

NH's "Building Capacity for Transformation" Waiver Frequently Asked Questions

On January 5, 2015, New Hampshire received approval from the Center for Medicare and Medicaid Services (CMS for the Building Capacity for Transformation Waiver ("transformation waiver"), a Medicaid Section 1115(a) research and demonstration waiver. Under the special terms and conditions (STCs) of the demonstration, New Hampshire has access to up to \$150 million in Medicaid funds over five years to expand community-based mental health, combat the opiate crisis, and drive delivery system reform for Medicaid beneficiaries. The funds will be used to support Integrated Delivery Networks -- networks of medical, behavioral health, substance use disorder (SUD) and social service providers – in undertaking projects aimed at furthering the objectives of the waiver and meeting performance metrics in seven service regions across New Hampshire. The projects will be aimed at building greater behavioral health capacity; improving integration of physical and behavioral health; and improving care transitions.

These FAQs are designed to provide additional information on how New Hampshire intends to implement the transformation waiver. Note that they are based in large part on draft materials submitted to CMS on March 1, 2016 outlining how New Hampshire intends to implement key elements of the waiver, specifically a "Planning Protocol" (which will become Attachment C of the STCs) and a "Funding and Mechanics Protocol" (which will become Attachment D of the STCs). Since these protocols may be modified based on CMS or public input, some of the information provided here is subject to change until final approval of the two protocols by CMS.

QUESTIONS REVISED AS OF MAY 3, 2016

- 1. Where can I get more information on the transformation waiver?** More information can be found on the Department's 1115 waiver website <http://www.dhhs.nh.gov/section-1115-waiver/index.htm>. This site can also be found by visiting the Department of Health and Human Services (DHHS) web site at <http://www.dhhs.nh.gov> and clicking on *1115 Transformation Waiver* under Quick Links on the right navigation bar. Questions can be submitted at any time to the following dedicated email address: 1115waiver@dhhs.state.nh.us.
- 2. How long does the transformation waiver funding last? When does it begin?** The transformation waiver has been approved by CMS for a five-year period, beginning January 5, 2016 and running through December 31, 2020. Over the course of the waiver, up to \$150 million is available to New Hampshire to invest in transforming the State's behavioral health delivery system to help improve care for people with mental illness and substance use disorders (SUDs), as well as to contain long-term growth in health care costs. In the first year of the waiver, the Department can distribute capacity building and planning funds to selected "Integrated Delivery Networks (IDNs)" – the key drivers of change under the transformation (see question 3) – as early as July 2016. Additional Year 1 funds will be available to implement projects as early as November 2016 for IDNs with approved Project Plans. Please consult the Department of Health and Human Services (DHHS) web site for timeline information at <http://www.dhhs.nh.gov>. Click on *1115 Transformation Waiver* under Quick Links on the left navigation bar.
- 3. What is an "Integrated Delivery Network" and what are the criteria for becoming an IDN?** The regional entities that are responsible for creating and implementing project plans are called Integrated Delivery Networks, or "IDNs." IDNs are groups of providers that form partnerships and collaborate on the implementation of a defined set of projects for beneficiaries served in a specified geographic region. IDNs will include medical, behavioral, SUD, and social services providers, and will have a designated administrative lead. Specific IDN composition and provider participation guidelines are outlined in the draft Funding and Mechanics Protocol (Attachment D). IDNs must meet all requirements described in the Standard Terms and Conditions (STCs) and supporting Protocols.

4. **Is an IDN different from the current provider system? Will it restructure the system?** The IDNs are not designed to replace current providers or Medicaid managed care organizations, but, to the contrary, to offer new resources to providers to improve integration of physical and behavioral health, build capacity and improve care transitions. Each IDN will establish a clear business relationship amongst its participating organizations, including a funding distribution plan that specifies in advance its methodology for distributing incentive funding to participating partner organizations.
5. **What kind of provider can submit an application to be an administrative lead?** Any willing entity, regardless of type, that meets the IDN administrative lead criteria may submit an application. The state will assess the application of a potential administrative lead based on its previous collaborative experience, unique leadership capabilities, administrative depth, and financial stability. The administrative lead will be asked to 1) demonstrate that it has experience to coordinate transformation efforts, 2) show evidence of active working relationships with partners, or the ability to establish such relationships, including with social services and community partners, 3) demonstrate the ability to administer financial responsibilities, 4) specify how it will comply with reporting requirements, and 5) provide consent for audit and oversight by the State and CMS. Please see the draft IDN Application for additional information on the requirements to serve as an administrative lead.
6. **How do I know if my organization is qualified to be an administrative lead?** Please consult the STCs, draft Protocols (draft Attachments C and D) that have been submitted to CMS, and the draft IDN Application. This information will help you to assess whether you may be qualified to serve as an administrative lead.
7. **Why are there only 7 IDN Service Regions?** In determining IDN Service Regions, the Department sought to balance the benefits of planning and programming tailored to local community health needs with the need to ensure sufficient scale and standardization across clinically integrated delivery networks. The 7 regions cover the entire state, ensuring that no part of the state is left out of the benefits of the waiver.
8. **Are the Service Regions final?** The Department has submitted draft Protocols (draft Attachments C and D) to CMS that contain the proposed service regions and is still in dialogue with CMS about various aspects of these Protocols. In addition, the Department has solicited concurrent input from stakeholders to inform the design of the waiver program and hosted 10 public information sessions throughout the state between March 4 and March 28, 2016.
9. **Can a provider belong to more than one IDN?** Yes.
10. **What happens to organizations that choose not to join an IDN? Are there incentives or penalties for joining or not joining?** The Department hopes that IDNs create broad coalitions of partners who will work together to provide the full spectrum of care and related social services that might be needed by an individual with a behavioral health condition. A clear incentive for joining an IDN is that incentive payments are distributed only to IDNs. However, an organization that is not interested in participating in the transformation waiver can still receive other kinds of Medicaid payments without penalty.
11. **Is the Department prescribing what kind of provider can deliver primary care?** No.
12. **Will staff be added to support IDNs?** Each IDN will have broad discretion to determine its staffing and capacity needs based on a local community health needs assessment. This local community health needs assessment will be a required component of IDN Project Plans.
13. **Will there be any collaboration among the IDNs? If so, what does the Department envision?** Collaboration among IDNs is critical to the overall success of this statewide initiative. Two required projects (Health Information Technology and Workforce Development) will be planned collaboratively across all IDNs at a statewide level. In addition, the Department envisions IDNs sharing lessons learned and best practices as part of a Learning Collaborative.
14. **How will IDN Applications be reviewed, and who will review them?** The state will contract with an Independent Assessor through a Request for Proposals (RFP) issued by the Department in **March, 2016**. The Department will announce the award of the Independent Assessor once the procurement process is complete.

The Independent Assessor will review and evaluate IDN Applications and IDN Project Plans, in collaboration with the Department.

15. **What happens if I join with an IDN that is not selected to represent my region? Do I get a chance to work with the selected IDN or am I left out?** After IDNs have been selected, there will be opportunities for IDNs to add providers to their networks. IDN provider networks will not be finalized until the Project Plan development is underway.
16. **How will IDN Project Plans be reviewed and evaluated for approval?** The state will contract with an Independent Assessor through a Request for Proposals (RFP) issued by the Department in **March, 2016**. The Department will announce the award of the Independent Assessor once the procurement process is complete. The Independent Assessor will review IDN Project Plans using a criteria approved by CMS. The criteria will be posted on the web site once finalized.
17. **Does each IDN have to do six projects?** Yes. Each IDN is expected to participate in two statewide projects; a core competency projects; and three community-driven projects. See Attachment C and the draft Project and Metrics Specification Guide (to be released for comment in **May, 2016**) for details.
18. **What if an IDN gets up and running and a provider isn't performing? Can the IDN replace a provider and if so, does the Department need to approve?** The Department anticipates that IDNs will have periodic opportunities to make adjustments to their networks over the course of the demonstration. The Department will work with IDNs to develop standard processes for network modification.
19. **What about children and schools; are they part of the IDNs?** It is up to each IDN to determine its participating organizations, within the requirements detailed in draft Attachments C and D to the Standard Terms and Conditions (STCs) of the waiver. IDNs can choose to include children and schools in their networks, especially if the IDN plans to implement projects targeted at school-based settings.
20. **A Community Needs Assessment is required. Can an IDN use a current needs assessment from the Public Health Regions or does a new one need to be done specific to this waiver?** The state requires that each IDN provide a Community Needs Assessment specific to its geography and that the assessment clearly identify specific capacity, service, and health gaps. The IDNs may choose to take advantage of existing needs assessments to inform its response to this requirement.
21. **How is the state defining peer supports for this program? Is it part of the program?** Peers are defined as individuals with lived experience with mental health or substance use conditions and who are trained in the provision of peer recovery support services in assisting clients with recovery by recognizing and developing strengths and setting goals. Expansion of peer support capacity will be a focus of the Behavioral Health Workforce Capacity Development project as well as the Community-driven project menu.
22. **Will IDNs be able to identify needed services?** As part of their Community Needs Assessments, IDNs will be responsible for identifying gaps in services and opportunities for building capacity and improving care.
23. **Will the Department weight projects?** The allocation of potential incentive payments to each project varies over time to reflect the relative intensity of effort and benefit of each project group over the life of the 5-year transformation waiver. Please refer to draft Attachment D for more information on project weighting.
24. **What is project valuation? How do you calculate project valuation?** Project valuation represents the maximum amount of incentive funding that an IDN can earn over the duration of the demonstration. This valuation is a function of the projects that the IDN implements, the value of those projects, and the size of its attributed population. The amount at which a project group is valued reflects the highest possible amount of incentive funding that an IDN can receive over the duration of the demonstration. IDNs may receive less than their maximum allocation if they do not meet certain metrics. To learn more, please consult draft Attachment D, which can be found on the DHHS web site.

