

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00321/1

TITLE: Substance Use Disorder Serious Mental Illness and Serious Emotional Disturbance Treatment Recovery and Access Demonstration

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 New Hampshire for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from July 10, 2018 through June 30, 2023, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable New Hampshire to operate the above-identified section 1115(a) demonstration.

1. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder or Serious Mental Illness or Serious Emotional Disturbance.** Expenditures for Medicaid state plan services furnished to eligible individuals who are primarily receiving short-term treatment and withdrawal management services for substance use disorder (SUD) and/or a serious mental illness (SMI) and/or serious emotional disturbance (SED) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

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I. PREFACE

The following are the Special Terms and Conditions (STCs) for the “Substance Use Disorder Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Treatment Recovery and Access” (SUD SMI SED TRA) section 1115(a) Medicaid demonstration (hereinafter “demonstration”), to enable the New Hampshire Department of Health and Human Services (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 set forth conditions and limitations on those expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted. The STCs are effective as of the date of the approval letter, unless otherwise specified.

On June 16, 2021 CMS approved an amendment that revised the SUD TRA’s per member per month (PMPM) limits—as its required Corrective Action Plan (CAP)—pursuant to former STC 64 (current STC 74).

On June 2, 2022 CMS approved an amendment that added expenditure authority for Medicaid state plan services furnished to eligible individuals who are primarily receiving short-term treatment services for a SMI or for a SED who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Eligibility and Enrollment
- V. Demonstration Programs and Benefits
- VI. Cost Sharing
- VII. Delivery System
- VIII. General Reporting Requirements
- IX. Monitoring
- X. Evaluation of the Demonstration

- XI. General Financial Requirements Under Title XIX
- XII. Monitoring Budget Neutrality for the Demonstration
- XIII. Schedule of State Deliverables for the Demonstration Approval Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Interim and Summative Evaluation Reports
- Attachment C: Evaluation Design
- Attachment D: Substance Use Disorder (SUD) Implementation Plan Protocol
- Attachment E: SUD Monitoring Protocol
- Attachment F: SUD Amendment/CAP Application
- Attachment G: SMI/SED Implementation Plan
- Attachment H: Reserved for SMI/SED Monitoring Protocol

II. PROGRAM DESCRIPTION AND OBJECTIVES

The goal of this demonstration is for the state to maintain critical access to opioid use disorder (OUD) and other substance use disorder (SUD), Serious Mental Illness (SMI), and Serious Emotional Disturbance (SED) services and continue delivery system improvements for these services to provide more coordinated and comprehensive SMI, SED, and SUD (including OUD) treatment for Medicaid beneficiaries. This demonstration will provide the state with authority to provide high-quality, clinically appropriate SMI, SED, and SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD). It will also build on the state's existing efforts to improve models of care focused on supporting individuals in the community and home, outside of institutions and strengthen a continuum of SMI, SED, and SUD services based on the American Society of Addiction Medicine (ASAM) criteria or other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines.

During the demonstration period, the state seeks to, and hypothesizes that the demonstration will, achieve the following goals:

SMI/SED Goals:

1. Reduce utilization and lengths of stay in hospital emergency departments (ED) among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings;
2. Reduce preventable readmissions to acute care hospitals and residential settings;
3. Improve availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs and psychiatric hospitals and residential treatment settings throughout the state;
4. Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI/SED including through increased integration of primary and behavioral health care; and
5. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

SUD Goals:

1. Increase rates of identification, initiation, and engagement in treatment for SUD;
2. Increase adherence to and retention in treatment;
3. Reduce overdose deaths, particularly those due to opioids;
4. Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Reduce readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improve access to care for physical health conditions among beneficiaries with SUD.

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 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).
2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to this 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 and 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 as needed to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STCs 6 and 7. CMS will notify the state within 30 days 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.
4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy.**

- 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 necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

- b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, 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, whichever is sooner.

5. State Plan Amendments. The state will not be required to submit title XIX or XXI state plan amendments (SPAs) 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 is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements 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 changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar 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 the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables 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 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
 - b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
 - c. 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 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) the impact of the amendment;
 - d. An up-to-date CHIP allotment worksheet, if necessary;
 - e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the Evaluation Design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.
- 8. Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 C.F.R. § 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a transition and phase-out plan consistent with the requirements of STC 9.
- 9. Demonstration Transition and 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 transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration’s suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a

30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

- b. Transition and 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 redetermine Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
- c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to determining the individual ineligible as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e) and 457.350. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR § 431.230.
- d. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR § 431.416(g).
- e. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into

the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

- f. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI, as applicable. 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's 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, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. 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.

12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR section § 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR § 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR § 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. Federal Financial Participation (FFP). No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in

the demonstration approval letter, or if later, as expressly stated within these STCs.

14. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. Common Rule Exemption. The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR § 46.104(b)(5).

IV. ELIGIBILITY AND ENROLLMENT

16. Eligibility Groups Affected by the Demonstration. Under the demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan. The demonstration will allow Medicaid recipients under age 65 with OUD/SUD and ages 21 to 64 with SMI to receive coverage for otherwise covered services furnished to them while they are short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD) primarily to receive OUD/SUD/SMI/SED treatment, which are not otherwise matchable expenditures under section 1903 of the Act and will allow Medicaid recipients under age 21 to receive coverage for treatment services furnished by Qualified Residential Treatment Programs for SMI/SED. Demonstration services are delivered through a managed care or fee for service (FFS) delivery system. FFS recipients are primarily those in their managed care plan selection period, except for a small number of recipients who are exempt from managed care. 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.

V. DEMONSTRATION PROGRAMS AND BENEFITS

17. SMI SED and SUD Program Benefits. Under this demonstration, beneficiaries will have access to high quality, evidence-based SMI, SED, and/or SUD treatment and withdrawal management services, ranging in intensity from medically supervised withdrawal management for SUDs and short-term acute care in inpatient settings for SMI/SED to ongoing chronic care

for these conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days in residential and inpatient treatment settings, to be monitored pursuant to the SMI, SED, and/or SUD Monitoring Plans as outlined in Section IX Monitoring below.

The coverage of SMI, SED, and/or SUD treatment services during short term residential and inpatient stays in IMDs will expand the state’s current SMI, SED, and/or SUD benefit package available to all the state’s Medicaid beneficiaries as outlined in Table 1 (except where prohibited in these STCs).

The state attests that the services indicated in Table 1 as being either already covered under the Medicaid state plan authority or being authorized under the terms of this demonstration.

Table 1. SMI, SED, and/or SUD Benefits Coverage Authorized with Expenditure Authority			
Benefit	Type	Medicaid Authority	Expenditure Authority
Outpatient services	SMI/SED and/or SUD	State plan	N/A
Intensive outpatient services	SMI/SED and/or SUD	State plan	N/A
Inpatient services	SMI/SED and/or SUD	State plan (Individual services covered)	Services provided to individuals in IMDs
Residential treatment services	SMI/SED and/or SUD	State plan (Individual services covered)	Services provided to individuals residing in IMDs
Medically Supervised Withdrawal Management	SUD	State plan	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	SUD	State plan (individual services covered)	Services provided to individuals in IMDs
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	SUD	State plan	Services provided to individuals in IMDs
Partial Hospitalization	SUD and/or SMI/SED	State plan	N/A
Recovery Support Services	SUD	State plan	Services provided to individuals in IMDs

18. SMI/SED Implementation Plan.

- a. The state must submit a draft SMI/SED Implementation Plan within ninety (90) calendar days after approval of the June 2, 2022 demonstration amendment for CMS review and comment. The state must submit the revised SMI/SED Implementation Plan within sixty (60) calendar days after receipt of CMS's comments. The state may not claim FFP for services provided in IMDs to beneficiaries with a primary diagnosis of SMI/SED until CMS has approved the SMI/SED Implementation Plan(s) and the SMI/SED Financing Plan described in STC 18(d). After approval of the applicable implementation plans required by these STCs, FFP will be available prospectively, not retrospectively. FFP will only be available for services provided pursuant to the demonstration to beneficiaries who are short-term residents in IMDs that meet the criteria specified in STC 18(b)(i)(A) or 18(b)(i)(B) below, as applicable, as further detailed in the approved SMI/SED Implementation Plan; these providers are referred to as participating hospitals or participating residential treatment providers.

Once approved, the SMI/SED Implementation Plan will be incorporated into the STCs as Attachment G and once incorporated, may be altered only with CMS approval. Failure to submit an SMI/SED Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR § 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STCs 29 and 30.

- b. At a minimum, the SMI/SED Implementation Plan must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.

- A. Participating hospitals must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and be either: a) certified by the state agency as being in compliance with those conditions through a state agency survey, or b) deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.
- B. Participating residential treatment providers must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential

facility that meets the definition of an IMD.

- C. Establishment of an oversight and auditing process that includes unannounced visits for ensuring psychiatric hospitals and residential treatment settings in which beneficiaries receiving coverage pursuant to the demonstration are residing meet applicable state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
- D. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
- E. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR § 431.407, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
- F. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and substance use disorders (SUDs) and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. Improving Care Coordination and Transitions to Community-Based Care.

- A. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that community-based providers participate in transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings and/or by hiring peer support specialists to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment);
- B. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who have been experiencing or are likely to experience homelessness or who would be returning to unsuitable or unstable housing with community providers that coordinate housing services, where

available;

- C. Implementation of a requirement that psychiatric hospitals and residential treatment settings that are discharging beneficiaries who have received coverage pursuant to this demonstration have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary and the community-based provider to which the beneficiary was referred within 72 hours of discharge to encourage the beneficiary to receive appropriate follow-up care after leaving those facilities;
- D. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI/SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);
- E. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

- A. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability;
- B. Commitment to implementation of the financing plan described in STC 18(d);
- C. Implementation of strategies to improve the state’s capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
- D. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

iv. Earlier Identification and Engagement in Treatment Including Through Increased Integration

- A. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;

- B. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers;
 - C. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI/SED.
- c. **SMI/SED Health Information Technology Plan (“Health IT Plan”).** The SMI/SED Health IT plan applies to all states where the SMI/SED Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #18-011, states must submit to CMS the applicable SMI/SED Health IT Plan, to be included as a section of the associated SMI/SED Implementation Plan (see STC 18(a) and 18(c) to develop infrastructure and capabilities consistent with the SMI/SED requirements.

The SMI/SED Health IT Plan must detail the necessary SMI/SED health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plan will also be used to identify areas of SMI/SED health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment G), and must be aligned with the state’s broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state’s Behavioral Health (BH) IT Health Plan.

- i. The state must include in its SMI/SED Monitoring Protocol (see STC 20) an approach to monitoring its SMI/SED Health IT Plan which will include performance metrics to be approved in advance by CMS.
- ii. The state must monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report (see STC 32).
 - i. As applicable, the state should advance the standards identified in the ‘Interoperability Standards Advisory—Best Available Standards and Implementation Specifications’ (ISA) in developing and implementing the state’s SMI/SED Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.
- iii. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or accountable care organization (ACO) participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, Standards and Implementation Specifications for Health Information Technology, the state should use the federally-recognized standards, barring another compelling state interest.

- iv. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring another compelling state interest.
 - i. Components of the SMI/SED Health IT Plan include:
 1. The SMI/SED Health IT Plan will, as applicable, describe the state’s capabilities to develop and leverage an event notification system (ENS) and closed-loop referrals (CLR) in support of SMI/SED to promote high-quality care coordination and the delivery of appropriate services. The ENS should allow for identification of patients across separate clinical, financial, and administrative systems to allow for information exchange to improve care coordination. The state will also indicate how current efforts or plans to develop and/or utilize the ENS and CLR support the programmatic objectives of the demonstration.
 2. The SMI/SED Health IT Plan will describe the state’s current and future capabilities to support providers implementing or expanding SMI/SED Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.
 1. In developing the SMI/SED Health IT Plan, states should use the following resources.
 - States may use federal resources available on Health IT.Gov (<https://www.healthit.gov/topic/behavioral-health>) including but not limited to “Behavioral Health and Physical Health Integration” and “Section 34: Opioid Epidemic and Health IT” (<https://www.healthit.gov/playbook/health-information-exchange/>).
 - States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicare.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
 - States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.
- d. **SMI/SED Financing Plan.** As part of the SMI/SED implementation plan referred to in STC 18(a), the state must submit, within 90 calendar days after approval of the demonstration, a draft financing plan that will be approved by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the SMI/SED

implementation plan in Attachment G and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI/SED Financing Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR § 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration.

Components of the SMI/SED Financing Plan must include:

- i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and
- ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings;
- iii. A plan to ensure the on-going maintenance of effort (MOE) on funding outpatient community-based services to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

19. SUD Implementation Protocol. The state submitted an OUD/SUD Implementation Protocol within 90 calendar days after approval of this demonstration, which CMS approved as part of the state's initially approved STCs on July 10, 2018. The state may not claim FFP for services provided in IMDs until CMS has approved the Implementation Protocol. Once approved, the Implementation Protocol will be incorporated into the STCs, as Attachment D, and once incorporated, may be altered only with CMS approval. After approval of the Implementation Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Protocol will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR § 431.420(d) and, as such, would be grounds for termination or suspension of the OUD/SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral. At a minimum, the OUD/SUD Implementation Protocol must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration program:

- a. Access to Critical Levels of Care for OUD and other SUDs: Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;
- b. Use of Evidence-based SUD-specific Patient Placement Criteria: Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of

OUD/SUD program demonstration approval;

- c. Patient Placement: Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;
- d. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities: Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in the New Hampshire Code of Administrative Rules at He-W 513. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval;
- e. Standards of Care: Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;
- f. Standards of Care: Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;
- g. Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for OUD: An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT, within 12 months of SUD program demonstration approval;
- h. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD: Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;
- i. SUD Health IT Plan: Implement the milestones and metrics as detailed in former STC 18; and

- j. Improved Care Coordination and Transitions between levels of care: Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

20. SMI/SED Monitoring Protocol. The state must submit a draft Monitoring Protocol for the SMI/SED program authorized by this demonstration within 150 calendar days after approval of the demonstration. The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The state must submit the revised SMI/SED Monitoring Protocol within sixty (60) calendar days after receipt of CMS's comments. Once approved, the SMI/SED Monitoring Protocol will be incorporated into the STCs, as Attachment H. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports. Components of the SMI/SED Monitoring Protocol include:

- a. A description of how the state will report information relevant to each of the program implementation areas listed in STC 18(a) and (c), information relevant to the state's SMI/SED financing plan described in STC 18(e), and information relevant to the state's SMI/SED Health IT plan described in STC 18(c);
- b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section VIII of the demonstration; and
- c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

21. SUD Monitoring Protocol. The state submitted a SUD Monitoring Protocol within 150 calendar days after approval of SUD program under this demonstration, which CMS approved on May 22, 2019. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment E. At a minimum, the SUD Monitoring Plan Protocol will include reporting relevant to each of the program implementation areas listed in former STC 18. The protocol will also describe the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. The SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in former STC 27 of the demonstration. In addition, for each performance measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points.

Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the Monitoring Protocol will be reported via the

quarterly and annual monitoring reports.

22. Evaluation. The SMI/SED Evaluation and the SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as described in Sections VIII (General Reporting Requirements) and X (Evaluation of the Demonstration) of these STCs.

23. Availability of FFP under the SMI/SED component of the demonstration. FFP is only available for services provided to beneficiaries who are residing in an IMD when the beneficiary is a short-term resident in the IMD to receive acute care for a primary diagnosis of SMI/SED. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30-day average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services under the demonstration. If the state cannot show that it is meeting the 30-day ALOS requirement within one standard deviation at the mid-point assessment, the state may only claim FFP for services furnished to beneficiaries in an IMD during stays of up to 45 days until such time that the state can demonstrate that it is meeting the 30-day ALOS requirement.

24. Qualified Residential Treatment Programs (QRTPs.) The state may receive FFP for treatment provided to beneficiaries residing in QRTPs with over 16 beds if the QRTPs meet the following requirements:

- a. The QRTP meets all of the requirements of the Family First Prevention Services Act (FFPSA) that was signed into law on February 9, 2018, as part of the Bipartisan Budget Act of 2018.
- b. The state performs a needs assessment for the beneficiary to assure the appropriateness of placement in the QRTP as specified in the FFPSA.
- c. QRTP meets any guidance or regulations that may be issued by the Administration for Children and Families in these settings.
- d. The billing provider is enrolled in Medicaid.
- e. The practitioner who furnishes a service meets federal and state qualifications to provide the service.
- f. QRTP complies with CMS regulations regarding seclusion and restraint found in 42 CFR Part 483 Subpart G.
- g. FFP is not available for room and board costs in QRTPs.
- h. QRTPs are not subject to the 30-day average length of stay requirement as described in STC 23 or the 60-day length of stay requirement as described in STC 23 for the first 2 years following the approval of the SMI/SED amendment to this demonstration.

25. SUD Mid-Point Assessment. The state must conduct an independent mid-point assessment

of the demonstration by December 31, 2021. The assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The mid-point assessment will also provide a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state’s implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. A copy of the report will be provided to CMS. CMS will be briefed on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Protocol and SUD Monitoring Plan Protocols for ameliorating these risks subject to CMS approval.

¹ Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the “opioid” epidemic and facilitate a nimble and targeted response.

² *Ibid.*

³ Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. *MMWR Morb. Mortal Wkly Rep.* 2017; 66: 265–269.

VI. COST SHARING

26. Cost Sharing. Cost sharing imposed upon individuals enrolled in the demonstration is consistent with the provisions of the approved state plan.

VII. DELIVERY SYSTEM

27. Delivery System. The state’s SMI/SED and/or SUD/ODU Medicaid delivery system is based on an integrated managed care model for physical and behavioral health. It utilizes Managed Care Organizations (MCO) to deliver integrated physical and behavioral health services, including SUD with a small number of members receiving services through FFS. Under the demonstration, Substance Use Disorder Serious Mental Illness and Serious Emotional Disturbance Treatment Recovery and Access, the delivery system will continue

to operate as approved in Section 1932(a) state plan authority for managed care and concurrent 1915(b) and 1115 demonstrations.

VIII. GENERAL REPORTING REQUIREMENTS

28. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

29. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as deliverable(s)) are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of FFP for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty (30) days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
- b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process will be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.
- c. If CMS agrees to an interim corrective action plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
- d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

- e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

30. Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward SMI/SED Milestones. Up to \$5,000,000 in FFP for services furnished to beneficiaries who are residing in IMDs and receiving covered services under this demonstration may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Plan agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to \$5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made. The state is expected to meet the milestones by the end of the first two years of the SMI/SED demonstration component.

31. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

- a. Revise the reporting templates and submission processes to accommodate timely compliance with the new requirements of federal systems;
- b. Ensure all section 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state timely and completely; and
- c. Submit deliverables to the appropriate system as directed by CMS.

