
Building Capacity for Transformation: **New Hampshire's DSRIP Waiver Program**

May 2016



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Overview



Key Challenges

Significant challenges remain in meeting the needs of individuals with mental health and substance use disorders (SUD). Expansion of Medicaid to newly-eligible adults and of SUD benefits is a significant opportunity, but also places new demands on already overtaxed providers, underscoring the need for transformation.

Capacity Constraints

- ❑ **Long wait lists:**
 - 2 - 10 weeks for residential treatment
 - 26 days for outpatient counseling
 - 49 days for outpatient counseling with prescribing authority
- ❑ **Limited SUD treatment options:**
 - In 2014, 92 percent of NH adults with alcohol dependence or abuse did not receive treatment, and four out of 13 public health regions had no residential SUD treatment programs
 - 84% of NH adults with illicit drug dependent or abuse did not receive treatment
- ❑ **Excess demand for beds:**
 - New Hampshire Hospital operates at 100% capacity
 - 2 out of 3 people admitted to NHH spend more than a day waiting in the ER before a bed is available

'Siloed' Behavioral and Physical Health

- ❑ **Limited integration:**
 - A 2015 review of physical and behavioral health integration in NH by Cherokee Health Systems found “while there are certainly pockets of innovation...overall there remains room for further advancement”
- ❑ **Workforce shortage:**
 - The Cherokee analysis highlighted an acute shortage in the workforce necessary for integrated care, including behaviorists with skills to work in the primary care setting

Gaps During Care Transitions

- ❑ **Lack of follow-up care:**
 - Between 2007 and 2012, the percent of patients hospitalized for a MH disorder who received follow-up care within 30 days of release deteriorated from 78.8 to 72.8%
- ❑ **Poor continuity:**
 - 48% of NH residents who leave a state correctional facility have parole revoked due to a substance use-related issue



Delivery System Reform Incentive Program (DSRIP) Waivers: The Basics

Using a Medicaid 1115 waiver, States fund networks of providers who meet metrics demonstrating improved patient outcomes and promoting delivery system reform.



DSRIP waivers are a key way to approach Medicaid delivery reform, among many other reform initiatives



Overview of New Hampshire's DSRIP Waiver Program: *Building Capacity For Transformation*

The waiver represents an unprecedented opportunity for New Hampshire to strengthen community-based mental health services, combat the opiate crisis, and drive delivery system reform.

Key Driver of Transformation



Integrated Delivery Networks : Transformation will be driven by regionally-based networks of physical and behavioral health providers as well as social service organizations that can address social determinants of health

Three Pathways

Improve care transitions

Promote integration of physical and behavioral health

Build mental health and substance use disorder treatment capacity

Funding Features



Menu of mandatory and optional community-driven projects



\$150 million in incentive payments over 5 years



Support for transition to alternative payment models



Funding for project planning and capacity building



Performance-based funding distribution



Integrated Delivery Networks



Integrated Delivery Networks (IDNs)

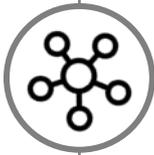


- New, regionally-based networks of providers called Integrated Delivery Networks ('IDNs') will drive system transformation by designing and implementing projects in a geographic region.
- IDNs will be organized into **7** regions throughout the State.
- Multiple IDNs may apply. It is anticipated that there will likely be 1 IDN in many areas of the state, but multiple IDNs may emerge in more heavily populated regions.