- 25. What is member attribution?** Member attribution refers to how Medicaid beneficiaries are assigned to an IDN for purposes of awarding incentive payments and evaluating performance. New Hampshire's proposed attribution method attributes beneficiaries to IDNs based on where they currently receive their care. More specifically, attribution would be based on a beneficiary's long-term care facility residence, CMHC affiliation, primary care physician (PCP) of record, behavioral health / substance use provider(s), and, if necessary, place of residence. For more information, please see draft Attachment D.
- 26. Can a member be attributed to more than one IDN? What if the member is supported by providers in different IDNs?** No. A member is attributed to only one IDN. However, member attribution does not limit a member's existing choice in providers.
- 27. When will the state release detailed information on the performance measures on which they will be evaluated and the targets they must reach to earn incentive funds.** Additional information on measures will be included in the draft Project and Metrics Specification Guide, which the Department anticipates it will post for public comment in May, 2016.
- 28. Given that the state is at risk for statewide performance, how does this risk impact potential incentive funding from the state to IDNs?** As described in STC 35, Section V, the state will be accountable to the federal government for demonstrating progress towards meeting the demonstration's objectives of building greater behavioral health capacity; improving integration of physical and behavioral health; and improving care transitions. If the State fails to meet its performance targets in Years 3, 4, and 5 of the transformation waiver, then the federal government will reduce the funding available for the waiver and, in turn, the state will be required to reduce incentive payments to IDNs. Funding reductions will be applied proportionately to all IDNs based on their maximum IDN Project Funding amount.
- 29. How will this funding be sustained? What happens after Year 5?** Under the STCs, New Hampshire is required to develop in collaboration with stakeholders a roadmap for moving 50 percent of Medicaid managed care payments to Alternative Payment Models (APMs). The APMs will move Medicaid from primarily a volume-based reimbursement approach to primarily a value-based payment approach. It is expected that this will create the opportunity to establish sustainable financing mechanisms for the work being undertaken by IDNs.
- 30. Will New Hampshire show savings over 5 years?** New Hampshire's investment in better integrated, higher-quality care is expected to lower the rate of projected per capita growth in Medicaid spending over time, more than offsetting the up to \$150 million spent on the waiver. In fact, under the STCs, the New Hampshire transformation waiver must be "budget neutral" (i.e., the cost to the federal government of Medicaid in New Hampshire with the transformation waiver will be no more than the cost without it), a requirement imposed on all Medicaid 1115 waivers).
- 31. What types of Alternate Payment Models (bundles, capitation, etc.) is the State considering?** Pursuant to STC 44, the State must ensure that IDNs participate in Alternative Payment Models (APMs) that move Medicaid payment from primarily volume-based to primarily value-based payment over the course of the demonstration period. The Department will work with MCOs and IDNs to develop a statewide roadmap for this transition and define potential APMs.
- 32. What are the criteria for achieving incentive payments? Who determines this?** Incentive funding in Year 1 will be awarded to selected IDNs upon successful submission and state approval of an IDN Application and Project Plan. In years 2 through 5, each IDN will be eligible to receive incentive payments up to its Maximum IDN Project Funding amount by meeting or exceeding its designated performance metrics (as specified in each approved IDN Project Plan). Performance on these metrics will be reported on a semi-annual basis.
- 33. I'm a community based organization, does this impact me? Can I be an administrative lead?** Community based organizations are key IDN team members and can serve as an administrative leads provided that they meet the IDN lead requirements.

- 34. How does this fit into managed care? Are MCOs part of this demonstration?** New Hampshire's Medicaid Managed Care Organizations will be integral to the success of this demonstration and the transition to Alternative Payment Models. The state will be working very closely with them to outline the roadmap to Alternative Payment Models, which is due to CMS in mid-2017.
- 35. Can funds be used for existing projects that align with those on the project menu?** All projects undertaken by an IDN must be a new or expanded initiative for the entity and must be distinct from initiatives already funded by CMS. If an IDN wants to build on a pre-existing, non-CMS funded initiative, the IDN must demonstrate in its project plan how the coalition is significantly augmenting the initiative and allowing for substantial transformation that improves upon current performance.
- 36. How does this demonstration align with SIM?** The state is working to ensure that the transformation waiver and the State Innovation Model (SIM) design process are closely coordinated because they share many common goals and approaches. Both SIM and this waiver address improving population health through practice transformation, payment reform, community initiatives, and health information exchange. The strategies developed as part of the SIM initiative will inform and, where appropriate, be adopted as part of the transformation waiver. For example, the SIM Practice Transformation work group recommended adoption of SAMHSA's continuum of behavioral and physical health framework. Building on this SIM recommendation, this same framework will inform the development and measurement of physical and behavioral health practice integration in the transformation waiver. At the same time, there are some differences between the two initiatives. The SIM design process is aimed at transforming the delivery of healthcare for all NH citizens whereas this waiver is focused primarily on improving the behavioral health system (including integration of physical and behavioral health) for Medicaid beneficiaries.
- 37. Previous communication from the State indicated that this funding would be used to establish a Health Home infrastructure. Is this still the case?** The Department still plans to pursue the Health Home option, and it will be closely integrated with the transformation waiver. Many of the transformation waiver projects are expected to contribute to a stronger infrastructure upon which New Hampshire can establish Health Homes.
- 38. Who from the Department is lead for this effort, and whom do we contact with questions?** Medicaid Director Katie Dunn is working in collaboration with Deputy Medicaid Director Deb Fournier and a senior team, including resources from the consulting firm Manatt Health, to stand up the planning and implementation efforts. If you have questions, please email the state's transformation waiver team at 1115waiver@dhhs.state.nh.us.
- 39. Is the information posted on the web site that was sent to CMS final? Do stakeholders have an opportunity to add projects or modify the proposed IDN Service Regions?** The Department has submitted draft Attachments C and D to CMS and is soliciting concurrent input from stakeholders. The Department encourages feedback that can inform the design of the waiver program, and will be hosting 10 public information sessions throughout the state between March 4 and March 28, 2016. Please consult the Department of Health and Human Services (DHHS) web site for a calendar of public information sessions at <http://www.dhhs.nh.gov>.
- 40. Is there a timeline available?** Please consult the Department of Health and Human Services (DHHS) web site for timeline information at <http://www.dhhs.nh.gov>. Click on *1115 Transformation Waiver* under Quick Links on the right navigation bar.
- 41. Does the Department have the right resources to support this effort?** The Department is fully committed to skilled management and oversight for this important effort. The Department has a core internal team that is working with Manatt Health, and, as required by the STCs, also will be using some of the transformation waiver funds to put in place additional evaluation and support capacity.
- 42. Where can I get background information on NH's "Building Capacity for Transformation" Waiver?** To learn more about this waiver program, including background, objectives, and ways to get involved, please visit the Department web site at <http://www.dhhs.nh.gov>. Click on *1115 Transformation Waiver* under Quick Links on the right navigation bar.

- 43. Has the Independent Assessor been selected?** The state will contract with an Independent Assessor through a Request for Proposals (RFP) issued by the Department **in March, 2016**. The Department will announce the award of the Independent Assessor once the procurement process is complete.
- 44. What is the role of the Independent Assessor?** The STCs for the transformation waiver require the state to procure an independent assessor to review IDN Project Plans, in accordance with waiver guidelines. The assessor's tasks include, but not are limited to, creating an application review tool and process for the transparent and impartial review of all Integrated Delivery Network Applications and Project Plans.
- 45. What is the role of the Independent Evaluator?** As a condition of the transformation waiver, CMS requires the state to secure an independent evaluator to assess the impact of the waiver.
- 46. Is the state working with or endorsing a specific IT vendor?** There are no specific IT vendor requirements for IDNs. However, IDNs will be expected to support projects with robust health information technology, to be further defined as part of the statewide Health Information Technology Infrastructure project.
- 47. What sort of communications systems will be needed to support data collection, reporting, etc.? Is there a requirements document for IDNs?** The Department is developing a strategy for data collection and reporting that will allow both the Department and IDNs to monitor the program. The Department's intent is to provide IDNs reports based on information the Department already has access to (e.g., claims data). Requirements for submission of IDN specific data not otherwise available to the Department are not yet available, but we are exploring the Electronic Clinical Quality Measure (eCQM) model used by CMS as part of meaningful use reporting.
- 48. Will the Department provide leadership for workforce development? How will this be looked at statewide?** The Department is exploring options for supporting statewide planning efforts for workforce development. The Department welcomes stakeholder input on this subject.
- 49. Will IDNs receive assistance with application support?** Please contact the Department through 1115waiver@dhhs.state.nh.us with any questions you have about the Application.
- 50. What is the purpose of the Letter of Intent?** The Letter of Intent helps the Department identify interested parties throughout the state. All Letters of Intent were posted on the Department web site by IDN region. In addition to promoting transparency, the Department hopes that this information will encourage dialogue between providers to form partnerships before the IDN Applications are due.
- 51. To submit a Letter of Intent, do you have to already have a corporate entity or have contractual relationships with providers that might be in IDNs?** No. Please consult draft Attachment D and the draft IDN Application for additional information on IDN administrative lead and IDN composition requirements. The "Request for Non-Binding Letters of Intent from Organizations Interested in Serving as Administrative Lead for an Integrated Delivery Network" is posted on the Department's web site for further clarity.
- 52. Is there funding to help with IDN start-up activities? Does the state intend to help IDNs with governance, etc.?** In the first year, IDNs will receive funding and technical assistance for planning, assessment, and project development. A Learning Collaborative will support IDNs in managing change, implementing integrated care models, and sharing best practices on specific projects.
- 53. Are you basing this demonstration on similar models from other states?** Given its focus on the behavioral health population, NH's transformation waiver is unique and unprecedented among Medicaid 1115 waiver programs aimed at delivery system reform (sometimes referred to as "Delivery System Reform implementation Project" or "DSRIP" waivers). The Department is incorporating lessons learned from some states and applying them to a NH-specific context and NH's specific demonstration goals.
- 54. How often will attribution be updated and how will it be done?** Medicaid beneficiaries will be attributed to IDNs in Year 1 of the demonstration for purposes of determining the "maximum IDN project funding," which is the

maximum amount that each IDN can earn for projects and for meeting associated metrics. In addition, attribution is used to identify the Medicaid beneficiaries used to evaluate an IDN's performance. The State may update attribution periodically for the purpose of IDN performance measurement; however, maximum IDN project funding will not be impacted by any updates.

