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► Vision for Delivery System Reform in New Hampshire
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► Key Elements for Delivery System Reform in New Hampshire
► Pathways & Projects for Delivery System Reform
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Vision for Delivery System Reform in New Hampshire
Transforming New Hampshire’s Delivery System

New Hampshire has an unprecedented opportunity to strengthen its delivery system to better address the behavioral health (both mental health and substance abuse) needs of all Medicaid beneficiaries. The waiver will allow New Hampshire to develop a sustainable infrastructure for providing high-quality, integrated physical and behavioral health services; improve the health of the State’s population; and reduce the rate of growth in Medicaid spending.

**High-Level Vision**

- Create a health system with the capacity to address the behavioral (both mental health and substance abuse) and physical health needs of all beneficiaries, including newly-eligible adults and children, pregnant women, people with disabilities and seniors who have long been eligible for Medicaid in New Hampshire.

- Promote integration of the physical and behavioral health system to ensure that needs are addressed before a crisis occurs and that beneficiaries, as appropriate, are connected with social services that can improve their health outcomes.

- Establish partnerships of providers and community-based organizations (“Integrated Delivery Networks” or “IDNs”) that implement projects to support delivery system reform across enabling pathways.

- Establish performance metrics for IDNs and statewide metrics to assess whether the vision is achieved.

**Enabling Pathways**

- Fostering Partnerships Among Providers Across the Care Spectrum To Support Care Transitions
- Building Capacity in the Behavioral Health System
- Promoting Provider Integration
Recent Developments and National Trends
NH’s Initial Waiver Submission

Chapter 3 of New Hampshire Laws 2014 (SB 413) directed DHHS to prepare and submit Section 1115 Waiver for transformation of NH Medicaid program

**April/May 2014:** Waiver concept paper and application drafted in consultation with stakeholders, including two public hearings and a public comment process.

**May 2014:** Waiver application, titled *Building the Capacity for Transformation*, approved by Fiscal Committee and submitted to CMS.

Waiver proposed funding of six designated state health programs:

- Establishing a Community Reform Pool
- Enhancing Community-Based Mental Health Services
- Sustaining Community-Based Services for Children and Youth under the System of Care/F.A.S.T. Forward Program
- Investing in Behavioral Health Workforce Development
- Expanding the InSHAPE program
- Launching Oral Health Pilot Program for Pregnant Women

Senate Bill 413: [http://www.gencourt.state.nh.us/legislation/2014/sb0413.html](http://www.gencourt.state.nh.us/legislation/2014/sb0413.html)
CMS requested that the Department articulate a **more cohesive vision** for how the waiver would transform the state’s health delivery system and serve its health reform goals of improving care, improving population health and impacting healthcare costs. In addition, several related developments at CMS reinforce the need for a refocused waiver amendment.

**Waiver Policy Priorities**

CMS increasingly is pushing **all** states to clearly assess and analyze the circumstances in which a waiver is needed versus a State Plan Amendment.

**Innovation Accelerator Program**

CMS recently announced the Medicaid Innovation Accelerator Program (IAP) to support delivery system reform in states. The IAP includes a strong focus on mental health and substance abuse issues.

**CMS priorities continue to be dynamic and additional guidance may be forthcoming**
Evolution of Delivery System Waivers

- No clear rules or official CMS guidance on how states may structure delivery system reform waivers, which increasingly are referred to as “Delivery System Reform Incentive Program” or “DSRIP” waivers.
- States have flexibility to design their programs to address the unique challenges facing their delivery system and Medicaid population.

Initially, states used DSRIP funding to support public hospitals and other safety net providers (e.g., CA, TX). Recently, states have taken a more strategic approach by articulating a clear vision, creating projects in support of the vision, and establishing performance benchmarks (e.g., NJ, NY).

