



STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

MARGARET WOOD HASSAN
Governor

July 21, 2014

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Dear Mr. Nah:

I am pleased to submit this letter of endorsement on behalf of the State of New Hampshire's application for the *State Innovation Models: Round Two of Funding for Design and Test Assistance*.

In the last 18 months, New Hampshire has undertaken three important efforts to improve and enhance our state's care delivery and payment systems: 1) establishing the New Hampshire Health Protection Program that will expand health coverage to more than 50,000, additional residents, and help make our health insurance market more competitive; 2) implementing high-quality patient-centered care for the Medicaid population through the Care Management Program with support and guidance of a Medicaid Care Management Commission that I established; and 3) making landmark investments in rebuilding and improving our mental health system.

I enthusiastically support this application led by the NH Department of Health & Human Services (DHHS) for Round Two of the Design Assistance because it will help us move to the next level of integrating care in our New Hampshire healthcare communities, and reducing the growth in costs across all of our health care systems.

With the resources provided by the Center for Medicare & Medicaid Innovation, we plan to focus on our providers who are integral to our systems of care but operate in rural or fragmented service areas. We will bring together a number of individuals, agencies and organizations to use State Innovation Model (SIM) funding to design a model that assists those on the frontlines of health care delivery to access and develop the infrastructure they need in this rapidly changing environment. Our approach recognizes the unique innovative capacity, infrastructure needs and public health goals at the regional and community level in ensuring that every citizen has access to high-quality, coordinated care. We want our system to be able to fully engage in system reform that will result in improving our population's health through evidence based practices.

The concept of using Regional Healthcare Cooperative Extensions is new to health care but not a new concept in system improvement. We look forward to exploring emerging models and tailoring one that will meet the challenges and opportunities in bringing together the population health and medical communities.

I am designating the NH DHHS as the lead agency for the Model Design application. A senior member of my staff will also serve on the Steering Committee of Round Two Design project. If you have any questions, please contact DHHS Public Health Director Jose Montero at 603-271-4612.

We look forward to the opportunity to develop a State Health Care Innovation Plan to achieve real health system reform in New Hampshire through an innovative delivery and payment system.

With every good wish,

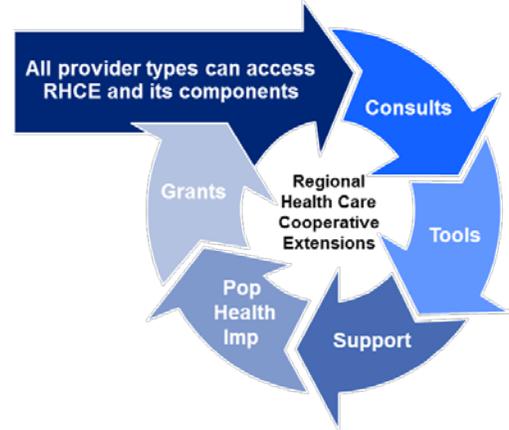


Margaret Wood Hassan
Governor

Project Abstract

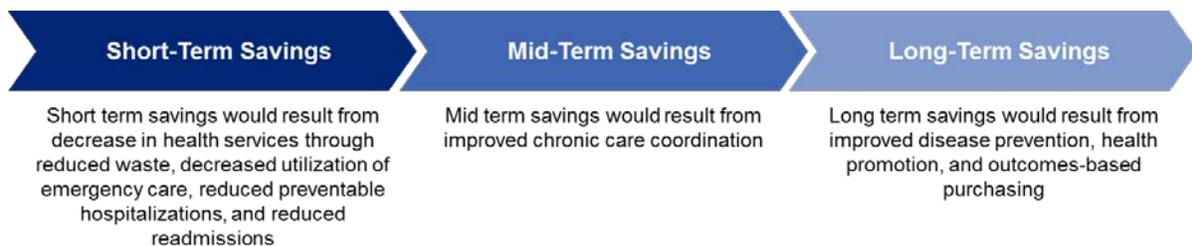
Just as a century ago the agricultural extensions guided and transformed individual farmers and farming practices in eliminating inefficiencies and food scarcity, the State of New Hampshire proposes transforming the State’s fragmented health care delivery system into a highly functional health care system through the development and use of Regional Healthcare Cooperative Extensions (RHCE). The RHCE will (1) champion health care systems engineering (HSE), (2) expand the use of information technologies, and (3) lead local population health improvement.

The New Hampshire Department of Health and Human Services (DHHS) will design the RHCEs to serve as “hubs” from which providers can access health care systems engineers and tools. Health systems engineers would offer consultation, technical assistance, and ongoing implementation support, including small grants to facilitate changes. These activities would serve as incentives for individual practitioners, organizations, and health care service providers of all types to participate in this opportunity to learn systems design, analysis, and control methods and apply these methods to improve the performance of their practices.



Additionally, DHHS’s SIM Model Design will also focus on mechanisms to increase the collection, exchange, and use of data. The combined results of HSE and improvements in communication and information technology will markedly improve the dynamic of health care delivery and decrease pre-capita health care spending. RHCE stakeholder collaborations will also explore multiple determinants of health, and the integration of health services and community resources as a part of population health improvement programs. RHCE population health improvements will be local solutions initially targeting tobacco use, obesity, and diabetes and subsequently addressing the state’s public health improvement plan priorities.

The reductions in inefficiencies and improvements in effectiveness as a result of three components of the RHCE will provide immediate cost savings to be reallocated to support population health improvement initiatives, and longer term improvements in population health will support sustained cost savings.



DHHS plans to expand upon the robust stakeholder process demonstrated in Round One of SIM to design this model alongside other State agencies, providers, payers, community members, advocates, academics and the Governor’s SIM Advisory Board, and is requesting \$2.2M in SIM funding from CMS to transform health care delivery in the State of New Hampshire.