- 55. How will the State disclose attributed lives, and at what stage?** Based on the draft IDN Application, IDNs are asked to provide preliminary information on the organizations who will be participating in the proposed IDN as part of the IDN Application process. The list of organizations and Medicaid Provider IDs provided will be used by the state to calculate the number of Medicaid beneficiaries that would be attributed to the IDN with the given provider network. This preliminary attribution analysis will be used to evaluate the relative size and reach of the proposed IDN to ensure each proposed IDN meets minimum size and reach thresholds. After IDNs have been selected, there will be opportunities for IDNs to add providers to their networks. IDN provider networks and the resulting attribution analysis will not be finalized until the Project Plan development is underway. Please refer to the draft IDN Application and draft Attachment D for more information on attribution.
- 56. How will the State reduce allowable funding if the State fails to meet statewide metrics? What if one IDN is a poor performer and that is the reason for missing the metrics?** In Years 3 through 5 of the transformation waiver (2018 – 2020), CMS will reduce the available waiver funding if New Hampshire fails to meet statewide performance goals. The size of the reduction is specified in STC 35. If this occurs, the State will apply the funding reduction proportionately to all IDNs based on their maximum IDN project funding amount, regardless of individual IDN performance. See FAQ 28, and refer to draft Attachment D for more information on statewide and IDN-specific penalties.
- 57. How flexible will the State be in dropping a community-driven project if something changes? Also, could an IDN decide to add a new project later in the demonstration? How will project plans/budget plans be amended to reflect changes throughout the 5 years?** The community-driven projects are designed to provide IDNs with the flexibility to focus on initiatives of particular importance to their communities, and they should be selected with great care based on the community needs assessment and input from community stakeholders. While IDNs may submit proposed modifications to an approved IDN Project Plan on an annual basis, IDNs will not be able to drop projects because they turn out to be more difficult to implement than expected or because it is challenging to achieve results. In certain extremely limited cases, the State and CMS may consider modification if it becomes evident that the methodology used to identify a performance goal and/or improvement target is no longer appropriate, or that unique circumstances/developments require the IDN to modify its original plan. If any modification decreases the scope of a project, the State also will decrease the project group's valuation. Please refer to draft Attachment C for more information on IDN project plan modification.
- 58. What are the current thoughts and expectations relative to sharing information across providers, IDNs and related partners given the wide variation in IT infrastructure that exists?** As part of the Statewide Health Information Technology Infrastructure to Support Integration project, IDNs are expected to participate in statewide planning to develop strategies around closing key HIT infrastructure gaps among medical providers, behavioral health providers, and community-based service organizations. These of gaps may include level of data sharing. As this work progresses, more details will become available on the expectations regarding HIT. Please refer to draft Attachment C and the draft Project and Metrics Specification Guide (to be posted for public comment in **May, 2016**) for more information on this project.
- 59. What responsibility will the Administrative Lead have for building and maintaining an IT/Data infrastructure for the IDN during the waiver period and beyond?** Each IDN must describe in its IDN Project Plan an organizational structure that enables accountability for data and information technology, including a data governance plan. This topic, including the Administrative Lead's role in building and maintaining IT and data infrastructure, will be developed further in the context of the Statewide Health Information Technology Infrastructure to Support Integration project.
- 60. What will happen to unearned funds if IDNs do not achieve measures?** IDNs will have a limited period of time during which to "reclaim" incentive funding that they missed out on because they failed to achieve performance metrics for a given reporting period. Specifically, unearned funding will be available for reclaiming for two

immediate, subsequent reporting periods if the IDN demonstrates that it has achieved the original process or outcome metric target and that it also has achieved or exceeded its most recent target for the same metric. Funds not reclaimed will be forfeited by the IDN and placed into a general DSRIP Performance Pool, which will be used for statewide DSRIP initiatives or to reward IDNs whose performance substantively and consistently exceeds their targets. Please refer to draft Attachment D for more information on unearned funds.

- 61. Will Year 1 funding be subject to the same performance model?** Some of the funds available in Year 1 are not subject to the same performance model that applies in future years, reflecting that IDNs need some funding to plan and develop the capacity to implement the transformation waiver before producing results. Specifically, up to 65% of demonstration Year 1 funding from the IDN Transformation Fund is available for payments from the IDN Project Design and Capacity Building Fund. These project design and capacity building funds will be distributed to approved IDNs to allow them to engage in planning and to build the capacity and tools needed to implement the waiver. They can only be used for allowable purposes, and IDNs that receive these funds are required to submit a Project Plan. The state will award the remaining 35% of Year 1 funding (excluding state administrative and other expenses) to approved IDNs upon successful submission and state approval of an IDN Project Plan. Please refer to draft Attachment D for more information on Year 1 funding.
- 62. Can an IDN decide to use a different approach in its region?** IDNs are required to implement six projects, two statewide projects; a core competency project; and three community-driven projects. However, project implementation details and deployment strategies are at the discretion of each IDN, and should be based on the particular needs of the region it serves.
- 63. Will the Administrative Lead be allocated a higher share of the funding because of its role in an IDN? Will each IDN have authority to determine how dollars will be distributed within its network? How will dollars be distributed, for example, if 10 agencies are participating in the IDN?** Funding allocations within IDNs will be determined by the participating partners. IDNs are expected to develop funding allocation plans as part of their Project Plans that will detail the amount of funding allocated for distribution to participating IDN organizations, including any funding for the Administrative Lead that reflects its additional responsibilities, as appropriate.
- 64. Will the State be providing technical assistance? Are there opportunities for the State to work with vendors to support/perform the administrative aspects of the program?** As described in the Special Terms and Conditions of the waiver, the state will support IDNs by providing technical assistance and the opportunity to participate in learning collaboratives that facilitate the sharing of best practices and across IDNs. Statewide resources will be developed to coordinate with other ongoing and emerging delivery system reform efforts in New Hampshire.
- 65. How about other states? Regions border other states.** The transformation waiver is focused on New Hampshire Medicaid beneficiaries.
- 66. How will the transformation waiver help individual clinicians? Will they receive any additional training or assistance?** Workforce development is a key goal of the demonstration. All IDNs will be required to participate in a statewide project focusing on expanding the state's behavioral health workforce capacity through education, recruitment, and training. In addition, clinicians may benefit from additional training opportunities sponsored by an IDN. See draft Attachment C to the STCs for additional details.
- 67. The state should encourage IDNs to address the social determinants of health.** By design, the waiver is intended to support IDNs in addressing social determinants of health as part of transforming the delivery system for people with behavioral health issues. In fact, the requirement that IDNs include a broad array of community-based social service organizations is a direct reflection of the recognition that such organizations are critical to addressing social determinants. IDNs are expected to pursue project goals in accordance with community-based priorities and to implement team-based approaches to care delivery that address physical, behavioral, and social barriers to improved outcomes. See draft Attachment C to the STCs for additional details.
- 68. Please explain the concept of aggregation of IDN regions into "larger zones".** For the purposes of collecting sufficient sample sizes for some performance metrics or to allow for risk sharing arrangements under alternative

payment models in future years, IDN service regions may be aggregated into larger areas, or “zones.” When zones are used as the unit of analysis for measuring progress toward milestones, any incentive funds earned will be distributed to individual IDNs based on their share of attributed Medicaid beneficiaries. See draft Attachment D for additional details.

