Office of New Hampshire Governor Maggie Hassan

For Immediate Release
Tuesday, January 5, 2016
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Governor Hassan, HHS Announce Federal Approval of Transformation Waiver to Strengthen Behavioral Health System, Substance Use Disorder Services

Federal Waiver to Provide $30 Million in Matching Funds Per Year for Five Years to Transform New Hampshire's Behavioral Health Delivery System

CONCORD – Continuing her efforts to strengthen community-based mental health and to combat the heroin and substance abuse crisis, Governor Maggie Hassan and Department of Health and Human Services (HHS) Commissioner Nick Toumpas announced today that the federal Centers for Medicare & Medicaid Services (CMS) has approved a $150 million waiver to transform New Hampshire's behavioral health delivery system to help lower the long-term growth in health care costs for the state.

Under the waiver, New Hampshire will receive up to $30 million in federal funding a year to create a transformation fund, which will make performance-based incentive payments to new regional networks of health care and community service providers (Integrated Delivery Networks) who propose specific projects that will strengthen the capacity of the state's behavioral health system, integrate mental health and substance use disorder care with primary care, and lower the long-term growth in health care costs for the state.

"Our strained mental health system and the heroin and substance abuse crisis are urgent public health and safety challenges facing our state, and demand for mental health and substance abuse – which frequently co-occur – services is increasing," Governor Hassan said. "With thousands of Granite Staters receiving coverage for these services under the bipartisan New Hampshire Health Protection Program, the extension of the substance use disorder benefit to the traditional Medicaid population beginning in July, and the ongoing need to strengthen our efforts to combat the opioid epidemic, it is critical that behavioral health provider capacity is positioned to effectively deliver the integrated care that our residents need. Strengthening these services is critical to the health and well-being of our people, the safety of our communities, and to the success of our businesses and economy."

Under the waiver, CMS will provide up to $30 million in funding per year for a total of five years to make payments to the new networks. In committing to fund the waiver, the federal Department of Health and Human Services has estimated that by the end of the five years, the

transformation projects would reduce what the federal government and the State of New Hampshire would otherwise be spending on Medicaid services.

Through the regional networks, New Hampshire will transform its behavioral health delivery system by: integrating physical and behavioral health to better address the full range of Medicaid beneficiaries' needs; expanding provider capacity to address behavioral health needs in appropriate settings; and reducing gaps in care during transitions – from treatment back into the community – through improved care coordination for individuals with behavioral health issues.

"The approval of this waiver is an important step forward for a New Hampshire-specific solution," Governor Hassan said. "It will allow better integration of behavioral health care with primary care across the state – along with the community supports that people need to succeed – improving outcomes for individuals and lowering the growth in health care costs for our state. Many people across the state have worked tirelessly on this waiver for the past few years, and I thank Commissioner Toumpas and the Department of Health and Human Services and legislators from both parties for their hard work, as well as the Centers for Medicare and Medicaid Services for its approval."

"This waiver aligns with the Department's focus on the whole person approach to meeting the physical and mental health needs of our residents and will transform the State's behavioral health system," said Commissioner Toumpas. "It will facilitate greater integration of behavioral health and substance use disorder services, leading to more efficient service delivery and better outcomes for the people we serve."

Before the end of January, HHS will begin a series of public stakeholder meetings around the state on the waiver's implementation.

The approval letter from CMS, expenditure authority, and terms and conditions of the waiver are attached.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JAN - 5 2016

Governor Margaret Wood Hassan
State House
107 North Main Street
Concord, New Hampshire 03301

Dear Governor Hassan:

The Centers for Medicare & Medicaid Services (CMS) is approving New Hampshire's application for a new five-year Medicaid demonstration project entitled, "Building Capacity for Transformation" (No. 11-W-00301/1). The demonstration is approved in accordance with section 1115(a) of the Social Security Act for the period of January 5, 2016 through December 31, 2020. Through this demonstration, the state aims to greatly improve access to and the quality of behavioral health services by establishing regionally-based Integrated Delivery Networks (IDN) that are coalitions of behavioral health and other health care and community providers working collaboratively to develop a sustainable integrated behavioral and physical health care delivery system in New Hampshire.

IDN performance will be evaluated and incentivized through a Delivery System Reform Incentive Payments (DSRIP) program that outlines a series of healthcare projects with associated performance metrics targeted towards promoting integration and coordination across provider specialties and care settings. This initiative will provide a short term federal investment, such that by the end of the demonstration the behavioral health infrastructure will be supported through the state's managed care delivery system using alternative payment methodologies, without the need for demonstration authority. Along with the implementation of this demonstration, the state will be expanding its substance use disorder benefit to cover those Medicaid enrollees not already protected by it—and by implementing value-based purchasing in its managed care and other Medicaid service contracting. The state will also continue to work with CMS to explore other program authorities to advance its goal of health care system modernization. New Hampshire's DSRIP program will serve as one component of the state's broader health reform efforts that includes, for example, the expansion of health coverage under the New Hampshire Health Protection Premium Assistance Section 1115(a) Medicaid Demonstration Program.

To further support the state's delivery system reformation, CMS has approved expenditure authority for Designated State Health Programs (DSHP) with the agreement that this one-time investment of DSHP funding would be phased down over the demonstration period. The detailed design of New Hampshire's DSRIP program will be finalized through the state's development of protocols to be submitted for approval to CMS by March 1, 2016 as specified in the enclosed Special Term and Conditions (STC). These protocols will outline the operational infrastructure and parameters for payments that will support system-wide transformation of the state's delivery system for behavioral health services and ensure the sustainability of the reforms after the end of the demonstration.

The authority to deviate from Medicaid requirements is limited to the specific expenditure authorities described in the enclosed list and limited to the purposes indicated for each authority. The enclosed STCs further define the nature, character, and extent of anticipated federal involvement in the project, the state's implementation of the expenditure authorities, and the state's responsibilities to CMS during the demonstration period. Our approval of the demonstration is conditioned upon the state's compliance with these STCs. Our approval is further subject to CMS receiving the state's written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Mr. Adam Goldman. He is available to answer any questions concerning your section 1115 demonstration. Mr. Goldman's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-2242
E-mail: Adam.Goldman@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Goldman and to Mr. Richard McGreal, Associate Regional Administrator in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Centers for Medicare & Medicaid Services
Office of the Regional Administrator
JFK Federal Building, Suite 2325
Boston, MA 02203-0003
Telephone: (617) 565-1226
E-mail: Richard.McGreal@cms.hhs.gov

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, State Demonstrations Group, Center for Medicaid & CHIP Services, at (410) 786-9686.

Thank you for all your work with us on developing this important demonstration. Congratulations on this approval.

Sincerely,

Andy Slavitt
Acting Administrator

Enclosures

cc: Richard McGreal, Associate Regional Administrator, CMS Boston Regional Office

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **No. 11-W-00301/1**

TITLE: **New Hampshire Building Capacity for Transformation**

AWARDEE: **New Hampshire Department of Health and Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903 of the Act) shall, for the period beginning as of the date of the approval letter through December 31, 2020, unless otherwise specified, be regarded as matchable expenditures under the state's Medicaid state plan:

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable New Hampshire (state) to operate its section 1115 Medicaid demonstration. These expenditure authorities promote the objectives of title XIX in the following ways:

1. Increase access to, stabilize, and strengthen, providers and provider networks available to serve Medicaid and low-income populations in the state;
2. Improve health outcomes for Medicaid and other low-income populations in the state; and
3. Increase efficiency and quality of care through initiatives to transform service delivery networks.

1. Designated State Health Programs (DSHP)

Expenditures for designated programs that provide or support the provision of health services that are otherwise state-funded, as specified in STC 58.