Project Narrative

There may be debate as to whether the United States health care system is broken or if it even has a health care system, but there is no debate that the current health care sector is an “underperforming conglomerate of independent entities.”ⁱ But just as a century ago when the agricultural extensions guided and transformed individual farmers and farming practices in eliminating inefficiencies and food scarcity, the State of New Hampshire proposes to transform the state’s fragmented health care delivery into a highly functional health care system through the development and use of Regional Healthcare Cooperative Extensions (RHCE). The RHCE will champion health care systems engineering (HSE), expand the use of information technologies, and lead local population health improvement. The resultant reductions in waste, defined by the Institute of Medicine as activities as resources that don’t add value,ⁱⁱ and improvement in efficiency will provide immediate cost savings to be reallocated to support population health improvement initiatives, and improvements in population health will support long term cost savings. The State of New Hampshire’s State Innovation Model (SIM) Model Design will be guided by three lessons from history.



1. Champion Health
Care Systems
Engineering

As was done with the regional agricultural extension services, under the authority of the Governor of New Hampshire and using SIM Model Design funding support, the New Hampshire Department of Health and Human Services (DHHS) will design the RHCEs to serve as hubs from which providers can access health care systems engineers. Although it will be determined through the Model Design process, we envision the engineers would offer consultation, technical assistance, and ongoing implementation support, including small grants to facilitate changes. These activities would serve as incentives for individual practitioners, organizations, and health care service providers of all types to

participate in this opportunity to learn systems design, analysis, and control methods and apply these methods to measure, characterize, and optimize the performance of their practices.ⁱⁱⁱ For example, Queuing Methods and Failure Mode Effect Analysis may improve access to care, and Productivity Measuring and Monitoring may inform better utilization of human resources or identify redundant, misused, or missing resources. DHHS's SIM Model Design will learn from early HSE consultations currently being selectively provided by Anthem Blue Cross Blue Shield in New Hampshire as a part of its Enhance Personal Health Care Program^{iv} with DHHS designing a model to offer HSE to all providers.

2. Expanding the Generation and Use of eData

Information and communication are essential for good medicine yet data exchange and the use of information technology among providers is poor.

History, along with diffusion of innovation science, points out that late majority and laggard adopters need different motivations for change. DHHS's SIM Model Design will develop mechanisms to increase the collection, exchange, and use of data. Early plans to be fully determined through the Model Design process will examine four potential methods.

1. Technical Assistance

The RHCEs would provide technical assistance for the use of data exchange through the New Hampshire Health Information Organization (NHHIO)⁵, a currently underutilized resource in the State that is establishing an electronic network to transmit protected health information (PHI) between health care providers in a timely, secure, and confidential manner. NHHIO is a non-profit organization, created by New Hampshire legislation and governed by a multi-stakeholder board. DHHS recognizes that the SIM Model Design has the opportunity to further incentivize providers by waiving NHHIO user fees for the first 12 months of use, for example.

2. Open Data

The State will examine ways to make health-related data, such as the Open Data Initiative underway in New York⁶, so that de-identified data is available to many users and can meaningfully contribute to greater transparency, data-driven quality improvement and research. An Open Data initiative could include existing data sources, such as the State's all payer claims database, DPHS's WISDOM data, BRFSS and YBRS data, the NHID HealthCost.gov data, the Medicaid Quality Indicators System, and commercial payor HEDIS and CAHPS data, as well as new data and a clinical quality measure data repository.

3. Clinical Quality Reporting	4. LTC EMR Adoption
DHHS will design a “One Stop Reporting” clinical quality measure (CQM) repository with real time feedback to providers, similar to the MiHIN Clinical Quality Measurement Recover and Repository program, to decrease provider burden in collecting and reporting quality measures for meaning use, maintenance of certification, managed care and other required CQM reporting, and increase the use of CQM for patient care and quality improvement. A “One Stop Reporting” program could also potentially be used to decrease the provider burden associated with utilization management.	Using contracting and rule-making authority, DHHS will work to ensure that long term care (LTC) service providers adopt electronic medical records (EMR). DHHS is currently examining whether it can use its Balancing Incentive Program ⁷ , whose purpose is to increase access to and use of LTC services and supports in community settings, to purchase and connect EMRs for Community Mental Health Centers (CMHC), area agencies (AA), skilled nursing facilities, substance use disorder (SUD) providers, and potentially other LTSS and community providers as funding allows.

The combined results of HSE and improvements in communication and information technology would markedly transform the health care delivery system and decrease per-capita health care spending. Activities and resources that do not add value should be eliminated. Through this elimination of waste in health care services, payors will quickly note a reduction in unnecessary medical services expenditures. Providers will improve their efficiency and effectiveness through practice redesign and realize a reduction in administrative burden through the use of meaningful and robust inter-provider connectivity and streamlined quality reporting. Improved information generation and exchange will improve patient care, for example, by improving communication between providers during transitions in care. Information exchanged between outpatient providers will reduce unnecessary diagnostic testing. Better use of data, registries, and EMRs should address and fill gaps in care. By becoming adept at various financial engineering and financial risk tools, and by optimizing service delivery, providers will be prepared for the introduction of value-based payments, either on a global level or in smaller episodes of care, to be instituted during future testing and implementation of DHHS’s SIM Model Design. And as importantly, the patient experience of care will also be improved through more efficient use of their time and expedient diagnosis and treatment.