- **California:** Bridge to Reform Waiver (2010-2015)
- **Texas:** Transformation & Quality Improvement Waiver (2012-2016)
- **Massachusetts:** MassHealth (2011-2014 w/ extension pending)
- **Kansas:** KanCare Waiver (2014-2017)
- **New York:** Medicaid Reform Transformation Waiver (2014-2019)
- **New Jersey:** Comprehensive Medicaid Waiver (2014-2017)
Emerging Themes from Recent DSRIP Waivers

The following high-level themes reflect the more defined and strategic characteristics of recent state DSRIP waivers in New Jersey and New York.

<table>
<thead>
<tr>
<th>Themes</th>
<th>State Examples</th>
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<tbody>
<tr>
<td><strong>Clear Vision</strong></td>
<td>- States must articulate a clear vision for delivery system reform in their waiver applications.</td>
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<td>- Recent DSRIP states have defined concrete visions and established metrics to measure their progress toward achieving them.</td>
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<td>- <strong>NY</strong>: Overall waiver goal is to reduce avoidable hospital utilization.</td>
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<td><strong>Defined Pathways</strong></td>
<td>- Some early DSRIP states provided more flexibility to eligible providers to choose projects and define performance metrics.</td>
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<td>- More recent DSRIP states have chosen to create a menu of defined projects and metrics.</td>
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<td>- <strong>NJ</strong>: Providers must select from a menu of 17 separate projects to address 1 of 8 chronic conditions.</td>
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<td></td>
<td>- <strong>NY</strong>: Providers select from a menu of 44 separate projects across four domains established by the state.</td>
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Emerging Themes from Recent DSRIP Waivers (cont.)

<table>
<thead>
<tr>
<th>Themes</th>
<th>State Examples</th>
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<tbody>
<tr>
<td><strong>State and Provider Performance Metrics</strong></td>
<td><strong>NY</strong>: State must meet statewide delivery system reform goals and metrics, including reducing inpatient admissions by 25% statewide.</td>
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<td><strong>NJ and NY</strong>: Each project has a defined set of outcome measures for providers (e.g., reduced admissions and ED visits, improved care processes), and providers must attain measures to receive payment.</td>
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<td><strong>NJ</strong>: Payments may be used for infrastructure expenses, including investments in “technology, tools, and human resources.”</td>
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<tr>
<td><strong>Transition Payments</strong></td>
<td><strong>In general, DSRIP states provide transition payments to support and stabilize providers as they transition to new delivery models.</strong></td>
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<td><strong>Transition payments are undergoing increasing scrutiny at the federal level.</strong></td>
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Background on Behavioral Health and Substance Abuse Issues in New Hampshire
In the 1980s, the State began the process of deinstitutionalization and transitioning to community-based providers. However, in recent years the State’s community-based provider network, along with its limited inpatient psychiatric facilities and substance use disorder services, have been unable to meet the evolving needs of the population.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tr>
<td>1981</td>
<td>Federal Court requires the State to eliminate unnecessary institutionalization and develop a community-based mental health system.</td>
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<tr>
<td>1982</td>
<td>Study Committee on Mental and Developmental Disabilities issues a report reinforcing the need to transition to a community-based mental health network.</td>
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<tr>
<td>1985</td>
<td>Mental Health Services System Law establishes a State policy of providing mental health care in community-based settings.</td>
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<tr>
<td>1986</td>
<td>Inpatient and community-based mental health provider capacity declines.</td>
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<tr>
<td>1985-2000s</td>
<td>NH Community Behavioral Health Association reports on the State’s progress in meeting the goals of the ten-year plan, but noted that significant gaps remain.</td>
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<tr>
<td>2008</td>
<td>NH DHHS releases a ten-year plan for improving the State’s mental health infrastructure. (The national recession of 2008-2010 severely impacts funding of the plan).</td>
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<tr>
<td>2012</td>
<td>Governor’s Commission releases a report on reducing drug and alcohol misuse and promoting recovery.</td>
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<tr>
<td>2013</td>
<td>NH Behavioral Health Collaborative releases a plan for improving children’s behavioral health care.</td>
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<tr>
<td>2014</td>
<td>Class Action Settlement directs the State to enhance its community mental health infrastructure.</td>
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<tr>
<td>2014</td>
<td>NH Health Protection Program expands Medicaid coverage to 50,000 residents. Its benefit package includes substance use disorder services</td>
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Current Challenges

- Despite recent efforts, significant challenges remain in meeting the needs of individuals with mental illness and substance use disorders (SUD).