Key Elements



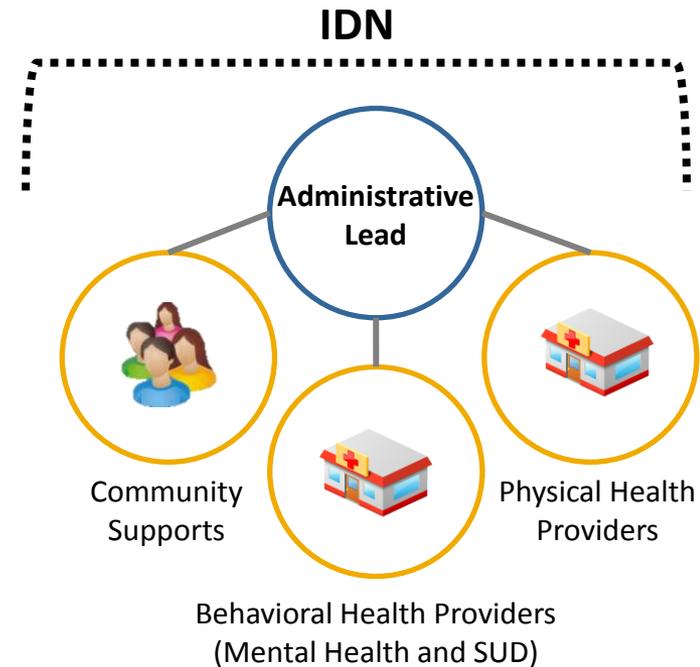
Participating Partners: Includes community-based social service organizations, hospitals, county facilities, physical health providers, and behavioral health providers (mental health and substance use).



Structure: Administrative lead serves as coordinating entity for network of partners in planning and implementing projects.

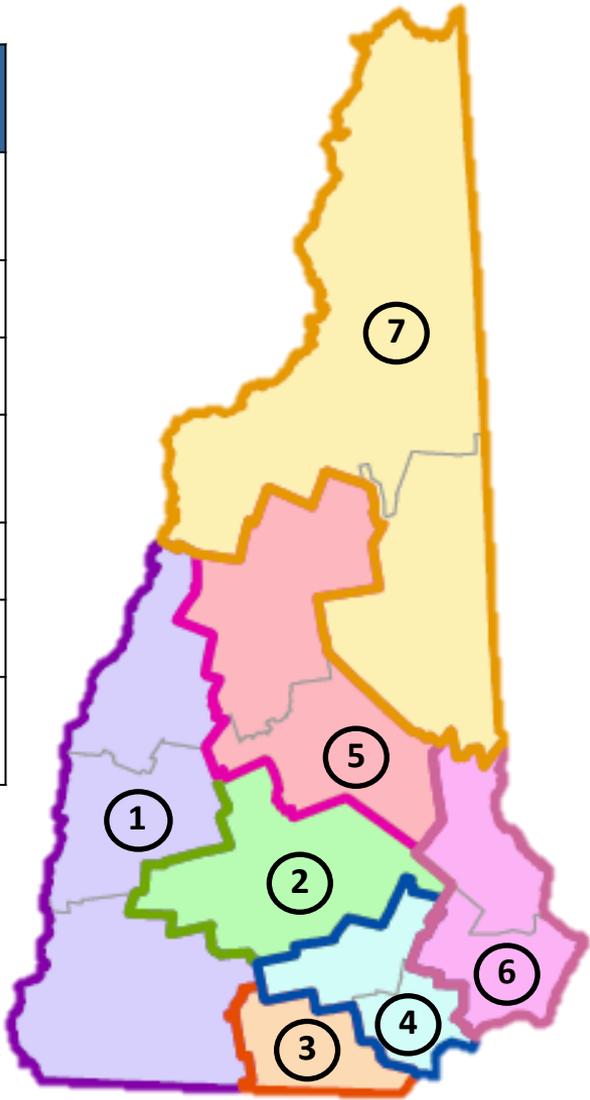


Responsibilities: Design and implement projects to build behavioral health capacity; promote integration; facilitate smooth transitions in care; and prepare for alternative payment models.



IDNs Will be Organized into 7 Regions

Illustrative IDN	Regional Public Health Networks (RPHN) Included	# of Medicaid members
1. Monadnock, Sullivan, Upper Valley	Greater Monadnock, Greater Sullivan County, Upper Valley	21,550
2. Capital	Capital Area	15,520
3. Nashua	Greater Nashua	19,110
4. Derry & Manchester	Greater Derry, Greater Manchester	34,900
5. Central, Winnipesaukee	Central NH, Winnipesaukee	15,230
6. Seacoast & Strafford	Strafford County, Seacoast	25,440
7. North Country & Carroll	North Country RHPN, Carroll County RHPN	15,300



Providers in each IDN region are encouraged to work together to form one IDN, particularly in less populated parts of the State.