3. Lead Local
Population Health
Improvement

The last lesson from history more directly improves population health and can be attributed to former Speaker of the United States House of Representatives, Tip O'Neill, in stating that all politics is local. By extension, the paradigm change needed to connect individual care to improved population health must also be local. The RHCEs, building from the state's current regional public health network, would bring together local stakeholders in a collaboration addressing population health. These collaborations will explore multiple determinants of health, with keen eye focused on the social circumstances, the environment, and behavioral patterns that are the greatest contributors to poor health and the most amenable to local influence.^{viii} By bringing together local citizens, educators, first responders, employers, health services providers, among others, novel and needed approaches can be developed and implemented. The integration of health services and community resources will be required as a part of RHCE population health improvement programs. In one community, the outcome of this process might be the creation of biking lanes to improve physical activity. In another community, developing a social network of newly pregnant women who smoke to address tobacco cessation might result. RHCE population health improvements will be data-driven and initially target tobacco use, obesity, and diabetes, as prescribed, as well as be guided by the New Hampshire State Health Improvement Plan (SHIP), produced by the Division of Public Health Services (DPHS).^{ix} The RHCE will act as a neutral convener as well as provide technical assistance and project management for local initiatives.^x Population health improvement programs would initially be funded through a combination of SIM-funded grants and the state's Building Capacity for Transformation Section 1115 Demonstration Waiver^{xi}, and subsequently funded through an RHCE trust drawn from health care payors through savings resulting from health care system transformation. DHHS would participate in measurement and

evaluation of RHCE improvement initiatives to ensure that issues needing a broader perspective, for example addressing disparities in health, are addressed and that transparency and accountability are maintained. Under this proposal, the Governor would appoint a SIM Advisory Board comprised of SIM stakeholders to include representation from providers, payors, State agencies such as the Department of Education and the New Hampshire Insurance Department, consumers, public health officials, health information technology stakeholders, town and county officials, among others, to provide oversight for the DHHS SIM Model Design process. The Governor's Advisory Board would ensure the Model Design addresses sustainability through policy, programs, or other means, successful regional initiatives, and to ensure that initiatives harmonize statewide to improve population health.

This proposal is New Hampshire's second application for a SIM Model Design award. The State's first Model Design recognized the profound need for improvements in the experience of care for citizens receiving community-based long term services and supports (LTSS). Round One also emphasized the need to build an infrastructure capable of achieving the Model Design goals and the need to connect health care delivery improvements made within this population to broader population health. The State recognized these factors and appreciates the opportunity to submit a second Model Design proposal that builds from its first Model Design and maintains a special focus on the LTSS community experience of care. Further, the State is using resources outside of SIM to build the infrastructure necessary so that LTSS providers can participate fully in this second Model Design, benefit from HSE consultation, improve their use of information exchange and information technologies, and participate as important members of the RHCE population health improvement initiatives. The LTSS community will remain an important

subpopulation in this broader SIM Model Design. The subsequent sections below describe how DHHS will address each of the prescribed areas of the FOA in its second Model Design.

Plan for Improving Population Health

Through regional population health improvement initiatives, DHHS will seek to:

- Improve health and well-being through locally driven health improvement projects;
- Initially address tobacco cessation, obesity, diabetes, and adult and child wellness and prevention priorities, and subsequently address NH SHIP priorities;
- Incorporate multiple determinants of health into programs;
- Integrate community resources and health care services; and
- Provide technical assistance via the RHCEs for population health program design and implementation.

Through improved systems effectiveness and enhanced data availability and exchange, DHHS will seek to:

- Improve chronic care coordination, management, and patient outcomes from emergency care; transitions of care, and improved coordination between providers; and
- Improve public health registries and disease surveillance.

In addition, the Governor's SIM Advisory Board will provide amplification and sustainability for successful regional initiatives.

Health Care Delivery System Transformation Plan

To transform the health care delivery system in New Hampshire, DHHS's Model Design will:

- Develop RHCE to promote HSE, provide technical assistance to increase the use of health information technology, and coordinate and implement regional population health improvement initiatives;

- Eliminate waste and improve the efficiency and effectiveness of health care delivery through HSE and implementation, including to evaluate workforce adequacy and use, create an environment in which providers can operate efficiently and effectively and with less administrative burden, allow providers to function at the top of their license, and prepare providers to progress and succeed with value-based reimbursement;
- Increase provider use of health information technology (HIT) by increasing the generation/use of electronic data and data connectivity between health care providers: PCPs, specialty care, mental health, substance use disorder (SUD), and LTSS providers, and emergency departments (EDs); allow real time access to CQM; ensure care coordination through robust data exchange for routine and emergency care and during care transitions;
- Incorporate psycho-social determinants of health, health outcomes, patient experience of care, and population health into clinical practice; and
- Create an Open Data Initiative to encourage broad quality improvement activities.

Payment and/or Service Delivery Model

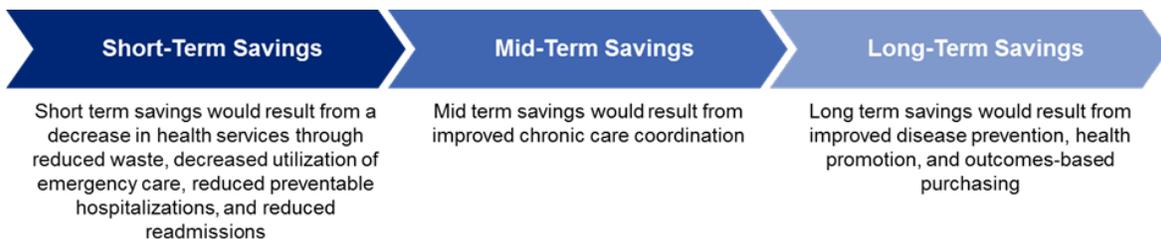
To reform payment and service delivery in NH, DHHS's Model Design proposes the following:

- To develop discrete payment methodologies for episodes of care with shared savings to be deployed throughout development to test systems improvement, as seen in Anthem's Enhancing Personal Health Care Program, and global budgets with shared savings will be developed for advanced accountable care organizations (ACOs) capable of expanding to include additional patients, such as the state's Citizens Health Initiative (CHI) Multi-payor ACO pilot^{xii} and Dartmouth's Pioneer ACO^{xiii}, or new ACOs;
- The state will be expanding Medicaid by purchasing coverage through Qualified Health Plans (QHPs) on the health insurance exchange through the New Hampshire Health Protection