IX. MONITORING

32. Monitoring Reports. The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR § 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

- a. Operational Updates. The operational updates will focus on progress toward meeting the demonstration's milestones. Additionally, per 42 CFR § 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also

include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; updates on the state's financing plan and maintenance of effort described in STC 18(d); legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

- b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's milestones. Additionally, per 42 CFR § 431.428, the Monitoring Reports must document the impact of the demonstration in providing coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.
- c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR § 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.
- d. Evaluation Activities and Interim Findings. Per 42 CFR § 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.
- e. SMI/SED Health IT and/or SUD Health IT. The state will include a summary of progress made in regards to SMI/SED and/or SUD Health IT requirements outlined in STC 18(c) and STC 19(i).

33. SMI/SED Mid-Point Assessment.

The state must conduct an independent SMI/SED mid-point assessment by May 30, 2025. The Mid-Point Assessment should address the first two years of the SMI/SED program, or if the demonstration is not renewed or is renewed for a term that ends on or before May 30, 2025, then it must address as much of the term for which the SMI/SED Program under the demonstration was authorized as is possible given the necessary time for metrics calculation and analysis. In the design, planning and conduct of the SMI/SED mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of managed care organizations (MCO), SMI/SED treatment providers, beneficiaries, and other key partners.

The state must require that the assessor provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the

methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 days after May 30, 2025. The state must brief CMS on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS proposed modifications to the SMI/SED Implementation Plan, the SMI/SED Financing Plan, and the SMI/SED Monitoring Protocol, as may be appropriate, for ameliorating these risks. Modifications to any of these plans or protocols are subject to CMS approval.

- i. Elements of the SMI/SED Mid-Point assessment must include:
 - A. An examination of progress toward meeting each milestone and timeframe approved in the SMI/SED Implementation Plans, the SMI/SED Financing Plan, and toward meeting the targets for performance measures as approved in the SMI/SED Monitoring Protocol;
 - B. An examination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;
 - C. An examination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
 - D. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SMI/SED Implementation Plans or SMI/SED Financing Plan or to pertinent factors that the state can influence that will support improvement; and
 - E. An assessment of whether the state is on track to meet the budget neutrality requirements.

34. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10; however, a corrective action plan is not a prerequisite to CMS proceeding to withdraw waivers or expenditure authorities, as outlined in STC 10.

35. Close-Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a Draft Close-Out Report to CMS for comments.

- a. The draft close-out report must comply with the most current guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the close-out report.

- c. The state must take into consideration CMS’s comments for incorporation into the final close-out report.
- d. The final close-out report is due to CMS no later than thirty (30) calendar days after receipt of CMS’s comments.
- e. A delay in submitting the draft or final version of the close-out report may subject the state to penalties described in STC 29.

36. Monitoring Calls. CMS will convene periodic conference calls with the state.

- a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.
- b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
- c. The state and CMS will jointly develop the agenda for the calls.

37. Post Award Forum. Pursuant to 42 CFR § 431.420(c), within six (6) months of the demonstration’s implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (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 must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR § 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

X. EVALUATION OF THE DEMONSTRATION

38. Cooperation with Federal Evaluators. As required under 42 CFR § 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR § 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 29 and/or 30.

39. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

40. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs.

The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) days after the approval of the demonstration or any amendment. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

- a. All applicable Evaluation Design guidance, including guidance about SUD/SMI. Hypotheses applicable to the demonstration as a whole, and to all key policies referenced above, will include (but will not be limited to): the effects of the demonstration on health outcomes; the financial impact of the demonstration (for example, such as an assessment of medical debt and uncompensated care costs),
- b. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD and SMI/SED Evaluation Designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.

41. Evaluation Budget. A budget for the evaluations must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

42. Evaluation Design Approval and Updates. The state must submit the revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS's comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR § 431.424(c), the state will publish the approved Evaluation Design to the state's website within thirty (30) calendar days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the

evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

43. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

44. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR § 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.
- b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
- c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting a renewal for the demonstration, the Interim Evaluation Report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
- d. The state must submit the final Interim Evaluation Report sixty (60) calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
- e. The Interim Evaluation Report must comply with Attachment B of these STCs.

45. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B Preparing the Interim and Summative Evaluation Reports of these STCs. The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within eighteen (18) months of the end of the

approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within sixty (60) calendar days of receiving comments from CMS on the draft.
- b. The final Summative Evaluation Report must be posted to the state's Medicaid website within thirty (30) calendar days of approval by CMS.

46. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10; however, a corrective action plan is not a prerequisite to CMS proceeding to withdraw waivers or expenditure authorities, as outlined in STC 10.

47. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report, and if requested, the state agrees to make such presentation and participate in such discussion.

48. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, the approved Evaluation Design, Interim Evaluation Reports, and Summative Evaluation Reports) on the state's website within thirty (30) calendar days of approval by CMS.

49. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment on or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

50. Allowable Expenditures. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the

pre-defined limits as specified in these STCs.¹

51. Unallowable Expenditures under the SUD Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any authority approved under this demonstration for any of the following:

- a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
- b. Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

52. Unallowable Expenditures under the SMI Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

- a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
- b. Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
- c. Costs for services provided to mentally ill individuals who are deemed incompetent to stand trial or found not guilty by reason of insanity or are statutorily mandated due to judicial determination to receive court-ordered treatment and who reside in psychiatric hospitals, residential treatment facilities or transitional living programs.
- d. Costs for services provided to individuals who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.
- e. Except as noted in STC 24, costs for services provided to beneficiaries under age 21 residing in an IMD primarily for the treatment of SMI/SED unless the IMD meets the requirements for the “inpatient psychiatric services for individuals under age 21” benefit under 42 CFR § 440.160, 441 Subpart D, and 483 Subpart G.

53. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will 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 federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state’s estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If

¹ For a description of CMS’s current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on 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.

54. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in section XI:

- 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. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration approval period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

55. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that the non-federal share is obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that such funds must not be used to match any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, CMS reserves the right to prohibit the use of any sources of non-federal share funding that it determines impermissible.

- a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to fund the demonstration.
- b. If CMS determines that any funding sources are not consistent with applicable federal regulations, the state must address CMS's concerns within the time frames allotted by CMS.
- c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

56. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share funding of demonstration expenditures have been met:

- a. Units of state or local government, including health care providers that are units of state or local government, that supply any funds used as non-federal share for expenditures under the demonstration must certify that only 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 (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit(s) of government must certify to the state the amount of public funds allowable under 42 CFR § 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as non-federal share to obtain additional federal matching funds, except as authorized by federal law, consistent with 42 CFR § 433.51(c).
- c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR § 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.
- d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, consistent with 42 CFR § 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments to return and/or redirect to the state any portion of the Medicaid payments to providers (except pursuant to court order as set out at 42 C.F.R. § 447.10(e)). 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.

57. Financial Integrity for Managed Care and Other Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

- a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR §§ 438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74.
- b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR § 447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

58. Requirements for health care related taxes and provider donations. As a condition of demonstration approval, the state attests to the following, as applicable:

- a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903 (w)(3)(A) of the Social Security Act and 42 CFR § 433.55 are broad-based as defined by Section 1903 (w)(3)(B) of the Social Security Act and 42 CFR § 433.68 (c).
- b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903 (w)(3)(C) of the Social Security Act and 42 CFR § 433.68 (d).
- c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903 (w)(3)(E)(i) of the Social Security Act and 42 CFR § 433.72.
- d. The tax does not contain a hold harmless arrangement as described by Section 1903 (w)(4) of the Social Security Act and 42 CFR § 433.68 (f).
- e. All provider related-donations as defined by 42 CFR § 433.52 are bona fide as defined by Section 1903 (w)(2)(B) of the Social Security Act, 42 CFR § 433.66, and 42 CFR § 433.54.

59. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

60. Medicaid Expenditure Groups (MEG). MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 2: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
SUD Medicaid Adults	Hypo 1	X		X	SUD Non-Group VIII Adults; see Table 3.
SUD Expansion	Hypo 1	X		X	SUD Group VIII Adults; see Table 3.

Adults					
SUD Adolescents	Hypo 1	X		X	SUD Adolescents; see Table 3
SMI Medicaid Adults	Hypo 2	X		X	SMI Non-Group VIII Adults; see Table 3
SMI Expansion Adults	Hypo 2	X		X	SMI Group VIII Adults; see Table 3

61. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00321/1). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

- a. Cost Settlements. The state will report any cost settlements attributable to the demonstration 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. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
- b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.
- c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.
- d. Administrative Costs. The state will 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. Unless indicated

otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

- e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in section IX Monitoring, the state must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration 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, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.
- f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
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SUD Medicaid Adults (Non-Group VIII Adults)	All expenditures for costs of medical assistance that could be covered for Medicaid Adults with SUD, were it not for the IMD prohibition, under the state plan, provided to otherwise eligible individuals during a month in an IMD.	Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	July 10, 2018	June 30, 2023
SUD Expansion Adults (VIII Adults)	All expenditures for costs of medical assistance that could be covered for Expansion Adults with SUD, were it not for the IMD prohibition, under the state plan, provided to otherwise eligible individuals during a month in an IMD.	Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	July 10, 2018	June 30, 2023

SUD Adolescents	All expenditures for costs of medical assistance that could be covered for Adolescents with SUD, were it not for the IMD prohibition, under the state plan, provided to otherwise eligible individuals during a month in an IMD.	Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	July 10, 2018	June 30, 2023
SMI Medicaid Adults	All expenditures for costs of medical assistance that could be covered for Medicaid Adults with SMI, were it not for the IMD prohibition, under the state plan, provided to otherwise eligible individuals during a month in an IMD.	Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	June 2, 2022	June 30, 2023

SMI Expansion Adults	All expenditures for costs of medical assistance that could be covered for Expansion Adults with SMI, were it not for the IMD prohibition, under the state plan, provided to otherwise eligible individuals during a month in an IMD.	Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	June 2, 2022	June 30, 2023
ADM	All demonstration-related administrative costs, see STC 54(a)	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of payment	ADM	N	1/1/20	12/31/24

62. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 4: Demonstration Years

Demonstration Year 1	July 1, 2018 to June 30, 2019	12 months
Demonstration Year 2	July 1, 2019 to June 30, 2020	12 months

Demonstration Year 3	July 1, 2020 to June 30, 2021	12 months
Demonstration Year 4	July 1, 2021 to June 30, 2022	12 months
Demonstration Year 5	July 1, 2022 to June 30, 2023	12 months

63. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing demonstration’s actual expenditures to the budget neutrality expenditure limits described in section XI. CMS will provide technical assistance, upon request.²

64. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. 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 will 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.

65. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

- a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

² 42 CFR § 431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and § 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS’s current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

- b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such 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 STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.
- c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

66. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

67. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

68. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual

limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

69. Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

70. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be “hypothetical;” that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS’s current view that states should not have to “pay for,” with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state’s WW hypothetical spending exceeds the supplemental test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by savings elsewhere in the demonstration or to refund the FFP to CMS.

- a. **Hypothetical Budget Neutrality Test 1: SUD Initiative.** All expenditures for costs of medical assistance that could be covered for Medicaid beneficiaries with SUD, were it not for the IMD payment exclusion, under the state plan, provided to otherwise eligible individuals during a month in which the beneficiary was a short-term resident in an IMD primarily to receive treatment for SUD. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR	TREND RATE	DY 1	DY 2	DY 3	DY 4	DY 5
SUD Medicaid Adults (Non-Group VIII Adults)	PC	Both	2017 (DY1-2) 2019 (DY3-5)	4.4% (DY1-2) 8.3% (DY3-5)	\$961	\$1,004	\$1,572.57	\$1,703.09	\$1,844.45
SUD Expansion Adults (VIII Adults)	PC	Both	2017 (DY1-2) 2019 (DY3-5)	4.7% (DY1-2) 6.4% (DY3-5)	\$608	\$636	\$1,643.22	\$1,748.39	\$1,860.29
SUD Adolescents	PC	Both	2017 (DY1-2) 2019 (DY3-5)	3.7% (DY1-2) 6.7% (DY3-5)	\$573	\$595	\$987.06	\$1,053.19	\$1,123.75

b. **Hypothetical Budget Neutrality Test 2: SMI Initiative.** All expenditures for costs of medical assistance that could be covered for Medicaid beneficiaries with SMI, were it not for the IMD payment exclusion, under the state plan, provided to otherwise eligible individuals during a month in which the beneficiary is a short-term resident in an IMD primarily for treatment of SMI. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

MEG	PC or Agg*	WOW Only, WW Only, or Both	BASE YEAR	TREND RATE	DY 1	DY 2	DY 3	DY 4	DY 5
SMI Medicaid Adults (Non-Group VIII Adults)	PC	Both	DY4	8.3%	N/A	N/A	N/A	N/A	\$12,281
SMI Expansion Adults (VIII Adults)	PC	Both	DY4	6.4%	N/A	N/A	N/A	N/A	\$7,285

71. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to 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 by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration’s approval period, 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. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

72. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from July 10, 2018 to June 30, 2023. The Main Budget Neutrality Test may incorporate net savings from the immediately prior demonstration period, if applicable, (but not from any earlier approval period). If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

73. Mid-Course Correction. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Main Budget Neutrality Test

Table 9: Main Budget Neutrality Test Mid-Course Correction Calculations		
	Cumulative Target Definition	Percentage
DY1	Cumulative budget neutrality limit plus:	2.0 percent
DY1 through DY2	Cumulative budget neutrality limit plus:	1.5 percent
DY1 through DY3	Cumulative budget neutrality limit plus:	1.0 percent
DY1 through DY4	Cumulative budget neutrality limit plus:	0.5 percent
DY1 through DY5	Cumulative budget neutrality limit plus:	0.0 percent

Hypothetical Budget Neutrality Test(s)

Table 10: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Year	Cumulative Target Definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
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:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent

XIII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Date	Deliverable	STC
30 days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 days after SUD program approval date	SUD Implementation Protocol	STC 19
90 days after SMI/SED program approval date	SMI/SED Implementation Plan	STC 18
150 days after SUD program approval date	SUD Monitoring Protocol	STC 21
180 days after approval date	Draft Evaluation Design	STC 40
60 days after receipt of CMS comments	Revised Draft Evaluation Design	STCs 42
30 days after CMS Approval	Approved Evaluation Design published to state's website	STC 42
December 31, 2021	SUD Mid-Point Assessment	STC 25
60 days after completion of assessment, due the earlier of May 30, 2025 (if demonstration is extended), or one year after the end of the demonstration (if not).	SMI/SED Mid-Point Assessment	STC 33
One year prior to the end of the demonstration, or with renewal application	Draft Interim Evaluation Report	STC 44(c)
60 days after receipt of CMS comments	Final Interim Evaluation Report	STC 44(d)
18 months of the end of the demonstration	Draft Summative Evaluation Report	STC 45
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 45(a)
30 calendar days of CMS approval	Approved Final Summative Evaluation Report published to state's website	STC 45(b)
Monthly Deliverables	Monitoring Calls	STC 36

Quarterly Deliverables	Quarterly Monitoring Reports	STC 32
Due 60 days after end of each quarter, except 4 th quarter	Quarterly Expenditure Reports	STC 32

Annual Deliverables - Due 90 days after end of each 4 th quarter	Annual Reports	STC 32
Within 120 calendar days after the expiration of the demonstration	Draft Close-out Operational Report	STC 35
30 calendar days after receipt of CMS comments	Final Close-out Operational Report	STC 35(d)

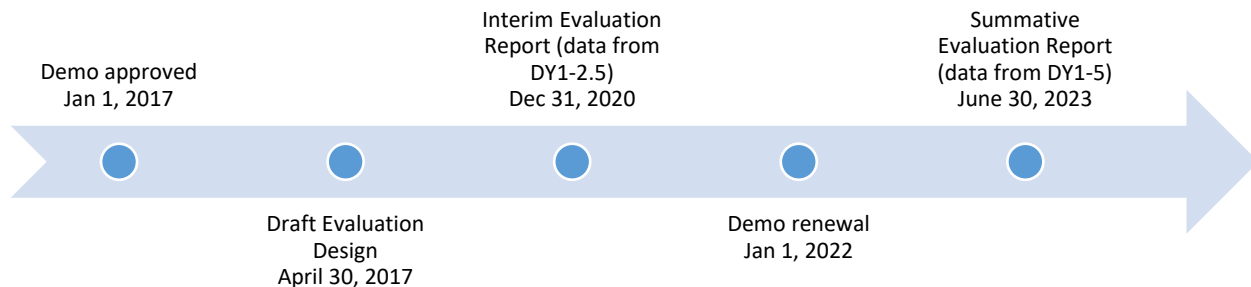
ATTACHMENT A Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov:

<https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to

follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- A. General Background Information;
- B. Evaluation Questions and Hypotheses;
- C. Methodology;
- D. Methodological Limitations;
- E. Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state’s hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state’s demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.
4. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: <https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure. Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.
2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3. *Evaluation Period* – Describe the time periods for which data will be included.
4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate. The state also should include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.
5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.
6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
 - a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
 - b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
 - c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
 - d. Consider the application of sensitivity analyses, as appropriate.
7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
 - a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
 - b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes;
 - b. No or minimal appeals and grievances;
 - c. No state issues with CMS-64 reporting or budget neutrality; and
 - d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state’s process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a “No Conflict of Interest” statement signed by the independent evaluator.
2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.
3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

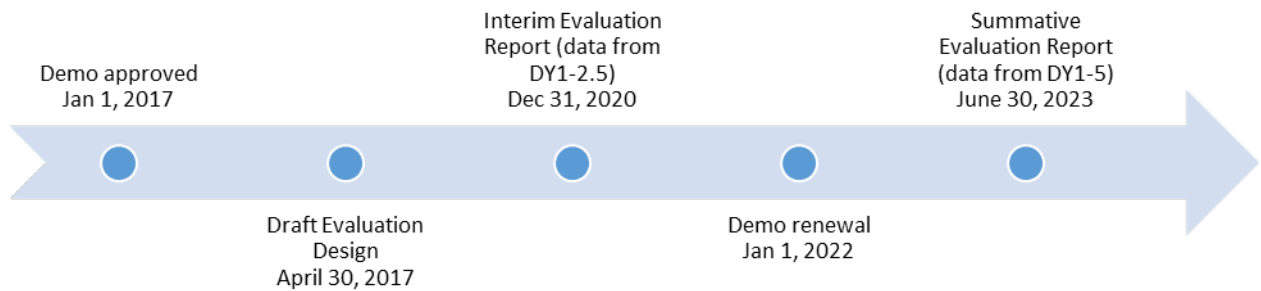
Attachment B: Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state’s submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state’s website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state’s website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for

constructing comparison groups and identifying causal inferences are available on Medicaid.gov: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

- A. Executive Summary;
 - B. General Background Information;
 - C. Evaluation Questions and Hypotheses;
 - D. Methodology;
 - E. Methodological Limitations;
 - F. Results;
 - G. Conclusions;
 - H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
 - I. Lessons Learned and Recommendations; and,
 - J. Attachment(s).
- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
 2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
 3. A description of the population groups impacted by the demonstration.
 4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.