2. Expenditures Related to the Integrated Delivery Networks (IDN)

Expenditures for performance-based incentive payments to providers who combine to form a regionally-based Integrated Delivery Network (IDN) to promote the integration of behavioral and physical health care in the state.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00301/1

TITLE: New Hampshire Building Capacity for Transformation

AWARDEE: New Hampshire Department of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STC) for New Hampshire Building Capacity for Transformation section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable the State of New Hampshire (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs further set forth in detail the nature, character, and extent of federal involvement in the demonstration, the state's implementation of the expenditure authorities, and the state's obligations to CMS during the demonstration period. The STCs are effective on the date of the signed approval letter through December 31, 2020.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description And Objectives
III. General Program Requirements
IV. Populations Affected by the Demonstration
V. Delivery System Reform Program
VI. General Reporting Requirements
VII. General Financial Requirements
VIII. Designated State Health Programs (DSHP)
IX. Monitoring Budget Neutrality
X. Evaluation of the Demonstration
XI. Schedule of State Deliverables for the Demonstration Period
Attachment A: Quarterly Report Template
Attachment B: DSHP Claiming Protocol
Attachment C: DSRIP Planning Protocol
Attachment D: DSRIP Program Funding & Mechanics Protocol

II. PROGRAM DESCRIPTION AND OBJECTIVES

In New Hampshire the demand for mental health and substance abuse services is increasing; current provider capacity is not well positioned to deliver the comprehensive and integrated care that can most effectively address the needs of New Hampshire residents with severe behavioral health or comorbid physical and behavioral health problems. A number of factors make behavioral health transformation a priority of the state including the enactment of the New Hampshire Health Protection Program (NHHPP) to cover the new adult group, an estimated one in six of whom have extensive mental health or substance use needs. New Hampshire now covers substance use disorder (SUD) services to the NHHPP population and the state is proposing to extend the SUD benefit to the entire Medicaid population in state fiscal year 2017. Finally, the expansion of coverage for new populations and new services coincides with an epidemic of opioid abuse in the state and across New England.

New Hampshire seeks to transform its behavioral health delivery system through:

- Integrating physical and behavioral health to better address the full range of beneficiaries' needs;
- Expanding provider capacity to address behavioral health needs in appropriate settings; and
- Reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues.

Delivery System Reform Incentive Payment (DSRIP) funding will enable the state to make performance based funding to regionally-based Integrated Delivery Networks (IDNs) that furnish Medicaid services. The state will use the IDNs as a vehicle to foster relationships between behavioral health providers and other health care and community service providers that are necessary to achieve the state's vision for Medicaid system transformation including the establishment of financial and governance relationships and investing in IT systems that enable data exchanges. The IDNs will be comprised of individual providers that will form coalitions and be evaluated by DSRIP project performance metrics—collectively as a single IDN. The lead applicant for each coalition, as described in STC 22, is responsible for coordinating between providers within the IDN to achieve metrics associated with the chosen projects.

The state also seeks to support IDNs through technical assistance and learning collaboratives—and by reforming its managed care organization (MCO) and Medicaid delivery contracts to include performance-based IDN funding and ensure sustainability of IDNs post-demonstration. During the demonstration period, the state will develop and implement DSRIP projects with the aim of moving to alternative payment model(s) in the MCO and Medicaid delivery contracts by the end of the demonstration period.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid program and Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing within 30 calendar days of receipt.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such a change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day, such state legislation becomes effective, or on the last day, such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state Plan is affected by a change to the demonstration, a conforming amendment to the appropriate

state plan may be required except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements specified in these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the secretary in accordance with section 1115 of the Act. The state must not implement or begin operational changes to these elements without prior approval by CMS of the amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to, failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the State consistent with the requirements of STC 15 to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group (EG)) the impact of the amendment;

    c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

    d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI state plan amendment, if necessary; and

    e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12

months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 10.

a. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.

b. Upon application from the state, CMS reserves the right to temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

9. **Compliance with Transparency Requirements 42 C.F.R. §§ 431.412:** As part of any demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 C.F.R. §§ 431, 412 and the public notice and tribal consultation requirements outlined in STC 15 as well as include the following supporting documentation:

a. Demonstration Summary and Objectives. The state must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.

b. Special Terms and Conditions. The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

c. Quality. The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and state quality assurance monitoring and any other documentation of the quality of care provided under the demonstration.

d. Compliance with the Budget Neutrality Cap. The state must provide financial data (as set forth in the current STCs) demonstrating that the state has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.

e. Interim Evaluation Report. The state must provide an evaluation report reflecting the hypotheses being tested and any results available.

10. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b. **Phase-out Plan Requirements:** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. **Phase-out Procedures:** The state must comply with all notice requirements found in 42 C.F.R. section 431.206, section 431.210, and § 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 C.F.R. section 431.220 and section 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 C.F.R. section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2010, State Health Official Letter #10-008.

d. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP will be limited to, normal

closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

e. **Post Award Forum:** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report as specified in STC 41 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 43.

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS must promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The state does not relinquish its rights to administratively and/or judicially challenge CMS' finding that the state materially failed to comply.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. The CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009 and the tribal consultation requirements at outlined in the state's approved state plan, when any program changes to the demonstration including (but not limited to) those referenced in STC

6, are proposed by the state. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state must to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any amendment or extension of this demonstration. The state must also comply with the Public Notice Procedures set forth in 42 C.F.R. section 447.205 for changes in statewide methods and standards for setting payment rates.

16. **FFP.** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or later date if so identified elsewhere in these STCs or in the lists of waiver or expenditure authorities.

17. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The state shall comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter.

IV. POPULATIONS AFFECTED BY THE DEMONSTRATION

Under the demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan.

18. **Eligibility Groups Affected By the Demonstration.** The demonstration will provide new incentives for the providers participating in IDNs, which serve all Medicaid beneficiaries through the fee-for-service system or Medicaid Care Management program . All affected groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable.

19. **Eligibility Groups Excluded from the Demonstration.** Individuals served under the New Hampshire Health Protection Program (NHHPP) Premium Assistance section 1115 demonstration (11-W-00298/1) are excluded from this demonstration and will continue to receive Medicaid benefits through qualified health plans (QHP).

V. DELIVERY SYSTEM REFORM PROGRAM

This demonstration is part of a multi-pronged approach to address barriers to providing behavioral health services in the appropriate setting and to address behavioral health capacity issues in the state. Specifically, the goals of the behavioral health delivery system transformation are to:

1. Deliver integrated physical and behavioral health care that better addresses the full range of a beneficiaries' needs;
2. Expand provider capacity to address emerging and ongoing behavioral health needs in an appropriate setting; and

3. Reduce gaps in care during transition across care settings

The state will make performance-based incentive payments available to providers to form regionally-based integrated delivery networks (IDNs). The IDNs will serve as the vehicle to foster relationships between behavioral health providers and other health care providers that are necessary to achieve the state's vision for system transformation; including the financial relationships, data exchanges and business relationships. Specifically, IDNs will receive incentive payments for its performance on projects to increase integration across providers and community social service agencies, expand provider capacity, develop new expertise and improve care transitions

20. **Integrated Delivery Network Transformation Fund**. The terms and conditions contained herein apply to the state's exercise of expenditure authority two (2): Expenditures Related to the IDN Fund. These requirements are further elaborated by the DSRIP Planning Protocol (Attachment C) and the DSRIP Program Funding and Mechanics Protocol (Attachment D).

    As described further below, system transformation funding is available to *networks* that consist of *providers* whose *project plans* are approved and funded through the process described in these STCs and who meet particular *milestones* described in their approved IDN Project Plans. IDN Project Plans are based on *projects* specified in the DSRIP Planning Protocol (Attachment C) and DSRIP Funding and Mechanics Protocol (Attachment D) and are further developed by to be directly responsive to the needs and characteristics of the low-income communities that they serve and to achieve the transformation objectives furthered by this demonstration.

21. **IDNs.** The provider networks that are funded to participate in projects are called IDNs. Participating providers must form regional coalitions that apply collectively for pool funds as a single IDN. IDNs must complete project milestones and measures as specified in the DSRIP Planning Protocol (Attachment C) and are the only entities that are eligible to receive IDN incentive payments.