Program (NHHPP)^{xiv}. These additional 50,000 lives, along with the 130,000 current Medicaid lives, totaling 13% of the state population, will be incorporated into value-based agreements and payment reform through the inclusion of the QHPs in the Model Design and through mandatory payment reform required in the state’s Medicaid Care Management (MCM) Program^{xv}. The proposed HSE and enhanced information use are intentional, preparatory steps to improve the health care system prior to large scale value-based payments;

- Design the state’s CMS-supported Health Homes program using HSE practices;
- Incorporate discrete payments for episodes of care for smaller providers and global budgets for ACOs, both with shared savings and transition to risk based payments with shared savings and/or incentive payments for ongoing quality improvement and better outcomes; and
- Aim to impact 1,326,000 New Hampshire residents in the Model Design, including all acute care services and long term services and supports. The financial impact of the model is expected to be realized in all New Hampshire markets and populations, including Medicaid beneficiaries, the currently eligible population, including dual eligibles and CHIP enrollees, the NHHPP adult expansion population, Medicare beneficiaries, traditional Medicare (i.e., fee-for-service) program enrollees, Medicare Advantage program enrollees, private insurance, including coverage inside and outside the ACA Marketplace, and the uninsured population. The current health care expenditures for the New Hampshire population and savings scenarios are detailed in the Financial Analysis section of this application.

The sources for cost savings from DHHS’s Model Design include, but are not limited to:



Leveraging Regulatory Authority

In its Model Design, DHHS plans to explore using regulatory and statutory authority to:

- Develop an Open Data Initiative in New Hampshire;
- Determine how to assist CMHCs, SUD, and LTSS providers to build out HIT infrastructure through such mechanisms as DHHS contracts;
- Work with the NHID to integrate SIM components and participation in the state's QHP certification process;
- Determine whether to require all QHPs to submit administrative and aggregate data measures to DHHS and to the all payor claims database through law or rules;
- Accelerate the NHHIO work on privacy and data exchange through law or rules; and
- Create a RHCE Trust to sustainability regional population health improvement initiatives through legislation.

Health Information Technology

DHHS's Model Design will work to improve data generation and exchange through:

- Enhanced health information exchange through NHHIO by capitalizing on and expanding current HIE through NHHIO pilots and expanding capacity to all providers, with specific attention to EDs, CMHCs, SUD providers, and LTSS providers;
- Incorporating patient reported measures and multiple health determinants into EMR infrastructure, where feasible;
- Building provider infrastructure with EMR with specific attention to CMHCs, SUD and LTSS providers, including skilled nursing providers; and
- Expanding the number of providers currently participating in the New Hampshire Medicaid EHR Incentive Program^{xvi}; while over 70% of PCPs in the state use an EHR, New Hampshire

currently has only 515 eligible Medicaid providers that have received incentive payments; however, all 26 of the in-state hospitals that have received payments.

Improve data collection, availability and use data, through:

- Required use of reporting for electronic CQMs aligned with CMS electronic measures, Value Set Authority Center (VASC) set, within EHRs;
- Enhance NHHIO current support for electronic auto-population of public health registries and auto-surveillance of disease;
- Develop a “One Stop Reporting” quality data repository for CQM reporting and real-time access and feedback to decrease provider reporting burden, provide real time access to CMQ to providers, and increase participation in CMS’ EHR Incentive Program;
- Develop a de-identified open data initiative for public health surveillance, transparency, quality assurance and improvement; incorporate the state’s all payor claims database, Medicaid quality indicators, DPHS WISDOM, BRFS and YBRS, commercial HEDIS and CAHPS data, among others, into open data strategy; build out the open data initiative to include other non-health services related data;
- Create a NH Quality Indicators website, reporting on the state population health, building off the Medicaid Quality Indicator Program, the principles of metadata analysis, and reporting capabilities in which different types of data, e.g. administrative, survey, aggregate measures, etc., are integrated into standard and user driven reports; and
- Work with the NHID to expand and amplify the use of the HealthCost^{xvii} website to facilitate consumer directed care through health savings accounts.

Stakeholder Engagement

During Round One of SIM, DHHS engaged stakeholders representing a wide range of organizations who were committed to developing a changed vision of the health care system. DHHS will retain and expand these stakeholders and consumers during its Round Two Model Design to include:

- **Payors and Medicaid Managed Care Organizations (MCOs):** WellSense, Inc., New Hampshire Health Families, Anthem Blue Cross Blue Shield, Harvard Pilgrim Health Care
- **Provider Organizations:** The Moore Center, The Elliot System, Upper Valley Community Nursing Project, Monadnock Peer Support Agency, Child and Family Services, Lakes Region Committee Services, Dartmouth Hitchcock Clinics, Service Link of New Hampshire
- **Professional Organizations:** NH Hospital Association, NH Behavioral Health Advisory Council, NH Medical Society, Community Support Network, Inc., BiState Primary Care Association, Medical Group Management Association, NH Public Health Association
- **Advocacy Organizations:** Granite State Federation of Families for Children’s Mental Health, The Children’s Alliance of NH, NH State Committee on Aging, Department of Education State Rehabilitation Council, Family Voices, State Committee on Aging, National Alliance for Mental Illness NH, NH Charitable Foundation, American Association for Retired Persons, Governor’s Commission on Disability, Endowment for Health, Engaging NH, NH Coalition on Substance Abuse Mental Health and Aging, NH Council on Developmental Disabilities, Granite State Independent Living, Brain Injury Association of NH
- **Academic Institutions:** University of New Hampshire Institute on Disability
- **State and Federal Agencies:** Department of Veterans Affairs, members of the New Hampshire House of Representatives DHHS Oversight Committee, NH Insurance Department