5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state’s hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of titles XIX and XXI.
3. Describe how the state’s demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
2. *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected.
4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.
6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. If the state did not fully achieve its intended goals, why not?
3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

**ATTACHMENT C:
Evaluation Design**

NEW HAMPSHIRE
SUBSTANCE USE
DISORDER
TREATMENT AND
RECOVERY ACCESS
DEMONSTRATION

This program is operated under a Section 1115(a) Medicaid Demonstration initially approved by the Centers for Medicare and Medicaid Services (CMS) July 10, 2018, Revised August 3, 2018

**EVALUATION
DESIGN
DEC 18, 2018**

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I. General Background Information

The New Hampshire Substance Use Disorder (SUD) Treatment and Recovery Access demonstration is necessary to address critical unmet needs for residential SUD treatment. These needs continue to exist despite significant improvements to New Hampshire's SUD treatment delivery system and substantial state investments in treatment capacity. In response to the opioid crisis, New Hampshire invested more than 30 million over the last two years to build service capacity and support a full continuum of care to treat individuals with SUD. These investments include those that maintain existing prevention, treatment, and recovery capacity while also expanding access to medication assisted treatment (MAT), peer recovery support services (PRSS), direct prevention services, and coordination of care through a statewide crisis hotline and development of nine regional treatment Hubs to serve as 24/7 access points to addiction treatment. Hubs will provide screening, evaluation, care management, social service referral and addiction treatment services across the state. The goal of these investments has been to build a robust, resiliency and recovery-oriented system of care for individuals with SUD. Although capacity for services has increased, the limited availability of treatment in all settings, particularly residential treatment, continues to be a challenge.

A. Rationale for Demonstration

New Hampshire is experiencing one of the most significant public health crises in its history. The striking escalation of opiate use and opioid misuse over the last five years is affecting individuals, families, and communities throughout the state.

New Hampshire currently has the third highest overdose death rate in the country (39 per 100,000).ⁱ The number of overdose deaths has increased dramatically; from 192 to 488ⁱⁱ. Between 2013 and 2017, the number of times emergency medical personnel administered Narcan more than doubled, from 1,039 to 2,774ⁱⁱⁱ. Most recent data show that opioid related emergency department visits rose by 9.8% from 2016 to 2017^{iv}.

As striking as these data are, the scope of the crisis extends beyond individuals with SUD to include family members. New Hampshire has seen a significant rise in neonatal abstinence syndrome (NAS), with the rate reaching 24.4 per 1,000 live births in 2015. Babies born with NAS require more complex medical care, with average hospital stays of twelve days.

The incidence of NAS is higher among Medicaid enrollees than other groups. In 2013, Medicaid paid for 78% of NAS births.^v In 2015, the DHHS' Division for Children, Youth, and Families reported that it received 504 reports of children born drug-exposed, an increase of 37% from 2014.^{vi}

In addition to the high rate of opioid use among the adult population, New Hampshire faces significant challenges with regard to adolescents. The state ranks among the top five for binge drinking among persons ages 12-20 years.^{vii} According to the 2015-2016 National Survey on Drug Use and Health (NSDUH), illicit drug use among individuals aged 12-17 in New Hampshire is higher than in the broader New England region and the United States. In 2015-2016, 8.98% (95% CI: 7.32-10.96) of New Hampshire adolescents ages 12-17 reported illicit drug use in the past month.^{viii}

Despite having some of the nation's highest rates of youth alcohol and drug use, New Hampshire

lacks both the outpatient and residential capacity to serve youth who present with substance use disorder (SUD).

Many adolescents are sent out-of-state to specialty treatment facilities. Still others go untreated until the progression of their disease leads them to involvement with the juvenile justice system, emergency departments, and other costly interventions.

B. Purpose of Demonstration

The New Hampshire Substance Abuse Treatment and Recovery Access Section 1115(a) demonstration was approved by CMS on July 10, 2018, with clarifying, non-substantive revisions approved on August 3, 2018, for a five-year term ending June 30, 2023. The goal of this demonstration is to maintain critical access to opioid use disorder (OUD) and other SUD services and continue delivery system improvements that will support coordinated and comprehensive OUD/SUD treatment for Medicaid enrollees. This demonstration authorizes New Hampshire to provide high-quality, clinically appropriate SUD treatment services in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD).

The demonstration will also encourage growth in SUD residential treatment capacity (IMD and non-IMD) and build on existing efforts to improve models of care focused on supporting enrollees in their home and community and strengthen the New Hampshire continuum of SUD services. New Hampshire's innovations and treatment decisions are based on the American Society of Addiction Medicine (ASAM) criteria and other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines.

C. SUD Benefits and Demonstration History

In August 2014, New Hampshire's expanded Medicaid program ("New Hampshire Health Protection Program") began offering a comprehensive benefit for SUD services to the Medicaid Expansion population. Approximately 7,500 enrollees in the New Hampshire Health Protection Program receive treatment services for SUD each quarter. Beginning in July of 2016, this SUD benefit, outlined in Table 1, was made available to all Medicaid enrollees, resulting in a total of 8,463 Medicaid enrollees receiving SUD treatment services as of March 31, 2018.

Table 1. New Hampshire Medicaid Substance Use Disorder Benefit

SUD Service Type	Description
Screening, by Behavioral Health practitioner	Screening for a SUD
SBIRT	Screening, Brief Intervention, Referral to Treatment
Crisis Intervention	Crisis services provided in an office or community setting
Evaluation	Evaluation to determine the level of care and/or other services needed
Medically Managed Withdrawal Management	Withdrawal management in a hospital setting, with or without rehabilitation therapy
Medically Monitored Withdrawal Management	Withdrawal management provided in an outpatient or residential setting
Opioid Treatment Program	Methadone or Buprenorphine treatment in a clinic setting
Office based Medication Assisted Treatment	Medication Assisted Treatment in a physician's office provided in conjunction with other SUD counseling services
Outpatient Counseling	Individual, group, and/or family counseling for SUDs
Intensive Outpatient	Individual and group treatment and recovery support services provided at least 3 hours per day, 3 days per week
Partial Hospitalization	Individual and group treatment and recovery support services for SUD and co-occurring mental health disorders provided at least 20 hours per week
Rehabilitative Services	Low, Medium, and High Intensity residential treatment provided by Comprehensive SUD Programs
Recovery Support Services	Community based peer and non-peer recovery support services provided in a group or individual setting
Case Management	Continuous Recovery Monitoring

In addition to expanding coverage for SUD services through Medicaid, the DHHS' Bureau of Drug and Alcohol Services (BDAS) contracts with thirteen SUD treatment providers across New Hampshire to provide SUD treatment and recovery services for those individuals who are not Medicaid eligible or whose commercial benefit plan leaves them underinsured for the medically necessary level of care.^{ix}

Nearly all state-funded SUD residential treatment facilities in New Hampshire have more than sixteen beds and provide services to individuals aged 22-64. In addition, the State has designed capacity at the Sununu Youth Services Center to create a 36-bed residential SUD treatment facility available for adolescents under 18 years old. Services provided include both low and medium intensity adolescent residential treatment for adolescents aged 12 to 18 years of age who qualify for such a level of care using the ASAM patient placement criteria.

Although New Hampshire's significant commitment of time and financial resources to the transformation of its SUD delivery system over the last five years has increased service capacity, the limited availability of treatment to meet the demand on the system continues to be a major challenge. As of February 2018, the waitlist for both ASAM Level 3.5 (Clinically Managed High-Intensity Residential Services for adults) and Level 3.1 (Clinically Managed Low-Intensity Residential Services) was 28 days.

D. Demonstration Goals

The goals of this demonstration are to: 1) maintain critical access to OUD and other SUD services and 2) continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment of Medicaid enrollees. The demonstration will provide the State with authority to offer high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as IMD.

It also will build on the State's existing efforts to improve models of care focused on supporting enrollees in the community and home, outside of institutions and strengthen a continuum of SUD services based on the ASAM criteria or other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines.

During the demonstration period, the State seeks to achieve the following:

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among enrollees.

E. Demonstration Population

Medicaid beneficiaries with a SUD requiring residential treatment, based on ASAM placement criteria, are eligible for the demonstration.

II. Evaluation Questions and Hypotheses

The SUD demonstration supports the federal Medicaid program in its core mission: to meet the health and wellness needs of our nation's vulnerable and low-income individuals and families. Demonstration goals align with the Title XIX objective: to improve access to high-quality, person-centered services that produce positive health outcomes for individuals.

The SUD demonstration is specifically designed to maintain and enhance access to treatment for enrollees with a SUD, support high quality care, and to maintain budget neutrality. The evaluation will examine the demonstration's impact in each of these areas.

First, related to access to care, it is hypothesized that adult and adolescent enrollees will have improved access to residential care. The SUD demonstration is expected to maintain and encourage growth in adult capacity and support the development of in-state capacity for adolescents. Specifically, an increase in 36-beds for adolescents, at the Sununu Center, will begin in late 2018 and is expected to be completed by the end of 2019. The increased adolescent capacity will provide valuable cost-effective services for youth who may otherwise go out-of-state for residential SUD treatment or go untreated.

Second, related to quality of care, it is hypothesized that the demonstration will improve the quality of care as evidenced by: fewer Emergency Department (ED) admissions, both in total use and for SUD related visits; improved rates of initiation and engagement in alcohol and other drug dependence treatment; lower hospital and IMD readmission rates; and improved rates of treatment retention.

Residential SUD treatment is an important component of the ASAM level of care framework; maintaining and enhancing capacity is expected to support treatment success that will result in improved health outcomes. In addition, residential SUD treatment providers are expected to assess the comprehensive needs of participants and use the results in the development of high quality discharge plans for enrollees. As such, residential SUD treatment providers are responsible for: supporting enrollee referral and engagement with community based SUD treatment providers, including Medication Assisted Treatment; PCP engagement; recovery supports (e.g., Alcoholics/Narcotics Anonymous and peer recovery support specialist) and relapse prevention plans. It is expected that maintaining and enhancing access to residential SUD treatment under this demonstration, will support high quality care and improve health outcomes for enrollees.

To further enhance the quality of residential treatment, the demonstration's SUD Implementation Plan (STC Attachment D) includes updates to current New Hampshire rules. These changes necessitate rulemaking through the State's Administrative Procedures Act (APA). Specifically, rules are being updated to clarify SUD provider program expectations and licensing requirements, including the use of ASAM criteria and best practices in discharge planning across all levels of SUD treatment.

DHHS began working on amending the Substance Use Disorder Treatment and Recovery Support Services rule (He-W 513) in June 2018. The process includes formal review by New Hampshire's Medical Care Advisory Committee (MCAC) and discussions with SUD stakeholder groups to obtain input on rule changes. The final proposed rules incorporating public input were approved and effective on November 15, 2018. Corresponding changes will be made in two additional rules

through coordination with the BDAS and the DHHS Health Facility Licensing Unit to align residential treatment expectations and limit administrative burden for providers.

Improvements in quality expected as a result of rule changes will be measured through structured provider interviews. Interviews will solicit provider feedback on their understanding of the DHHS rule changes and its impact relative to consistency in residential SUD programs and expanded discharge planning requirements.

Lastly, related to cost of care, the State is expected to maintain or reduce spending in comparison to what would have been spent absent the demonstration. In the case of adolescents, it is hypothesized that the cost of residential SUD treatment will be reduced as more youth access in-state treatment options in lieu of more costly out-of-state SUD treatment.

Quality Strategy and SUD Monitoring Plan

New Hampshire has a [Comprehensive Quality Strategy \(CQS\)](#) that integrates all aspects of quality improvement programs, processes, and requirements across the State's Medicaid Managed Care program. The CQS is the framework through which all aspects of Medicaid operations are assessed and measurable goals and targets for improvement are identified.

Through this demonstration, the State has added a SUD Monitoring Protocol (SUD MP) and SUD mid-point assessment to its quality improvement activities. The SUD MP includes: monthly, quarterly and annual descriptive detail (e.g., number of enrollees and service delivered); annual outcome and quality metrics (e.g., HEDIS® measures); and milestone-specific process measures (e.g., use of IT strategies to improve SUD services). The SUD MP identifies a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points.

The CQS and SUD MP represent comprehensive processes to monitor progress. Key elements from those activities will be used in the design of this evaluation.

Please see Figures 1-3 for a visual depiction (Driver Diagram) of the relationship between the demonstration's purpose, the primary drivers that contribute to realizing that purpose and the secondary drivers that are necessary to achieve the primary drivers.

ⁱ <https://www.cdc.gov/drugoverdose/data/statedeaths.html>

ⁱⁱ New Hampshire Drug Monitoring Initiative, 2017 Final Overview Report, October 5, 2018: <https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-2017-overview.pdf>

ⁱⁱⁱ *ibid*

^{iv} *ibid*

^v <https://scholars.unh.edu/cgi/viewcontent.cgi?article=1330&context=carsey>

^{vi} <https://www.nhbar.org/publications/display-news-issue.asp?id=8377>

^{vii} Center for Behavioral Health Statistics and Quality (2016). 2015-2016 National Survey on Drug Use and Health: Model-Based Prevalence Estimates. Substance Abuse and Mental Health Services Administration, Rockville, MD.

<https://www.samhsa.gov/data/sites/default/files/NSDUHsacPercents2016/NSDUHsacPercents2016.pdf>

^{viii} Meier, A., Moore, S., Saunders, E., Metcalf, S., McLeman, B., Auty, S. and Marsch, L. (2017). HotSpot Report: Understanding Opioid Overdoses in New Hampshire | NDEWS | National Drug Early Warning System | University of Maryland. [online] [Ndews.umd.edu](https://ndews.umd.edu). Available at:

<https://ndews.umd.edu/publications/hotspot-report-understanding-opioid-overdoses-new-hampshire>