22. **Attributed Population**. After consultation with community members, providers, and other stakeholders, the state will approve a defined population for each IDN based on geographic and member service loyalty factors, as described in the DSRIP Program Funding and Mechanics Protocol (Attachment D). Coalitions will be evaluated on performance of IDN milestones collectively as a single entity. Coalitions are subject to the following conditions in addition to the requirements specified in the DSRIP Program Funding and Mechanics Protocol (Attachment D):

    a. IDNs will be composed of a lead applicant and several partners. Networks must designate a lead provider who will be held responsible under the IDN for ensuring that the coalition meets all requirements of IDNs, including reporting to the state and CMS.

    b. IDNs must establish a clear business relationship between the component providers, including a joint budget and funding distribution plan that specifies in advance the methodology for distributing funding to participating

providers. The funding distribution plan must comply with all applicable laws and regulations, including, but not limited to, the following federal fraud and abuse authorities: the anti-kickback statute (sections 1128B(b)(1) and (2) of the Act); the physician self-referral prohibition (section 1903(s) of the Act); the gainsharing civil monetary penalty (CMP) provisions (sections 1128A(b)(1) and (2) of the Act); and the beneficiary inducement CMP (section 1128A(a)(5) of the Act). State approval of an IDN plan does not alter the responsibility of Integrated Delivery Networks to comply with all federal fraud and abuse requirements of the Medicaid program.

c. Each IDN must, in the aggregate, identify a proposed geographic catchment area for the IDN. The proposed geography will support the population attribution methodology specified in the DSRIP Program Funding and Mechanics Protocol (Attachment D).

d. Each IDN must have a data agreement in place to share and manage data on system-wide performance.

23. **Project Objectives**. IDNs will design and implement projects that further each of the objectives, which are elaborated further in the DSRIP Planning Protocol (Attachment C). Each IDN is responsible for project activity that addresses each of the four objectives.

a. Creating appropriate behavioral health capacity in order to expand effective community based-treatment models; reduce unnecessary use of emergency rooms and hospitals as the site of care for individuals with behavioral health issues; and support prevention through screening, early intervention, and population health management initiatives. Projects will bolster behavioral health capacity by supporting workforce development programs; medication adherence trainings; cross training of mental health, physical health and substance use providers; development of new treatment and intervention capacity (e.g., behavioral health community crisis stabilization and ambulatory detoxification initiatives); and expansion of community-based health navigation services with community based social service agencies.

b. Promoting integration of physical and behavioral health providers through physical or virtual integration. Projects may include: co-location of behavioral health providers with primary care providers as a first step at sites that currently have little to no integration, but, more often will be used to foster fuller integration thorough bi-directional embedding of providers; adoption of evidence-base standards of integrated care including medication management for individuals with serious mental illness, medication-assisted treatment for individuals with substance use disorders; and use of team-based approaches to care delivery that address physical, behavioral and social barriers to improved outcomes. Along with directly promoting integration, the projects will promote ancillary changes by supporting the IT capacity and protocols needed for

integration, offering training to providers on how to adopt the required changes; and creating integrated care delivery protocols and models.

c. Promoting smooth transitions across the continuum of care for beneficiaries and incentivizing coordination of providers. Projects will be used to promote evidence-based practices such as behavioral health specific discharge and care coordination plans, coordinated referrals to socials service agencies, medication adherence and management plans, medication assisted treatment and continuity of care for individuals transitioning between the community and institutions, including hospitals, prisons, and jails.

d. Ensuring IDNs participate in Alternative Payment Models that are adopted by the State with Medicaid Service delivery and Medicaid managed care plans.

24. Project Milestones. Progress towards achieving the goals specified above will be assessed by specific milestones, which will be measured by particular metrics that are further defined in the DSRIP Planning Protocol (Attachment C). These milestones are to be developed by the state in consultation with stakeholders and members of the public and approved by CMS. They are organized into the following Stages:

a. *Project planning and progress milestones (Stage 1).* Creation of plans for investments in technology, tools, stakeholder engagement, and human resources that will allow IDNs to build capacity to serve target populations and pursue IDN project goals in accordance with community-based priorities. Performance in this stage is measured by a common set of project progress milestones that will include evaluation of the appropriateness and viability of proposed project development plans, consistency with statewide goals and metrics, and implementation of project plans.

b. *Project utilization milestones (Stage 2).* that assess process-based improvements, as established by the state, in the delivery of care and gains in clinical outcomes consistent with the demonstration's objectives of building capacity; promoting greater integration of behavioral and physical care; and fostering smoother transitions of care. Performance in this domain will be evaluated by state developed measures consistent with the objectives of the demonstration outlined in STC 23, such as initiation of treatment following a substance abuse-related hospitalization or incarceration; reductions in waiting times for behavioral health treatment; use of behavioral health screening in primary care settings; and integration of care for adults with severe mental illness.

c. *System transformation utilization milestones (Stage 3).* These state-established outcomes measure the overall systemic impact of IDNs and progress toward the statewide objectives of the waiver, such as material increase in system-wide workforce capacity for the delivery of substance use disorder services; greater use of community-based care; fewer hospitalizations and institutionalizations by individuals with behavioral health issues; reductions in the inappropriate use of emergency departments across the state, and reductions in undiagnosed and untreated physical and behavioral health conditions

among Medicaid beneficiaries.

d. *Alternative Payment Model milestones (Stage 4).* These measures will evaluate IDNs ability to respond to system wide transformation to alternative payment models and to accept alternative payments to promote sustainability. In the early years of the demonstration, these measures will be used to assess whether IDNs are making adequate preparations, such as whether they have the data infrastructure, financial infrastructure, and other changes that may be required. In later years, IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals outlined in STC 33.

25. **IDN Performance Indicators & Outcome Measures.** The state will choose performance indicators and outcome measures that are connected to the achievement of the goals identified above and in the DSRIP Planning Protocol, Attachment C. The DSRIP performance indicators and outcome measures will comprise the list of reporting measures that IDNs will be required to report under each of the DSRIP Stages.

26. **DSRIP Planning Protocol.** The state must develop and submit to CMS for approval a DSRIP Planning Protocol no later than March 1, 2016. Once approved by CMS, this document will be incorporated as Attachment C of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure authorities and STCs. Changes to the protocol will apply prospectively unless otherwise indicated in the protocols. The DSRIP Planning Protocol must:

    a. Outline the global context, goals and outcomes that the state seeks to achieve through the combined implementation of individual projects by IDNs;

    b. Specify the Stage, as required in STC 24, and for each Stage specify a menu of activities, along with their associated population-focused objectives and evaluation metrics, from which each eligible IDN will select to create its own projects;

    c. Detail the requirements of the IDN Project Plans, consistent with STC 28, which must include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;

    d. Specify a set of outcome measures that must be collected and reported by all IDNs, regardless of the specific projects that they choose to undertake;

    e. Include required baseline and ongoing data reporting, assessment protocols, and monitoring/evaluation criteria aligned with the evaluation design and the monitoring requirements in sections IV and X of the STCs.

    f. Include a process that allows for potential IDN Project Plan modification

(including possible reclamation, or redistribution, pending state and CMS approval) and an identification of circumstances under which a plan modification may be considered, which shall stipulate that the state or CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved.

g. When developing the DSRIP Planning Protocol, the state should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section X of the STCs. The state must select a preferred evaluation plan for the applicable evaluation question, and provide a rationale for its selection. To the extent possible, participating IDNs should use similar metrics for similar projects to enhance evaluation and learning experience between IDNs.

27. **DSRIP Program Funding and Mechanics Protocol**. The state must develop a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval no later than March 1, 2016. Once approved by CMS, this document will be incorporated as Attachment D of these STCs, and once incorporated may be altered only with CMS approval, and only to the extent consistent with the approved expenditure authorities and STCs. Changes to the protocol will apply prospectively, unless otherwise indicated in the protocols. DSRIP payments for each participating IDN are contingent on the participating providers fully meeting project metrics defined in the approved IDN Project Plan. In order to receive incentive funding relating to any metric, the IDN must submit all required reporting, as outlined in the DSRIP Program Funding and Mechanics Protocol (Attachment D). In addition, the DSRIP Program Funding and Mechanics Protocol must:

a. Describe, and specify the role and function, of a standardized IDN report to be submitted to the state on a semi-annual basis for the utilization of DSRIP funds that outlines a status update on the IDN Project Plan, as well as any data books or reports that IDNs may be required to submit to report baseline information or substantiate progress. IDNs must use a standardized reporting form to document their progress and qualify to receive DSRIP Payments if the specified performance levels were achieved;

b. Specify a review process and timeline to evaluate IDN progress based on the IDN's quarterly reports on their IDN Project Plans.

c. Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating IDN may be eligible to receive during the implementation of the DSRIP project, consistent with these STCs and a formula for determining the incentive payment amounts associated with the specific activities and metrics selected by each IDN, such that the amount of incentive payment is commensurate with the value and level of effort required.

d. Specify that IDN's failure to fully meet a performance metric under its IDN DSRIP Plan within the time frame specified will result in a penalty, including but not limited to, forfeiture of the associated incentive payment.

e. Describe a process by which a IDN that fails to meet a performance metric in a timely fashion may possibly reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric, or by which a payment missed by one IDN can be redistributed to other IDNs, including rules governing when missed payments can be reclaimed or must be redistributed; and

f. Include a state process for developing an evaluation of DSRIP as a component of the draft evaluation design as required by STC 72.

g. Payment of funds allocated in an IDN DSRIP Plan to outcome measures may be contingent on the IDN reporting DSRIP performance indicators to the state and CMS, on the IDN meeting a target level of improvement in the DSRIP performance indicator relative to base line, or both. At least some of the funds so allocated in DSRIP Year 2 and DSRIP Year 3, and all such funds allocated in DSRIP Year 4 and DSRIP Year 5, must be contingent on meeting a target level of improvement, IDNs may not receive credit for metrics achieved prior to approval of their IDN DSRIP Plans.

28. **IDN Project Plans.** IDNs must develop and secure approval from the state of an IDN Project Plan that is designed to meet the transformation objectives of this demonstration. The plan must be based on the DSRIP Planning Protocol (Attachment C), and further developed by the IDN to be directly responsive to the needs and characteristics of the low-income communities that it serves. In developing its IDN Project Plan, an IDN must solicit and incorporate community input to ensure it reflects the specific needs of its region. IDN Project Plans must be approved by the state and may be subject to additional review by CMS. The DSRIP Planning Protocol (Attachment C) will provide a structured format for IDNs to use in developing their IDN Project Plan submission for approval. At a minimum, it will include the elements listed below.

a. Each IDN Project Plan must identify the target populations, projects, and specific milestones for the proposed project, which must be chosen from the options described in the approved IDN Project Planning Protocol (Attachment C).

b. Goals of the IDN Project Plan should be aligned with each of the objectives as described in STC 23 of this section.

c. Milestones should be organized as described above in STC 23 and STC 24 of this section reflecting the overall goals of the demonstration and subparts for each goal as necessary.

d. The IDN Project Plan must describe the need being addressed and the starting point of the IDN related to the project. The starting point of the IDN Project Plan must be after January 1, 2017.

e. Based on the starting point, the IDN must describe its expected outcome for each of the stages described in STC 24 of this section. IDNs must also describe why the IDN selected the project drawing on evidence for the potential for the interventions to achieve these changes.

f. The IDN Project Plan must include a description of the processes used by the IDN to engage and reach out to stakeholders, including a plan for ongoing engagement with the public, based on the process described in the DSRIP Planning Protocol (Attachment C).

g. IDNs must demonstrate how the project will transform the delivery system for the target population and do so in a manner that is aligned with the central goals of the IDN, the statewide objectives of the IDN Fund, and in a manner that will be sustainable after DSRIP Year 5. The projects must implement new, or significantly enhance existing health care initiatives; to this end, providers must identify existing, notable delivery system reform initiatives related to the objectives of this demonstration in which they currently participate or already plan to participate and explain how the proposed IDN activities are not duplicative of activities that are already or have recently been federally funded (e.g. SIM grants).

h. For each stated goal or objective of a project, there must be an associated outcome metric that must be reported in all years. The initially submitted IDN DSRIP Plan must include baseline statewide data on all quality improvement and outcome measures.

i. IDN DSRIP Plans shall include specific allocation of funding proposed within the IDN DSRIP Plan.

j. Each individual IDN DSRIP Plan must report on progress to receive DSRIP funding. Eligibility for DSRIP payments will be based on successfully meeting metrics associated with approved activities as outlined in the IDN DSRIP Plans. IDNs may not receive credit for metrics achieved prior to approval of their IDN DSRIP Plans.

29. Project Valuation. IDN payments are earned for meeting the performance milestones (as specified in each approved IDN Project Plan). The value of funding for each milestone and for IDN projects overall should be proportionate to its potential benefit to the health and health care of Medicaid beneficiaries, as further explained in the DSRIP Program Funding and Mechanics Protocol (Attachment D).

a. *Maximum project valuation.* As described further in the IDN Program Funding and Mechanics Protocol (Attachment D), a maximum valuation for each project on the project menu shall be calculated based on valuation components as specified in the IDN

Program Funding and Mechanics Protocol.

b. *Progress milestones and outcome milestones.* An IDN project's total valuation will be distributed across the milestones described in the IDN Project Plan, according to the specifications described in the DSRIP Program Funding and Mechanics Protocol (Attachment D). An increasing proportion of IDN funding will be allocated to performance on outcome milestones each year, as described in the DSRIP Program Funding and Mechanics Protocol.

c. *Performance based payments.* IDNs may not receive payments for metrics achieved prior to the baseline period set by CMS and the state in accordance with these STCs and the DSRIP Funding and Mechanics Protocol. Achievement of all milestones is subject to audit by CMS and the state. The state shall also monitor and report proper execution of project valuations and funds distribution as part of the implementation monitoring reporting required under STC 45 of this section. In addition to meeting performance milestones, the state and IDN providers must comply with the financial and reporting requirements for IDN payments specified in STCs and any additional requirements specified in the DSRIP Program Funding and Mechanics Protocol.

30. Data. The state shall make the necessary arrangements to assure that the data needed from the IDNs, and data needed from other sources, are available as required by the CMS approved DSRIP Planning Protocol (Attachment C).

31. Pre-implementation Activities. In order to authorize IDN funding for DY 1 to DY 5, the state must meet the following implementation milestones according to the timeline outlined in these STCs. Failure to complete these requirements will result in a state penalty, as described below:

a. During calendar year 2016, the state may provide allotted amounts to providers for IDN design and implementation from a designated IDN Project Design and Capacity Building Fund. This funding will enable providers to develop specific and comprehensive IDN Project Plans and to begin to develop the capacity and tools required to implement these plans. New Hampshire may expend up to 65 percent of demonstration Year 1 payments from the IDN Fund for this purpose. IDN Project Design and Capacity Building payments count against the total amounts allowed for IDN under the demonstration.

   i. Submitting an application for IDN Project Design and Capacity Building Funding. Providers and coalitions must submit an IDN Project Design and Capacity Building application that outlines the IDN's design proposal.

   ii. Use of IDN Project Design and Capacity Building Funds. The providers and coalitions that are approved to be IDNs will receive IDN Project Design and Capacity Building funds that must be used to prepare an IDN Project Plan and to begin developing capacity to implement projects. Providers and coalitions that receive IDN Project Design and Capacity Building funds must submit an IDN Project Plan.

b. *Stakeholder engagement.* The state must engage the public and all affected stakeholders (including community stakeholders, Medicaid beneficiaries, physician groups, hospitals, and health plans) by soliciting feedback and comment on the draft DSRIP Planning Protocol (Attachment C) and DSRIP Program Funding and Mechanics Protocol (Attachment D) including all relevant background material.

c. *Allowable changes to IDN protocols.* The state must post any technical modifications the state makes to the DSRIP Planning Protocol (Attachment C) and the DSRIP Program Funding and Mechanics Protocol (D). The state will submit the final protocols and CMS will review and take action on the changes (e.g. approve, deny or request further information or modification) no later than 30 business days after the state's submission.

d. *Baseline data on IDN measures.* The state must use existing data accumulated prior to implementation to identify performance goals for IDN providers. The state must identify high performance levels for all anticipated measures in order to ensure that providers select projects that can have the most meaningful impact on the Medicaid population, and may not select projects for which they already are high performers, with the exception of projects needed for the State to meet statewide objectives

e. *Procurement of entities to assist in the administration and evaluation of IDNs.* The state will identify independent entities with expertise in delivery system improvement, including an independent assessor and any other entity required for the state to implement, monitor and evaluate the performance of IDNs and the demonstration as a whole. At a minimum, the independent entities will work in cooperation with one another to do the following:

   i. Independent Assessor: Conduct a transparent review of all proposed IDN Project Plans and make project approval recommendations to the state.

   ii. Administrative Costs: The state may use a share of the IDN Fund for the administrative costs associated with the entities assisting it with the design, implementation, administration, and evaluation of the waiver. Any costs paid for with IDN Fund will be matched at the state's regular administrative matching rate.