- Newly available substance abuse coverage for the Medicaid expansion population is a major step forward but places new demands on already overtaxed SUD providers, underscoring the need for transformation.

NH Hospital operates at capacity, while the need for intensive psychiatric care is growing.

- Inpatient psychiatric beds decreased statewide from 526 beds in 2005 to 384 beds in 2013.
- In 2014, on average 11 to 31 adults and 2 to 8 children awaited admission at NH Hospital.
- Nearly 1 out of 3 people waited more than 24 hours in the ED.

Inpatient and residential alternatives to NH Hospital have diminished over the last 15 years.

- Availability of outpatient, community providers varies geographically across the State.
- Community DRF beds decreased from 101 beds in the 2000s to 18 in 2014, as have Acute Psychiatric Residential Treatment Program beds (from 52 to 16).
- CMHCs closed 44 beds since 2008 in response to substantial Medicaid reimbursement cuts.

SUD providers are at capacity and facing financial challenges

- Availability of SUD providers varies across State, particularly for withdrawal management and residential services.
- Most state-funded residential treatment programs and transitional living programs have wait lists of between 2 and 10 weeks.
- Decreases in the availability of SUD services and treatment programs have coincided with increases in drug and opiate-related deaths over the past five years.
Key Elements for Delivery System Reform in New Hampshire
New Hampshire’s goal is a “whole person” approach to health care for its residents, including Medicaid beneficiaries with significant mental health and/or substance abuse issues. To implement comprehensive reform, it will adopt a multi-pronged approach.

**Key Elements**

- **Transition Funding.** Transition funding will be used to strengthen providers so they can provide mental health and SUD services to growing numbers of State residents even as they prepare for delivery system reform.

- **Integrated Delivery System Networks.** At the heart of the DSRIP program will be regional networks of providers responsible for providing integrated care that addresses the physical and behavioral needs of beneficiaries and connecting them with social services that affect their health.

- **Coordination with Medicaid managed care.** To ensure the sustainability of the initiative, the State will establish a system and incentives for care management organizations and IDNs to work together to provide high quality, cost-effective care to Medicaid beneficiaries.

- **State-wide resources.** New Hampshire could create state-wide resources to support DSRIP implementation, such as a state-wide technical assistance entity.
Key Elements: Transition Funding

Transition funding will be used to strengthen providers so they can provide mental health and SUD services to growing numbers of NH residents even as they prepare for delivery system reform. Funds available only to those providers that agree to participate in longer-term delivery system reform efforts, but funds are not otherwise tied to milestones.

Allowable Uses

**Strengthening SUD Treatment Capacity.** To address severe shortages in SUD treatment options exacerbated by the Medicaid expansion, transitional funding will be used to support recovery support services, opioid treatment programs, intensive outpatient counseling, medication assisted treatment, and residential services.

**Inpatient behavioral health services.** To address the acute shortage of hospital beds for mentally ill individuals in crisis, transition funding will be used to support hospitals that provide in-patient alternatives to the New Hampshire Hospital. Inpatient beds will be used only when strictly necessary and will be integrated into a continuum of care for those with behavioral health issues.

**Community mental health services.** Transition funding will be used to support and strengthen Community Mental Health Centers and other community-based providers to coordinate physical and behavioral health services.
To pursue its delivery system reform goals, New Hampshire will establish new “integrated delivery networks” or “IDNs.” The IDNs will be regionally-based networks of providers charged with ensuring that Medicaid beneficiaries receive integrated physical and behavioral health care in the community to the maximum extent possible.

**Key Elements: Integrated Delivery Networks (IDNs)**

- **Provider Partners:** Includes hospitals, physical health providers, behavioral health providers (mental health and substance abuse), and community support organizations (e.g., social services).