Note: pending final approval by CMS and subject to change



Administrative Lead: Responsibilities

Integrated Delivery Networks will be composed of an Administrative Lead and several partners



Administrative Lead Responsibilities*

- Organize consortium partners in geographic region
- Act as single point of accountability for DHHS
- Submit single application on behalf of IDN
- Implement IDN governance structure in accordance with DHHS parameters
- Receive funds from DHHS and distribute funds to partners
- Compile required reporting
- Collaborate with partners in IDN leadership and oversight
- Collaborate with IDN partners to manage performance against goals and metrics

**Partners may lead implementation efforts for specific projects*



IDN Composition



General Principles

- IDNs must include a broad range of organizations that can participate in required and optional projects
- IDNs must ensure 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 or substance use disorder need



Specific Requirements

IDN partner networks must include :

- A substantial percentage of the **regional primary care practices** and facilities serving the Medicaid population
- A substantial percentage of the **regional SUD providers**, including recovery providers, serving the Medicaid population
- Representation from **Regional Public Health Networks**
- One or more Regional **Community Mental Health Centers**
- **Peer-based support** and/or **community health workers** from across the full spectrum of care
- One or more **hospitals**
- One or more **Federally Qualified Health Centers, Community Health Centers, or Rural Health Clinics**, if available
- Multiple **community-based organizations** that provide social and support services (transportation, housing, employment, community supports, legal assistance, etc.)
- **County organizations** representing nursing facilities and correctional systems



Pathways and Projects



Three Pathways to Delivery System Reform

IDNs will implement defined projects addressing the three pathways to delivery system reform:

Build mental health and SUD treatment capacity

Projects will support mental health and substance use disorder treatment capacity and supplement existing workforce in all settings.

- Develop workforce initiatives and new treatment and intervention programs
- Implement alternative care delivery models (telemedicine, etc.)

Improve care transitions

Projects will support beneficiaries transitioning from institutional settings to the community and within organizations in the community.

- Create incentives for IDNs to adopt evidence-based practices for the management of behavioral health patients during transitions
- Incentivize provider collaboration