^{ix} <https://www.dhhs.nh.gov/dcbcs/bdas/documents/mid-year-commission.pdf>

Figure 1: Access Driver Diagram

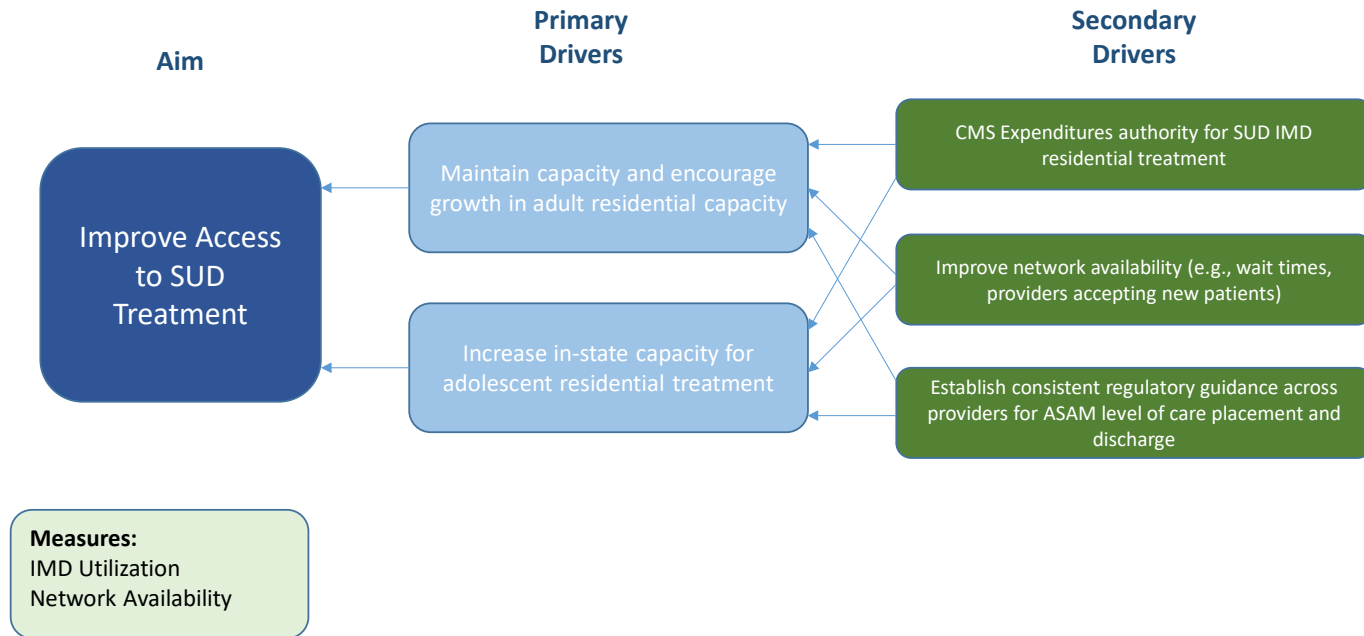


Figure 2: Quality Driver Diagram

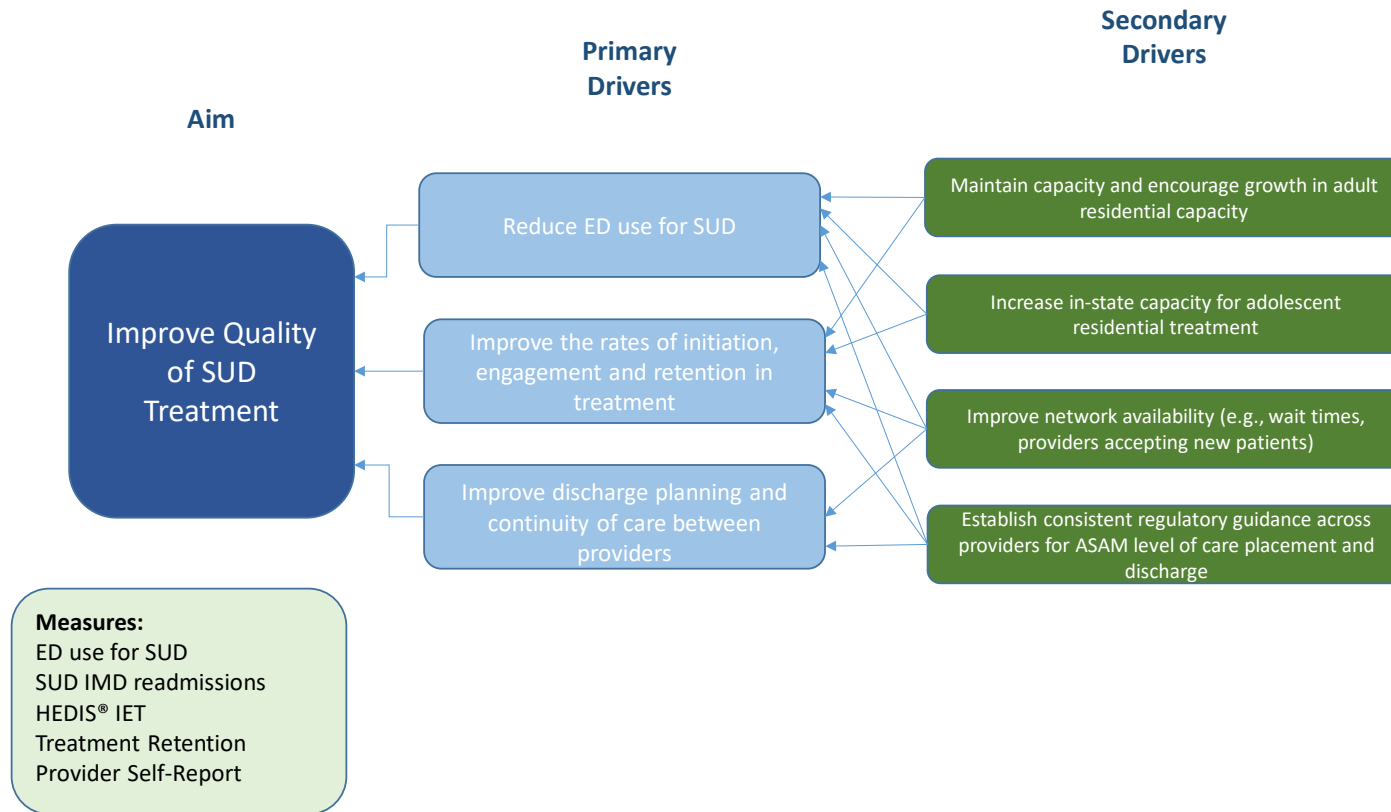
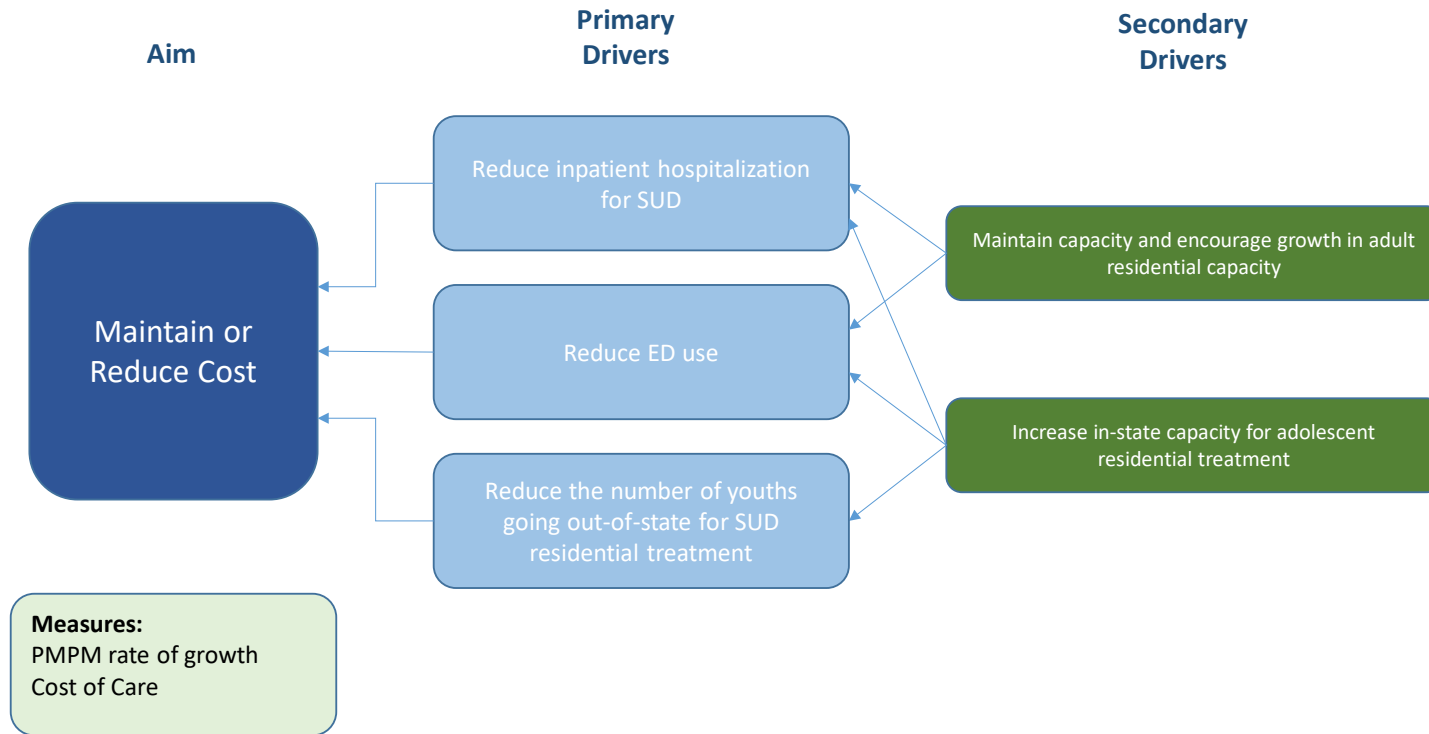


Figure 3: Cost Driver Diagram



The evaluation will study the impact of the demonstration on SUD program participation and examine certain hypotheses by age group and IMD service status. An overview of each hypothesis, the research questions and expected study cohorts are outlined in Table 2.

Table 2. SUD Demonstration Evaluation Questions, Hypotheses and Study Cohorts

Demonstration Component	Evaluation Question	Hypothesis	Study Cohort
Access to Care	1. What are the impacts of the demonstration on access to SUD residential treatment services for demonstration enrollees?	A. Adult enrollees will have better access to SUD residential treatment services.	Individuals ages 18 up to age 64 with a SUD diagnosis
		B. Adolescent enrollees will have better access to in-state SUD residential treatment services.	Individuals ages 12 to 17 with a SUD diagnosis
Quality of Care	2. What are the impacts of the demonstration on the quality of care for demonstration enrollees with an SUD diagnosis?	A. Enrollees with SUD will have fewer ED visits for SUD.	All individuals with a SUD diagnosis
		B. Enrollees with SUD will have fewer total ED visits.	All individuals with a SUD diagnosis
		C. Enrollees with SUD will have fewer ED visits post discharge from an SUD IMD.	All individuals with a SUD diagnosis who received IMD services
		D. Enrollees with SUD will have improved rates of initiation and engagement in alcohol and other drug treatment (IET).	Individuals ages 18 to 64 with a SUD diagnosis
		E. Enrollees with SUD will have lower acute care hospital readmission rates.	All individuals with a SUD diagnosis
		F. Enrollees with SUD will have lower IMD readmission rates.	All individuals with a SUD diagnosis who received IMD services
		G. Enrollees with SUD will have improved rates of treatment completion.	All individuals with a SUD diagnosis
		H. Medicaid IMD providers will report consistency in program design and discharge planning policies.	All SUD IMD Providers
Cost of Care	3. Will the demonstration maintain or reduce spending in comparison to what would have been spent absent the demonstration?	A. The demonstration will be cost neutral.	All individuals with a SUD diagnosis who received IMD services
		B. The cost of adolescent residential SUD treatment services will be reduced.	Individuals ages 12 to 17 who received residential SUD treatment services.

III. Methodology

The demonstration will employ both quantitative and qualitative design techniques. The quantitative analysis will rely on longitudinal evaluation methods to measure change over time. Wherever possible, existing measures will be used to limit administrative burden on providers and Managed Care Organizations. Evaluators may employ secondary analysis to reexamine existing data to address demonstration hypothesis or isolate IMD service recipients from the general Medicaid population. A detailed discussion of expected data analysis is provided in Section III C below.

A. Evaluation Design

Time-series methods will be used to characterize differences over time for participants and subpopulations using a pre/post demonstration design. The length of any pre/post study period is expected to be a minimum of 12 months. When employed, this method will look for trends and patterns in the data. Appropriate measures of access, cost, and quality will be compared to national benchmarks, when applicable and assessed relative to a baseline of calendar year 2017 for HEDIS measures.

Qualitative methods will be employed to measure access (network availability) and quality (impact of DHHS rule changes). Specifically, Telephone surveys will be used to assess network availability by replicating a ‘secret shopper’ approach used by DHHS, in 2018, to determine whether residential SUD IMD providers:

- Accept Medicaid enrollees
- Accept new patients
- Have timely appointment availability³

Structured interviews will be employed to assess Provider understanding of DHHS rule changes and their impact on quality of care. SUD IMD administrators and discharge planning staff will be interviewed to determine: awareness of rule changes; perceptions of impact and utility of changes; and specific practices that have been improved based on rule changes.

Structured interviews will be conducted by phone or face-to-face and will last approximately 30 to 45 minutes. The State and its employees will not conduct, transcribe or have access to interview notes or transcripts. The interview will examine topics such as:

- Provider awareness and understanding of DHHS expectations and rule changes
- The impact of rule revisions on discharge planning in residential care settings and service delivery post-discharge
- The impact of rule changes on perceived administrative burden

³ The 2018 baseline study provides a reliable baseline for providers accepting Medicaid enrollees and new patients. However, limitations including but not limited to small numbers prevent DHHS from using data around timely appointments.

- Existing or planned growth in capacity due to rule changes or SUD IMD demonstration authority.

Interview questions will be finalized by the Independent Evaluator and approved by NH DHHS. NH DHHS will share interview questions with CMS if requested prior to administration.

Target and Comparison Populations

Medicaid beneficiaries with a SUD requiring residential treatment, based on ASAM placement criteria, are eligible for the demonstration. The estimated number of potentially eligible enrollees is 74,000 in 2018 and 115,000 in 2019, following the transition of premium assistance program enrollees to the State Medicaid Care Management program. Based on current programs under the Medicaid State plan and the New Hampshire Health Protection Program-Premium Assistance Program, approximately 320 Medicaid enrollees are expected to receive a residential treatment each quarter.

It is expected that enrollees who have 12 months of continuous enrollment with no more than a 45-day gap in eligibility will be included in the evaluation. However, final criteria will be determined based on sample size and impact. Additionally, measurement standards for specific measures will align with the approved NH SUD monitoring plan specifications, as noted.

Enrollees with an SUD will be identified using the population definition found in the Mathematica Policy Research Manual developed specifically for CMS: *1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics October 20, 2018*.

Enrollees will be stratified into the subgroups outlined in Table 3, when applicable for measures and hypotheses.

Table 3. SUD Evaluation Enrollee Sub-Groups

Enrollee Sub-Group	Definitions
Adults	Individuals who are ages 18 through age 64 at any time in the measurement period
Adolescents	Individuals who are between the ages of 12 through 17 on the first and last day of measurement period
IMD Recipients	Individuals who have at least one IMD discharge during the measurement period

Medicaid SUD IMD providers also will be included as key informants on the implementation and impact of DHHS rule changes to update and align: He-A 300 and He-P 826, in coordination with BDAS and the DHHS Health Facility Licensing Unit; and He-W 513, through the Office of Medicaid. Additionally, all residential facilities, serving Medicaid enrollees, will be included in a telephone survey to assess network availability. Specifically, appointment availability, acceptance of Medicaid and wait times will be assessed.

Sampling Methodology

All demonstration population enrollees who meet study criteria will be included. The evaluation

will not employ random sample, representative sample or other sampling methods. Evaluation measures will be developed based on State defined and HEDIS® specifications that include Medicaid enrollees with a SUD. Inclusion criteria will be specific to each measure. A statistically valid sample is expected based on the number of potentially eligible Medicaid enrollees (e.g., 115,000) and assumptions presented above.

Comparison Groups

Comparison groups are not expected. The state-wideness of program providers coupled with the nature of ASAM criteria for placement decisions make the development of regional cohorts, matched samples of enrollees not receiving IMD care and other in-state comparison groups difficult. New Hampshire residential SUD IMD treatment facilities are existing statewide providers. IMD placement decisions are made based on nationally recognized ASAM level of care guidelines, thus individuals admitted to a residential SUD program have a clinically different profile and level of care need than those who are not admitted. Along these lines, comparisons to individuals with private coverage are not expected due to social and other barriers to health faced in Medicaid cohorts that are not typically present in a commercially insured cohort.

The State is proposing a one-group quasi-experimental pretest-posttest design with annual observation points. Given the lack of a feasible control group, a pre-posttest design is the most appropriate and robust study design.

Evaluation Period

The evaluation will span the demonstration approval period (July 10, 2018-June 30, 2023), with a baseline period beginning 7/1/2017. Measures developed using HEDIS® specifications will include a baseline period of calendar year 2017. An interim evaluation report will be produced one year prior to the end of the demonstration, no later than June 2022. A final summative report will be produced within 18 months of June 30, 2023. Table 4 illustrates the overall evaluation and measurement periods.

Table 4. Evaluation Period

Measure Type	SUD Demonstration Evaluation Years*						
	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5	Post Demo Report
Utilization	7/1/17-6/30/18	7/01/18-6/30/19	7/01/19-6/30/20	7/01/20-6/30/21	7/01/21-6/30/22	7/01/22-6/30/23	7/01/23-12/31/24
HEDIS®	CY2017	CY2018	CY2019	CY2020	CY2021	CY2022	N/A

*IMD authority granted effective July 10, 2018 – June 30, 2023

Evaluation Measures

Evaluation questions, hypotheses and measures are outlined below for each hypothesis. Included is a description of each measure, the measure steward, source of data, measurement period, and national alignment and benchmarks, as applicable. However, final technical specifications, sub-groups and statistical methods will be determined following the engagement of the independent evaluator.

Evaluation Question #1: *What are the impacts of the demonstration on access to SUD residential treatment services for demonstration enrollees?*

Hypothesis

- A. Adult enrollees will have better access to residential SUD treatment services.
- B. Adolescent enrollees will have better access to in-state residential SUD treatment services.

To evaluate the demonstration’s impact on access to care, the following measures will be examined by age group against baseline levels for Evaluation Question #1, Hypothesis A and B.

Measure 1.A Medicaid Beneficiaries Treated in an IMD for SUD	
NH Alignment	SUD MP #5
Definition	Percent of enrollees with an SUD claim for treatment in an IMD with a discharge date during the measurement period. Number of enrollees with a claim for treatment in an IMD during the reporting year divided by the total number of Medicaid enrollees with a SUD.
Exclusion Criteria	As defined in SUD MP #5
SUD Sub-groups	Adults; Adolescents
Measurement Period	Demonstration Year
Comparison Group	Pre/Post 7/1/18; year over year change
Comparison Method(s)	Mann-Whitney U-test Regression (for the initial pre/post comparison); Regression (for year over year change throughout the evaluation period)
Data Source	Medicaid Paid Claims; MMIS
Data Steward	DHHS
National Benchmark	N/A

Measure 1.B Provider Availability – Residential Services	
NH Alignment	Secret Shopper CY2018
Definition	Network availability for SUD residential services (appointments, wait times, acceptance of Medicaid) Telephone Survey: Specifications and telephone scripts will be identical to those used in the baseline study conducted by DHHS in fiscal year 2019.
Exclusion Criteria	Non-residential providers
SUD Sub-groups	All Residential SUD Service Providers
Measurement Period	Point-in-Time
Comparison Group	CY2018 results/CY2022 results
Comparison Method(s)	McNemar Chi-square test; Mann-Whitney U-test Regression
Data Source	Survey Results
Data Steward	DHHS (baseline)/Independent Evaluator
National Benchmark	N/A

Measure 1.C		SUD Capacity – Residential Services
NH Alignment	New	
Definition	Bed Capacity for SUD residential services The number of SUD residential treatment beds available through providers who are licensed and enrolled as a NH Medicaid provider at the time of measurement	
Exclusion Criteria	Non-residential providers	
SUD Sub-groups	Residential SUD Providers (Adult and Adolescent)	
Measurement Period	Point-in-Time Annually , July 1 of each demonstration year	
Comparison Group	Pre/Post Approval	
Comparison Method(s)	McNemar Chi-square test; Mann-Whitney U-test Regression	
Data Source	Medicaid Provider Enrollment Files	
Data Steward	DHHS	
National Benchmark	N/A	

Evaluation Question #2. What are the impacts of the demonstration on quality of care for Medicaid enrollees with a SUD diagnosis?

Hypothesis

- A. Enrollees with SUD will have fewer ED visits for SUD.
- B. Enrollees with SUD will have fewer total ED visits.
- C. Enrollees with SUD will have fewer ED visits post discharge from an SUD IMD.
- D. Enrollees with SUD will have improved rates of initiation and engagement in alcohol and other drug treatment (IET).
- E. Enrollees with SUD will have lower IMD readmission rates.
- F. Enrollees with SUD will have improved rates of treatment retention.

To evaluate the demonstration’s impact on access to care, the following measures will be examined by age group against baseline levels for Evaluation Question #2, Hypothesis A - F. In addition, the evaluator will review trends in the general Medicaid population, for similar measures, where available.