      1. The state must describe the functions of each independent entity and their relationship with the state as part of its DSRIP Planning Protocol (Attachment C).

      2. Spending on the independent entities and other administrative cost associated within the IDN Transformation Fund is classified as a state administrative activity of operating the state plan as affected by this demonstration. The state must ensure that all administrative costs for the independent entities are proper and efficient for the administration of the IDN Transformation Fund.

f. *Submit evaluation plan.* The state must submit an evaluation plan for the demonstration consistent with the requirements of STC 72 of this section no later than 120 days after award of the demonstration and must identify an independent evaluator.

32. **Post Approval Protocols.** The state must submit for CMS approval a draft DSRIP Planning Protocol and DSRIP Funding & Mechanics Protocol for approving, overseeing, and evaluating IDN project implementation funding no later March 1, 2016 as identified in STC 26 and STC 27 above. The protocols are subject to CMS approval. The state shall provide the final protocols within 30 calendar days of receipt of CMS comments. If CMS finds that the final protocols adequately accommodates its comments, then CMS will approve the final protocols within 30 business days. These protocol will become Attachments C and D of these STCs

33. **MCO and Medicaid Service Delivery Contracting Plan.** 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, and will over time improve the ability of plans to coordinate care and efficiently deliver high quality services to Medicaid beneficiaries with diagnosed or emerging behavioral health issues through comprehensive payment reform, strengthened provider networks and care coordination, the state must take steps to plan for and reflect the impact of IDN in Medicaid provider contracts and rate-setting approaches. Prior to the state submitting to CMS contracts and rates for approval for any contract period beginning July 1, 2017, the state must 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 stages of IDN, this should 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. This plan must be approved by CMS before the state may claim FFP for Medicaid provider contracts for the 2018 state fiscal year. The state shall update and submit the MCO and Medicaid service delivery contracting plan annually on the same cycle and with the same terms, until the end of this demonstration period and its next renewal period. Progress on the MCO and Medicaid service delivery contracting plan will also be included in the quarterly demonstration report. The Medicaid service delivery plan should address the following:

a. What approaches service delivery providers will use to reimburse providers to encourage practices consistent with IDN objectives and metrics, including how the state will plan and implement a goal of 50 percent of Medicaid provider payments to providers using Alternative Payment Methodologies.
b. If and when plans' currents contracts will be amended to include the collection and reporting of IDN objectives and measures.
c. How the IDN objectives and measures will impact the administrative load for Medicaid providers, particularly insofar as plans are providing additional technical assistance and support to providers in support of IDN goals, or themselves carrying out programs or activities to further the objectives of the waiver. The state should also discuss how these efforts, to the extent carried out by plans, avoid duplication with IDN funding or other state funding; and how they differ from any services or

administrative functions already accounted for in capitation rates.

d. How alternative payment systems deployed by the state and MCO/Medicaid service delivery contracts will reward performance consistent with IDN objectives and measures.

e. How the state will assure that providers participating in and demonstrating successful performance through IDNs will be included in provider networks.

f. How managed care rates will reflect changes in case mix, utilization, cost of care and enrollee health made possible by IDNs, including how up-to-date data on these matters will be incorporated into capitation rate development.

g. How actuarially-sound rates will be developed, taking into account any specific expectations or tasks associated with IDNs that the plans will undertake. How plans will be measured based on utilization and quality in a manner consistent with IDN objectives and measures, including incorporating IDN objectives into their annual utilization and quality management plans submitted for state review and approval by January 31 of each calendar year.

h. How the state will use IDN measures and objectives in their contracting strategy approach for MCO/Medicaid service delivery contract plans, including reform.

i. How the state has solicited and integrated community and MCO/Medicaid service delivery contract provider organization input into the development of the plan.

34. Federal Financial Participation (FFP) for DSRIP. The following terms govern the state's eligibility to claim FFP for DSRIP.

a. IDN payments are not direct reimbursement for expenditures or payments for services. Payments from the IDN Funds are intended to support and reward IDNs and their participating providers for integrating physical and behavioral health, expanding provider capacity and reducing gaps in care during transitions. Payments from the IDN Transformation Fund are not considered patient care revenue, and shall not be offset against disproportionate share, IDN expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) or administrative expenses as defined under these Special Terms and Conditions, and/or under the State Plan.

b. The state may not claim FFP for DSRIP until after CMS has approved the DSRIP Planning Protocol (Attachment C) and DSRIP Funding and Mechanics Protocol (Attachment D).

c. The state may claim FFP for payments to IDNs out of the IDN Project Design and Capacity Building Fund application and for submission and approval of their IDN DSRIP Project Plans. The state may claim FFP for incentive payments to IDNs.

d. The state may not claim FFP for DSRIP payments in DSRIP Year 1 through DSRIP Year 5 until both the state and CMS have concluded that the IDNs have met the performance indicated for each payment. IDNs' reports must contain sufficient data and documentation to allow the state and CMS to determine if the IDN has fully met the specified metric, and IDNs must have available for review by the state or CMS, upon

request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved IDN DSRIP Plan.

e. The non-federal share of Fund payments to IDNs may be funded by state general revenue funds, certified public expenditures or any other allowable source of non-federal share consistent with federal law. The funding will flow to the participating providers according to the methodology specified in the DSRIP Funding and Mechanics Protocol.

f. The state must inform CMS of the funding of all DSRIP payments to providers through quarterly reports submitted to CMS within 60 calendar days after the end of each quarter, as required in STC 41. This report must identify the funding sources associated with each type of payment received by each provider.

35. IDN DSRIP Funding. The amount of demonstration funds available for the IDN DSRIP program is shown in Chart A below.

a. *Funding At Risk for Outcomes and Quality Improvement.* A share of total IDN funding will be at risk if the state fails to demonstrate progress toward meeting the demonstration's objectives. The percentage at risk will gradually increase from 0 percent in DY 1-3 to 5 percent in DY 3 to 10 percent in DY 4 and 15 percent in DY 5. The at-risk outcome measures will be developed by the state and included in the DSRIP Planning Protocol for approval by CMS. They must be statewide and measure progress toward the state's goal of building greater behavioral health capacity; better integrating physical and behavioral health; and improving care transitions.

Chart A: IDN DSRIP Fund

	DY 1	DY 2	DY 3	DY4	DY5
	01/01/16-12/31/16	01/01/17-12/31/2017	01/01/18 - 12/31/18	01/01/19 - 12/31/19	01/01/20 - 12/31/20
Maximum Allowable Funds	$30,000,000	$30,000,000	$30,000,000	$30,000,000	$30,000,000
Percent At Risk for Performance	0%	0%	5%	10%	15%
Dollar Amount at Risk for Performance	$	$	$1,500,000	$3,000,000	$4,500,000

36. Life Cycle of Five-Year Demonstration. Synopsis of anticipated activities planned for this demonstration and the corresponding flow of funds.

a. ***Demonstration Year 1- Planning and Design:*** In the first year of the demonstration, New Hampshire will undertake implementation activities, including the following:

i. *Submit the DSRIP Planning Protocol (Attachment C) and DSRIP Program Funding and Mechanics Protocol (Attachment D)* Working closely with stakeholders and CMS, the State will submit the two required protocols in accordance with STCs 26, 27 and 32 by March 1, 2016.

ii. *Develop and oversee application process for IDNs.* The State will develop an application that IDNs must complete to be certified as an IDN and to receive IDN Project Design and Capacity Building funding. The application will require, among other things, that the IDNs: (1) describe the qualifications of the lead applicant and participating providers; (2) describe the stakeholder process used to solicit community input; and (3) identify how IDN Project Design and Capacity Building funding will be used to build capacity and prepare a project plan by December 31, 2016. The State will review and approve or reject IDN applications and requests for IDN Project Design and Capacity Building funds by June 30, 2016.

iii. *Review and approve project plans submitted by IDNs.* Once the IDNs submit project plans and they are reviewed by the independent assessor, the state will approve applications and initial IDN Fund payments by December 31, 2016 in accordance with the DSRIP Funding and Mechanics Protocol.

iv. *Establish Statewide Resources To Support IDNs.* The State will also support IDNs with statewide resources. Specifically, IDNs will be provided with technical assistance and the opportunity to participate in learning collaboratives that facilitate the sharing of best practices and lessons learned across IDNs. The statewide resources will be developed to coordinate with other ongoing and emerging delivery system reform efforts in New Hampshire.

b. ***Demonstration Years 2-4- Implementation, Performance Measurement and Outcomes*:**

i. In these years, New Hampshire will move the distribution of IDN Fund payments to more outcome-based measures, making them available over time only to those IDNs that meet performance metrics.

ii. In Year 3, the state will prepare a report on using IDNs as the basis for alternative payment methodologies by MCO and MDC plans in the state, and, depending on the recommendations, may begin implementing changes as early as Year 4.

c. ***Demonstration Year 5- Performance Measurement and Alternative Payment Model Integration:*** IDN Fund payments to IDNs that meet performance standards will continue, but, increasingly, IDNs may be expected to be working with MCO and MDC plans in the State and others to facilitate the use of alternative payment methods on behalf of Medicaid beneficiaries.