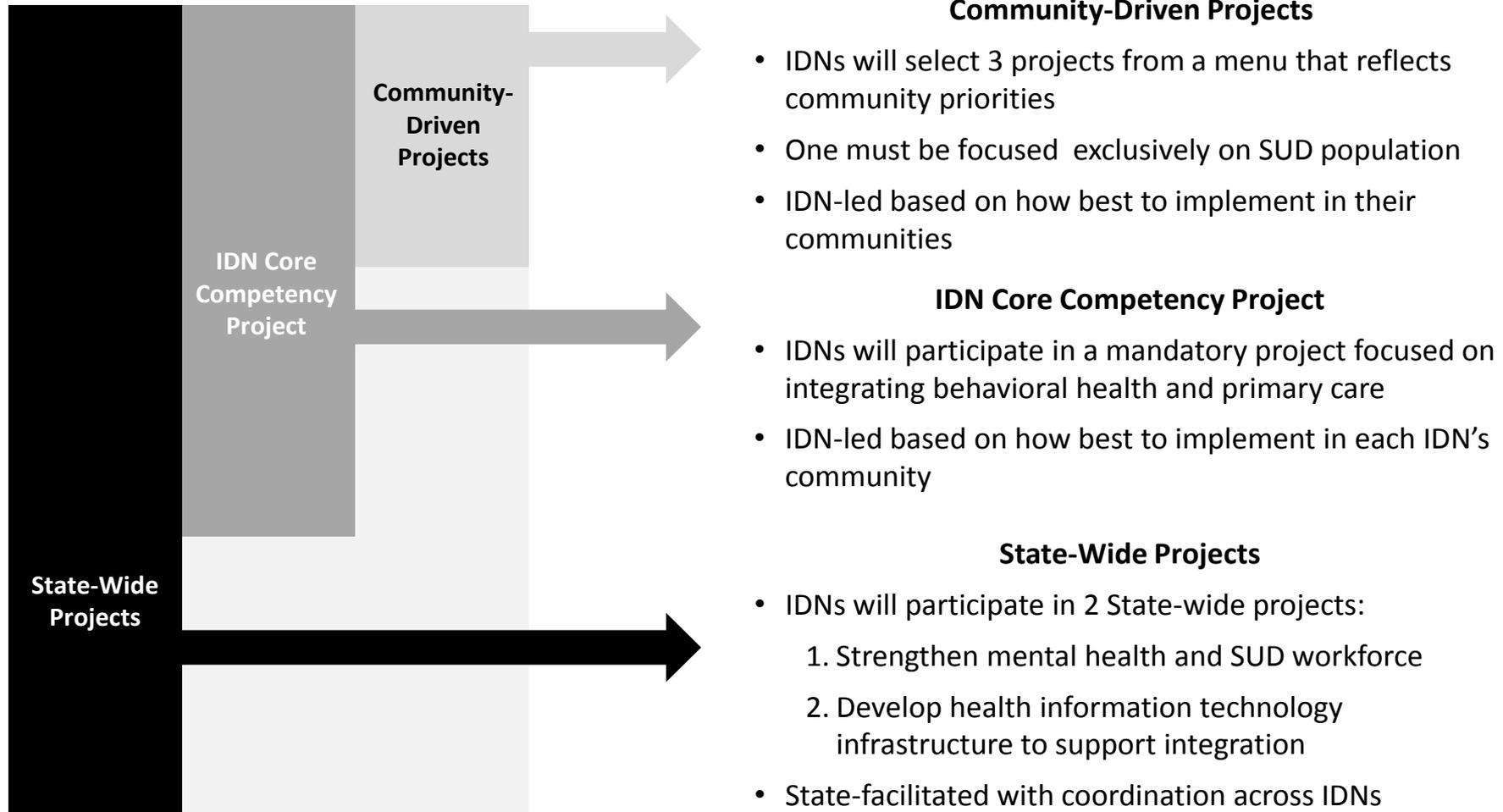
Integrate physical and behavioral healthcare

Projects will promote provider integration and collaboration between primary care, behavioral health care and community services.

- Support physical and virtual integration in primary care and behavioral health settings
- Expand programs that foster collaboration among physical and behavioral health providers
- Promote integrated care delivery strategies that incorporate community-based social support providers



Project Menu Structure



Each IDN will implement the Core Competency Project.



Integrated Healthcare

- Primary care providers, mental health and SUD providers, and social services organizations will partner to:
 - Prevent, diagnose, treat and follow-up on both behavioral health and physical conditions
 - Refer patients to community and social support services
 - Address health behaviors and healthcare utilization
- Standards will include:
 - Core standardized assessments for depression, substance use, and medical conditions
 - Integrated electronic medical records and patient tracking tools
 - Health promotion and self-management support
 - Care management services
- NCQA accreditation is not required



Community-Driven Project Menu

Each IDN will select three community-driven projects from a DHHS-defined menu.

Care Transitions:

Support beneficiaries with transitions from institutional settings to the community

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

Capacity Building:

Supplement existing workforce with additional staff and training

- Medication Assisted Therapy of Substance Use Disorders
- Expansion of Peer Support Access, Capacity, and Utilization
- Expansion in intensive SUD Treatment Options, including partial hospital and residential care
- Multidisciplinary Nursing Home Behavioral Health Service Team

Integration:

Promote collaboration between primary care and behavioral health care

- Wellness Program to address chronic disease risk factors for SMI/SED population
- School-Based Screening and Intervention
- Substance Use Treatment and Recovery Program for Adolescents and Young Adults
- Integrated Treatment for Co-Occurring Disorders
- Enhanced Care Coordination for High –Need Populations



Community Reentry Program for Justice-Involved Adults and Youth with Substance Use Disorders or Significant Behavioral Health Issues