- 69. Many current initiatives and programs already have documented metrics that we are required to achieve. Will DSRIP metrics be another unique set? And how will CMS view these new metrics in five years in relation to the others?** The State is looking to leverage existing metrics as much as possible while ensuring that the demonstration’s measurements reflect the aims of the waiver and can be used to assess progress in system transformation.
- 70. If someone wants to participate in an IDN who should they be in contact with?** Organizations and providers seeking to participate in an IDN should contact entities that have submitted a Letter of Intent to become an Administrative Lead. All Letters of Intent were posted on the Department web site by IDN region. In addition to promoting transparency, the Department hopes that this information will encourage dialogue between providers to form partnerships before formal IDN Applications are due.
- 71. Who is responsible for the Community Needs Assessment?** Each IDN will be responsible for developing the process by which it will conduct its Community Needs Assessment.
- 72. Does the Department have a goal regarding the percentage / types / balance of various services for each region?** IDNs are required to develop comprehensive networks made up of a variety of providers, but precise IDN makeup will depend on the needs of the region that the IDN serves.
- 73. Will the Department reserve a portion of the funding for administration? What portion of the total funding will be available to the IDNs? Can you clarify the flow of dollars?** The transformation waiver provides up to \$150 million over 5 years, and the State must meet statewide metrics in order to secure full funding beginning in 2018. Up to 65% of Year 1 funding will be available for capacity building and planning, but in Years 2-5, IDNs must earn payments by meeting metrics defined by DHHS and approved by CMS to secure full funding. A share of the \$150 million will be used for administration, learning collaboratives, and other State-wide initiatives.
- 74. How will start up costs be funded? After performance measurement or before? How will incentive dollars in the first year be dispersed, and for what?** In the first year of the waiver, the Department will distribute up to 65% of Year 1 funding as Project Design and Capacity Building funds for IDNs. These funds are expected to be distributed as early as July of 2016. Additional Year 1 funds will be available to IDNs with approved Project Plans as early as November 2016.
- 75. Is the Administrative Lead solely responsible for forming an IDN? How will the process work?** Administrative Leads are responsible for assisting in organizing consortium partners in a geographic region, acting as the IDN’s point of accountability, submitting a single application on behalf of the IDN, and implementing the IDN governance structure, among other tasks. It is likely that different regions in New Hampshire will formulate IDNs in different ways.
- 76. The total populations vary widely by region. How will that work?** In determining IDN Service Regions, the Department sought to balance the benefits of planning and programming tailored to local community health needs with the need to ensure sufficient scale and standardization across clinically integrated delivery networks. IDN funding will be allocated partially based on the number of people attributed to each IDN.
- 77. Regarding governance, how will the IDNs operate?** IDNs are required to provide details on their composition and governance structure in their Project Plans. Each IDN must specify its approach to the following: financial governance, including how decisions about the distribution of funds will be made, the roles and responsibilities of each partner, and project budget development; clinical governance, including standard clinical pathways development and strategies for monitoring and managing patient outcomes; data/IT governance, including data sharing among partners and reporting and monitoring processes; and community/consumer engagement,

including a description of the steps taken to engage the community in the development and implementation of the IDN. See the draft IDN application for details.

- 78. Are nursing facilities included? What about private nursing facilities?** IDNs must ensure that they have a network of non-medical providers and medical providers that together represent the full spectrum of care that might be needed by an individual with a mental health issue or substance use disorder. County organizations representing nursing facilities must be included in IDN networks.
- 79. Are any of the CMHCs split amongst the IDNs?** IDN partner networks must include one or more regional CMHCs. It is permissible for organizations, including CMHCs, to participate in more than one IDN.
- 80. Please clarify the timeline and how the identification of Administrative Leads fits into it.** Non-binding Letters of Intent from potential Administrative Leads were due on 4/4/16. Administrative Leads are required to submit an IDN application on behalf of themselves and participating organizations by 5/31/16. See draft IDN Application and draft Attachment D for more details.
- 81. Is the State thinking about the number of people coming in and out of correctional facilities (especially in the large northern region) and how that might impact services provided by IDNs?** IDNs must ensure that they have a network of non-medical providers and medical providers that together represent the full spectrum of care that might be needed by an individual with a mental health issue or substance use disorder. County organizations representing correctional facilities must be included in IDN partner networks. The draft menu of Community-driven projects includes a project option focused specifically on justice-involved individuals (please see Attachment C and the draft Project and Metrics Specification Guide to be posted for public comment in **May, 2016** for more details).
- 82. Does the transformation waiver include services for families?** IDNs have the option of selecting projects that include services for families. See draft Attachment C and the draft Project and Metrics Specification Guide to be posted for public comment in **May, 2016** for more details.
- 83. Will the transformation waiver include treatment alternatives to incarceration?** Although the original draft project menu for the demonstration included an option of selecting a treatment alternative to incarceration project, this project has been removed from the Community-driven project menu in its latest iteration. Please the draft Project and Metrics Specification Guide to be posted for public comment in **May, 2016** for more details.
- 84. Will the transformation waiver address the heroin issue?** Addressing the opioid crisis is a core focus of the waiver. IDNs have the option of selecting projects that implement medication assisted therapy, peer support programs, school-based screenings and interventions, and integrated dual disorder treatment, all of which address substance use disorders. In addition, the mandatory statewide workforce development project will focus on addressing substance use workforce gaps, and the mandatory Core Competency project will focus on the integration of comprehensive screening and assessment into primary care and behavioral health settings. See draft Attachment C for more details, along with the draft Project and Metrics Specification Guide to be posted for public comment in **May, 2016**.

NEW QUESTIONS AS OF APRIL 8, 2016, REVISED AS OF MAY 3, 2016

- 85. How will the primary care relationship be incorporated into the member attribution logic? How will changes to attribution be handled?** The principle of New Hampshire's attribution methodology is that beneficiaries should be attributed to IDNs based on where they currently receive their care, if possible. Accordingly, attribution of New Hampshire's eligible Medicaid beneficiaries will be driven by a 5-step hierarchical methodology that is based on the following four factors: Use of preventive and primary care services, use of mental health / substance use disorder providers, including Community Mental Health Center (CMHC) providers, use of long-term care facility providers and geographic criteria (when necessary). Please see the Draft IDN Application for more information on the proposed attribution methodology, including a table that outlines the 5-step logic by which a member will be attributed to an IDN. After accounting for any 1) existing long-term care or 2) CMHC relationships, the third step in the attribution logic is to attribute members based on evidence of using

services at a primary care provider. Identification of primary care provider will be based on the member's most recent preventive care claim(s), followed by the most recent visit E&M office visit or clinic visit codes to FQHCs, RHCs, APRNs, pediatricians, family practice, and internal medicine providers. Member attribution has two primary purposes 1) As a component of the formula used to determine the Maximum five-year IDN Project Funding amount for each IDN, described in more detail in draft Attachment D to the Standard Terms and Conditions of the waiver and 2) For measurement of IDN performance metrics. Once the attribution of beneficiaries to IDNs is finalized, the state will calculate the Maximum IDN Project Funding amount for each IDN for the 5-year demonstration period, as described in draft Attachment D to the STCs. This valuation calculation will occur during Year 1 of the demonstration. Attribution may subsequently be updated periodically for the purposes of IDN performance measurement. However, Maximum IDN Project Funding will not be impacted by any updates to attribution calculations. The timing and process associated with these updates is still being determined. It is important to note that beneficiaries will continue to be free to seek care where they choose, regardless of attribution. There is no formal 'enrollment' or 'disenrollment' of a member from an IDN, and members will naturally seek care outside of the IDN to which they are attributed.

- 86. Given the fact that health care organizations are constrained in the availability of cash and margins are extremely tight, can payments be made prospectively under the program? Can funds be allocated based on the severity of the enrollees?** New Hampshire's DSRIP waiver is a performance-based incentive program. In accordance with the Standard Terms and Conditions of the waiver, IDNs will receive incentive funding tied to achievement of certain process and outcome metrics. As such, the program will not be providing prospective incentive payments. However, recognizing the need for IDNs to begin building capacity and foundational tools necessary to implement the program, the waiver allows for up to 65% of Year 1 funding to be distributed prospectively in the form of Project Design and Capacity Building Funds. In addition, it is proposed that the remaining Year 1 funding available for distribution to IDNs be tied to the successful approval of an IDN Project Plan. As described in Attachment D, the maximum funding amount that can be earned by an IDN over the five-year demonstration will be driven by the number of Medicaid beneficiaries attributed to the IDN and allocated across projects in proportion to the relative intensity of effort and benefit. The funding methodology does not incorporate the acuity or severity of health status among those beneficiaries.
- 87. Will the state be able to provide a 12 month claims history as well as ongoing monthly claims reports to each IDN on its attributed population?** The state recognizes the importance of data for IDNs to plan for project implementation and manage the care of its Medicaid beneficiaries. Plans for the release and distribution of data are still being formulated and will be communicated to IDNs when more information is available.
- 88. What is the path to long-term financial sustainability, and how will the state make its long-term funding plans clear?** In recognition that the IDN investments represented in this demonstration must be recognized and supported by the state's MCO and Medicaid service delivery contracts as a core component of long term sustainability, the state will take steps to plan for and reflect the impact of IDNs in Medicaid provider contracts and rate-setting approaches. Specifically, the state will plan and implement a goal that 50 percent of Medicaid provider payments to providers be made via Alternative Payment Methodologies. Prior to the state submitting to CMS contracts and rates for approval for any contract period beginning July 1, 2017, the state will submit a roadmap for how it will amend contract terms and reflect new provider capacities and efficiencies in Medicaid provider rate-setting. Recognizing the need to formulate this plan to align with the demonstration phases, this will be a multi-year plan developed in consultation with managed care plans and other stakeholders, and necessarily be flexible to properly reflect future IDN progress and accomplishments. Please see Section 33 of the Standard Terms and Conditions of the waiver for more information.
- 89. Can you clarify the role and expectations around Health Information Technology and Health Information Exchange?** More information on expectations regarding the statewide HIT project and planning process will be included in the Project and Metrics Specification Guide to be posted for public comment in May 2016.
- 90. Will the state consider additional flexibility in the geographic boundaries defined by 7 regions within the IDN and allow for a more narrow scope of geography that will allow a lead IDN to be more selective on its partners that are committed to the work?** In determining IDN Service Regions, the Department sought to

balance the benefits of planning and programming tailored to local community health needs with the need to ensure sufficient scale and standardization across clinically integrated delivery networks.