Measure 2.A		Emergency Department Utilization for SUD per 1,000 SUD Demonstration Enrollees
NH Alignment	SUD MP #23	
Definition	The total number of ED visits for SUD per 1,000 SUD demonstration enrollees during the measurement period ED visits type is defined using HEDIS® 2018 value sets as defined in SUD MP #23 for determining an ED visits was for SUD; Total ED visits for SUD/total number of SUD enrollees =x/1,000	
Exclusion Criteria	As defined in SUD MP #23	
SUD Sub-groups	Adults; Adolescents	
Measurement Period	Demonstration Year	

Comparison Group	Pre/Post 7/1/18; year over year change
Comparison Method	Mann-Whitney U-test Regression (for the initial pre/post comparison); Regression (for year over year change throughout the evaluation period)
Data Source	Medicaid Paid Claims; MMIS
Data Steward	DHHS
National Benchmark	N/A

Measure 2.B	Emergency Department Utilization, For Any Reason, per 1,000 SUD Enrollees
NH Alignment	New
Definition	The total number of ED visits for any reason per 1,000 SUD demonstration enrollees during the measurement period Total ED visits for SUD/total number of SUD demonstration enrollees =x/1,000
Exclusion Criteria	None
SUD Sub-groups	Adults; Adolescents
Measurement Period	Demonstration Year
Comparison Group	Pre/Post 7/1/18; year over year change
Comparison Method	Mann-Whitney U-test Regression (for the initial pre/post comparison); Regression (for year over year change throughout the evaluation period)
Data Source	Medicaid Paid Claims; MMIS
Data Steward	DHHS
National Benchmark	N/A

Measure 2.C	Emergency Department Utilization Pre IMD Admission and Post Discharge
NH Alignment	New
Definition	The frequency and rate of change in ED use, for enrollees receiving SUD IMD services, 90-days prior to their IMD admission and 90-days post their IMD discharge. Total number of ED visits in the 90-day period preceding an IMD admission as compared to the total number of ED visits in the 90-day period post day of discharge during the measurement period.
Exclusion Criteria	Enrollees who were not discharged from an IMD during the measurement period.
SUD Sub-groups	IMD service recipients; Adults and Adolescents
Measurement Period	Demonstration Year
Comparison Group	Pre/Post 7/1/18; year over year change
Comparison Method	Mann-Whitney U-test Regression (for the initial pre/post comparison); Regression (for year over year change throughout the evaluation period)
Data Source	Medicaid Paid Claims; MMIS
Data Steward	DHHS

National Benchmark	N/A
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Measure 2.D		Initiation and Engagement of Alcohol and Other Substance Use Disorder Treatment (IET)	
NH Alignment	SUD MP #15		
Definition	(1) Initiation of Alcohol or Other Drug (AOD) Treatment—percentage of enrollees who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis. (2) Engagement of AOD Treatment—percentage of enrollees who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit		
	As defined by HEDIS®IET		
Exclusion Criteria	As defined by HEDIS®IET		
SUD Sub-groups	As defined by HEDIS®IET		
Measurement Period	Calendar Year 2017 - 2022		
Comparison Group	Pre/Post 1/1/18; year over year change		
Comparison Method	Mann-Whitney U-test Regression (for the initial pre/post comparison); Regression (for year over year change throughout the evaluation period)		
Data Source	Medicaid Paid Claims; MMIS		
Data Steward	DHHS		
National Benchmark	Annual HEDIS® Quality Compass at 50 th Percentile		

Measure 2.E		Readmissions for SUD - IMD	
NH Alignment	New		
Definition	The percent of SUD IMD stays during the measurement period followed by an SUD IMD readmission for SUD within 30 days. Count of readmission to any SUD IMD that occurred within 30-days of discharge from an SUD IMD facility, divided by the total number of SUD IMD admissions.		
Exclusion Criteria	None		
SUD Sub-groups	IMD service recipients; Adults and Adolescents		
Measurement Period	Demonstration Year		
Comparison Group	Pre/Post 7/1/18; year over year change		
Comparison Method	Mann-Whitney U-test Regression (for the initial pre/post comparison); Regression (for year over year change throughout the evaluation period)		
Data Source	Medicaid Paid Claims; MMIS		
Data Steward	DHHS		
National Benchmark	N/A		

Measure 2.F		Member Retention in SUD Services	
NH Alignment	New		

Definition	Count and percent of members with a SUD who are retained in treatment. Using HEDIS® IET definition of initiation; Beneficiaries who received AOD treatment within 14 days of diagnosis (IET initiation) and received at least 6 additional services within 60 days of “initiation”.
Exclusion Criteria	As defined by HEDIS®IET and SUD MP #15 specifications
SUD Sub-groups	Adults
Measurement Period	Demonstration Year
Comparison Group	Pre/Post 7/1/18; year over year change
Comparison Method	Mann-Whitney U-test Regression (for the initial pre/post comparison); McNemar Chi Square; Regression (for year over year change throughout the evaluation period)
Data Source	Medicaid Paid Claims; MMIS
Data Steward	DHHS
National Benchmark	N/A

Measure 2.G DHHS Rule Enhancement and Alignment	
NH Alignment	New
Definition	Structured interviews will explore SUD IMD Providers perceptions about the impact of DHHS rule changes on administrative burden and discharge planning. Approximately 15-20 interviews will be conducted with SUD IMD Providers who have provided care to Medicaid enrollees during the preceding six months. Interviews will be transcribed for thematic analysis.
Exclusion Criteria	Providers who have not served Medicaid enrollees in the preceding six months.
SUD Sub-groups	SUD IMD Providers
Measurement Period	Point-in-Time
Comparison Group	Post final rule changes HeW-513 final on Nov 15, 2018; He-A 300 and He-P 826 expected final by end of 2019
Comparison Method	Thematic Analytics
Data Source	Structured Interview
Data Steward	Independent Evaluator
National Benchmark	N/A

Evaluation Question #3. Will the demonstration maintain or reduce spending in comparison to what would have been spent absent the demonstration?

Hypothesis

- A. The demonstration will be cost neutral.
- B. The cost of adolescent residential SUD treatment services will be reduced.

To evaluate the demonstration’s impact on cost of care, the following measures will be examined by age group against baseline levels for Evaluation Question #3, Hypothesis A -B.

Measure 3.A		Rate of Growth in PMPM
NH Alignment	STC #48	
Definition	The PMPM trend rates and per capita cost estimates for each eligibility group defined in STC 48 for each year of the demonstration. Total demonstration payments made during the measurement period divided by the total member months in which a demonstration participant was in an IMD	
Exclusion Criteria	None	
SUD Sub-groups	Adults; Adolescents	
Measurement Period	Demonstration Year	
Comparison Group	Year over year change	
Comparison Method	Mann-Whitney U-test Regression (for the initial pre/post comparison); Regression (for year over year change throughout the evaluation period)	
Data Source	Medicaid Paid Claims; MMIS	
Data Steward	DHHS	
National Benchmark	N/A	

Measure 3.B		Cost of Adolescent Residential SUD Treatment
NH Alignment	New SUD measure	
Definition	Total Medicaid expenditures for adolescents receiving residential treatment services (including in-state and out-of-state care sub-totals) Total IMD SUD payments made during the measurement period divided by the total number of adolescent enrollees receiving care in an in-state residential facility. Total IMD SUD payments made during the measurement period divided by the total number of adolescent enrollees receiving care in an out-of-state residential facility.	
Exclusion Criteria	Enrollees over age 18	
SUD Sub-groups	Adolescents	
Measurement Period	Demonstration Year	
Comparison Group	Pre/Post 7/1/18; year over year change	
Comparison Method	Mann-Whitney U-test Regression (for the initial pre/post comparison); Regression (for year over year change throughout the evaluation period)	

Data Source	Medicaid Paid Claims; MMIS
Data Steward	DHHS
National Benchmark	N/A

B. Data Sources

The SUD demonstration evaluation will rely on data and performance measures developed in the SUD Monitoring Protocol, Medicaid Care Management MCO Model Contract Reporting Requirements and Fee-for-Service claims. Use of fee-for-service and managed care encounters will be limited to final paid status claims and encounters. Managed care encounter, claims and cost data is available through the MMIS and will be made available to evaluators as needed to support the evaluation. Existing agreements with Managed Care Organizations require that all MCO's make data available to support evaluations and performance monitoring efforts. DHHS does not anticipate problems with data collection and reporting.

Table 5. SUD Evaluation Data Sources

SUD Evaluation Data Sources		
Lead	Source	Brief Description
DHHS	Medicaid Management Information System (MMIS)	Claims data submitted to the State by providers used to support HEDIS® and HEDIS®-like performance, utilization and cost metrics for all enrollees
	State Medicaid Eligibility and Enrollment System (EES) files	Eligibility and enrollment detail for Medicaid beneficiaries used to determine enrollee aid category and stratify data into sub-groups, when applicable.
	Premium Assistance Program Encounter data	QHP encounter data reported to the State and used to assess service utilization for NHHPP PAP members in 2017 and 2018 and who transition to Medicaid Managed Care in 2019

C. Analytic Methods

The evaluation data analysis will consist of both exploratory and descriptive strategies and incorporate univariate, bi-variate, and multi-variate techniques. Data analysis will systematically apply statistical and/or logical techniques to describe, summarize, and compare data within the State and across time, and to prepare data, wherever possible in a manner that permits comparison to results from other states applying the same methodology (e.g., HEDIS® reports).

Descriptive statistics will be used to describe the basic features of the data and what they depict, and to provide simple summaries about the sample and the measures. Together with simple graphics analysis, the descriptive statistics form the basis of quantitative analysis of data. They are also used to provide simple summaries about the participants and their outcomes. An exploratory data analysis is used to compare many variables in the search for organized patterns. Data will be analyzed as rates, proportions, frequencies, measures of central tendency (e.g., mean, median, mode).

Quantitative Analysis Descriptive quantitative analysis methods will be used to examine outcomes including the: McNemar's chi-square, Mann-Whitney U Test, and Wilcoxon Signed Rank Test. These nonparametric tests are appropriate when data are (1) categorical or (2) continuous but do not meet the assumptions (e.g., normality) used by parametric tests. Parametric analyses (e.g., t-tests, etc.) may be used as appropriate. The Independent Evaluator will test whether continuous measures (e.g., number of ED visits, etc.) meet the assumptions of parametric

analyses. If these measures do not meet the assumptions of parametric tests, non-parametric methods (e.g., Mann-Whitney U) will be used to analyze the data. The non-parametric tests will be used to assess whether any differences found between the pre- and post-test periods are statistically significant (i.e., unlikely to have occurred in the data through random chance alone). The traditionally accepted risk of error ($p \leq 0.05$) will be used for all comparisons.

Multivariate Analysis: A pre-post design will be used to examine the statewide impact of the demonstration on evaluation measures. Outcomes will be calculated annually for each of the five demonstration years and a baseline period. Regression models accounting for members in more than one year (clustering) will be used to assess the rate of change over time in evaluation outcomes. To assess change over time, the evaluation will use Poisson or negative binomial regression models for the utilization measures, generalized linear models for the cost measures, and logistic regression for the quality measures. Age and gender will be controlled for in the models examining cost and utilization measures. Statistically significant results will be reported based on $p \leq 0.05$. The specific method used will be determined by the evaluator after reviewing the available claims and encounter data.

Qualitative Analysis: Qualitative methods will be used to examine the impact of DHHS administrative rule changes for SUD providers. DHHS changes are planned to align the BDAS and Office of Medicaid Policies. The goals of these changes are to limit administrative burden in compliance audits and to improve the quality of discharge planning across all provider types. A Thematic Analysis will be used to assess interview responses. These analyses examine semi-structured interview data for patterns across interviews. Themes will be defined based on their appearance in the data and not on a pre-defined structure. For example, enrollees may describe the demonstration as improving the coordination of care in six unique ways and impeding their care in four ways.

Thematic analysis will be conducted separately on each semi-structured interview transcript, for each group of interviewees using an inductive approach. Patterns in the transcripts will be identified and grouped into themes. Themes will be checked against the original transcripts for validity. To ensure inter-coder reliability and the reliability of the analyses, both methods will utilize at least two coders. Neither method is intended to support comparison between groups of interviewees or follow principles of statistical significance.

Isolation from Other Initiatives

The State of New Hampshire is engaged in multiple delivery system reform efforts related to the State's Opioid Response Plan and the creation of Integrated Delivery Networks (IDNs) for the promotion of better integration between behavioral and physical health providers. IDNs have been developed in seven regions and represent a partnership between hospitals, health systems, FQHC, rural health clinics, Community Mental Health programs, SUD providers and social safety net organizations to improve the quality of care for New Hampshire residents.

In addition, DHHS is in the process of terminating the State's Premium Assistance Program (PAP), for the Medicaid Expansion population and implementing the Granite Advantage Program. In January of 2019, the State will no longer provide subsidies for Medicaid Expansion enrollees to

purchase a Qualified Health Plan on the marketplace. Instead Medicaid enrollees formerly served in a QHP will be transitioned to one of two existing Medicaid managed care organizations (MCOs) operating in New Hampshire. Along with the PAP transition, the State is in the re-procurement process for MCOs. Thus, it is possible MCO entities new to the state may begin operations in New Hampshire by July 1, 2019.

As such, it will be difficult to determine if trends in quality for SUD services are solely related to IMD capacity. Where market conditions and other contextual factors (e.g., health plan, provider or geographical differences) could have an impact, DHHS and its evaluators will develop approaches to quantify and/or isolate the impact of such factors. For example, when possible, the evaluators will include variables at the state and regional levels as indicators of when Opioid Response Strategies are implemented or new MCO entities begin operating in the state. These variables will serve as controls in the year over year regression analyses. In the absence of a true comparison group, this will allow for the isolation of other initiatives from the demonstration on key outcome measures. Based on staff, budget and data considerations, the State will explore the feasibility of comparing outcomes for enrollees who may be attributed to a specific opioid response initiative with those who are not involved in the initiative.

IV. Methodological Limitations

The SUD demonstration evaluation is limited by several factors including:

Lack of true experimental comparison groups: IMD facilities in New Hampshire serve residents from across the state. Thus, regional comparison groups are not available. In addition, residential placement decisions are made based on nationally recognized ASAM level of care guidelines; thus, individuals admitted to a residential SUD program have a clinically different profile and level of care need than those who are not admitted. These clinical differences eliminate the possibility of matched sample of enrollees who receive services versus those who did not. Lastly, all Medicaid enrollees who meet SUD criteria are eligible for the demonstration.

Continuity of Services: New Hampshire residential SUD IMD treatment facilities are existing statewide providers who have been delivering care to Medicaid enrollees prior to the implementation of the SUD demonstration.

Multiple Delivery Reform Efforts: New Hampshire is engaged in multiple efforts aimed at improving mental health and SUD services, including a separate Delivery System Reform and Incentive Payment (DSRIP) demonstration and a multi-faceted Opioid response strategy.

Reliance on Administrative Data: The evaluation may be limited by its reliance on claims and diagnostic codes to identify the beneficiary population with SUD. These codes may not capture all participants especially if the impact or severity of the SUD is not evident on initial assessment. For example, an ED visit for a broken arm due to inebriation may not be coded as SUD related, if the member does not present as inebriated, the ED provider has not ascertained causation, or the member fails to disclose the cause.

Sample Size: The evaluation may be limited by the small size of the New Hampshire SUD demonstration population and IMD capacity. This limitation is especially apparent as it relates to creating sub-populations for adolescents (e.g., 36-bed capacity phased-in over time) and IMD recipients. Final determination of methods and viability of analytics approach for sub-populations will be made by the evaluator following the review of sample size and available data points over the life of the demonstration.

Attachments

A. Independent Evaluator

Procurement for an evaluation contractor to assist the State in executing its SUD demonstration evaluation plan will be pursuant to the State of New Hampshire procurement guidelines with resulting agreement contingent upon approval from New Hampshire's Governor and Executive Council. The State retains responsibility for monitoring the SUD delivery system, mid-point assessment of the program's effectiveness and overall demonstration performance. To mitigate any potential conflict of interest, the evaluation contractor is responsible for secondary analysis of the State's findings, benchmarking performance to national standards, evaluating changes over time, isolating key variables and interpreting results. As part of the focused IMD evaluation, the evaluator is responsible for final measure selection, identifying, if viable, other State systems that may serve as comparisons, conducting all data analysis, measuring change overtime and developing sensitivity models as necessary to address study questions.

The State anticipates one procurement for all summative evaluation activities and the production of required CMS reports. The successful bidder will demonstrate, at a minimum, the following qualifications:

- The extent to which the evaluator can meet State RFP minimum requirements;
- The extent to which the evaluator has sufficient capacity to conduct the proposed evaluation, in terms of technical experience and the size/scale of the evaluation;
- The evaluator's prior experience with similar evaluations;
- Past references; and
- Value, e.g., the assessment of an evaluator's capacity to conduct the proposed evaluation with their cost proposal, with consideration given to those that offer higher quality at a lower cost.

B. Evaluation Budget

The final evaluation budget will be created following the procurement of an independent evaluator. The final total will be dependent on the state budget and available funds at the time of procurement. Outlined below is the expected independent evaluation budget.

Evaluation Activity	Total Estimated Cost						Total
	Year 1 (DY 2019)	Year 2 (DY 2020)	Year 3 (DY 2021)	Year 4 (DY 2022)	Year 5 (DY 2023)	Post Demo (DY 2024)	
Project Management (e.g., regular project meetings, status updates and ad hoc discussions)		\$9,511	\$9,511	\$9,511	\$9,511	\$4,756	\$42,800
Semi-Structured Interviews Data Collection and Analysis		\$30,000					\$30,000
Secret Shopper Data Collection and Analysis				\$60,000			\$60,000
Quantitative Data Collection, Cleaning and Analysis		\$68,000	\$68,000	\$68,000	\$68,000		\$272,000
Interim Evaluation Report Generation				\$33,000			\$33,000
Summative Evaluation Report Generation						\$33,000	\$33,000
Total	-	\$107,511	\$77,511	\$170,511	\$77,511	\$37,756	\$470,800

C. Timeline and Major Milestones

Outlined below is a timeline, for each demonstration year, for conducting the various evaluation activities, including dates for procurement of an independent evaluator and evaluation-related milestones.