Research indicates that significant numbers of adults in correctional facilities and youth in juvenile justice residential facilities have diagnosed and undiagnosed mental illness and/or substance use disorders. Community re-entry is a time-limited program to assist those individuals with behavioral health conditions to safely transition back into community life. The program is initiated pre-discharge and continues for 12 months post discharge. **The program's objectives** are to:

- ❑ **Support adults and youth leaving the state prison, county facilities or juvenile justice residential facilities who have behavioral health issues** (mental health and/or substance misuse or substance use disorders) in maintaining their health and recovery as they return to the community.
- ❑ **Prevent unnecessary hospitalizations and ED usage** among these individuals by connecting them with integrated primary and behavioral health services, care coordination and social and family supports.

Note: The objective of this project is to improve care and health outcomes for justice-involved individuals and youth transitioning back into the community, but the State also anticipates that improvements in care will improve public safety and result in a lower recidivism rate.



Core elements of the community re-entry program include:

Screening for Behavioral Health Conditions: Prior to departure, all persons in correctional facilities and juvenile justice facilities will be screened for behavioral health conditions. The facility participating in the initiative will select the screening tool in collaboration with participating IDN partners. It can rely on an existing tool if the tool serves to identify behavioral health conditions and individuals at particularly high risk for relapse.

Discharge Assessment: For individuals with behavioral health conditions, the IDN (or participating partners within the IDN) will work with the correctional facility or juvenile justice facility to begin assessments, case management and care coordination, treatment planning, family support services, and programming with identified individuals at least 30 days prior to release. This will include a documented core standardized assessment by the care team and a physical exam that becomes the basis for a post-release care plan appropriate for release and/or parole. This plan, described in more below, will be developed in collaboration with the correctional facility/detention center to ensure appropriate linkage of services and needs.

Care management services: The integrated care team will include a care manager who will be in regular contact with individual in person and by phone at decreasing levels of intensity/frequency during the 12 months following release. The care manager will assist in arranging and coordinating medical, behavioral health, family and social support services; assist the individual and, for youth, the family, in following the agreed-upon transition plan, including by assisting with adherence to treatment regimen and in securing needed services; and ensure the care plan remains useful and is updated regularly. For adults, the care manager will also serve as a link with parole officers and for children with juvenile justice services.



Transitional Care Plan

Transitional care plan: Working in collaboration with the correctional facility or juvenile justice facility, the IDN (or participating partners) will develop a goal-oriented transitional care plan with the individual. The care plan is designed to guide the individual and the care team through a successful transition that links the individual to needed community supports and, as appropriate, family supports. It will provide for:

- Clear identification of the person who is responsible for leading the effort to support the individual's re-entry into the community and family life.
- Linkage with an integrated care team including primary and behavioral health service providers for treatment, medication management, recovery services and care management, as described in more detail below.
- Steps that will be taken to connect the individual to community-based social support services as necessary, including:
 - Assistance in securing housing (including supported housing or other housing options for hard-to-place individuals)
 - Training and supported employment aimed at assisting the individual to find employment despite a history of involvement in the justice system
 - Re-engagement and mediation with family members and other care givers
 - Linkages to and enrollment in entitlement programs and other social supports, including, as appropriate, parenting classes.



Transitional Care Plan (cont.) Care Management and Staffing

- Trained peer support specialists who can work directly with the justice involved person to provide peer mentoring, listening, transportation to services, and/or other forms of support.
- Completion of releases to allow for secure communication among team members
- For youth, linkages to family-based supports (including for foster families, as appropriate)

Care management services: The integrated care team will include a care manager who will be in regular contact with individual in person and by phone at decreasing levels of intensity/frequency during the 12 months following release. The care manager will assist in arranging and coordinating medical, behavioral health, family and social support services; assist the individual and, for youth, the family, in following the agreed-upon transition plan, including by assisting with adherence to treatment regimen and in securing needed services; and ensure the care plan remains useful and is updated regularly. For adults, the care manager will also serve as a link with parole officers and for children with juvenile justice services.