VI. GENERAL REPORTING REQUIREMENTS

37. **General Financial Reporting Requirements.** The state must comply with all general financial requirements under title XIX of the Social Security Act in section VII of the STCs.

38. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 C.F.R Section 438 et. seq. except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.

39. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section IX of the STCs, including the submission of corrected budget neutrality data upon request.

40. **Monthly Monitoring Calls.** The state must participate in monitoring calls with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addresses include, but are not limited to, IDN operations and implementation activities, care integration activities, mental health capacity and community supports, and gaps during transitions in care. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

41. **Quarterly Operational Reports.** The state must submit progress reports in the format specified by CMS, no later than 60 calendar days following the end of each quarter along with any other Protocol required deliverables described in these STCs. The intent of these reports is to present the state's analysis and the status of the various operational areas in reaching the goals of the DSRIP activities. These quarterly reports, using the quarterly report guideline outlined in Attachment A, must include, but are not limited to the following reporting elements:

    a. Summary of quarterly expenditures related to IDNs, DSRIP Project Plans, and the IDN Funds;
    b. Updated budget neutrality spreadsheets
    c. Summary of all public engagement activities, including, but not limited to the activities required by CMS;
    d. Summary of activities associated with the IDNs, DSRIP Project Plans, and the IDN Fund. This shall include, but is not limited to, reporting requirements in STC 41 of this section and the DSRIP Planning Protocol (Attachment C):
    e. Provide updates on state activities, such as changes to state policy and procedures, to support the administration of the IDN Fund,
    f. Provide updates on provider progress towards the pre-defined set of activities and associated milestones that collectively aim towards addressing the state's goals;
    g. Provide summary of state's analysis of IDN Project Plans;

h. Provide summary of state analysis of barriers and obstacles in meeting milestones;
i. Provide summary of activities that have been achieved through the IDN DSRIP Fund; and
j. Provide summary of transformation and clinical improvement milestones and that have been achieved.
k. Summary of activities and/or outcomes that the state and MCO and Medicaid service delivery plans have taken in the development of and subsequent approval of the MCO and Medicaid service delivery IDN Contracting plan; and
l. Evaluation activities and interim findings.

42. **Rapid Cycle Assessments.** The state shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment of IDN projects, performance indicators and outcomes, and for monitoring and evaluation of the demonstration.

43. **Annual Report**. The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under STC 41. The state must submit the draft annual report no later than October 1st of each year. Within 60 calendar days of receipt of comments from CMS, a final annual report must be submitted.

44. **Final Report.** Within 120 calendar days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 calendar days after receipt of CMS' comments.

45. **State Monitoring Requirements.** The state will be actively involved in ongoing monitoring of IDN DSRIP Project Plans, including but not limited to the following activities.

a. *Review of milestone achievement.* IDNs seeking payment under the DSRIP program shall submit semi-annual reports to the state as required in STC 24 demonstrating progress on each of their projects as measured by project-specific milestones and metrics achieved during the reporting period. The reports shall be submitted using the standardized reporting form approved by the state and CMS. Based on the reports, the state will calculate the incentive payments for the progress achieved according to the approved DSRIP project plan. The IDNs shall have available for review by New Hampshire or CMS, upon request, all supporting data and back-up documentation. These reports will serve as the basis for authorizing incentive payments to IDNs for achievement of DSRIP milestones.

b. *Learning collaboratives.* With funding available through this demonstration, the state will support regular learning collaboratives regionally and at the state level, which will be

a required activity for all IDNs, and may be organized either geographically, by the goals of the DSRIP, or by the specific DSRIP projects as described in the DSRIP Planning Protocol (Attachment C). Learning collaboratives are forums for IDNs to share best practices and get assistance with implementing their DSRIP projects. Learning collaboratives should primarily be focused on learning (through exchange of ideas at the front lines) rather than teaching (i.e. large conferences), but the state should organize at least one face-to-face statewide collaborative meeting a year. Learning collaboratives should be supported by a web site to help providers share ideas and simple data over time. In addition, the collaboratives should be supported by experts who can travel from site to site in the network to answer practical questions about implementation and harvest good ideas and practices that they systematically spread to others.

c. *Rapid cycle evaluation.* In addition to the comprehensive evaluation of DSRIP described in these STCs of this section, the state will be responsible for compiling data on DSRIP performance after each milestone reporting period and summarizing DSRIP performance to-date for CMS in its quarterly reports. Summaries of DSRIP performance must also be made available to the public on the state's website along with a mechanism for the public to provide comments.

d. *Additional progress milestones for at risk projects.* Based on the information contained in an IDN's semiannual report or other monitoring and evaluation information collected, the state or CMS may identify particular projects as being "at risk" of not successfully completing its DSRIP project in a manner that will result in meaningful delivery system transformation. The state or CMS may require these projects to meet additional progress milestones in order to receive DSRIP funding in a subsequent semi-annual reporting period.

VII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

46. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the expenditures as specified in section IX of the STCs.

47. Reporting Expenditures Under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the

demonstration project number (11-W-00301/1) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered.

b) Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

c) Pharmacy Rebates. When claiming these expenditures the State may refer to the July 24, 2014 CMCS Informational Bulletin which contains clarifying information for quarterly reporting of Medicaid Drug Rebates in the Medicaid Budget and Expenditures (MBES) (http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-24-2014.pdf). The State must adhere to the requirement at section 2500.1 of the State Medicaid Manual that all state collections, including drug rebates, must be reported on the CMS-64 at the applicable Federal Medical Assistance Percentage (FMAP) or other matching rate at which related expenditures were originally claimed. Additionally, we are specifying that states unable to tie drug rebate amounts directly to individual drug expenditures may utilize an allocation methodology for determining the appropriate Federal share of drug rebate amounts reported quarterly. This information identifies the parameters that states are required to adhere to when making such determinations.

Additionally, this information addresses how states must report drug rebates associated with the new adult eligibility group described at 42 CFR 435.119. States that adopt the new adult group may be eligible to claim drug expenditures at increased matching rates. Drug rebate amounts associated with these increased matching rates must be reported at the same matching rate as the original associated prescription drug expenditures.

d) Use of Waiver Forms. For each demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below. Expenditures should be allocated to these forms based on the guidance found below.

1) **DSHP:** Expenditures authorized under the demonstration for the Designated State Health Programs (DSHP)

2) **IDN:** Expenditures authorized under the demonstration for delivery system transformation payment made to and by IDN.

48. Expenditures Subject to the Budget Neutrality Agreement. For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for the EGs outlined in section IV of the STCs, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

49. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

50. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms, in order to properly account for these expenditures in determining budget neutrality.

51. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:

    a. For the purpose of calculating the budget neutrality agreement and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 41, the actual number of eligible member months for the populations affected by this demonstration as defined in STC 19. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

    b. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

    c. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

52. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. New Hampshire must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 calendar days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

53. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole for the following, subject to the limits described in Section IX of the STCs:

    a. Administrative costs, including those associated with the administration of the demonstration;

    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Net medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period.