DHHS will ensure the ongoing engagement of a broad array of statewide stakeholders throughout both Model Design and ensuing Model Test by introducing two new stakeholder processes:

- **Governor's SIM Advisory Board:** Comprised of SIM stakeholders, health care providers, consumers. The Governor's Advisory Board will convene regional stakeholders to design the RHCEs, which will assist in the identification and development of local initiatives to address tobacco, obesity, diabetes, and wellness and prevention. The Governor's Advisory Board will have oversight and funding authority for the RHCE Collaboratives, once formed. This oversight body is described in more detail in the Operational Plan.
- **Regional Healthcare Cooperative Extension Collaboratives (RHCEs):** Local stakeholders such as citizens, educators, first responders, employers, health services providers, among others, engaged in population health improvement programs. RHCE collaborations will explore multiple determinants of health, including social, environmental and behavioral determinants and integrate health services and community resources in developing local strategies to improve population health.

New Hampshire has a rich history of bringing together stakeholders on a voluntary basis to develop significant policy initiatives. With that framework in mind, DHHS will involve the stakeholders referenced in this proposal, among others, in the development of this Model Design. The strategies in which this group will focus will include the development of the outcomes-based payment initiatives built on the foundation of community-based reform using health care systems engineering principles, the identification of additional regulatory authorities and existing initiatives that can be leveraged, and the refinement of goals for both measure alignment and HIT improvements described in this proposal.

Quality Measure Alignment

To develop a statewide plan to align quality measures across all payors in the state, DHHS's Model Design proposes to do the following:

- Where available, utilize electronic Clinical Quality Measures (eCQM) aligned with Value Set Authority Center (VASC) vocabulary sets; where eCQMs are not available, use standard measure definitions drawn from national measures sets;
- RHCE population health programs must use DHHS-approved measures; measures evaluating and supporting HSE analysis and implementation will align across HSE sites and will be developed in consultation with health care systems engineers;
- All providers, payors, etc. participating in the Model Design would have access to "One Source" data repository using eCQM with real time quality measures dashboards; and
- Measurement of patient satisfaction would be via CAHPS; incorporate patient reported outcomes into EHR, where feasible will be standardized.

Monitoring and Evaluation Plan

To regularly monitor the impact of its proposed Model Design, DHHS will:

- Measure health systems transformation changes (structure and process) and the impact of those changes (outcomes). Specific measures will be determined during HSE development;
- Monitor strengthening the population health through health service access, utilization, health outcomes, patient experience of care, and health costs. Health outcomes measurement will focus on the CMS/CDC core priorities: tobacco, obesity, diabetes, and SHIP priorities: heart disease and stroke, healthy mothers and babies, cancer prevention, asthma, injury prevention, infectious disease, alcohol, and substance misuse.

DHHS will also monitor the decreasing cost of care through:

- Per-capita cost measurement: total cost, cost by service categories (pharmacy, outpatient, diagnostic evaluation, etc.);
- Utilization measurement: ambulatory sensitive care conditions, all-cause readmission, emergency department utilization, etc., and
- Subpopulation analysis: geographic/regional, demographic, payors (including Medicaid, Medicare, Dual-eligibles, commercial payors, the NHHPP population, QHP members, etc.), disability/comorbidity, etc.
- DHHS will also be fully participatory in any CMS monitoring and evaluation as part of the Model Design process.

Alignment with State and Federal Innovation

To ensure that federal funding will not be used for duplicative activities, DHHS will coordinate with and build upon existing innovation efforts underway within the State, including the:

- CMS EHR Incentive Program: Increase the number of providers using EHRs, increase the use of eCQM through “One Stop Reporting” initiative and DHHS supported new EHRs;
- CMS Balancing Incentive Program: Payments from BIP will be used to build EHRs for the CMHC, area agencies, SUD and LTSS providers, including skilled nursing facilities;
- CMS Health Home: The enhanced match will be used to develop care coordination as informed by HSE;
- CMS Pioneer ACO Model: DHHS will look to Dartmouth-Hitchcock Health for leadership and lessons learned to inform additional ACO development in the state; no CMS Pioneer ACO Model funds will be used to support DHHS’s Model Design;
- Anthem Blue Cross Blue Shield: DHHS will look to Anthem for leadership and lessons learned from their Improving Person Health Care Program for the development/use of HSE;

- Robert Wood Johnson Foundation: New Hampshire Citizen’s Health Initiative (CHI) received funding from the Robert Wood Johnson Foundation to support a five-year multi-payor ACO pilot program. The state will look to CHI for leadership and lessons learned to inform additional ACO development in the state;
- The NH Building Capacity for Transformation Section 1115 Demonstration Waiver Submitted CMS on May 30, 2014 includes DHHS-funded grants to hospitals, health systems, and/or community providers to form pilots related to improving the delivery and coordination of physical health, mental health, and/or SUD treatments and services, and improving population health. The waiver also contains an oral health pilot program for pregnant women and mothers of young children focused on increasing access to dental services, tobacco cessation, and oral health education. DHHS plans to align the Model Design with these related initiatives without any duplication of CMS funds; and
- Institute of Medicine (IOM) and the President’s Council of Advisors on Science and Technology (PCAST): The fundamental approach proposed in DHHS’s Model Design is based on the concept of health care systems engineering, a federal recommendation set forth by the IOM in 2005 and PCAST in 2014^{xviii}.