Staffing: The integrated care team will be multi-disciplinary and serve between 25-50 individuals, depending on severity. The staff should include:

- Care manager with Bachelor or Master's degree in social work or human relations field with training/experience in serving the justice-involved population, including youth and veterans:
- Mental health professional (e.g., LCSW, Psychologist) who will support and supervise the care coordinator
- Consulting psychiatrist to design medication regimen and serve as an advisor to the team
- Primary care provider (PCP)
- For youth, family support specialists



Financing



Funding for the Transformation Waiver

Key Funding Features:

- The transformation waiver provides up to \$150 million over 5 years.
 - State must meet statewide metrics in order to secure full funding beginning in 2018
 - State must keep per capita spending on Medicaid beneficiaries below projected levels over the five-year course of the waiver
- Up to 65% of Year 1 funding will be available for capacity building and planning.
- In Years 2-5, IDNs must earn payments by meeting metrics defined by DHHS and approved by CMS to secure full funding. Under the terms of New Hampshire’s agreement with the federal government, this is not a grant program.
- A share of the \$150 million will be used for administration, learning collaboratives, and other State-wide initiatives.

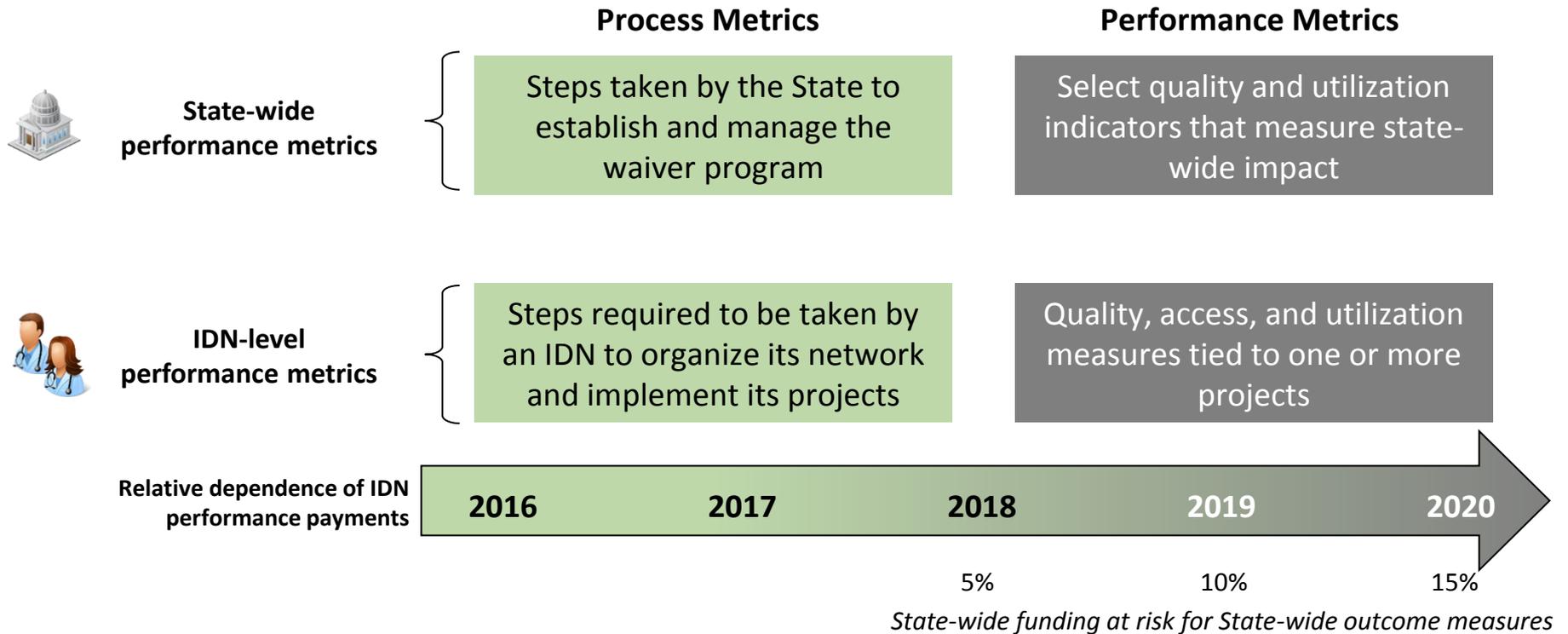
	2016 (Year 1)	2017 (Year 2)	2018 (Year 3)	2019 (Year 4)	2020 (Year 5)	Total Funding
Capacity Building (Up To 65% of Year 1 Funding)	\$19,500,000	n/a	n/a	n/a	n/a	\$19,500,000
Other Funding (IDN payments, administrative expenses, etc.)	\$10,500,000	\$30,000,000	\$30,000,000	\$30,000,000	\$30,000,000	\$130,500,000
Percent at Risk for Performance	0%	0%	5%	10%	15%	
Dollar Amount at Risk for Performance	(\$0)	(\$0)	(\$1,500,000)	(\$3,000,000)	(\$4,500,000)	

