2019 Q2: 4/1/19 - 6/30/19 (updated from prior report)

Year	Month		Days in Month	Member Months
2019	4	3,180,221	30	106,007
2019	5	3,271,824	31	105,543
2019	6	3,151,254	30	105,042
2019 Q2 Total				**316,592**

2019 Q3: 7/1/19 - 9/30/19 (updated from prior report)

Year	Month		Days in Month	Member Months
2019	7	3,250,349	31	104,850
2019	8	3,257,212	31	105,071
2019	9	3,147,932	30	104,931
2019 Q3 Total				**314,852**

2019 Q4: 10/1/19 - 12/31/19

Year	Month	Eligibility Days	Days in Month	Member Months
2019	10	3,239,728	31	104,507
2019	11	3,118,429	30	103,948
2019	12	3,205,064	31	103,389
2019 Q4 Total				**311,844**

Notes:

* Waiver began on 1/5/16, resulting in 27 days in January.

1. Excludes all members in Granite Advantage - Medicaid Expansion, CHIP, 64.9T, Family Planning Only Program, and non-QMB Medicare Savings Programs.
2. Enrollment data is subject to change and includes retroactive eligibility.

** Beginning in October 2018, approximately 2.5 thousand additional 64.9T members were reported to CMS for enhanced match. They were not reported previously due to a system issue that was dropping some of the population. Impacted months have been adjusted, resulting in a similar decrease in member months.

DSRIP CY 2019 Q4 - Quarterly Enrollment Changes

Source: MMIS enrollment data as of 1/27/2020

IDN	IDN Attributed Population[1]	Newly Enrolled in Current Quarter[2]	Disenrolled in Current Quarter	Current Enrollees: Year to Date[3]
1	27,581	2,226	2,178	27,629
2	17,356	1,646	1,412	17,590
3	24,302	2,145	2,004	24,443
4	45,328	3,686	3,392	45,622
5	16,226	1,442	1,276	16,392
6	31,927	2,721	2,693	31,955
7	17,504	1,513	1,442	17,575
Total	**180,224**	**15,379**	**14,397**	**181,206**

Notes:

1. Attributed population includes 165,436 members from the 6/30/2019 Outcome Attribution who were attributed through claims and geography and were Medicaid Eligible on 10/1/2019, and 14,788 members newly enrolled between 10/1/2019 and 12/31/2019 who were attributed through geography only.
2. Newly Enrolled population includes members who were attributed on 6/30/2019, but were not eligible as of 10/1/2019, and became eligible later in the quarter.
3. Current population are members who were Medicaid Eligible on 12/31/2019.

Amounts Reported By Quarter On CMS-64 DSHP Waiver Line 49

QE	DSHP Total Computable and Cap Earned DSRIP			DSHP Cap Earned / Used / Balance / for DSRIP			DSRIP Column Spend by Source of Funds			
	Amount - Total Computable	Amount - DSHP Cap Earn for DSRIP	Cumulative - DSHP Cap Earn for DSRIP	Col C DSHP Cap Earn for DSRIP	DSHP Cap Earn for DSRIP Used	DSHP Cap Earn for DSRIP Balance	Total Funds Spent	Federal Funds	DSHP Cap Earn for DSRIP Used	County Funds Used
3/31/2016	$0	$0	$0	$0	$0	$0	$0	$0	$0	
6/30/2016	$12,361,921	$6,180,961	$6,180,961	$6,180,961	$0	$6,180,961	$0	$0	$0	
9/30/2016	$9,669,565	$4,834,782.36	$11,015,743	$4,834,782	$10,020,436	$995,307	$20,040,872	$10,020,436	$10,020,436	
12/31/2016	$3,841,698	$1,920,849.17	$12,936,592	$1,920,849	$85,989	$2,830,167	$171,978	$85,989	$85,989	
3/31/2017	$6,903,609	$3,451,804.64	$16,388,397	$3,451,805	$2,746,955	$3,535,017	$5,493,910	$2,746,955	$2,746,955	
6/30/2017	$6,627,039	$3,313,520	$19,701,916	$3,313,520	$302,189	$6,546,347	$604,378	$302,189	$302,189	
9/30/2017	$1,963,083	$981,542	$20,683,458	$981,542	$175,868	$7,352,021	$351,736	$175,868	$175,868	
12/31/2017	$2,803,906	$1,401,953	$22,085,411	$1,401,953	$6,907,055	$1,846,919	$13,814,110	$6,907,055	$6,907,055	
3/31/2018	$3,765,738	$1,882,869	$23,968,281	$1,882,869	$214,696	$3,515,093	$429,393	$214,696	$214,696	
6/30/2018	$4,420,406	$2,210,202.93	$26,178,483	$2,210,203	$3,661,437	$2,063,858	$7,322,873	$3,661,437	$3,661,437	
9/30/2018	$0	$0	$26,178,483	$0	$974,825	$1,089,033	$1,949,649	$974,825	$974,825	
12/31/2018	$0	$0	$26,178,483	$0	$139,637	$949,396	$279,274	$139,637	$139,637	
3/31/2019	$2,548,902	$1,273,750	$27,452,233	$1,273,750	$151,372	$2,071,774	$302,745	$151,372	$151,372	
6/30/2019	$2,664,893	$1,332,446	$28,784,680	$1,332,446	$2,355,373	$0	$17,485,336	$8,742,668	$2,355,373	$6,387,295
9/30/2019	$2,079,210	$1,039,605	$29,824,285	$1,039,605	$147,526	$892,079	$295,052	$147,526	$147,526	
12/31/2019	($149,914)	($74,957)	$29,749,328	($74,957)	$145,025	$672,097	$290,050	$145,025	$145,025	