ⁱ [Building a Better Delivery System: A New Engineering/Health Care Partnership](#)

ⁱⁱ [Err is Human: Building a Safer Health Care System](#)

ⁱⁱⁱ [Better Health Care and Lower Costs: Accelerating Improvement through Systems Engineering](#)

^{iv} [Anthem Enhance Personal Health Care Program](#)

^v [New Hampshire Health Information Organization](#)

^{vi} [Liberating Data to Transform Health Care: New York’s Open Data Experience](#)

^{vii} [New Hampshire Balancing Incentive Program](#)

^{viii} McGinnis, JM, Williams-Russo, P, Knickman, JR: The case for more active policy attention to health promotion. Health Affairs, 2002;21:78-93

^{ix} [New Hampshire State Health Improvement Plan](#)

^x [NQF Population Health Community Action Guide](#); Draft

^{xi} [New Hampshire Building Capacity for Transformation Section 1115 Demonstration Waiver](#)

^{xii} [Citizen’s Health Initiative](#)

^{xiii} [CMS Pioneer ACO Model](#)

^{xiv} [New Hampshire Health Protection Program](#)

^{xv} [New Hampshire Medicaid Care Management \(MCM\) Program](#)

^{xvi} [New Hampshire Medicaid Electronic Health Record Incentive Program](#)

^{xvii} [NH HealthCost Website](#)

^{xviii} [Better Health Care and Lower Costs: Accelerating Improvement through Systems Engineering](#)

Financial Analysis

The State of New Hampshire will engage communities, providers, and payors across the state to work together in designing a model that will achieve statewide, long term health care delivery system transformation. To achieve this goal, the health care delivery system for all New Hampshire residents will be engaged in the SIM process, including all acute care services and long term services and supports. The financial impact of the SIM initiatives is expected to be realized in all New Hampshire markets and populations, including:

- Medicaid beneficiaries
 - Currently eligible population, including dual eligibles and CHIP enrollees
 - New Hampshire Health Protection Program (NHHPP) adult expansion population
- Medicare beneficiaries
 - Traditional Medicare (i.e., fee-for-service) program enrollees
 - Medicare Advantage program enrollees
- Private insurance, including coverage inside and outside the ACA Marketplace
- Uninsured population

The table below shows an estimate of New Hampshire’s 2014 population by health care coverage source, based on 2012 data with adjustments to reflect estimates for 2014 commercial marketplace enrollment and the implementation of the New Hampshire Health Protection Program (NHHPP) starting in September 2014. The per member per month (PMPM) medical and other service costs are based on New Hampshire Medicaid data, publicly available Medicare data, and Milliman data sources for the commercial and uninsured population. The State of New Hampshire will develop a more detailed summary of the target population during the SIM Model Design process.

New Hampshire Population Summary			
Estimated 2014 Enrollment and Health Care Expenditures by Coverage Source			
Coverage Source	Estimated Enrollment	PMPM Service Cost	Estimated Expenditures (\$ millions)
Medicaid – currently eligible			
Medicaid only and CHIP	119,300	\$480	\$687.2
Dual eligibles ¹	17,300	2,250	467.1
Medicaid – NHHPP adults ²	50,000	770	462.0
Medicare (includes dual eligibles)			
Traditional Medicare	223,600	950	2,549.0
Medicare Advantage	11,300	920	124.8
Private Insurance	871,800	570	5,963.1
Uninsured	50,000	200	120.0
Total New Hampshire Population	1,326,000		\$10,373.2

Notes:

¹ Excluded from total enrollment counts because dual eligibles are also counted in the Medicare enrollment total.

² Assumes members are enrolled in NHHPP for a full year.

The total expected cost savings and return on investment are not known at this time because the specific SIM initiatives will be developed during the Model Design performance period. The following table summarizes a range of reasonable savings goals to demonstrate potential aggregate financial savings across the New Hampshire health care delivery system. The State of New Hampshire will develop more detailed savings projections during the SIM Model Design process.

New Hampshire Population Cost Savings Illustration	
Targeted System-wide Savings Percentage	Illustrative System-wide Cost Savings (\$ millions)
1%	\$103.7
2%	\$207.5
3%	\$311.2
4%	\$414.9
5%	\$518.7

Operational Plan

The State will begin by working with the Governor to appoint an Advisory Board comprised of Governor's Office staff, SIM stakeholders, and representation from providers, payors, consumers, advocacy groups, health information technology (HIT) stakeholders, and public health, city and county officials, among others. The Governor's Advisory Board will provide overarching perspective for the SIM Model Design process and ensure that the design addresses sustainability through policy, programs, or other means, successful regional initiatives, and to ensure that initiatives harmonize statewide to improve population health.

As directed by the Governor's office, The New Hampshire Department of Health and Human Services (DHHS) is the lead agency applying for a State Innovation Model (SIM) Model Design award. DHHS is the largest agency in New Hampshire state government, responsible for the health, safety and well-being of the citizens of New Hampshire. DHHS provides services for individuals, children, families and seniors, and administers programs and services such as mental health, developmental disability, substance abuse, and public health. This is accomplished through partnerships with families, community groups, private providers, other state and local government entities.^{xviii} DHHS plans to build on its robust partnerships and stakeholder relationships to develop a SIM Model Design capable of statewide health care delivery system transformation.

Multiple divisions within DHHS will contribute to the Model Design, including the Division of Public Health Services (DPHS), the Office of Medicaid Business and Policy (OMBP), the Division of Community Based Care Services (DCBCS), the Office of Human Services (OHS), and the Office of Information Services (OIS). DHHS has demonstrated significant capacity to design, implement, monitor, and sustain strategic initiatives both regionally and statewide. Recent examples of this capacity include implementing the Medicaid Care Management (MCM) Program that launched on December 1, 2013^{xviii}, designing the New Hampshire Health Protection Program (NHHPP) that will expand health coverage to nearly 50,000 newly eligible adults beginning on August 15, 2014^{xviii}, developing the State Health Improvement Plan (SHIP) that is the State's public health roadmap^{xviii}, operating The New Hampshire Medicaid Electronic Health Record (EHR) Incentive Program^{xviii} and the Comprehensive Healthcare Information System (an all payor claims database), and overseeing the State's Balancing Incentive Program (BIP)^{xviii}, among many others.