TOTAL \$150,000,000



State-wide and IDN-level Metrics

- Performance metrics at the state- and IDN-levels will be used to monitor progress toward achieving the overall waiver vision. Payments from CMS to the state and from the state to IDNs will be contingent on meeting these performance metrics.
- Accountability shifts from process metrics to performance metrics over the course of the 5-year program.



Examples of Potential Metrics

	Process Metrics	Performance Metrics
<p>State-wide Performance Metrics</p> 	<ul style="list-style-type: none"> • Approval of IDNs and planning/capacity building grants • Approval of IDN Project Plans • Submission of CMS reports • Procurement of independent assessor and independent evaluator • Implementation of learning collaboratives 	<ul style="list-style-type: none"> • Reduction in readmissions for any reason for individuals with co-occurring behavioral health issues • Use of core standardized assessment • Reduction in avoidable ED use for behavioral health population and general population • Reduction in ED waitlist length for inpatient behavioral health admissions
<p>IDN-level Performance Metrics</p> 	<p>General IDN Metrics</p> <ul style="list-style-type: none"> • Establishment of an IDN governance committee structure (clinical governance, financial, etc.) • Development and submission of IDN plan to transition to value-based payment models <p>Project-Specific Metrics</p> <ul style="list-style-type: none"> • Document baseline level of integration of primary care – behavioral health using SAMHSA <i>Levels of Integrated Healthcare</i> • Establishment of standard core assessment framework and evidence based screening tools 	<ul style="list-style-type: none"> • Improvement in rate of follow-up after hospitalization for mental illness • Improvement in rate of screening for clinical depression using standardized tool • Improvement in rate of screening for substance use • Improvement in rate of smoking and tobacco cessation counseling visits for tobacco users • Reduction in wait time for substance use disorder treatment



Funding Allocations by Earning Category and Metric Type

Over the DSRIP period, funding shifts to emphasize Community-Driven Projects and performance measures.

Funding Allocation by Earning Category	Year 1 2016	Year 2 2017	Year 3 2018	Year 4 2019	Year 5 2020
Design and Capacity Building Funds	65%	0%	0%	0%	0%
Approval of IDN Project Plan	35%	0%	0%	0%	0%
Statewide Projects	0%	50%	40%	30%	20%
Core Competency Project	0%	30%	30%	20%	20%
Community-Driven Projects	0%	20%	30%	50%	60%
Total	100%	100%	100%	100%	100%

Funding Allocation by Metric Type	Year 1 2016	Year 2 2017	Year 3 2018	Year 4 2019	Year 5 2020
Process Metrics	100%	90%	75%	0%	0%
Performance Metrics	0%	10%	25%	100%	100%
	100%	100%	100%	100%	100%