54. **Sources of Non-Federal Share.** The state provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The state further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

    a. The CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

    c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

55. **State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

    a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.

    b. To the extent, the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

    c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies as allowable under 42 C.F.R. § 433.51 used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match;

       The state may use intergovernmental transfers to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

    d. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between

health care providers and state and/or local government to return and/or redirect to the State any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

56. **Monitoring the Demonstration.** The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

57. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

VIII. DESIGNATED STATE HEALTH PROGRAMS

58. **Designated State Health Programs (DSHP).** The state may claim FFP for certain DSHP expenditures following procedures and subject to limits as described below. FFP may be claimed for expenditures made for the following DSHPs beginning January 1, 2016 through December 31, 2020 except as noted in Chart C below.

Chart B: Approved DSHP through December 31, 2020.

Agency	Program
DHHS	Community Mental Health Center Emergency Services
DHHS	Adult Assertive Community Treatment (ACT) Teams
DHHS	Children Assertive Community Treatment (ACT) Teams
DHHS	Family Planning Program
DHHS	Tobacco Prevention
DHHS	Immunization Program
DHHS	Governor's Commission on Drug and Alcohol Abuse, Prevention and Treatment, and Recovery

Chart C: Approved DSHP through July 1, 2017

Agency	Program
Counties	County Funding for Payment of Medical Services for Nursing Home Residents ("County Nursing Home")

59. **Limit of FFP for DSHP.** The amount of FFP that the state may receive for DSHP may not exceed the limits described below. If upon review, the amount of FFP received by the state is found to have exceeded the applicable limit, the excess must be returned to CMS as a negative adjustment to claimed expenditures on the CMS-64.

a. The state may claim up to $30 million (total computable) annually for DSHP expenditures incurred through June 30, 2017. The total computable DSHP amount for DY2 will not exceed $19,419,390. Beginning in DY3, the total computable DSHP amount will be reduced by nine (9) percent, per year, as detailed in Table D below.

b. The state may claim FFP via 1115 expenditure authority for county medical nursing home expenditures through June 30, 2017 (DY2a). As of July 1, 2017 (DY2b), the state will no longer exercise 1115 expenditure authority to receive FFP for these expenditures will expire.

c. The state may continue receiving FFP for DSRIP in DY 2 through DY 5 up to $30 million, as long as the state has an allowable source of non-federal share for the amounts between the total computable DSHP annual limit (see Table D) and $30 million.

Table D. DSHP Annual Limits: Total Computable

	DY 1 01/01/16-12/31/2016	DY 2a 01/01/17-06/30/17	DY 2b 07/01/17-12/31/17	DY 3 01/01/18-12/31/18	DY4 01/01/19-12/31/19	DY5 01/01/20-12/31/20
General DSHP*	$8,995,761	$8,995,761		$8,186,143	$7,376,524	$6,566,906
DSHP: County Nursing Home**	$20,847,257	$10,423,629	-	-	-	-
Total DSHP	**$29,843,018**	**$19,419,390**		**$8,186,143**	**$7,376,524**	**$6,566,906**

* "General DSHP" represents the DSHPs in Chart B approved through December 31, 2020.
** "DSHP: County Nursing Home" represents the county medical nursing home expenditures in Chart C. The state will be authorized to receive FFP for these expenditures via 1115 authority through June, 30 2017 (DY2a).

60. DSHP Claiming Protocol. The state will develop a CMS-approved DSHP claiming protocol with which the state will be required to comply in order to draw down DSHP funds for the demonstration. State expenditures for the DSHP listed above must be documented in accordance with the protocols. The state is not eligible to receive FFP until an applicable protocol is approved by CMS. Once approved by CMS, the protocol becomes Attachment B of these STCs, and thereafter may be changed or updated with CMS approval. Changes and updates are to be applied prospectively. For each DSHP, the protocol must contain the following information:

a. The sources of non-federal share revenue, full expenditures and rates.

b. Program performance measures, baseline performance measure values, and improvement goals. (CMS may, at its option, approve the DSHP Claiming Protocol for a DSHP without this feature.)

c. Procedures to ensure that FFP is not provided for any of the following types of expenditures:
   i. Grant funding to test new models of care

ii. Construction costs (bricks and mortar)
iii. Room and board expenditures
iv. Animal shelters and vaccines
v. School based programs for children
vi. Unspecified projects
vii. Debt relief and restructuring
viii. Costs to close facilities
ix. HIT/HIE expenditures
x. Services provided to undocumented individuals
xi. Sheltered workshops
xii. Research expenditures
xiii. Rent and utility subsidies normally funded by the United State Department of Housing and Urban Development
xiv. Prisons, correctional facilities, services for incarcerated individuals and services provided to individuals who are civilly committed and unable to leave
xv. Revolving capital fund
xvi. Expenditures made to meet a maintenance of effort requirement for any federal grant program
xvii. Administrative costs
xviii. Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans)
xix. Cost of services for which payment was made by Medicare or Medicare Advantage
xx. Funds from other federal grants
xxi. Needle-exchange programs

61. **DSHP Claiming Process.** Documentation of each designated state health program's expenditures, as specified in the DSHP Protocol, must be clearly outlined in the state's supporting work papers and be made available to CMS. In order to assure CMS that Medicaid funds are used for allowable expenditures, the state will be required to document through an Accounting and Voucher system its request for DSHP payments. The vouchers will be detailed in the services being requested for payment by the state and will be attached to DSHP support.

    Federal funds must be claimed within two years following the calendar quarter in which the state disburses expenditures for the DSHP. Federal funds are not available for expenditures disbursed before January 1, 2016 or after December 31, 2020.

    Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHP listed above, they shall not be used as a source of non-federal share. The administrative costs associated with the DSHP listed above, and any others subsequently added by amendment to the demonstration, shall not be included in any way as demonstration and/or other Medicaid expenditures. Any changes to the DSHP listed above

shall be considered an amendment to the demonstration and processed in accordance with STC 7 in Section III.

62. **Reporting DSHP Payments**. The state will report all expenditures for DSHP payments to the programs listed above on the forms CMS-64.9 Waiver and/or 64.9P Waiver under the waiver name "DSHP" as well as on the appropriate forms.

IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

63. **Budget Neutrality Effective Date.** Notwithstanding the effective date specified in section I of the STCs or in any other demonstration documentation, all STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning January 1, 2016.

64. **Limit on Title XIX Funding**. New Hampshire will be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the state using the procedures described in section VII, STC 47. The data supplied by the state to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.

65. **Risk.** New Hampshire shall be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, New Hampshire will not be at risk for changing economic conditions which impact enrollment levels. However, by placing New Hampshire at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

66. **Demonstration Populations Used to Calculate Budget Neutrality Expenditure Limit.**

All eligible populations as referenced in STC 18 must be used in the budget neutrality expenditure limit calculations.

Demonstration Year (DY)	Without Waiver Ceiling	With Waiver	Savings
DY1 (1/01/16 - 12/31/16)	$1,030,048,714	$1,055,659,968	($25,611,253)
DY2 (1/01/17 - 12/31/17)	$1,062,196,255	$1,077,912,322	($15,716,067)
DY3 (1/01/18 - 12/31/18)	$1,095,355,227	$1,077,867,460	$17,487,767
DY4 (1/01/19 - 12/31/19)	$1,129,547,358	$1,089,688,768	$39,858,591
DY5 (1/01/20 - 12/31/20)	$1,164,794,760	$1,111,014,432	$53,780,328
TOTALS:	**$5,481,942,314**	**$5,412,142,949**	**$69,799,365**

67. **Expenditures Excluded From Budget Neutrality Test.** Regular FMAP will continue for costs not subject to budget neutrality limit tests. Those exclusions include:

a) Expenditures made on behalf of enrollees who are institutionalized in a nursing facility, chronic disease or rehabilitation IDN, intermediate care facility for the mentally retarded, or a state psychiatric IDN for other than a short-term rehabilitative stay;

b) Expenditures for covered services currently provided to Medicaid recipients by other state agencies or cities and towns, whether or not these services are currently claimed for federal reimbursement;

c) All other non-MMIS payments, such as DSH, GME, Medicaid Quality Incentive Payments (MQIP), Proportionate Share Payments, gross adjustments, reconciliations, and other settlement payments.

d) New Hampshire's Healthy Kids Silver program (CHIP) from January 1, 2009 – June 30, 2012. CHIP members transitioned to Medicaid and are included in the historical base data as of July 1, 2012.

e) Individual enrolled in the New Hampshire Health Protection Program (NHHPP),

f) The Medically frail population; and

g) Allowable administrative expenditures.