Demo Year 1: (7/1/2018-06/30/2019)

Activity/Milestone	2018						2019					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Procure Independent Evaluation Design	X	X	X									
Draft Evaluation Design				X	X	X						
CMS Review (1/4-4/5 2019)							X	X	X	X		
Incorporate CMS Revisions									X	X		
Final Evaluation Design									X	X		
Publish Evaluation Design to Website (30-days after approval)									X	X		
Procure Independent Evaluator									X	X	X	X
Finalize Research Methods												X
Finalize Performance Measures												X

Demo Year 2: (7/1/2019-06/30/2020)

Activity/Milestone	2019						2020					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Collect, Analyze, Interpret Data	X	X	X	X	X	X	X	X	X	X	X	X
Design Structured Interview Tool								X	X			
CMS Review of Interview Tool									X	X		
Identify and Schedule Key Informants										X	X	
Conduct Structured Interviews												X

Demo Year 3: (7/1/2020-06/30/2021)

Activity/Milestone	2020						2021					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Collect, Analyze, Interpret Data	X	X	X	X	X	X	X	X	X	X	X	X

Demo Year 4: (7/1/2021-06/30/2022)

Activity/Milestone	2021						2022					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Collect, Analyze, Interpret Data	X	X	X	X	X	X	X	X	X	X	X	X
Create Draft Interim Evaluation Report									X			
Revise design, if needed, for renewal									X			
Disseminate Interim Evaluation Report Findings for Feedback									X			
Finalize Draft Interim Evaluation Report										X	X	
Submit Interim Evaluation Report to CMS (with renewal by 6/30/22)												X

Demo Year 5: (7/1/2022-06/30/2023)

Activity/Milestone	2022						2023					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
CMS Review (7/1-9/30/22)	X	X	X									
Incorporate CMS Comments			X									
Submit Final Interim Evaluation Report			X									

Publish Final Interim Evaluation Report (within 30-days after approval)			X									
Collect, Analyze, Interpret Data	X	X	X	X	X	X	X	X	X	X	X	X
Replicate Secret Shopper Tools	X	X	X	X	X	X						
Conduct Secret Shopper Assessment				X	X	X						

Post Demo: (7/1/2023-6/30/2024)

	2023						2024					
Activity/Milestone	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Create Draft Summative Evaluation Report	X	X	X	X	X	X						
Disseminate Draft Summative Evaluation Report Findings for Feedback							X	X				
Submit Draft Summative Evaluation Report to CMS									X			

Post Demo: (7/1/2024-3/30/2025)

	2024						2025					
Activity/Milestone	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Incorporate CMS Comment (60 days after CMS comments)					X	X						
Submit Final Summative Evaluation Report to CMS							X					

Publish Final Summative Evaluation Report (within 30-days after approval)								X				
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ATTACHMENT D:
SUD Implementation Plan Protocol

Section I – Milestone Completion

Milestones

1. Access to Critical Levels of Care for OUD and Other SUDs

To improve access to OUD and SUD treatment services for Medicaid beneficiaries, it is important to offer a range of services at varying levels of intensity across a continuum of care since the type of treatment or level of care needed may be more or less effective depending on the individual beneficiary. To meet this milestone, state Medicaid programs must provide coverage of the following services:

- Outpatient Services;
- Intensive Outpatient Services;
- Medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state);
- Intensive levels of care in residential and inpatient settings; and
- Medically supervised withdrawal management

Current state:

New Hampshire provides coverage for a robust array of substance use disorder services, including all of those outlined above. Additional services covered by NH Medicaid include peer and non-peer recovery support services and continuous recovery monitoring. Where possible, all covered services are in alignment with the American Society for Addiction Medicine (ASAM) patient placement criteria. Medically supervised withdrawal management is in alignment ASAM criteria Levels 1WM-3.7WM. Coverage details for these services are in the state plan. Provider qualifications and eligible provider types are outlined in NH rule He-W 513 available at <https://www.dhhs.nh.gov/oos/aru/documents/hew513adopted.pdf>.

There are multiple ways SUD treatment services are paid for in NH. Typically, funding for services is blended between state General Funds, Medicaid, private insurance, and Federal funding. The state uses federal block grant funding through SAMHSA to enter into contracts with SUD providers. These contracts fund services that are either not covered by Medicaid/other insurance or the person’s insurance leaves them underinsured for the needed level of care. These entities are considered state funded programs. Additionally, Medicaid is used to cover all levels of care as outlined above. There are some entities in the state that do not accept Medicaid or state funding. In those instances, standards for facilities licensing and program expectations are outlined in rules which align with NH’s Medicaid requirements and those in state contracts.

Table 1. NH Medicaid Substance Use Disorder Benefit

SUD Service Type	Description
Screening, by Behavioral Health practitioner	Screening for a substance use disorder
SBIRT	Screening, Brief Intervention, Referral to Treatment
Crisis Intervention	Crisis services provided in an office or community setting
Evaluation	Evaluation to determine the level of care and/or other services needed.
Medically Managed Withdrawal Management	Withdrawal management in a hospital setting, with or without rehabilitation therapy
Medically Monitored Withdrawal Management	Withdrawal management provided in an outpatient or residential setting
Opioid Treatment Program	Methadone or Buprenorphine treatment in a clinic setting
Office based Medication Assisted Treatment	Medication Assisted Treatment in a physician's office provided in conjunction with other substance use disorder counseling services.
Outpatient Counseling	Individual, group, and/or family counseling for substance use disorders
Intensive Outpatient	Individual and group treatment and recovery support services provided at least 3 hours per day, 3 days per week.
Partial Hospitalization	Individual and group treatment and recovery support services for substance use disorder and co-occurring mental health disorders provided at least 20 hours per week.
Rehabilitative Services	Low, Medium, and High Intensity residential treatment.
Recovery Support Services	Community based peer and non-peer recovery support services provided in a group or individual setting.
Case Management	Continuous Recovery Monitoring

Future state:

NH will update the He-W 513 rule to align with the recently updated state plan. This will allow for Medicaid providers to understand what types of services are covered under each ASAM level of care. For example, for Level 2.1 intensive outpatient SUD services, the rule will be updated to include the following:

Support Systems

In Level 2.1 programs, necessary support systems include:

- Continued treatment planning individualized to the patients' needs
- Medical, psychological, psychiatric, laboratory, and toxicology services, which are available through consultation or referral. Psychiatric and other medical consultation is available within 24 hours by telephone and within 72 hours in person.
- Emergency services, which are available by telephone 24 hours a day, 7 days a week when the treatment program is not in session.
- Direct affiliation with (or close coordination through referral to) more and less intensive levels of care and supportive housing services.

Therapies

Therapies offered by Level 2.1 programs include:

- A minimum of 3 hours per day, 3 days per week for adults (age 21 and over) and 2 hours per day, 3 days per week for adolescents (under age 21) of skilled treatment services. Such services may include evaluation, individual and group counseling, medication management, family therapy with patient present, psychoeducational groups, skill restoration therapy, and other skilled therapies. Skill restoration therapy which is defined as services intended to reduce or remove barriers to clients who are achieving recovery and then maintaining recovery is also included. Services are provided in amounts, frequencies, and intensities appropriate to the objectives of the treatment plan.
- In cases in which the patient is not yet fully stable to safely transfer to a Level 1 program that is not associated with the treatment agency, the patient's treatment for Level 1 services may be continued within the current Level 2.1 program. Therapies must be delivered by, or recommended by, a physician or other licensed practitioner of the healing arts.
- Family therapy, which involves for the family members, guardians, or significant others and which is for the direct benefit of the patient in accordance with the patient's needs and treatment goals identified in the patient's treatment plan, and for the purpose of assisting in the patient's recovery in the assessment, treatment, and continuing care of the patient with the patient present.
- A planned format of therapies delivered on an individual and group basis and adapted to the patient's developmental stage and comprehension level.
- Motivational interviewing, enhancement, and engagement strategies, which are used in preference to confrontational approaches.

Milestone Criteria	Current State	Future State	Summary of Actions
<p>State Medicaid programs must provide coverage of the following services:</p> <ul style="list-style-type: none"> • Outpatient Services; • Intensive Outpatient Services; • Medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); • Intensive levels of care in residential and inpatient settings; and • Medically supervised withdrawal management levels of care with codes covering 	<p>New Hampshire provides coverage for a robust array of substance use disorder services, including all of those outlined in the milestone requirement</p>	<p>NH will update the He- W 513 rule to align with the recently updated state plan. This update will include a list of therapies and supports that are offered under each ASAM level of care covered by NH. This will allow for Medicaid providers to understand what types of services are covered under each ASAM level of care, including understanding requirements around therapeutic milieu, hours of services, and types of staff required to deliver each.</p>	<p>Medicaid authority will update the He-w 513 rule in collaboration with Bureau of Drug and Alcohol Services by November 30, 2018.</p>

2. Use of Evidence-based, SUD-specific Patient Placement Criteria

Implementation of evidence-based, SUD-specific patient placement criteria is identified as a critical milestone that states are to address as part of the demonstration. To meet this

milestone, states must ensure that the following criteria are met:

- Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and
- Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings.

Current state:

Patient Placement Criteria

All substance use disorder treatment programs and insurance carriers in NH are required to utilize the ASAM Criteria for placement per state law RSA 420-J:16, I, available at <http://www.gencourt.state.nh.us/rsa/html/XXXVII/420-J/420-J-16.htm>. In addition, all state funded treatment providers, are contractually obligated to use evidence based screening and assessment tools. To ensure that there is no entity in the state operating SUD services without the application of ASAM, all regulatory bodies require the same language regarding ASAM and evidence-based standards. This is critical due to the fact that while all state funded (state contracted) treatment providers are also Medicaid/MCO enrolled, not all Medicaid/MCO enrolled providers hold contracts with the state and receive additional state dollars. In instances when a provider is not Medicaid enrolled and also not funded through a contract with the state, the facilities licensing rules require ASAM. When ASAM is not applicable, both state funded providers and Medicaid providers are required to deliver services that are evidence based, as demonstrated by meeting one of the following criteria:

- a. The service shall be included as an evidence-based mental health and substance abuse intervention on the SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP), available at <http://www.nrepp.samhsa.gov/AllPrograms.aspx>;
- b. The services shall be published in a peer-reviewed journal and found to have positive effects; or
- c. The SUD treatment and recovery support service provider shall be able to document the services' effectiveness based on the following:
 1. The service is based on a theoretical perspective that has validated research; or
 2. The service is supported by a documented body of knowledge generated from similar or related services that indicate effectiveness.

Future State

Effective January 11, 2018, SAMHSA has removed NREPP and the state rule must be updated to reflect that change.

Milestone Criteria	Current State	Future State	Summary of Actions
Use of Evidence-based, SUD-specific Patient Placement Criteria	He-W 513 rule has NREPP as qualifying source for evidence based services	Update the evidence based language in rule to reflect changes made to NREPP. Explore additional criteria to offer to qualify an evidence based	Medicaid authority will update the He-w 513 rule in collaboration with Bureau of Drug and Alcohol Services by November 30, 2018

Current state:

Utilization management

Utilization management (UM) takes place between MCOs and providers based on contractual agreements. The Department monitors utilization management through various channels. MCO utilization management policies are initially approved by DHHS and reviewed when changes are made. Timeliness of UM decisions as well as volume are monitored on a quarterly basis. The Department’s External Quality Review Organization conducts annual contract compliance reviews, which periodically includes MCO compliance with the UM standards in the Department’s contracts with the MCOs. Finally, the MCOs are required to be accredited by the National Committee for Quality Assurance of Health Plans (NCQA). The NCQA accreditation process includes the evaluation of 58 standards for the MCOs UM process and operations.

Additionally, NH DHHS conducts annual contract compliance audits for all state funded treatment facilities to ensure adherence to clinical standards when determining level of care placement. This is done through random chart audits that are conducted by licensed professionals familiar with ASAM criteria. Additionally, all state funded programs submit client placement data to the state sponsored Web Information Technology System when billing the Department for state-eligible clients and data is audited at the time of billing on a monthly basis to ensure that adequate information and documentation is presented for the level of care or services rendered. All state funded contractors are held to documentation standards in contracts explicitly noting that *“the Contractor shall maintain a data file on each recipient of services hereunder, which file shall include all information necessary to support an eligibility determination and such other information as the Department requests. The Contractor shall furnish the Department with all forms and documentation regarding eligibility determinations that the Department may request or require.”* Further, documentation standards are outlined in NH rule He-W 513 for all Medicaid SUD providers and the NH DHHS Program Integrity Unit reviews documentation as part of their pre and post enrollment site visits and re-validation processes for SUD providers. Specifically, documentation requirements state:

- (a) SUD treatment and recovery support services providers shall maintain supporting records, in accordance with He-W 520.

(b) Supporting documentation shall include:

(1) A complete record of all physical examinations, laboratory tests, and treatments including drug and counseling therapies, whether provided directly or by referral;

(2) Progress note for each treatment session, including:

- a. The treatment modality and duration;
- b. The signature of the primary therapist for each entry;
- c. The primary therapist's professional discipline; and
- d. The date of each treatment session; and

(3) A copy of the treatment plan that is:

- a. Updated at least every 4 sessions or 4 weeks, whichever is less frequent;
- b. Signed by the provider and the recipient prior to treatment being rendered; and
- c. Signed by the clinical supervisor, prior to treatment being rendered, if the service is an outpatient or comprehensive SUD program.

(c) The recipient's individual record shall include at a minimum:

- (1) The recipient's name, date of birth, address, and phone number; and
- (2) A copy of the evaluation described in He-W 513.05(p)(4).

NH DHHS also holds regular monthly meetings on behavioral health matters, including substance use disorder with each of the two managed care organizations. In these meetings, there is the opportunity to discuss trends in audit findings, provider needs related to technical assistance, opportunities for audit alignment, and information sharing. Information shared in these meetings may be used to inform state contract audits, reviews of provider practices, or offer training or technical assistance to specific contractors.

New Hampshire is confident that it has met this milestone based on the information presented above.

3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Through the new Section 1115 initiative, states will have an opportunity to receive federal financial participation (FFP) for a continuum of SUD services, including services provided to Medicaid enrollees residing in residential treatment facilities that qualify as institutions for mental diseases. To meet this milestone, states must ensure that the following criteria are met:

- Implementation of residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts, or other guidance) that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff for residential treatment settings;
- Implementation of a state process for reviewing residential treatment providers to assure compliance with these standards; and

Residential treatment provider qualifications

Current state:

All residential treatment providers must be licensed by NH Bureau of Health Facilities Licensing. NH rule He-W 513 dictates specific provider qualifications for delivery of SUD services including required credentials. The rule defers to ASAM Criteria to reflect the types of covered services.

The Bureau of Drug and Alcohol Services has expired rules governing the Certification and Operation of Alcohol and other Drug Disorder Treatment Programs. These rules apply to all state funded SUD programs. Presently, requirements for these programs are outlined in contract. State contracts require specific staffing ratios for SUD programs, including the following:

The selected vendor must meet minimum staffing requirements that include:

- A minimum of one (1):
 - Masters Licensed Alcohol and Drug Counselor (MLADC); or
 - Licensed Alcohol and Drug Counselor (LADC) who also holds the Licensed Clinical Supervisor (LCS) credential.
- One (1) program director who assumes responsibility for the daily operation of each specific program.
- Minimum staff to resident ratios with documentation of the same on file for a minimum of 6-months, which includes:
 - One (1) staff person to 6 residents during awake hours.
 - One (1) staff person to 12 residents during sleeping hours.
- The selected vendor must ensure that all staff, including contracted staff;
 - Meet the educational, experiential and physical qualification of the position as listed in their job description;
 - Meet all criminal background standards; Are licensed, registered or certified as required by state statute and as applicable

- Receive an orientation within the first three (3) days of work, or prior, to direct contact with clients, which includes;
 - The vendor's code of ethics, including ethical conduct and reporting of unprofessional conduct;
 - The vendor's policies on client rights and responsibilities and complaint procedures;
 - Confidentiality requirements;
 - Grievance procedures for both clients and staff;
 - The duties and responsibilities and the policies, procedures and guidelines of the position they were hired for;
 - Topics covered by both the administrative and personnel manuals;
 - The vendor's infection prevention program;
 - The vendor's fire, evacuation and other emergency plans, which outline the responsibilities for personnel in an emergency; and
 - Mandatory reporting requirements for abuse or neglect, such as those found in RSA 161-F and RSA 169-C:29; and
 - Sign and date documentation that they have taken part in an orientation;
 - Complete a mandatory annual in-service education, which includes a review of all orientation elements.
- The selected vendor must ensure all unlicensed staff providing treatment, education and/or recovery support services shall be under the direct supervision of a licensed supervisor.
- The selected vendor must ensure no licensed supervisor supervises more than eight (8) unlicensed staff, unless the Department has approved an alternative supervision plan.
- The selected vendor must provide a minimum of one (1) Certified Recovery Support Worker (CRSW) for every 50 clients or portion thereof.
- The selected vendor must ensure unlicensed staff providing clinical or recovery support services obtain a CRSW certification within 6 months of hire or contract effective date, whichever is later.
- The selected vendor shall ensure a staff to resident ratio that is more stringent than the required staff to resident ratios stated above, when required by the resident's treatment plan.
- The selected vendor must provide ongoing clinical supervision that occurs at regular intervals. The selected vendor must ensure clinical supervision includes, but is not limited to:
 - Receipt of, at least, one (1) hour of supervision for every twenty (20) hours of direct client contact;
 - Weekly discussion of cases with suggestions for resources or therapeutic approaches, co-therapy, and periodic assessment of progress;
 - Group supervision to help optimize the learning experience, when enough candidates are under supervision;
 - Training on:

- Knowledge, skills, values, and ethics with specific application to the practice issues faced by supervised staff;
- The 12 core functions as described in Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice, available at <http://store.samhsa.gov/product/TAP-21-Addiction-Counseling-Competencies/SMA15-4171> and
- The standards of practice and ethical conduct, as determined by licensing and review boards, with particular emphasis given to the counselor’s role and appropriate responsibilities, professional boundaries, and power dynamics.

Future state:

NH DHHS rule will be updated to reflect the types of services covered under each ASAM level of care. See example under *Milestone 1*.

Where possible, specific staffing ratio requirements as noted above will be included in He-A 300 rule and He-W 513 rules updates.

Milestone Criteria	Current State	Future State	Summary of Actions
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings	All residential treatment providers must be licensed by NH Bureau of Health Facilities Licensing. NH rule He-W 513 dictates specific provider qualifications for delivery of SUD services including required credentials, hours of clinical care. The rule defers to ASAM Criteria to reflect the types of covered services The Bureau of Drug and Alcohol Services has expired rules (He-A 300) governing the Certification and	He-W 513 explicitly outlines the types of services and hours of clinically directed programming covered under each ASAM level of care. He-W 513 will outline required staffing ratios for residential programs. He-A 300 will be updated to outline required staffing ratios for residential programs.	Medicaid authority will update the He-W 513 rule in collaboration with Bureau of Drug and Alcohol Services by November 30, 2018 Bureau of Drug and Alcohol Services will update the He-A 300 rule by Fall 2019.

Reviewing compliance to standards

Current state:

NH DHHS is in the process of conducting contract audits for SUD providers and developing new health facilities rules to allow for better compliance oversight process. Additionally, the Bureau of Health Facilities conducts annual reviews of all licensed residential facilities. This entity will also follow up on any complaints or concerns shared about a facility. The NH DHHS Medicaid Program Integrity Unit also oversees compliance with He-W 513 as part of their pre and post enrollment site visits and re-validation processes. The Bureau of Drug and Alcohol Services has expired rules governing the Certification and Operation of Alcohol and other Drug Disorder Treatment Programs. These rules apply to all state funded SUD programs and compliance audits are done against contract requirements absent the He-A 300 rules.