Note: pending final approval by CMS and subject to change

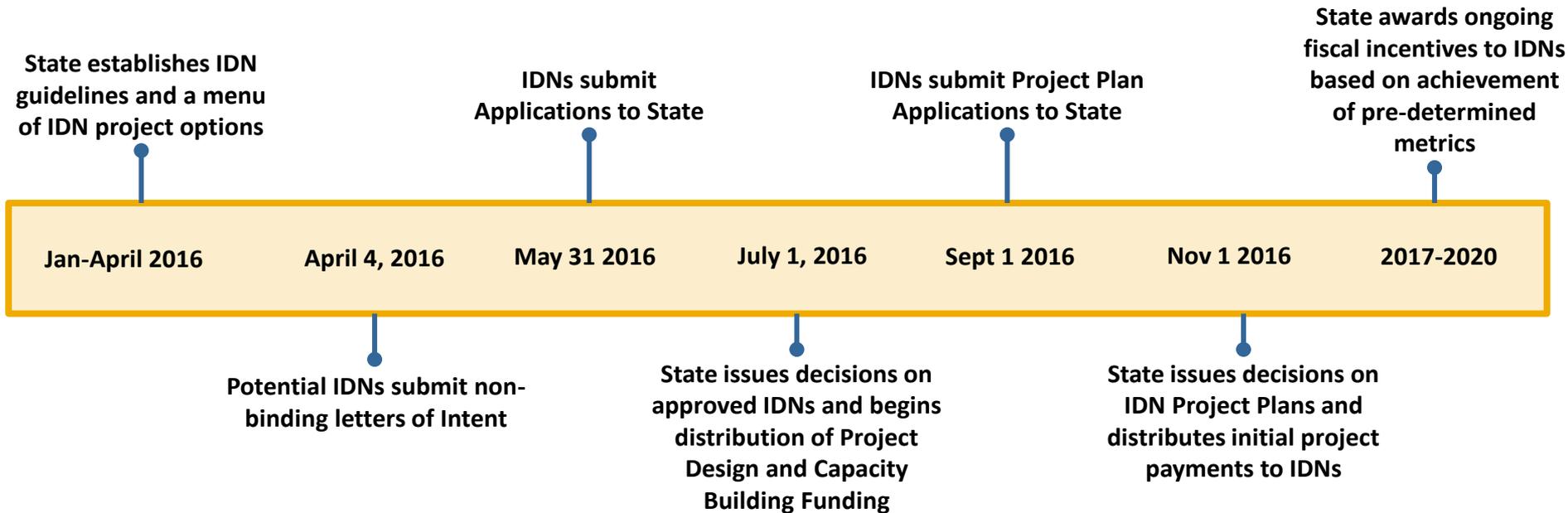


Implementation of Integrated Delivery Networks



- IDN applications are due May 31, 2016
- IDNs applications approved by June 30, 2016
- Detailed DSRIP project plans are due by September 1, 2016
- Distribution of project funds is targeted for Nov 1, 2016

Target Implementation Timeline



Opportunities for Public Comment

Stakeholder input and engagement is critical to the success of the transformation waiver. It will be actively solicited at all stages of implementation.

Selected Upcoming Opportunities for Input Below. DHHS will review all materials in light of public input for any potential changes concurrent with CMS approval:

- March:** Opportunity to prepare and submit comments on the draft planning and funding protocols.
- April 1-April 15:** Opportunity to prepare and submit comments on the draft IDN application materials, including the application for selection to be an Administrative Lead and to apply for Project Design and Capacity Building Funds.
- July 1-July 15:** Opportunity to comment on the draft IDN Project Plan Template.
- Summer and Fall of 2016:** Opportunity to comment on the proposed project plans of individual IDNs. *In addition, DHHS will hold a series of stakeholder meetings through March and April of 2016 to generate discussion and input from stakeholders on the early design phases of the transformation waiver.*

Comments and questions can be submitted at any time to 1115waiver@dhhs.state.nh.us

For more information, please visit:

<http://www.dhhs.nh.gov/section-1115-waiver/index.htm>



FOR MORE INFORMATION

Transformation DSRIP waiver webpage:

<http://www.dhhs.nh.gov/section-1115-waiver/index.htm>

- Special Terms and Conditions of NH's DSRIP Waiver
- Draft Funding and Mechanics Protocol
- Draft DSRIP Planning Protocol
- LOIs and Application
- Draft Project Menu and Specification Guide

Email: 1115waiver@dhhs.state.nh.us