- 91. What happens to remaining partners if some organizations choose to not continue the process? Are the remaining organizations left handling the coordination without necessary partners or funding?** Once IDN networks are finalized in Year 1 of the demonstration, there may be opportunities for additional organizations to be added to an IDN network, but organizations will not be removed from the IDN's network list. Therefore, organizations cannot formally 'exit' an IDN. However, there may be cases when an organization chooses to cease participating in an IDN's planning and implementation activities, which may have implications for the adequacy of the IDN's range of available services and the flow of funds to organizations. The process by which IDNs handle the network adequacy and financial implications of partners choosing to cease participating in an IDN will be defined by each IDN as part of the IDN Project Plan. Within the IDN Project Plan, IDNs will be asked to describe various aspects of the IDN's planned governance structure/processes, and flow of funds. As part of that plan, IDNs will be asked to describe both the process by which the IDN will ensure adequacy of its network in the event a particular provider chooses to cease participation in the IDN and the process by which funds flow decisions stemming from a provider exit will be handled.
- 92. What is the specific definition of people who may be included in services to be developed through the waiver program? And how will the current baseline of beneficiaries be created which will serve as a benchmark against which the IDNs will be measured? ATTACHMENT C: DSRIP Planning Protocol, page 3 suggests two definitions with language requiring clearer definition underlined - "The population to be addressed by the demonstration includes Medicaid beneficiaries of all ages with, or at risk for, behavioral health conditions ranging from moderate depression and anxiety to substance abuse, to serious mental illness." "The demonstration is aimed at achieving the following goals: improve the health and well-being of Medicaid beneficiaries and other New Hampshire residents with behavioral health conditions through evidence-supported programs couples with..."**
The demonstration includes all New Hampshire Medicaid beneficiaries, and the attribution of beneficiaries to a particular IDN will be calculated based on this population. While all Medicaid beneficiaries are included, given behavioral health focus of the demonstration, the state has targeted the clinical interventions to the subset of Medicaid beneficiaries with or at risk for behavioral health conditions.

The population included in the calculation of individual performance measures will vary by measure. For example, certain measures focused on outcomes across a broad population will likely include the entire Medicaid population, while metrics that measure improvements in a specific sub-set of the population may be limited to that sub-set. More information on individual performance measures, including the timing of baseline measures, will be included in the draft Project and Metrics Specification Guide targeted to be posted for public comment in May, 2016.
- 93. Will the claims data of current Medicaid managed care beneficiaries be made available to the IDNs to support timely interventions under the required project areas? What is the expected timeframe following a beneficiaries service for an IDN to receive a claims data report?** The state will be providing the IDNs with data on its attributed population to support planning and implementation efforts. The state is still in the process of developing the timelines, process, and nature of this data transmission and will be sharing that information with IDNs as soon as it is available. SEE ALSO QUESTION 87
- 94. When will the specific definitions for the project metrics be available to IDNs to determine what projects they might undertake and the capacity of providers to understand their performance related to the projects?** Additional detail on each project requirements and metrics will be included in the draft Project and Metrics Specification Guide, to be posted for public comment in May 2016.
- 95. Can you describe the funding relationship of (p. 21 of the 'Building Capacity for Transformation PPT', "5% (\$1.5 M) Risk for Performance payments to IDNs in 2018") to (ATTACHMENT D, p. 13, "2018 Example of achieving Community-Driven Projects metrics 40% of the \$1M or \$400K")? It was stated at one of the informational sessions that at risk percentages were designed to create some accountability for the State, including the allocation of NH state funds. Could you elaborate on that perspective? During years 3, 4, and**

5 of the demonstration, a certain percentage of the overall funding received by the State is contingent on the state achieving select statewide performance outcomes. Therefore, if the state fails to achieve one or more of those outcome goals, the overall funding available for distribution to IDNs as performance incentive payments would be reduced. Performance payments from the state to IDNs is also dependent on performance, but at the IDN-level. IDNs will be required to achieve certain process and/or outcome targets to earn these payments over the course of the demonstration. The level of performance funding tied to particular project groups changes over the course of the demonstration. The question cites the example of 2018 performance funding allocation. In 2018, 40% of maximum performance payments to IDNs will be tied to the achievement of process and/or outcome measures associated with Community-driven projects.

- 96. Does “the value of individual projects within a project group will be identical” (ATTACHMENT D., p. 11) mean that each Community-driven project would have the same “value of funding” tied to it?** The maximum funding value that an IDN can earn based on performance tied to the Community-driven project group is the same regardless of which projects the IDN chooses. The IDN will need to achieve the process and outcome metrics associated with its chosen projects in order to earn this funding. It is important to note that in order to achieve these outcome measures, IDNs may choose to use these performance incentive funds to implement interventions that go beyond the requirements of its specific chosen projects.
- 97. Will participating in an IDN require significant investment in resources? Is there any support for smaller entities that may not be able to afford to participate?** In the first year of the waiver, the Department will be distributing up to 65% of demonstration Year 1 funding as capacity building and planning funds to IDNs to offset start-up costs associated with participation. Additional Year 1 funds will be available to implement projects as early as November 2016 for IDNs with approved Project Plans. Each IDN will be responsible for developing funds flow plans that adequately support all IDN participants and ensure that IDN participation is not an undue burden on any one entity.
- 98. Can the state allow Medicaid reimbursement for pre-licensed doctoral clinicians who are doing their internship or otherwise help with regulatory barriers that are inhibiting hiring and retaining behavioral health care workers?** Workforce development is a key goal of the demonstration. All IDNs will be required to participate in a statewide project focusing on expanding the state’s behavioral health workforce capacity through education, recruitment, and training. As part of this project, IDNs will seek to identify current barriers to meeting workforce gaps.
- 99. Will the state rethink its proposed regions, which in some ways disadvantage smaller regions?** In determining IDN Service Regions, the Department sought to balance the benefits of planning and programming tailored to local community health needs with the need to ensure sufficient scale and standardization across clinically integrated delivery networks.
- 100. Will the Child and Adolescent Needs and Strengths (CANS) assessment instrument be utilized in the integration model?** A core standardized assessment framework will be utilized in implementing behavioral health and primary care. More guidance on the components of this assessment will be included in the draft Project and Metrics Specification Guide to be posted for public comment in May 2016.
- 101. Will ACES methodologies and strategies be utilized?** More information on the specific instruments that will be utilized in implementing the DSRIP projects will be included in the draft Project and Metrics Specification Guide to be posted for public comment in May 2016.
- 102. Can the state place more emphasis on improving community behavioral health systems for children within the waiver? Specifically: community based alternatives to incarceration through early identification and diversion programming; building linkages with schools; New Hampshire Children’s**

Behavioral Health Workforce development network as a piece of the 1115 waiver system. IDN project selection will be based on each IDN's community needs assessment and input from community stakeholders. IDNs have the opportunity to choose projects that are specifically focused on improving community behavioral health systems for children, including the School-Based Screening/Intervention Project (E2), which develops programming planning for school-based mental health and substance use screening and interventions. In addition, IDNs have the flexibility to choose to place particular emphasis on community behavioral health systems for children as part of other projects if that focus aligns with community needs and will contribute to the improvement in overall outcomes. Finally, the New Hampshire Children's Behavioral Health Workforce development network is expected to play an important role in planning associated with the statewide Behavioral Health Workforce Capacity Development project. More information on these projects will be included in the draft Project and Metrics Specification Guide to be posted for public comment in May 2016.

- 103. What type of Medicaid enrollees are included in the attributable lives calculation?** The demonstration includes all New Hampshire Medicaid beneficiaries, and the attribution of beneficiaries to a particular IDN will be calculated based on this population.
- 104. What sort of criteria and oversight will be in place to ensure that non-traditional services contemplated by the waiver are delivered in a way that protects the safety and well-being of those receiving the services (eg, peer support services)? What quality standards will be developed for those services and how will those be monitored?** Within the IDN Project Plan, IDNs will be asked to describe various aspects of the IDN's planned governance structure/processes, including oversight of all services provided through the IDN.
- 105. Is there any prohibition to the Administrative Lead being a new company if the members can demonstrate their collective experience in the minimum necessary requirements?** No. However, specific the new company will have to demonstrate that it has the requisite experience and 2) DHHS would anticipate that may likely result in receiving an attestation from the member organization whose experience is being relied upon that it will be taking the lead on the specific function. Please see the draft IDN application for more details on the criteria to serve as an Administrative Lead.
- 106. What type of epidemiological data will be made available to communities/IDNs to complete the required needs assessment?** Each IDN will be responsible for developing the process by which it will conduct its Community Needs Assessment. If epidemiological data is required, IDNs should work with the state to request the data they need.
- 107. Can you clarify the Treatment alternatives to incarceration/CIT project? Are these two separate programs?** More information on the latest project menu will be included in the draft Project and Metrics Specification Guide targeted to be posted for public comment in May 2016.
- 108. Will the Waiver include training to certify peer support specialists.** Expansion of peer support capacity will be a focus of the Behavioral Health Workforce Capacity Development project as well as the Community-driven project menu. More information on the project will be included in the draft Project and Metrics Specification Guide targeted to be posted for public comment in May 2016.
- 109. Would there be any flexibility in the number of community driven projects allowed within the North Country/Carroll County region to accommodate the broad range of needs there?** Each IDN is expected to participate in two statewide projects; a core competency project; and three community-driven projects. However, IDNs have the flexibility to implement a broad range of interventions in order to address local community needs and ensure improvement in outcomes outcome measures.