In addition to the divisions present within DHHS, other agencies will be important to engage in the Model Design process. Specifically, DHHS will coordinate with the New Hampshire Insurance Department (NHID), the Department of Administrative Services (DAS), which is responsible for issuing health coverage to State employees, the Department of Information Technology (DoIT), the Department of Education (NHDOE), and the New Hampshire Health Information Organization (NHHIO), whose role is discussed in detail in the Project Narrative.

New Hampshire's SIM Model Design project will be co-lead by Dr. Doris Lotz, the Medicaid Chief Medical Officer within DHHS, and Dr. José Thier Montero, the Director of DPHS within DHHS.

Dr. Lotz has been the Medicaid Chief Medical Director for the State of New Hampshire since 2002. She completed her medical degree at Ohio State University in 1986, her Emergency Medicine residency at Harbor-UCLA Medical Center in California in 1989 and a Masters in Public Health in 2005 and residency in General Preventive Medicine from Johns Hopkins Bloomberg School of Public Health in 2009. Dr. Lotz was selected by the Patient Centered Outcomes Research Institute (PCORI) to serve and co-chair PCORI's inaugural Advisory Panel on Improving Healthcare Systems, and is also an instructor at the Geisel School of Medicine at Dartmouth College, Department of Psychiatry.

In her role as Medicaid Chief Medical Director, Dr. Lotz is responsible for Medicaid quality assurance and improvement, and Medicaid clinical and business operations, including clinical policy development and oversight, provider partnerships, external stakeholder relations, and state regulations development and implementation. Dr. Lotz's co-lead role will include the conceptualization and design of the Regional Health Care Cooperative Extensions (RHECs) as part of DHHS's SIM Model Design and leading DHHS's strategy development for quality measure alignment.

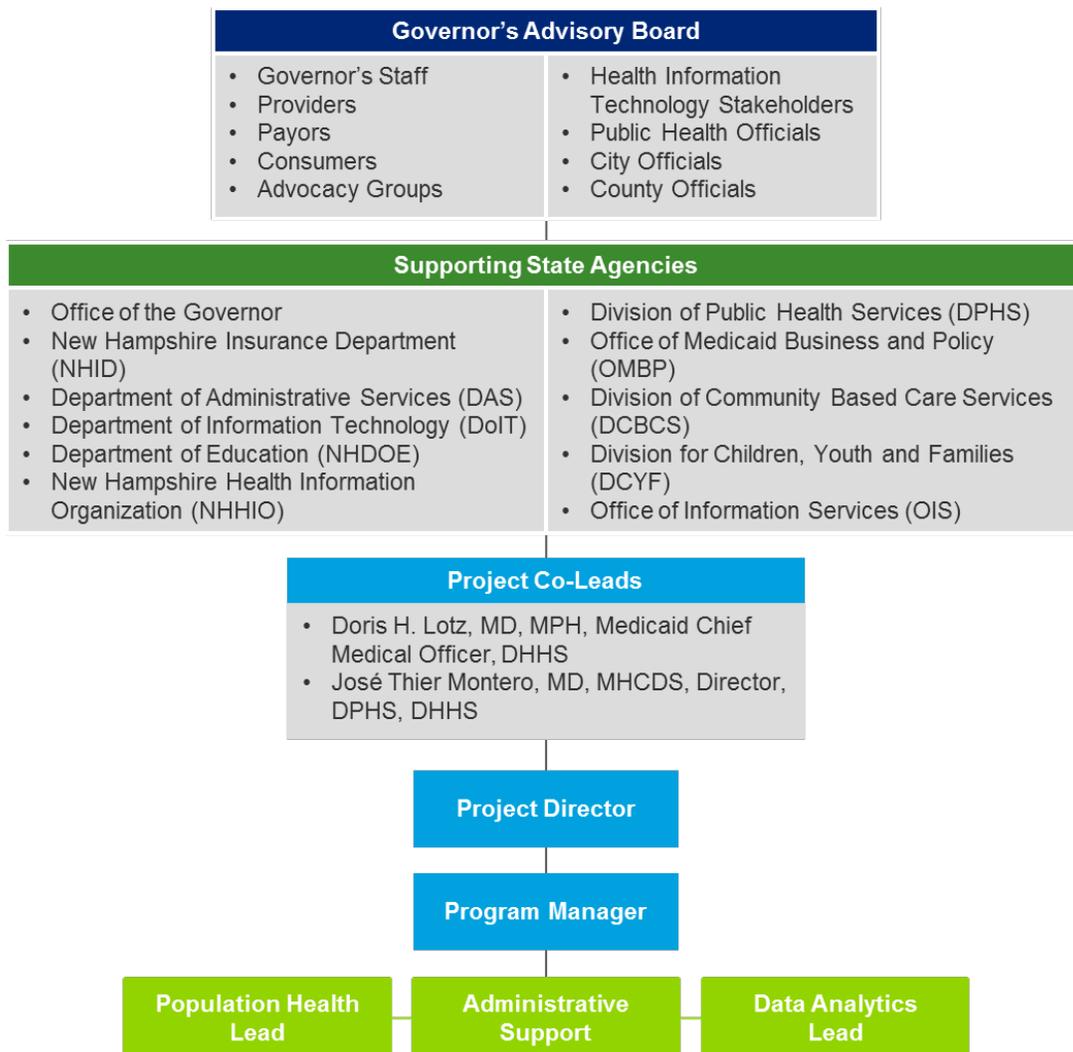
Dr. Montero has served as Director of DPHS since 2008. In addition to serving as Director of DPHS, Dr. Montero is a National Academy for State Health Policy (NASHP) Academy Member sitting on the Health System Performance and Public Health steering committee and president of the Association of State and Territorial Health Officials (ASTHO). He serves on several committees including the federal Advisory Committee on Immunization Practices (ACIP, as ASTHO Liaison) and has been recently appointed to the CDC's board of scientific councilors for the Office of infectious diseases. He is a member of the Institute of Medicine (IOM) roundtable on population health.