Future state:

The NH DHHS will pursue several rule changes to ensure that there are clear and consistent standards for all SUD residential treatment providers. There will also be language specific to compliance requirements and frequencies of compliance audits across the various DHHS bureaus responsible for oversight. The rule changes proposed include:

- 1) The update of Bureau of Health Facilities rules specific to SUD residential treatment facilities to include requirements related to staffing, physical space expectations, programmatic design, and compliance requirements.
- 2) The update of He-A 300 through the Bureau of Drug and Alcohol Services rules to outline requirements related to staffing, physical space expectations, programmatic design, and compliance. These rules will govern the eligibility of all state-funded SUD treatment providers, including those enrolled in Medicaid to operate in the State of NH. Every effort will be made to align expectations in the He-A 300 rules with those in the He-W 513 rules to mitigate duplication of administrative requirements on providers and align expectations between program areas and Medicaid.
- 3) The update of He-W 513 rules through the Office of Medicaid to outline specific requirements around staffing, licensing, and service expectations for all SUD Medicaid services.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards</p>	<p>NH DHHS is in the process of conducting contract audits for SUD providers and developing new health facilities rules to allow for better compliance oversight process.</p> <p>Bureau of Health Facilities conducts annual reviews of all licensed residential facilities for compliance with He-P 807 rules governing facilities licensing. This entity will also follow up on any consumer or provider complaints or concerns reported about a facility.</p> <p>The DHHS Medicaid Program Integrity Unit oversees compliance with He-W 513 as part of their pre and post enrollment site visits and re-validation processes.</p> <p>The Bureau of Drug and Alcohol Service He-A 300 rules</p>	<p>Bureau of Health Facilities creates new rules specific to SUD residential treatment facilities; this includes requirements related to staffing, physical space expectations, programmatic design, and compliance requirements. The Bureau of Health Facilities will inspect facilities for compliance prior to issuing or renewing a license.</p> <p>Additional controls will be put in place through updates to He-W 513 and He-A 300 rules to ensure compliance checks from Medicaid Program Integrity and Bureau of Drug and Alcohol Service staff on an annual basis.</p>	<p>Health Facilities rule updated and effective by December 31, 2018</p> <p>He-W 513 rules will be updated to include language regarding annual compliance checks by Fall 2018</p> <p>He-A 300 rules will be updated to include language regarding specific standards and annual compliance by Fall 2019.</p>

Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off site.

Current state:

All state contracted treatment providers are required to recognize all paths to recovery and facilitate MAT access either on or off site. This is not a requirement for all Medicaid providers.

Future state:

NH DHHS will update the He-W 513 rule to require that all Medicaid providers follow the same standards for MAT that state funded providers adhere to.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off site	All state contracted treatment providers are required to recognize all paths to recovery and facilitate MAT access either on or off site. This is outlined in a contract with the provider but is not a requirement for all Medicaid providers.	Update to He-W 513 rule requiring that all Medicaid providers follow same standards for MAT that state funded providers adhere to. Update to He-A 300 rule that requires on-site or facilitated access to MAT for all state funded SUD providers. This	Medicaid authority will update the He-w 513 rule in collaboration with Bureau of Drug and Alcohol Services by November 30, 2018 He-A 300 rules will be updated to include language around specific standards and requirements regarding offering

4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

To meet this milestone, states must complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment must determine availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in availability of services for beneficiaries in the critical levels of care.

Current state:

NH has no formal assessment process to determine availability of providers enrolled in Medicaid that are accepting new patients. NH has a state funded treatment locator which identifies providers by service type and payers accepted.

A treatment capacity report was created in early 2014 prior to expansion of Medicaid and is available at <https://www.dhhs.nh.gov/dcbcs/bdas/documents/nh-sud-treatment-capacity-report.pdf>

Future state:

NH will establish an assessment process to meet this milestone.

Milestone Criteria	Current State	Future State	Summary of Actions
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT:	NH has no formal assessment process to determine availability of providers enrolled in Medicaid that are accepting new patients. NH has a state funded treatment locator which identifies providers by service type and payers accepted.	NH will establish an assessment process to identify Medicaid providers that are accepting new patients in critical levels of care, including those who offer MAT and those who offer adolescent-specific programming. This will be accomplished through secret shopper quality activities conducted by the NH DHHS EQRO	Secret shopper planning to begin Spring 2018, assessment to begin by Summer 2018, assessment to be completed by early 2019.
Outpatient Services;	A treatment capacity report was created in early 2014 prior to expansion of Medicaid.	NH will explore the possibility of updating the 2014 treatment capacity report.	Discuss opportunities of treatment capacity and treatment locator updates with current vendor by November 30, 2018
Intensive Outpatient Services;			
Medication Assisted Treatment (medications as well as counseling and other services);		NH will work with the vendor	

5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse:

Current state:

NH has created specific opioid prescribing guidelines via the Office of Professional Licensure through the Board of Medicine. Additionally, NH has implemented significant changes to the PDMP through statute.

NH Medicaid has several controls in place for opioid prescribing, specifically related to prevention of opioid abuse. Through requirements and reporting measures in the current managed care contracts, NH tracks several measures related to opioid prescribing (*Table 1*).

Measure ID	Measure Name	Data Collection Status	Results
CMS _A_ O HD	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage (CMS Adult Core Set)	Started with FFY 2016 Reporting (for measurement year 2015)	https://medicaid.quality.nh.gov/reports/use-of-opioids-at-high-dosage-ohd-
CMS _A_ C UOB	Concurrent Use of Opioids and Benzodiazepines	Will start with FFY 2018 Reporting (for measurement year	N/A
PHA RM Q I.09	Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	Started with CY 2016 Quarter 2	https://medicaid.quality.nh.gov/reports/safety-monitoring---opioid-prescriptions-meeting-nh-dhhs-morphine-equivalent-dosage-prior
SUD _11 1 5.01	Continuity of Pharmacotherapy for Opioid Use Disorder	Will start with SFY 2019 Reporting	N/A

Table 1. Managed care opioid prescribing metrics

Future state:

New Hampshire DHHS intends to further enhance implementation of existing laws related to

opioid prescribing in collaboration with key partners. NH will also explore language and reports that can be added to future managed care contracts to ensure a comprehensive and robust approach to controlling and monitoring unnecessary opioid prescriptions.

Milestone Criteria	Current State	Future State	Summary of Actions
<p>Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse</p>	<p>The Office of Professional Licensure and Certification (OPLC) developed prescribing guidelines that were placed in administrative rules for their licensees which include physicians, APRNs, Pas, dentists and veterinarians.</p> <p>The Opioid Prescribing Guidelines from the NH Board of Medicine went into effect on January 1, 2017 (https://www.oplc.nh.gov/medicine/documents/med502-adopted.pdf) Please see attached prior authorization criteria for Methadone, Long Acting Narcotics, Short Acting Fentanyl and Morphine Milligram Equivalence (MME).</p> <p>The pharmacy point of sale (POS) system has a cumulative morphine milligram equivalence (MME) calculator. NH DHHS has a system edit in place that will not allow claims to process once the cumulative MME is equal or greater than 100mg. Beneficiaries that require doses that are equal to or greater than 100mg MME are required to get prior authorization. Prior Authorization ensures that the high dose is medically necessary. Doses that exceed 100mg MME will not be authorized with concurrent use of benzodiazepines. The MCOs are also required to have a MME calculator in built into the pharmacy POS system and to require prior authorization for all prescriptions where the dose is equal to or greater than 100mg MME</p> <p>The MCOs are required to submit a quarterly report</p>	<p>NH will explore additional opportunities for enhancing opioid prescribing guidelines through Managed Care re-procurement efforts</p> <p>NH will further enhance implementation of existing laws related to opioid prescribing in collaboration with the OPLC and Board of Medicine.</p>	<p>Meet with PDMP by August 2018</p> <p>Meet with Governor's Commission on Opioid and Healthcare taskforces to discuss guidelines by August 2018</p> <p>Consult with vendor assisting with managed care re-procurement to develop</p>

Expanded coverage of and access to naloxone for overdose reversal

Current state:

In 2015, NH DHHS began the Statewide Naloxone Distribution and Training Initiative in partnership with the Department of Safety (DOS) in an effort to combat the opioid crisis.

Funding from the SAMHSA block grant was used to purchase naloxone kits in order to supplement current state efforts to combat opioid abuse.

Each participating organization was required to meet the following criteria before receiving free kits:

1. The organization must have a current standing order, allowing them to dispense the medication without a prescription;

2. The organization must have been educated by State-approved staff and educate end users on how to administer the medication, and;

3. The organization must have written policies for their dispensing protocol. Organizations including social service agencies, treatment providers, and recovery organizations are screened by the DHHS Emergency Services Unit (ESU) before they receive a kit.

There are currently four ways for New Hampshire residents to get naloxone kits for themselves or someone they care about:

1. A physician or any licensed prescriber can write a prescription for naloxone that can be purchased at a pharmacy.

2. Naloxone can be purchased at a pharmacy through standing orders, which allow the purchase without a prescription.

3. Free kits are provided to clients of state-contracted health centers or treatment providers who are at risk for opioid overdose and don't have insurance that covers the cost or cannot afford to purchase naloxone.

4. Free kits are provided through events held by Regional Public Health Networks to those unable to access kits through another avenue.

The distribution of Naloxone following these guidelines continues and additional resources for Naloxone were recently made available to NH through the 21st Century Cures Act. As part of that funding, NH is providing naloxone kits to individuals re-entering the community from incarceration or who are on parole who are at risk of an overdose. Through these efforts, New Hampshire is confident that it has met this milestone.

Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

Current state:

The New Hampshire Controlled Drug Prescription Health and Safety Program was authorized in June 2012 for the purpose of enhancing patient care, curtailing the misuse and abuse of

controlled substances, combating illegal trade in and diversion of controlled substances, and enabling access to prescription information by practitioners, dispensers, and other authorized individuals and agencies.

The New Hampshire Board of Pharmacy administers and oversees the operation of the program and has selected Appriss Health to develop a database that will collect and store prescribing and dispensing data for Schedule II, III, and IV controlled substances. Appriss Health's prescription drug monitoring program (PDMP), PMP AWA_Rx_E, is a web-based program that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances.

New Hampshire law requires that each dispenser submit information regarding each prescription dispensed for a Schedule II, III, or IV controlled substance. Each time a controlled substance is dispensed, the dispenser shall submit the information required by New Hampshire law to the PDMP database within seven (7) days of the date the prescription was dispensed.

NH continues to work on strategies and policies associated with the PDMP.

Future state:

NH DHHS will work with NH PDMP staff and Board of Pharmacy to identify opportunities to increase utilization of PDMP.

Milestone Criteria	Current State	Future State	Summary of Actions
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	NH PDMP is functional and there are laws in place regarding utilization of the program	NH DHHS will work with NH PDMP staff and Board of Pharmacy to identify opportunities to increase utilization of PDMP	NH DHHS to meet with PDMP contacts by November 30, 2018. Plan to improve utilization and functionality of the

6. Improved Care Coordination and Transitions between Levels of Care

To meet this milestone, states must implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities.

Improved Care Coordination and Transition between Levels of Care

Current state:

All state contracted treatment providers are required to begin discharge planning immediately upon entry into treatment based on contract terms. A review of compliance with this obligation is included in the annual chart audits conducted by program staff.

State managed care organizations also work with providers on discharge plans and care transition plans. Each managed care organization is required to evaluate patients with a substance use disorder for care coordination services and support the coordination of all their physical and behavioral health needs and for referral to SUD treatment. The current MCO contract requires the following:

For those beneficiaries with a diagnosis for substance use disorder (SUD) and all infants with a diagnosis of neonatal abstinence syndrome (NAS), or that are otherwise known to have been exposed prenatally to opioids, alcohol or other drugs, the MCO shall evaluate these patients needs for care coordination services and support the coordination of all their physical and behavioral health needs and for referral to SUD treatment.

NH has also expanded peer recovery community services to link individuals to recovery supports and continuous recovery monitoring following a facility stay. This has been accomplished through state funding of a recovery community organization facilitating organization that subcontracts with nine recovery community organizations to provide both peer recovery support services and telephone recovery support. Medicaid covers the peer recovery support services provided by these entities, while state and federal funds cover the infrastructure and technical assistance costs associated with developing these services. Referrals to these services are a requirement of state contracted treatment providers.

Future state:

Expand discharge planning requirements to all Medicaid providers to align with state contracted provider requirements. The below language will be added as a new section to the He-W 513 rule outlining discharge and continuing care requirements:

1) Continuing Care and Discharge

All providers must adhere to continuing care and discharge guidelines, including but not limited to:

- Closed loop referrals to community providers.
- Providing active outreach to clients following discharge.
- Coordinating referrals, acceptance, and appointments for required services prior to discharge.

All services must have continuing care, transfer and discharge plans that address all ASAM (2013) domains as follows:

- Begin the process of discharge/transfer planning at the time of the client's intake into the program.
- Review the three (3) criteria for continuing services or the four (4) criteria for transfer/discharge, when addressing continuing care or discharge/transfer that include:
 - Continuing Service Criteria A: The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals; or

- Continuing Service Criteria B: The patient is not yet making progress, but has the capacity to resolve his or her problems. He/she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his/her treatment goals; and /or
- Continuing Service Criteria C: New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. The level of care which the patient is receiving treatment is therefore the least intensive level at which the patient's problems can be addressed effectively
- Transfer/Discharge Criteria A: The Patient has achieved the goals articulated in the individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care. Continuing the chronic disease management of the patient's condition at a less intensive level of care is indicated; or
- Transfer/Discharge Criteria B: The patient has been unable to resolve the problem(s) that justified the admission to the present level of care, despite amendments to the treatment plan. The patient is determined to have achieved the maximum possible benefit from engagement in services at the current level of care. Treatment at another level of care (more or less intensive) in the same type of services, or discharge from treatment, is therefore indicated; or
- Transfer/Discharge Criteria C: The patient has demonstrated a lack of capacity due to diagnostic or co-occurring conditions that limit his or her ability to resolve his or her problem(s). Treatment at a qualitatively different level of care or type of service, or discharge from treatment, is therefore indicated; or
- Transfer/Discharge Criteria D: The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively at a more intensive level of care.

Language regarding collaboration of care coordination for all entities offering it to clients with SUD will be added to state contracts, He-W 513 rules and updated managed care contracts. This will ensure continuity between various levels of care coordination provided to clients by multiple entities. The goal with this language change will be to reduce duplication and communication errors regarding care coordination responsibilities.

Specific requirements and standards for care coordination for co-occurring physical and mental health conditions will be added to the He-W 513 rule and He-A 300 rule. These rules will apply to all SUD Medicaid providers and state-funded SUD treatment providers. This language will come from a modified model of care coordination that is supported by NH's 1115(a) DSRIP Transformation Waiver, specifically requiring:

- Systematic strategies to identify and intervene with the client
- A care plan for each patient, updated on a regular basis
- Care coordination services that facilitate linkages and access to needed primary and

specialty health care, prevention and health promotion services, mental health and

substance use disorder treatment, and long-term care services, as well as linkages to other community supports and resources

- Transitional care coordination across settings, including from the hospital to the community
- Robust patient engagement process around information sharing consent
- Coordination with other care coordination/management programs or resources that may be following the same patient so that to the extent possible, only one care coordinator/manager is playing a lead role in managing the patient’s care plan.

Milestone Criteria	Current State	Future State	Summary of Actions
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	Discharge planning is required for all state contracted treatment facilities.	Expand discharge planning and continuing care requirements to all Medicaid providers Expand continuing care requirements for all Medicaid providers and state contracted SUD facilities.	Medicaid authority will update the He-W 513 rule in collaboration with Bureau of Drug and Alcohol Services by November 30, 2018 Bureau of Drug and Alcohol Services will update the He-A 300 rule regarding discharge planning and care coordination for all state funded SUD providers by

Section II – Implementation Administration

Please provide the contact information for the state’s point of contact for the Implementation plan.

Name and Title: Deborah Scheetz, New Hampshire Medicaid Deputy Director
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 Email Address: Deborah.Scheetz@dhhs.nh.gov

Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

Attachment A – Template for SUD Health Information Technology (IT) Plan

The New Hampshire Controlled Drug Prescription Health and Safety Program was authorized in June 2012 for the purpose of enhancing patient care, curtailing the misuse and abuse of controlled

substances, combating illegal trade in and diversion of controlled substances, and enabling access to prescription information by practitioners, dispensers, and other authorized individuals and agencies.

The New Hampshire Board of Pharmacy administers and oversees the operation of the program and has selected Appriss Health to develop a database that will collect and store prescribing and dispensing data for Schedule II, III, and IV controlled substances. Appriss Health's prescription drug monitoring program (PDMP), PMP AWA_Rx_E, is a web-based program that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances.

New Hampshire law requires that each dispenser submit information regarding each prescription dispensed for a Schedule II, III, or IV controlled substance. Each time a controlled substance is dispensed, the dispenser shall submit the information required by New Hampshire law to the PDMP database within seven (7) days of the date the prescription was dispensed.

As noted above, the PDMP is administered and overseen by the Board of Pharmacy, which is housed at the Office of Professional Licensure. As such, the NH DHHS has no control over the rules promulgated or administration related to the PDMP and its use. NH DHHS intends to meet with the Board of Pharmacy, Office of Professional Licensure, and PDMP staff to identify opportunities to align the SUD Health IT Plan requirements with the capabilities of the NH Prescription Drug Monitoring Program and Board of Pharmacy policies to ensure practicability of requirements and identify the timelines associated with accomplishing demonstration goals following waiver approval. NH intends to utilize the offered technical assistance from CMS to aid in conducting an assessment and developing the plan to ensure NH has the specific health IT infrastructure necessary to meet the demonstration goals. The scope of the project NH is able to commit to for this plan is guided by the Centers for Disease Control report, *Integrating & Expanding Prescription Drug Monitoring Program Data*, issued in February 2017. It is expected that there may also be a need for alignment with HIT work being undertaken by the Integrated Delivery Networks to ensure that changes proposed under this plan for PDMP interoperability would align with the goals and activities outlined in the Statewide HIT Plan created by the IDNs.

Section I.

As a component of Milestone 5, Implementation of Strategies to Increase Utilization and Improve Functionality of Prescription Drug Monitoring Programs (PDMP), in the SMD #17-003, states with approved Section 1115 SUD demonstrations are generally required to submit an SUD Health IT Plan as described in the STCs for these demonstrations within 90 days of demonstration approval.

The SUD Health IT Plan will be a section within the state's SUD Implementation Plan Protocol and, as such, the state may not claim FFP for services provided in IMDs until this Plan has been approved by CMS.

In completing this plan, the following resources are available to the state:

- a. Health IT.Gov in “Section 4: Opioid Epidemic and Health IT.”⁴
- b. CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” and, specifically, the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.⁵

As the state develops its SUD Health IT Plan, it may also request technical assistance to conduct an assessment and develop its plan to ensure it has the specific health IT infrastructure with regards to the state’s PDMP plan and, more generally, to meet the goals of the demonstration.

Contacts for technical assistance can be found in the guidance documents.

In the event that the state believes it has already made sufficient progress with regards to the health IT programmatic goals described in the STCs (i.e. PDMP functionalities, PDMP query capabilities, supporting prescribing clinicians with using and checking the PDMPs, and master patient index and identity management), it must provide an assurance to that effect via the assessment and plan below (see Table 1, “Current State”).