- **Structure:** A model in which a lead applicant will serve as the coordinating entity for the IDN while provider partners will help to design and implement delivery system reform changes. Hospitals and community providers will be eligible to serve as lead applicants.

- **Responsibilities:** Building greater behavioral health capacity; promoting the integration of care; and preparing for greater value-based purchasing through implementation of projects.

See appendix for additional parameters for IDNs
The state will provide funding to providers to establish IDNs and create a menu of projects from which they will select as part of the application process. The projects will be composed of activities that will support NH’s vision for delivery system reform.

**Implementation Process**

1. **State provides planning funds to providers so that they can form IDNs**
2. **State establishes a menu of projects from which IDNs can select**
3. **IDNs apply to participate in DSRIP program by selecting projects**
4. **State approves applications**
5. **State funds IDNs based on hitting pre-determined metrics**
Pathways & Projects for Delivery System Reform
Building Capacity in the Behavioral Health System

Projects will support behavioral health capacity by supporting workforce initiatives, new treatment and intervention programs, and alternative care delivery models (e.g., telemedicine).

Example Projects

✓ Investing in a mental health workforce development program to support access to behavioral health providers in underserved areas of the State, including on behalf of individuals with co-occurring mental health and SUDs.*

✓ Establishing a specific workforce development initiative for SUD providers to promote increasing SUD treatment capacity throughout the State.*

✓ Increasing access to behavioral health community crisis, intervention, and stabilization services.^

✓ Enhancing Assertive Community Treatment (ACT) services in a community.*^

✓ Developing an evidence-based medication adherence program in community-based sites for behavioral health medication compliance.

✓ Implementing telemedicine programs to support and deliver behavioral health services.*

*retained from original waiver submission
^noted in the Community Mental Health Settlement Agreement
Promoting Provider Integration

Projects will promote provider integration by supporting physical or virtual integration, and expanding programs that foster collaboration among physical and behavioral health providers.

Example Projects

✓ Promoting virtual or physical integration among physical and behavioral health staff.

✓ Expanding the InSHAPE program to additional populations and provider settings.*

✓ Developing models to integrate physical and behavioral health care with developmental services for individuals with co-occurring developmental disabilities and behavioral health issues.

*retained from original waiver submission

^noted in the Mental Health Settlement Agreement
Fostering Partnerships Across the Care Spectrum in Support of Care Transitions

Projects will promote smoother care transitions by creating incentives for IDNs to adopt evidence-based practices for the treatment of behavioral health patients during transitions and incentivizing provider collaboration.

**Example Projects**

- ✓ Establish and implement a behavioral-health specific discharge plan for individuals moving between care settings or returning to the community^

- ✓ Promote routine medication management reviews for discharged patients with structured follow up visits*

- ✓ Support facilitation of access to social services and community supports^

- ✓ Establish and implement a discharge plan for individuals with behavioral health issues leaving corrections facilities

- ✓ Provide community-based support and services to children with severe behavioral health needs to enable them to remain in community-based care settings

*retained from original waiver submission  
^noted in the Mental Health Settlement Agreement
Program Accountability

Performance metrics will be established at the state- and provider-levels to monitor progress toward achieving the overall waiver vision. Payments from CMS to the state and from the state to providers will be contingent on meeting these performance metrics.

<table>
<thead>
<tr>
<th>Statewide Performance Metrics</th>
<th>Provider Performance Metrics</th>
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<tbody>
<tr>
<td><strong>Purpose</strong></td>
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<tr>
<td>Measures statewide progress toward meeting the waiver vision.</td>
<td>Measures individual provider performance based on selected projects.</td>
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<tr>
<td><strong>Funding Impact</strong></td>
<td></td>
</tr>
<tr>
<td>CMS waiver funding may be contingent on achieving vision.</td>
<td>Ongoing provider support payments are tied to performance.</td>
</tr>
<tr>
<td><strong>Examples</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Inpatient psych admissions</td>
<td>▪ Initiation and engagement of alcohol and other drug dependence treatment</td>
</tr>
<tr>
<td>▪ Inpatient admissions/readmissions for individuals with co-occurring behavioral health issues</td>
<td>▪ Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month</td>
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<tr>
<td>▪ Acuity levels</td>
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</tbody>
</table>
Funding Model

Supports the overall vision and enables programs to ramp up and demonstrate success. At the conclusion of the waiver, programs will have data to support entering into value-based contracting with public and private payers.