68. **Composite Federal Share Ratio.** The federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C. with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for extended family planning program must be subtracted from numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method.

69. **Future Adjustments to the Budget Neutrality Expenditure Limit**. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulation with respond to the provisions of services covered under this demonstration.

70. **Enforcement of Budget Neutrality.** CMS shall enforce the budget neutrality agreement over the life of the demonstration, rather than on an annual basis However, if the State exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Target Definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2.0percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0 percent

In addition, the state may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap indicates a possibility that the demonstration will exceed the cap during this extension.

71. **Exceeding Budget Neutrality**. If the budget neutrality expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds must be returned to CMS using the methodology outlined in STC 68, composite federal share ratio. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

X. EVALUATION OF THE DEMONSTRATION

72. **Submission of a Draft Evaluation Design Update.** The state must submit to CMS for approval a draft evaluation design no later than 120 calendar days after CMS' approval date of the demonstration. At a minimum, the draft evaluation design must include a discussion of the goals, objectives, and evaluation questions specific to the entire delivery system reform demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population, specific testable hypothesis, including those that focus on target populations for the demonstration and more generally on beneficiaries, providers, plans, market areas and public expenditures. The draft design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented. It must discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring within the state i.e. SIM grant. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as

appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results. Information from the external quality review organization (EQRO) may be considered for the purposes of evaluation, as appropriate.

The state must acquire an independent entity to conduct the evaluation. The evaluation design must describe the state's process to contract with an independent evaluator, including a description of the qualifications the entity must possess, how the state will ensure no conflict of interest, and budget for evaluation activities.

73. **Demonstration Hypothesis.** The state will test the following hypotheses in its evaluation of the demonstration.

    a. Individuals with co-occurring physical and behavioral health issues will receive higher quality of care after IDNs are operating.
    b. The total cost of care will be lower for Medicaid beneficiaries with co-occurring physical and behavioral health issues after IDNs are operating.
    c. The rate of avoidable re-hospitalizations for individuals with co-occurring physical and behavioral health issues will be lower at the end of the demonstration than prior to the demonstration.
    d. Percentage of Medicaid beneficiaries waiting for inpatient psychiatric care will be lower at the end of the demonstration than prior to the demonstration.
    e. Average wait times for outpatient appointments at community mental health centers will be lower at the end of the demonstration than prior to the demonstration.

74. **Domains of Focus**. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the state may propose a more narrow focus for the evaluation.

    a. Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement? To what degree can improvements be attributed to the activities undertaken under DSRIP?

    b. To what extent has the DSRIP enhanced the state's health IT ecosystem to support delivery system and payment reform? Has it specifically enhanced these four key areas through the IDNs: governance, financing, policy/legal issues and business operations?

    c. To what extent has the DSRIP improved integration and coordination between providers, including bi-directional integrated delivery of physical, behavioral health services, SUD services, transitional care, and alignment of care

coordination and to serve the whole person?

75. **Evaluation Design Process:** Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the DSRIP Planning Protocol, the state should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design. From these, the state must select a preferred research plan for the applicable research question, and provide a rationale for its selection.

    To the extent applicable, the following items must be specified for each design option that is proposed:

    i. Quantitative or qualitative outcome measures;
    ii. Baseline and/or control comparisons;
    iii. Process and improvement outcome measures and specifications;
    iv. Data sources and collection frequency;
    v. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);
    vi. Cost estimates;
    vii. Timelines for deliverables.

76. **Levels of Analysis:** The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

77. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft Evaluation Design within 60 business days of receipt, and the state shall submit a final Evaluation Design within 60 calendar days after receipt of CMS comments. The state shall implement the Evaluation Design and submit its progress in each of the quarterly and annual reports.

78. **Evaluation Reports.**

    a. **Interim Evaluation Report.** The state must submit a Draft Interim Evaluation Report 90 calendar days following the completion of DY 4. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings, and plans for completing the evaluation design and submitting a Final Evaluation Report according to the schedule outlined in (b). The state shall submit the final Interim Evaluation Report within 60 calendar days after receipt of CMS comments.

    b. **Final Evaluation Report.** The state must submit to CMS a draft of the Final Evaluation Report by January 30, 2021. The state shall submit the final evaluation report within 60 calendar days after receipt of CMS comments.

79. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state must submit the required data to CMS or the contractor.

XI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Date	Deliverable	STC
Administrative		
30 days after approval date	State acceptance of demonstration STCs and Expenditure Authorities	Approval letter
Post Approval Protocols		
March 1, 2016	Submit Draft DSRIP Planning Protocol and DSRIP Program Funding & Mechanics Protocol	STCS 27, 27, 32
60 days after approval date	Submit Draft DSHP Protocol	STC 60
Evaluations		
120 calendar days after approval date	Submit Draft Design for Evaluation Report	STC 72
90 days after the completion of DY 4	Submit Draft Interim Evaluation Report	STC 78
60 business days after receipt of CMS comments	Submit Final Interim Evaluation Report	STC 77, 78
January 31, 2021	Submit Draft Final Evaluation Report	STC 78, 44
60 business days after receipt of CMS comments	Submit Final Evaluation Report	STC 78
Quarterly/Annual/Final Reports		
Quarterly Deliverables Due 60 calendar days after end of each quarter, except 4th quarter	Quarterly Progress Reports	STC 41
	Quarterly Expenditure Reports	STC 46
Annual Deliverables - Due 120 calendar days after end of each 4th quarter	Annual Reports	STC 43
Final Report Due 120 days after the end of the demonstration		STC 44

ATTACHMENT A:
QUARTERLY REPORT FORMAT

Quarterly Report Template

Pursuant to STC 41 (Quarterly Operational Reports), the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One:	New Hampshire Building Capacity for Transformation Section 1115 Waiver Demonstration
Title Line Two:	Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:	***[Example: Demonstration Year: 1 (1/1/2016– 12/31/2016)*** ***Federal Fiscal Quarter:*** ***Footer: Date on the approval letter through end of demonstration period]***

Introduction

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

Integrated Delivery Network (IDN) Attribution and Delivery System Reform Information

Discuss the following:

1. Trends and any issues related to access to care, quality of care, care integration and health outcomes.

2. Any changes, issues or anticipated changes in populations attributed to the IDNs, including changes to attribution methodologies.

3. Information about each regional IDN, including the number and type of service providers, lead provider and cost-savings realized through IDN development and maturation.

4. Information about the state's Health IT ecosystem, including improvements to governance, financing, policy/legal issues, business operations and bi-directional data sharing with IDNs.

5. Information about integration and coordination between service providers, including bi-directional integrated delivery of physical, behavioral health services, SUD services, transitional care and alignment of care.

6. Information about specific SUD-related health outcomes including opioid and other SUD-dependency rates, opioid and other SUD-related overdoses and deaths—and trend rates related to Hepatitis C and HIV acquisition.

Please complete the following table that outlines all attribution activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

Attribution Counts for Quarter and Year to Date

Note: Enrollment counts should be unique enrollee counts by *each* regional IDN, not member months

IDN Attributed Populations	Total Number of IDN participants Quarter Ending – MM/YY	Current Enrollees (year to date)	Disenrolled in Current Quarter

IV. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration participants or potential eligibles.

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

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

IX. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the state's actions to address these issues.

XI. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

XII. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XIII. Managed Care and Medicaid Delivery Contracts Reporting Requirements

Address network adequacy reporting from plans including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates; summary of RCO appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of RCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation. The state must include additional reporting requirements within the annual report as outlined in STC 43.

XIV. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XV. Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XVI. State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

RESERVED FOR ATTACHMENT B
DSHP Claiming Protocol

RESERVED FOR ATTACHMENT C
DSRIP Planning Protocol
(Reserved)

RESERVED FOR ATTACHMENT D
DSRIP Funding & Mechanics Protocol
(Reserved)