110. Could the community driven projects focus on a specific population such as veterans or military families? The focus of this demonstration is all Medicaid beneficiaries with mental health and/or substance use disorder needs. All IDN projects can potentially benefit veterans or military families. Additionally, IDNs have the option of selecting projects that focus on specific populations or choosing to implement project requirements in a way that focuses on specific populations, depending on community need. See draft Attachment C for more details.

111. How will the state manage the data needs of the IDNs given the disparate systems in use in NH? As part of the Statewide Health Information Technology Infrastructure to Support Integration project, IDNs are expected to participate in statewide planning to develop strategies around closing key HIT infrastructure gaps among medical providers, behavioral health providers, and community-based service organizations. These gaps may include the management of data needs across disparate systems. As this work progresses, more details will become available on the expectations regarding HIT. Please refer to draft Attachment C and the draft Project and Metrics Specification Guide (to be posted for public comment in **May, 2016**) for more information on this project.

112. Can funds be used for salaries for new hires? The staffing categories refer to "onboarding" but we're not sure if this means we can use that for salaries across all five years.

Yes. Retaining direct service personnel and hiring direct service personnel are allowable uses of the capacity building funds. The draft IDN application includes the following as allowable uses of funds:

Capacity building for direct care or service provision workforce: Recruitment and Hiring—Funds can be used to support the recruitment and hiring of front-line staff involved in the direct delivery of health care, behavioral health care (mental health and substance use disorder), or social services, with a focus on job categories associated with regional service gaps and shortages identified in Section V. These activities may include the development of job descriptions, advertising of positions, interviewing, and onboarding of new staff.

Capacity building for direct care or service provision workforce: Retention of existing staff—Funds can be used to promote retention of existing front-line staff involved in the direct delivery of health care, behavioral health care, or social services, in job categories associated with regional service gaps and shortages identified in Section V. This may include reasonable compensation adjustments, professional development programs, cross-training initiatives, and other retention strategies.

QUESTIONS/COMMENTS RELATED TO IDN APPLICATION PUBLIC COMMENT PERIOD in APRIL, 2016

113. Can the minimum number of attributed lives per IDN be reduced or deleted to allow potential smaller regions to build IDNs?

In determining IDN Service Regions and setting the minimum threshold of 15,000 attributed lives per IDN, the Department has sought to balance the benefits of planning and programming tailored to local community health needs with the need to ensure sufficient scale and standardization across clinically integrated delivery networks. As of now, the Department does not plan to modify these minimum requirements.

114. Will the state reconsider the possibility that an IDN can serve more than one region? Allowing IDNs to serve more than one region is a potential barrier to meeting the needs of community members.

IDN Service Regions were designed to balance local community health needs with the need for scale and standardization across IDNs. It is the expectation that at least 1 IDN will be formed per Service Region. However, in the event that a sufficiently broad and qualified network is not successfully formed in a given region, it may be necessary for an IDN to serve multiple regions. IDNs that serve multiple regions must serve the totality of all of those regions.

115. Will the state consider utilizing the 13 pre-existing regional public health networks (RPHNs) as the basis for the IDN Service Regions?

The State's RPHNs are the building block on which the IDN Service Region framework was designed, and IDNs are required to include representation from RPHNs in their networks. However, leveraging the 13 RPHNs as individual IDN Service Regions would not generate sufficient scale and standardization across clinically integrated delivery networks. Therefore, the Department consolidated certain RPHNs into 7 IDN Service Regions.

116. Will the department reconsider its plan to allow more than one IDN operate in a region? Having multiple IDNs in a region may present challenges.

Providers and social service organizations are strongly encouraged to collaborate and build a single IDN per region when feasible, particularly for less populated service regions. However, due to population size and a multiplicity of services in some areas, regions with single IDNs may not be possible. Therefore, more than one IDN can serve in a region, so long as the minimum attributed lives number is met for each IDN.

117. We are concerned that the focus on behavioral health systems improvement will drive individuals to access care at community health centers who will not have the capacity to serve them in an integrated setting due to shortages in primary care funding and staffing capacity.

The mandatory workforce development project will support IDNs in building staffing capacity across settings, and the mandatory Core Competency project will focus on the integration of primary care and behavioral health service delivery throughout IDNs. Based on each IDN's Project Plan, many organizations participating in IDNs, including community health centers, will receive support to integrate care and expand staffing capacity.

118. Can you clarify whether Project Design/Capacity Building funds are to be used in their entirety in year one? Project Design and Capacity Building funds are distributed once in Year 1, but can be spent at any point over the 5-year demonstration. Given that these funds are intended to support upfront planning and capacity building, it is anticipated that the majority of funds will be invested by IDNs during the first year.

119. Will this initiative encourage IDNs and the state to invest in understanding the factors that impact recruitment and retention of the behavioral health workforce and to develop and implement strategies that will support community agencies in their ability to attract, recruit, and retain this critical workforce?

All IDNs must participate in the mandatory statewide behavioral health workforce capacity development project, which will consist of a workgroup with members drawn from provider communities in each IDN. Using the workgroup's findings, the IDNs will be required to develop regional approaches to closing the workforce gaps that impact provider capacity. The work groups will assess the current state and develop a future state vision that incorporates strategies to efficiently implement statewide workforce solutions, including solutions supporting recruitment and retention.

120. Not every patient in a long-term care facility requires behavioral health services, and beneficiaries in long-term care facilities should only be included if they are concurrently receiving behavioral health services. Additionally, patients should be attributed to where they receive primary care services before they are attributed to where they receive CMHC services.

All New Hampshire Medicaid members will be attributed to IDNs regardless of whether or not they have been diagnosed with a behavioral health condition. Attribution will be based on a beneficiary's long-term care facility residence, CMHC affiliation, primary care provider, behavioral health / substance use provider(s), and, if necessary, place of residence. This 'order of operations' allows seeks to assign beneficiaries to IDNs whose network includes behavioral health providers the beneficiaries have had existing, consistent relationships with.

121. Will Medicaid beneficiaries as part of the project planning and IDN governance?

IDNs are required to engage with community stakeholders in the process of developing its Project Plan. IDNs can choose to include Medicaid beneficiaries as part of their governance structure.

122. Will the state include IDN members as part of the team actively engaged in development of Alternative Payment Models?

The State will be partnering with Managed Care Organizations, IDNs and other providers in the development of a roadmap for implementation of the transition to Alternative Payment Models.

123. Can the state explain the rationale behind the Community-driven project menu?

The IDN Community Driven menu of projects gives IDNs the flexibility to undertake work reflective of community-specific priorities identified through a behavioral health needs assessment and community engagement. As they select and implement community-driven projects, IDNs will have significant flexibility to target key sub-populations; to change the way that care is provided in a variety of care delivery settings and at various stages of treatment and recovery for sub-populations; and to use a range of strategies to change the way care is delivered and connected with social supports. The three Community Driven project categories map to the three overarching goals of the demonstration.

124. Will IDNs be permitted to improve or expand upon a current best practice through the implementation of its projects?

All projects undertaken by an IDN must be a new or expanded initiative for the entity and must be distinct from initiatives already funded by CMS. However, IDNs are encouraged to build on and spread existing best practices.

125. Can IDNs implement different projects within the IDN if they are all working toward the same goal?

IDNs must meet the minimum process requirements for each project it implements; however, project implementation details and deployment strategies are at the discretion of each IDN, and should be based on the particular needs of the region it serves. IDNs may choose to use incentive funds to implement interventions that go beyond the requirements of its specific chosen projects if they feel these interventions will improve performance on outcome metrics.

126. Could you expand the description, clarify, or provide examples of what would be considered 'costs for ordinary and normal rearrangement or alteration of facilities' that are noted as not being excluded expenses?

Examples of 'ordinary and normal rearrangement or alteration of facilities' that are allowable expenses include minor renovations and accommodations for new staff. For example, funding can be used to support the addition of primary care exam rooms to a behavioral health clinic. Project Design and Capacity Building Funds may not be used to purchase land, build a new facility, etc. without prior state approval

127. Please clarify language regarding the State's role in interoperability of electronic health and social services records.

As part of the Demonstration HIT Infrastructure to Support Integration project, IDNs are expected to participate in statewide planning to develop milestones for IDNs to enable data exchange and the sharing of care coordination data across all IDN providers, including social service providers. Please refer to the Project and Metrics Specification Guide for more detail on this project.

128. Define language for use of funding on the state-wide projects as it relates to IT development for the purpose of interoperability of electronic health and social services records.

IDN valuation will include incentive funding that can be earned by an IDN through participation in the Statewide HIT Infrastructure to Support Integration Project. Please refer to the Project Metrics and Specification Guide for more details on this project.

129. Will the state be clarifying the processes and vehicles that will support the integration of primary care provider and behavioral health care provider cultures throughout the waiver process and learning activities?

The state will be launching a Learning Collaborative to support IDNs in managing change, implementing integrated care models, and sharing best practices on specific projects.

130. Does the the wide range of options for community-driven projects dilute the impact of each?

The number of Community Driven Projects available for selection has been reduced. Please see the Project and Metrics Specification Guide for more details on the latest project menu. In terms of the risk of dilution, it is important to keep in mind that three of these projects to be implemented by IDNs are foundational to the transformation initiative, and, therefore, are mandatory for all IDNs. These projects are the cornerstone of the transformation initiative and will require a significant majority of the IDN's available planning, resources, and organizational bandwidth to implement. In turn, these projects are intended to support interventions that will drive much of improvement in performance outcomes the IDNs are accountable for achieving. The IDN Community Driven menu of projects gives IDNs the flexibility to undertake work reflective of community-specific priorities identified through a behavioral health needs assessment and community engagement.