**Transition Payments**

Provides transition funding (i.e., start-up capital) at the outset of the program to support the development of provider partnerships.

Transition funds could also be used to stabilize existing providers and increase capacity in the short-term.

**Ongoing Support Payments**

Supports ongoing partnership and program infrastructure development. Payments are used to fund:

- Program staff and training
- Investments in tools needed (e.g., care management software)

Funding is disbursed based on established performance metrics that initially focus on process measurement and shift to outcomes measurement over time.

**Value-Based Contracting**

At the conclusion of the waiver, funding transitions to value-based contracting with public/private payers (Medicaid, commercial, employers, etc).

As alluded to in New Hampshire’s State Innovation Model (SIM) proposal, the State could require that Medicaid MCOs enter into value-based contracts with provider partnerships.
Questions?
Appendix
Integrated delivery network will be composed of a lead applicant and several partners.

### Lead Applicant Responsibilities
- Organize partners in geographic region
- Coordinate program application
- Act as single point of accountability for DHHS
- Receive funds from DHHS and distribute funds to partners
- Compile required reporting

**NOTE:** Partners may lead implementation efforts for specific projects.
Building IDNs: Qualifications for Lead Applicants

Organizational Capabilities

Lead applicant must have demonstrated capabilities to lead transformation effort, such as:

- Previous collaborative experience with partners in the region
- Project management experience
- Experience implementing clinical transformation projects, including grant-funded pilots
- Relationships with social services organizations or the ability to establish such relationships

Financial Stability

Lead applicant must demonstrate financial stability:

- Adequate performance on standard benchmarks for current financial stability (e.g., days cash on hand, operating margin)
- Capacity to absorb unexpected financial shocks in the future
- A history of and commitment to using financial practices that will allow for transparency and accountability with respect to DSRIP funds

Key Takeaway: Lead applicants are not required to be a specific provider type (e.g., hospital or community mental health center). Any provider meeting the criteria can act as lead applicant.
Building IDNs: Defining the Relationships Among Partners

Within parameters established by the State, each IDN will need to create a governance structure that defines the nature of the partnership among the lead applicant and the partner providers and establishes a decision-making process.

Governance Structures

- **Structures.** Governance is effectuated through boards and committees
- **New Entity or Contracts?** Partners may choose to create a new entity or enter into contracts defining the relationships among the parties

Key Issues

- **Board/Committee Participation.** How much representation will each partner have on governance board/committees?
- **Veto Power.** What veto authority, if any, will lead applicant have over decisions made by governance board/committees?
- **Accountability.** What power does the board/committee have to monitor performance and engage in corrective action, as necessary?
- **Community and Consumer Engagement.** What role will the governance structure play in facilitating community and consumer involvement in the IDN?

Within guideposts established by the State of NH, each IDN will develop its own approach to these questions.
# Building IDNs: Governance Goals & Requirements

## Core Governance Principles

- **Participatory.** Ensure that partners have active role in decision-making process.
- **Accountable.** Lead applicant and partners should be accountable to each other, with clearly defined mechanisms to facilitate decision-making.
- **Flexible.** Within some guideposts, allow each IDN to create a structure that works best for it. State will not establish a “one-size-fits-all” governance structure.

State will require that IDNs explain how their governance structure will provide for the following:

- **Financial governance.** Includes the distribution of funds among partners and the development of budgets for projects.
- **Clinical governance.** Includes the development of standard clinical pathways and monitoring and managing patient outcomes.
- **Data/IT governance.** Includes data sharing among partners and reporting and monitoring processes
- **Community/consumer engagement.** Includes engagement of consumers/community-based in IDN activities and promotes connections with social services agencies.