As Director of DPHS, Dr. Montero leads the development and implementation of policies that help create the conditions to improve and maintain a healthy population. To do so, he relies on the development of systematic approaches for actionable data collection, use, and dissemination, as well as better coordination of the public health systems and the health care delivery system, with a clear expectation of population health improvement. Dr. Montero's co-lead role will include ensuring DHHS's SIM Model Design encompasses these approaches and continues to draw from the New Hampshire's Plan for Improving Population Health.

The Model Design Project Team will be organized to ensure that staff, State agencies, the Governor's Advisory Board, and stakeholders work collaboratively to develop the design of the new Model. DHHS will recruit and/or appoint a Project Director and Program Manager to manage the SIM Model Design process on a daily basis, monitor work against the project plan, resolve project issues, and direct project resources and activities. The Project Director and Program Manager will work in close coordination with both Dr. Lotz and Dr. Montero in the development of the project plan and stakeholder engagement activities, and will be responsible for research and material development, progress reporting as required by CMS, and coordinating with actuarial support to develop the financial model as part of SIM. The Project Director and Program Manager will also be responsible for conducting outreach and engagement strategies

with each of the State agencies and stakeholder groups represented in this proposal, as well as the Governor’s Advisory Board.

In addition to the Project Director and Program Manager roles, DHHS proposes additional resources in the areas of public health, data analytics, and administrative support to provide support to the Model Design process from a population health, analysis, and administrative perspective. The population health and data analytics leads will be existing DHHS in-kind support. These resources will be managed by the Program Manager, therefore receiving overall design guidance from Dr. Lotz and Dr. Montero. The structure below depicts how the SIM Model Design Project Team will be organized and how the Project Team will interact with both the Governor’s Advisory Board and with supporting State agencies.



To design a model that is positioned for successful statewide health care delivery system transformation, DHHS follow an Operational Plan that contains six defined phases:



Upon receiving notice of a SIM Model Design award, DHHS will **Complete Internal Planning**. During this phase of the Operational Plan, the Project Co-Leads will focus on organizing both internal and external resources and developing the project plan, as well as working with the Governor and staff to form the Governor’s Advisory Board.

Shortly after forming the complete Project Team and Governor’s Advisory Board, DHHS will **Reengage Stakeholders**. Starting with a kick-off meeting to introduce the effort, its goals, and a high-level project plan, DHHS will establish smaller workgroups to address Outreach and Engagement, HIT, Legal and Regulatory, Contracting and Procurement, Quality Assurance, Finance, Population Health Initiatives, RHCE Development, and Communications, among others, in which stakeholders will be involved. Both at the midpoint of planning and toward the end of the design period, DHHS will hold larger group meetings and maintain regular communication with all stakeholders.

The third phase of the Operational Plan will be to **Define the Model Design Components**. In conjunction with the Governor’s Advisory Board and other stakeholders, the Project Co-Leads and supporting staff will work to define the model components and identify the necessary health information technology, policy levers, regulatory authorities, and stakeholder involvement needed to support the initiative. These requirements will touch on each aspect of the design, providing the specificity that will be necessary for implementing and testing the model.

DHHS will continue to **Develop the Detailed Design Requirements**. The longest phase of the Operational Plan, this phase will contain the robust stakeholder engagement process described in the Project Narrative and will be focused on developing plans and/or system changes to address to components identified in the define phase described above. This process will continue up until the Model Design is finalized.

Simultaneously to developing the detailed design requirements, DHHS will work to **Develop the Financial Model** for its Model Design. The Project Co-Leads and supporting actuarial staff will work in conjunction with the Governor’s Advisory Board to develop a financial model that best supports the design, including potential cost savings, and that will quickly move the state to value based reimbursement.

The final phase of the Operational Plan is to **Finalize the Model and Conduct Implementation Planning**. It is DHHS’s intent in Round Two of SIM to develop a model positioned for future testing, and will therefore focus on developing a plan that contains strategies and key considerations necessary to successfully implement and test this model.

The timeline below depicts the sequencing, duration, and timing of each of the six phases of work within the Model Design performance period anticipated between January 1, 2015 and December 31, 2015.

NH DHHS State Innovation Model (SIM) Model Design Application
 Extending Health: A Regional Approach to Transformation

Model Design Performance Period (January – December 2015)												
Month	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Phase 1: Complete Internal Planning	→											
Phase 2: Conduct Stakeholder Outreach	→	→										
Phase 3: Define the Model Design Components		→	→	→	→							
Phase 4: Develop Detailed Model Design Requirements					→	→	→	→	→	→	→	→
Phase 5: Develop the Financial Model							→	→	→	→	→	→
Phase 6: Finalize Model and Conduct Implementation Planning										→	→	→

DHHS is requesting \$2.2M in SIM Cooperative Agreement funding from CMS to develop this Model Design and implement each phase of this Operational Plan. A complete breakdown of this budget is located in the Budget Narrative section of this application.

DHHS recognizes that potential risks to this Operational Plan and timeline exist. For example, DHHS’s ability to contract in a timely manner for needed outside consultants is a risk that DHHS plans to mitigate by identifying and conditionally procuring outside resources prior to the Model Design award, where feasible. DHHS will also develop a data plan prior to the Model Design award that will work to mitigate risks in DHHS’s ability to collect and analyze data in a timely manner. Similarly, DHHS recognizes the importance in being able to develop payor and provider consensus around specific payment reform initiatives. To do so, DHHS will build upon the existing health care reform initiatives underway in the State and also look at statutory and regulatory strategies to encourage participation in the components of this Model Design.