QUESTIONS POSED DURING/AFTER IDN APPLICANT IN-SERVICE SESSION MAY 4, 2016

131. The state's IDN Service Regions may contain 2-3 existing delivery systems within a given region. Is there a restriction or requirement for inclusion?

Please see Attachment D, Section II and the IDN Application (Section I) for more information on minimum IDN network composition requirements. IDNs are required to include a range of specific types of organizations.

132. What type of access to Medicaid data will be provided to IDNs to enable data-driven IDN planning and implementation decisions? When will it be provided to the IDNs?

The state recognizes the importance of data for IDNs to plan for project implementation and manage the care of its Medicaid beneficiaries. Plans for the release and distribution of data are still being formulated and will be communicated to IDNs when more information is available. SEE ALSO QUESTIONS 87 and 93.

133. Will the statewide Workforce project dovetail to the Governor's recent executive order. When will IDNs get involved in the workforce initiative?

As detailed in the draft Project and Metrics Specification Guide, the statewide workforce project (A1) will align with, leverage, and complement many existing/ongoing workforce capacity development assessments and initiatives, including the commission cited in the Governor's recent Executive Order. The state anticipates that planning will kick-off for the Workforce project during the summer of 2016.

134. Will there be an opportunity to explore statewide solutions to meet HIT and data sharing needs?

As detailed in the draft Project and Metrics Specification Guide, the 'HIT Infrastructure to Support Integration' project (A2) will begin with a statewide planning effort that includes representatives from all IDNs. This project will be spearheaded by a facilitated statewide Taskforce that will assess current HIT infrastructure gaps across the state and come to consensus on statewide HIT implementation priorities given the objectives of the demonstration.

135. What 'look-back' timeframe will the state's Attribution methodology use in identifying whether there is claims-based evidence that a Medicaid beneficiary has used services at a particular provider within an IDN?

The principle of NH's attribution methodology is that beneficiaries should be attributed to IDNs based on where they currently receive their care. Although the 5-step Attribution logic is outlined in Section I of the IDN Application, certain details related to the Attribution logic are still being refined by the state, including the precise look-back timeframe window (e.g. 6 months, 12 months, 18 months).

136. The overview presentation being used in public information sessions includes a slide that provides the numbers of Medicaid beneficiaries in each IDN Service Area. Are these numbers the result of an attribution calculation?

No. These numbers are based only on Medicaid beneficiary home address and were provided as a proxy for the number of beneficiaries in each Service Region. Actual member attribution will be based on the networks of providers being brought together to form proposed IDNs.

137. Are out-of-state providers (e.g., in Vermont, Maine, Massachusetts) eligible to receive DSRIP funds through an IDN?

The Department is reviewing this question and will be providing guidance shortly.

138. Will out-of-state providers (e.g., in Vermont, Maine, Massachusetts) who provide care to NH beneficiaries be included the state's member attribution logic?

The Department is reviewing this question and will be providing guidance shortly.

139. Is there a way for applicant IDNs to receive preliminary information on the number of Medicaid beneficiaries attributed to its proposed provider network in advance of final IDN applications due on May 31st?

The Department has made the option available for a preliminary attribution analysis. Please see separate communication regarding the process and timeline of this option.

140. What happens if an IDN is only 1,000 lives short of required attribution?

The Department has made the option available for a preliminary attribution analysis. In addition, during the first half of June, IDNs will be provided with feedback in cases where an Application fails to meet minimum requirements and will be given the opportunity to adjust the network/Application accordingly.

141. Will Medicaid beneficiaries know which IDN they are attributed to?

IDNs are provider-driven coalitions intended to foster the redesign of care. IDNs are not patient-facing entities and are not networks in the traditional way that 'provider networks' are thought of in a managed care context. As such, beneficiaries should experience the positive impact and improved outcomes of improved care and coordination across providers, but IDNs themselves should be 'invisible' to Medicaid beneficiaries.

142. How are the attribution hierarchies being de-duplicated?

Please refer to the IDN Application for additional detail on the 5-step attribution methodology. Each Medicaid beneficiary will be attributed to one IDN, based a sequential logic that prevents duplication.

143. What obligations do IDNs have around data-sharing rules and consent? Will the state be providing standardized consent forms/templates?

IDN Leads and providers participating in IDNs must continue to comply with all laws and regulations that govern patient privacy and data sharing (e.g. HIPAA). In addition, the state will establish data sharing agreements with each of the IDN Administrative Lead organizations as part of its contracting process.

144. Can organizations applying to be IDNs convene meetings outside of the state's in-services and the eventual Learning Collaborative?

Yes. The state will be convening regular sessions (in-person and via webinar) to answer questions and share information. As part of the demonstration, the state will also be supporting a Learning Collaborative for IDNs to

share best practices. However, IDNs are free to convene and engage in planning activities outside of state-facilitated forums.

145. In developing its community needs assessments, can IDNs leverage existing assessments that are not specific to the Medicaid population

Yes. The IDNs may choose to take advantage of existing needs assessments.

146. What happens if a provider leaves an IDN?

The process by which IDNs handle the network adequacy and financial implications of partners choosing to cease participating in an IDN will be defined by each IDN as part of the IDN Project Plan.

147. How will performance outcome metric targets be determined? Are the performance metrics all or nothing? 7. How will thresholds be determined?

Please refer to the draft Project and Metrics Specification guide for high-level information on performance outcome metrics and target-setting methodologies. Additional information regarding outcome metrics, baseline measurement, and performance goals will become available as part of the IDN Project Plan development process.

148. What are the state's guidelines with regard to IDN governance and management?

Please refer to the final IDN Application posted on May 9, 2016 for additional detail on state guidance related to IDN governance and management. It is required that an IDN identify a primary governing body (e.g., a Board or Executive Committee) and that this body reflect representation from across all organization types required to be part of an IDN. The primary governing body should be no larger than 15 members if possible. In addition, the overall structure of governance bodies established by the IDN must reflect oversight over the following four domains, at a minimum:

- Financial governance, including how decisions about the distribution of funds will be made, the roles and responsibilities of each partner organization, and budget development
- Clinical governance, including standard clinical pathways development and strategies for monitoring and managing patient outcomes
- Data/IT governance, including data sharing among partners and reporting and monitoring processes
- Community engagement, including the processes by which the IDN will engage the community in the development and implementation of the IDN

In addition, as part of its Project Plan, each IDN will be asked to identify individuals serving the following key management functions:

- Executive Director, or equivalent
- Medical Director, or equivalent
- Financial Director, or equivalent

149. Regarding the requirement that IDNs identify an ED, CFO, and Medical Director, is the state viewing the reporting structure for these entities as being to the administrative lead or to the entire IDN? Is the IDN supposed to become or create its own separate organization? Would IDN members then serve as an advisory council to this organization? What about the use of consultants as opposed to staff? Must those specific positions be included or, for example, can you have a Project Manager?

IDNs have the flexibility to establish the governance and management structure that best fits its circumstances, within the parameters set by the Department (see Question 148 for a summary of these parameters). The IDN will be required to identify individuals serving in the Executive Director, Finance Director, and Medical Director roles (or equivalent), but it is up to each IDN to determine its own reporting structure. It is also up to each IDN to

determine whether it will create a separate organization. It is also up to each IDN to determine how it will resource and support its planning and implementation efforts. Some IDNs may choose to contract with consultants for these services.

150. How should IDNs handle cases where a CMHC's service area crosses more than one IDN?

CMHCs and other participating IDN organizations can be part of more than one IDN.

151. Are there minimum requirements for the Executive Director, Medical Director, and Finance Director roles? Does the Medical Director need to have an MD?

It will be up to each IDN to determine the minimum requirements for these roles, consistent with the requirements used for similar roles in participating organizations in the IDN.

QUESTIONS ADDED MAY 31, 2016

152. Does the population for which the RFP applies only include Behavioral Health (Mental Health and Substance Use Disorder)?

The demonstration includes all New Hampshire Medicaid beneficiaries. However, given the behavioral health focus of the demonstration, the state has targeted the clinical interventions to the subset of Medicaid beneficiaries with or at risk for behavioral health conditions.

153. Will awards be granted for the full five years or will there be an initial period and re-application for subsequent years?

No re-application is required. IDNs will be approved and eligible to possibly receive capacity building funds and possibly to earn incentive funds during Demonstration Years 2 through 5. The amount of incentive funding earned by each IDN will be dependent on the performance of each IDN in each reporting period.

154. Are Managed Care Organizations (MCOs) eligible to participate in IDNs?

Prior to the state submitting to CMS contracts and rates for approval for any contract period beginning July 1, 2017, the state will submit to CMS a multi-year roadmap for how the state will implement a goal of using Alternative Payment Methodologies for at least 50 percent of Medicaid provider payments. In developing this roadmap, the state will engage with Managed Care Organizations, IDNs, providers and other stakeholders to evaluate payment model options, set payment methodology standards, and establish intermediate milestones. The expectations for the relationship between IDNs and MCOs will be further defined through this process. Please see Section 33 of the Standard Terms and Conditions of the waiver for more information.

155. Will IDNs be compensated on a fee-for-service or capitated rate model? Will their revenue be based on total costs of care? If so, what experience will be used to develop total cost of care payment?

Under the demonstration, IDNs will neither be reimbursed on a fee-for-service basis nor via a capitated model. The demonstration allows IDNs to earn performance-based incentive payments for achieving specified process milestones and clinical outcome goals. It is not a grant program nor a replacement for Medicaid managed care. Prior to the state submitting to CMS contracts and rates for approval for any contract period beginning July 1, 2017, the state will submit to CMS a multi-year roadmap for how the state will implement a goal of using Alternative Payment Methodologies for at least 50 percent of Medicaid provider payments. In developing this roadmap, the state will engage with Managed Care Organizations, IDNs, providers and other stakeholders to evaluate payment model options, set payment methodology standards, and establish intermediate milestones.

156. How is the IDN Project Design and Building Fund funded?

The Special Terms and Conditions of the demonstration allow New Hampshire to use up to 65 percent of demonstration Year 1 funding for the Project Design and Capacity funds.

157. If up to 65% of the Fund's monies are available for distribution in year 1, what are the remaining funds earmarked for? Does the IDN get any of the remaining funds? If yes, how?

The state will award the remaining 35 percent of Year 1 funding (excluding state administrative and other expenses) to approved IDNs upon their receipt of approval of an IDN Project Plan, for the execution of the outlined projects.

158. Will IDNs take on insurance risk?

As previously communicated, funds under this demonstration are available to be earned by IDNs as incentive-based payments for meeting specific milestone and metric targets.

159. Will there be specific network requirements on IDNs other than what is outlined in the document? The document highlights types of providers like PCPs, CMHCs but does not say how many need to be in network. Will MCOs network wrap around these IDNs?

The state's expectations for the type of providers and social service organizations that must be included in the IDN are outlined in detail in a number of demonstration documents, including the draft Planning Protocol (Attachment C of the Special Terms and Conditions). Of particular note, IDNs must ensure that a majority of the individuals attributed to them have a recent history of using providers in the proposed IDN network. MCO networks will not be impacted by the attribution algorithm.

160. Will there be any continuity of care requirements for IDNs?

No. Beneficiaries will continue to be free to seek care where they choose, regardless of attribution. Patients who are using providers outside the IDN to which they are attributed may continue to see that provider as they wish.

161. Will members know that they have been assigned to an IDN?

IDNs are networks of providers and social service organizations working together to foster the redesign of care. They are not patient-facing entities and are not networks in the traditional way that 'provider networks' are thought of in a managed care context. As such, beneficiaries should experience the positive impact and improved outcomes of improved care and coordination across providers, but IDNs themselves will not necessarily be 'visible' to Medicaid beneficiaries.

162. Will IDNs have the capacity to steer patients to particular services/providers?

Under the demonstration, beneficiaries will continue to have the same choice of providers through their MCO networks as they have today, and providers participating in IDNs will not be required to refer within the IDN network. State approval of an IDN network and plan does not alter the responsibility of Integrated Delivery Networks to comply with all federal fraud and abuse requirements of the Medicaid program, including, but not limited to, the anti-kickback statute (sections 1128B(b)(1) and (2) of the Social Security Act and the physician self-referral prohibition. The state anticipates that it may provide additional guidance on its expectations around referrals as implementation continues.

163. Is the expectation that Applications to be submitted on 5/31/16 include Letters of Intent among the parties (hospitals, PCPs, MCOs, etc.) to form an IDN?

Yes. IDN applications must include non-binding Letters of Commitment from all participating IDN organizations listed in the Application as having actively agreed to participate in the IDN.

164. Can an MCO submit an application to serve as an administrative lead and if selected then subsequently work to secure commitments from providers to participate in the IDN? Or does that inter-organizational commitment need to be made at time of application?

The commitment needs to be made at the time of application. IDN applicants must submit preliminary information on the organizations who will be participating in the IDN with the IDN application, including non-binding Letters of Commitment from all participating IDN organizations listed in the Application as having actively agreed to participate in the IDN.

165. Would an agency from Vermont be eligible to participate in this RFP?

No.

166. Question 16 of the IDN Application template references "one time" Project Design and Capacity Building Funds" in 2016. Our question pertains to the initial equal distribution (of the 50% of the first year

funding) for IDN administration and infrastructure design and operation. Are these dollars for this purpose paid in 2016 designed to last the entire 5 years? Or can a portion of the year 2-5 performance and process metric payments be allocated to the ongoing IDN administration, governance and leadership activities?

The Special Terms and Conditions of the demonstration allow New Hampshire to use up to 65 percent of demonstration Year 1 funding for the Project Design and Capacity Building Funds. The amount of Project Design and Capacity Building Funds allocated to each IDN will be based on a calculation with two components: 1) a fixed component, calculated assuming equal distribution of 50 percent of total available Project Design and Capacity Building funds evenly across all approved IDNs and 2) a variable component that is calculated by assuming the remaining 50 percent of Project Design and Capacity Building funds is distributed proportionately among IDNs based on their share of attributed Medicaid beneficiaries resulting from the preliminary partner network submission.

While these Project Design and Capacity Building funds will be distributed as a one-time payment in 2016, IDNs can choose to spend these funds at any point over the 5-year demonstration. Given that these funds are intended to support upfront planning and capacity building, it is anticipated that the majority of funds will be invested by IDNs during the first year. However, since incentive funding during Years 2-5 are not guaranteed and must be earned through the achievement of milestones and metrics, IDNs may choose to reserve portions of the Project Design and Capacity Building funds to support certain activities over the course of the demonstration. Incentive funding earned by IDNs over the course of Years 2-5 of the demonstration can also be used to support IDN administration, governance, and leadership activities.

167. On questions 17 and 18 of the IDN Application template, IDNs are asked to provide preliminary estimates for how Project Design and Capacity Building funds will be allocated across several categories. Can the Department provide guidance to IDNs around how to handle these estimates given that a detailed gap assessment has not been completed and other state initiatives may impact these estimates? This is particularly true for staffing and HIT/HIE related estimates.

Given that IDNs are in the nascent stages of planning, it is understood that these estimates are highly preliminary. As part of the Project Plan development process, approved IDNs will have an opportunity to refine and update the estimates. It is anticipated that these final Project Plans will be due on September 1, 2016.

168. In Appendix E of the IDN Application RFP, please confirm that the reference to Q3-Q4 2016 is referencing calendar years vs. state fiscal year. If true, Q3-Q4 2016 refers to July-December 2016.

Yes. 2016 refers to calendar year 2016.

169. Regarding allowable and non-allowable expenditures for Project Design and Capacity Building Funds, can funds pay for establishment of an Integrated Delivery Network's administrative infrastructure if costs were incurred prior to approval of application? Is there a possibility of Governor and Executive Council retroactive approval of contracts so these costs can be absorbed by the contract?

No. Capacity Building Funds are awarded to approved IDNs for development of the IDN and the work they plan to do under the Demonstration – not for work they have already done.

170. Has children's behavioral health been removed from the target populations for the 1115 waiver activities?

No. To the contrary, the fundamental mission of this demonstration is to improve the quality and access to the behavioral health delivery system for all New Hampshire Medicaid beneficiaries, inclusive of children and youth.

A focus on children and youth is built into the demonstration's design, which requires that IDNs pursue performance goals by implementing a set of six projects, three of which are mandatory for all IDNs. These three foundational, mandatory projects serve as the cornerstone of this transformation initiative and include all Medicaid beneficiaries (inclusive of children and youth) in their target populations.

One of these mandatory projects—the Integrated Healthcare Core Competency Project (B1)— seeks to integrate care across primary care, behavioral health and social support service providers and includes a mandatory requirement that “all children receive standardized, validated developmental screening, such as the ASQ:3 and/or ASQ SE at 9, 18 and 24/30 month pediatric visits; and use Bright Futures or other American Academy of Pediatrics recognized developmental and behavioral screening system.” In the most recent draft of the IDN project menu described in the Draft Project and Metrics Specification Guide, this developmental screening was incorporated to be a requirement of this mandatory project rather than a component of a project that had previously been included as an optional Community Driven project focused on “Early Childhood Prevention and Interventions”. Other Community Driven projects are described further below.

IDNs will select their remaining three projects from a menu of twelve “Community Driven” projects. These projects allow IDNs the flexibility to tailor their programs to local, community-specific priorities identified through a behavioral health needs assessment and community engagement. These projects focus on specific sub-populations or interventions.

Many of these projects include children and youth in the target population, for example:

- Project C2: Community Re-entry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues
- Project E1: Wellness programs to address chronic disease risk factors for SMI/SED populations
- Project E5: Enhanced Care Coordination for High-Need Populations, including children diagnosed with chronic serious emotional disturbance

In addition, two of these project options are focused exclusively on children or youth:

- *Project E2: School-based Screening and Intervention*

This project seeks to build the knowledge and skills of school-based staff to recognize children at-risk-of or in need of mental health or substance use services and to link them with the IDN’s community-based provider network, avoiding unnecessary referral to the emergency department and taking full advantage of schools as a key point of entry in a ‘no wrong door’ approach to identification and effective management of behavioral health risks/conditions. By equipping school-based staff to act as the first line of support for positive outcomes, project E2 is anticipated to result in improved diagnosis of and early intervention/treatment for the mental health and substance use disorder problems of children and adolescents.

- *Project E3: Substance Use Treatment and Recovery Program for Adolescents and Young Adults*

This project seeks to expand IDN capacity to deliver effective services that have been shown to reduce substance misuse and risky behaviors among adolescents and young adults that lead to involvement in the justice system, long term or even life-long misuse of illicit drugs, opioids and alcohol.

In addition, IDNs have the flexibility to invest funds earned through this demonstration to further strengthen the behavioral health delivery system for children and youth based on local community needs.