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

The specific milestones to be achieved by developing and implementing an SUD Health IT Plan include:

- Enhancing the health IT functionality to support PDMP interoperability; and
- Enhancing and/or supporting clinicians in their usage of the state’s PDMP.

The state should provide CMS with an analysis of the current status of its health IT infrastructure/”ecosystem” to assess its readiness to support PDMP interoperability. Once completed, the analysis will serve as the basis for the health IT functionalities to be addressed over the course of the demonstration—or the assurance described above.

The SUD Health IT Plan should detail the current and planned future state for each functionality/capability/support—and specific actions and a timeline to be completed over the course of the demonstration—to address needed enhancements. In addition to completing the summary table below, the state may provide additional information for each Health IT/PDMP milestone criteria to further describe its plan.

⁴ Available at <https://www.healthit.gov/playbook/opioid-epidemic-and-health-it>.

⁵ Available at <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>.

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p><i>5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is:</i> <i>--Enhance the state’s health IT functionality to support its PDMP; and</i> <i>--Enhance and/or support clinicians in their usage of the state’s PDMP.</i></p>	<p><i>Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians’ use of the state’s health IT functionality to achieve the goals of the PDMP.</i></p>	<p><i>Provide an overview of plans for enhancing the state’s PDMP, related enhancements to its health IT functionalities, and related enhancements to support clinicians’ use of the health IT functionality to achieve the goals of the PDMP.</i></p>	<p><i>Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item</i></p>
<p>Prescription Drug Monitoring Program (PDMP) Functionalities</p>			
<p>Enhanced interstate data sharing in order to better track patient specific prescription data</p>	<p>NH does not have access or grant access to other state PDMPs</p>	<p>NH DHHS will develop a plan to identify the future state within 60 days of waiver submission on April 9, 2018</p>	<p>The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress towards future state goals.</p>

<p>Enhanced “ease of use” for prescribers and other state and federal stakeholders</p>	<p>The NH PDMP is web-based and has been assessed for ease of use, requiring approx. 3 clicks for providers to navigate through the program when conducting a query</p>	<p>NH DHHS will develop a plan to identify the future state within 60 days of waiver submission on April 9, 2018</p>	<p>The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress</p>
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			towards future state goals.
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	There is no connectivity between the PDMP and other local HIE	NH DHHS will develop a plan to identify the future state within 60 days of waiver submission on April 9, 2018	The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress towards future state goals.
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns ⁶ (see also "Use of PDMP" #2 below)	NH is continuing to invest in the capacity of the PDMP to identify data points that will enable the PDMP to aid in combating opioid and substance use. At this time, there are no formal processes for using the PDMP for this purpose given that NH is still working to build staffing and program capacity. Metrics being considered for identifying outliers that need intervention include:		The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress towards future state goals.

⁶ Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood

of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: <http://dx.doi.org/10.15585/mmwr.mm6610a1>.

	<p>1) Individuals that have received prescriptions for a controlled drug from 3 prescribers who are filling those prescriptions at 3 separate pharmacies</p> <p>2) Combined total daily dosage of 100 MME</p> <p>3) Individuals prescribed opioids and benzodiazepines.</p>		
Current and Future PDMP Query Capabilities			
Facilitate the state’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state’s master patient index (MPI) strategy with regard to PDMP query)	The current state of this milestone is unknown at this time.	NH DHHS will submit the current state of this milestone to CMS within 30 days of waiver submission to CMS on April 9, 2018 and NH DHHS will develop a plan to identify the future state within 60 days of waiver submission on April 9, 2018	The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress towards future state goals.
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	The NH PDMP is web-based and has been assessed for ease of use for embedding the process into workflow, requiring approx. 3 clicks for providers to navigate through the program when conducting a	NH DHHS will develop a plan to identify the future state within 60 days of waiver submission on April 9, 2018	The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress

			towards future state goals.
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	The current state of this milestone is unknown at this time.	NH DHHS will submit the current state of this milestone to CMS within 30 days of waiver submission to CMS on April 9, 2018 and NH DHHS will develop a plan to identify the future state within 60 days of waiver submission on April 9, 2018	The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress towards future state goals.
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The current state of this milestone is unknown at this time.	NH DHHS will submit the current state of this milestone to CMS within 30 days of waiver submission to CMS on April 9, 2018 and will develop a plan to identify the future state within 60 days of waiver submission on April 9, 2018	The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress towards future state goals.
Overall Objective for Enhancing PDMP Functionality & Interoperability			

<p>Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids</p>	<p>The current state of this milestone is unknown at this time.</p>	<p>NH DHHS will submit the current state of this milestone to CMS within 30 days of waiver submission to CMS on April 9, 2018 and NH DHHS will develop a plan to identify the future state within 60 days of waiver submission on April 9, 2018</p>	<p>The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress towards future state goals.</p>
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Attachment A, Section II – Implementation Administration

Please provide the contact information for the state’s point of contact for the SUD Health IT Plan.

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 Telephone Number: 603-271-9459
 Email Address: Deborah.Scheetz@dhhs.nh.gov

Attachment A, Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

**ATTACHMENT E:
SUD Monitoring Protocol**

1. Transmittal Title Page for New Hampshire’s SUD Demonstration or SUD Components of Broader Demonstration

State	New Hampshire (NH)
Demonstration Name	Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver
Approval Date	July 10, 2018
Approval Period	July 10, 2018 – June 30, 2023
SUD (or if broader demonstration, then SUD Related) Demonstration Goals and Objectives	<p>The goal of this demonstration is for NH to maintain critical access to opioid use disorder (OUD) and other substance use disorder (SUD) services and continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid beneficiaries.</p> <p>During the demonstration, NH seeks to achieve the following:</p> <ol style="list-style-type: none"> 1 . Increased rates of identification, initiation, and engagement in treatment. 2. Increased adherence to and retention in treatment. 3. Reductions in overdose deaths, particularly those due to opioids. 4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate through improved access to other continuum of care services. 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate. 6. Improved access to care for physical health conditions among Medicaid beneficiaries.

2. Proposed Modifications to SUD Narrative Information on Implementation, by Reporting Topic

Summary of proposed modification	Related metric (if any)	Justification for modification
1. Assessment of Need and Qualification for SUD Services		
<p>NH proposes the use of a checklist format in the Summary Column</p>		<p>NH will not analyze relevant trends until Demonstration Year 2 Quarter 1. This request was previously approved by CMS at the September 21, 2018, SUD monitoring call to assure that NH has sufficient data to determine seasonality and common cause variation associated with the data (e.g., flu season impact).</p> <hr/> <p>NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:</p> <p>Section 1.2.1 Metric Trend</p> <p><input type="checkbox"/> Trends have not been evaluated in this report as NH does not have sufficient data to analyze.</p> <p><input type="checkbox"/> No, NH reports no relevant metric trends greater than 2 percent related to the assessment of need and qualifications for SUD.</p> <p><input type="checkbox"/> Yes, NH reports the following metric trends greater or less than 2 percent for the assessment of need and qualifications for SUD as described: <i>[narrative response if applicable]</i></p> <p>Section 1.2.1 Implementation Update</p> <p>(a) <u>Target Populations</u></p> <p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to the target population(s) of the demonstration.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to the target populations(s) of the demonstration as described: <i>[narrative response if applicable]</i></p> <p>(b) <u>Clinical Criteria</u></p> <p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to the clinical criteria that qualify a beneficiary for the demonstration.</p>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<input type="checkbox"/> Yes, NH expects to make the following changes to the clinical criteria that qualify a beneficiary for the demonstration as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> No, there are no anticipated program changes that may impact NH’s metrics related to the assessment and qualifications for SUD services. <input type="checkbox"/> Yes, the following are anticipated program changes that may impact NH’s metrics related to the assessment and qualifications for SUD services as described: <i>[narrative response if applicable]</i>
<input checked="" type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input type="checkbox"/> The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
2. Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)		
NH proposes the use of a checklist format in the Summary Column		NH will not analyze relevant trends until Demonstration Year 2 Quarter 1. This request was previously approved by CMS at the September 21, 2018, SUD monitoring call to assure that NH has sufficient data to determine seasonality and common cause variation associated with the data (e.g., flu season impact). <hr/> NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report: 2.2.1 Metric Trend <input type="checkbox"/> Trends have not been evaluated in this report as NH does not have sufficient data to analyze. <input type="checkbox"/> No, NH reports no relevant metric trends greater than 2 percent related to the assessment of need and qualifications for SUD. <input type="checkbox"/> Yes, NH reports the following metric trends greater or less than 2 percent for the assessment of need and qualifications for SUD as described: <i>[narrative response if applicable]</i>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<p>2.2.2 Implementation Update</p> <p>(a) <u>Access Across the Continuum of Care</u></p> <p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries as described: <i>[narrative response if applicable]</i></p> <p>(b) <u>Benefit Coverage Under Medicaid State Plan/Expenditure Authority</u></p> <p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to planned activities to SUD benefit coverage under the Medicaid state plan or the Expenditure Authority.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to planned activities to SUD benefit coverage under the Medicaid state plan or the Expenditure Authority for:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Residential Treatment as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Medically supervised withdrawal management as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Medication Assisted Treatment to individuals in IMDs as described: <i>[narrative response if applicable]</i> <p><input type="checkbox"/> No, NH does not anticipate making any program changes that may impact metrics related to access to critical levels of care of OUD and other SUDs.</p> <p><input type="checkbox"/> Yes, NH anticipates making the following program changes that may impact metrics related to access to critical levels of care of OUD and other SUDs as described: <i>[narrative response if applicable]</i></p>
<p><input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.</p>		

Summary of proposed modification	Related metric (if any)	Justification for modification
<input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
3. Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)		
NH proposes the use of a checklist format in the Summary Column		<p>NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:</p> <p>3.2.1 Metric Trend There are no monitoring metrics associated with Milestone #2. As a result, NH will not be reporting trends.</p> <p>3.2.2 Implementation Update</p> <p>(a) <u>Placement Criteria</u></p> <p><input type="checkbox"/> No, NH does not expect to make any changes to planned activities to improve providers' use of evidence-based, SUD-specific placement criteria.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to planned activities to improve providers' use of evidence-based, SUD-specific placement criteria as described: <i>[narrative response if applicable]</i></p> <p>(b) <u>Utilization Management Approach</u></p> <p><input type="checkbox"/> No, NH does not expect to make any changes to implement a utilization management approach.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to implement a utilization management approach to ensure:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Beneficiaries have access to SUD services at the appropriate level of care as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Interventions are appropriate for the diagnosis and level of care as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Use of independent process for reviewing placement in residential treatment settings as described: <i>[narrative response if applicable]</i>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<input type="checkbox"/> No, NH does not expect to make any other changes that may impact metrics related to the use of evidence-based, SUD-specific patient placement criteria. <input type="checkbox"/> Yes, NH expects to make the following changes that may impact metrics related to the use of evidence-based, SUD-specific patient placement criteria as described: <i>[narrative response if applicable]</i>
<input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
4. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)		
NH proposes the use of a checklist format in the Summary Column		<p>NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:</p> <p>4.2.1 Metric Trend There are no monitoring metrics associated with Milestone #3. As a result, NH will not be reporting trends.</p> <p>4.2.2 Implementation Update</p> <p>(a) <u>Provider Qualifications</u></p> <input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to implement residential treatment provider qualifications that meet the ASAM criteria or other nationally recognized, SUD-specific program standards. <input type="checkbox"/> Yes, NH expects to make the following changes to implement residential treatment provider qualifications that meet the ASAM criteria or other nationally recognized, SUD-specific program standards as described: <i>[narrative response if applicable]</i> <p>(b) <u>State Review Process</u></p>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<p><input type="checkbox"/> No, there have been no changes, and NH does not expect to make any changes to implement the state review process for residential treatment providers' compliance with qualification standards.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to implement the state review process for residential treatment providers' compliance with qualification standards as described: <i>[narrative response if applicable]</i></p> <p>(c) <u>Medication Assisted Treatment (MAT)</u></p> <p><input type="checkbox"/> No, there have been no changes, and NH does not expect to make any changes to the availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to the availability of medication assisted treatment at residential treatment facilities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> On-site as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Facilitated access to services off site as described: <i>[narrative response if applicable]</i> <p><input type="checkbox"/> No, NH does not anticipate any other program changes that may impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities.</p> <p><input type="checkbox"/> Yes, NH anticipates the following program changes that may impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities as described: <i>[narrative response if applicable]</i></p>
<p><input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.</p>		
<p><input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).</p>		
<p>5. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)</p>		

Summary of proposed modification	Related metric (if any)	Justification for modification
<p>NH proposes the use of a checklist format in the Summary Column</p>		<p>NH will not analyze relevant trends until Demonstration Year 2 Quarter 1. This request was previously approved by CMS at the September 21, 2018, SUD monitoring call to assure that NH has sufficient data to determine seasonality and common cause variation associated with the data (e.g., flu season impact).</p> <hr/> <p>NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:</p> <p>5.2.1 Metric Trend</p> <p><input type="checkbox"/> Trends have not been evaluated in this report as NH does not have sufficient data to analyze.</p> <p><input type="checkbox"/> No, NH reports no relevant metric trends greater than 2 percent related to the assessment of need and qualifications for SUD.</p> <p><input type="checkbox"/> Yes, NH reports the following metric trends greater or less than 2 percent for the assessment of need and qualifications for SUD as described: <i>[narrative response if applicable]</i></p> <p>5.2.2 Implementation Update</p> <p><input type="checkbox"/> No, NH does not expect to make any changes to planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients across the continuum of SUD care.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients across the continuum of SUD care as described: <i>[narrative response if applicable]</i></p> <p><input type="checkbox"/> No, NH does not anticipate any program changes that may impact metrics related to provider capacity at critical levels of care, including MAT for OUD.</p>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<input type="checkbox"/> Yes, NH anticipates the following program changes that may impact metrics related to provider capacity at critical levels of care, including MAT for OUD as described: <i>[narrative response if applicable]</i>
<input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
6. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)		
NH proposes the use of a checklist format in the Summary Column		<p>NH will not analyze relevant trends until Demonstration Year 2 Quarter 1. This request was previously approved by CMS at the September 21, 2018, SUD monitoring call to assure that NH has sufficient data to determine seasonality and common cause variation associated with the data (e.g., flu season impact).</p> <hr/> <p>NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:</p> <p>6.2.1 Metric Trend</p> <input type="checkbox"/> Trends have not been evaluated in this report as NH does not have sufficient data to analyze. <input type="checkbox"/> No, NH reports no relevant metric trends greater than 2 percent related to the assessment of need and qualifications for SUD. <input type="checkbox"/> Yes, NH reports the following metric trends greater or less than 2 percent for the assessment of need and qualifications for SUD as described: <i>[narrative response if applicable]</i> <p>6.2.2 Implementation Update</p> <p>(a) <u>Opioid Prescribing Guidelines</u></p>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to the implementation of opioid prescribing guidelines and other interventions related to the prevention of OUD.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to the implementation of opioid prescribing guidelines and other interventions related to the prevention of OUD as described: <i>[narrative response if applicable]</i></p> <p>(b) <u>Coverage and Access to Naloxone</u></p> <p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to the expansion of coverage for and access to naloxone.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to the expansion of coverage for and access to naloxone as described: <i>[narrative response if applicable]</i></p> <p><input type="checkbox"/> No, NH does not anticipate any other program changes that may impact metrics related to the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.</p> <p><input type="checkbox"/> Yes, NH anticipates the following program changes that may impact metrics related to the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD as described: <i>[narrative response if applicable]</i></p>
<p><input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.</p>		
<p><input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).</p>		
<p>7. Improved Care Coordination and Transitions between Levels of Care (Milestone 6)</p>		
<p>NH proposes the use of a checklist format in the Summary Column</p>		<p>NH will not analyze relevant trends until Demonstration Year 2 Quarter 1. This request was previously approved by CMS at the September 21, 2018, SUD monitoring call to assure that NH has sufficient data to determine seasonality and common cause variation associated with the data (e.g., flu season impact).</p>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<p>NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:</p> <p>7.2.1 Metric Trend</p> <p><input type="checkbox"/> Trends have not been evaluated in this report as NH does not have sufficient data to analyze.</p> <p><input type="checkbox"/> No, NH reports no relevant metric trends greater than 2 percent related to the assessment of need and qualifications for SUD.</p> <p><input type="checkbox"/> Yes, NH reports the following metric trends greater or less than 2 percent for the assessment of need and qualifications for SUD as described: <i>[narrative response if applicable]</i></p> <p>7.2.2 Implementation Update</p> <p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to implement policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to implement policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports as described: <i>[narrative response if applicable]</i></p> <p><input type="checkbox"/> No, NH does not anticipate any other program changes that may impact metrics related to care coordination and transitions between levels of care.</p> <p><input type="checkbox"/> Yes, NH anticipates the following program changes that may impact metrics related to care coordination and transitions between levels of care as described: <i>[narrative response if applicable]</i></p>
<p><input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.</p>		
<p><input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).</p>		

Summary of proposed modification	Related metric (if any)	Justification for modification
8. SUD Health Information Technology (Health IT)		
<p>NH proposes the use of a checklist format in the Summary Column</p>		<p>NH will not analyze relevant trends until Demonstration Year 2 Quarter 1. This request was previously approved by CMS at the September 21, 2018, SUD monitoring call to assure that NH has sufficient data to determine seasonality and common cause variation associated with the data (e.g., flu season impact).</p> <hr/> <p>NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:</p> <p>8.2.1 Metric Trend</p> <p><input type="checkbox"/> Trends have not been evaluated in this report as NH does not have sufficient data to analyze.</p> <p><input type="checkbox"/> No, NH reports no relevant metric trends greater than 2 percent related to the assessment of need and qualifications for SUD.</p> <p><input type="checkbox"/> Yes, NH reports the following metric trends greater or less than 2 percent for the assessment of need and qualifications for SUD as described: <i>[narrative response if applicable]</i></p> <p>8.2.2 Implementation Update</p> <p>(a) <u>Health IT Used to Slow Growth</u></p> <p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to demonstrate how health IT is being used to slow down the rate of growth of individuals identified with SUD.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to demonstrate how health IT is being used to slow down the rate of growth of individuals identified with SUD as described: <i>[narrative response if applicable]</i></p> <p>(b) <u>Health IT Used to Effectively Treat</u></p>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to demonstrate how health IT is being used to effectively treat individuals identified with SUD.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to demonstrate how health IT is being used to effectively treat individuals identified with SUD as described: <i>[narrative response if applicable]</i></p> <p>(c) <u>Health IT Used to Monitor Recovery</u></p> <p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to demonstrate how health IT is being used to effectively monitor recovery supports and services for individuals identified with SUD.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to demonstrate health IT is being used to effectively monitor recovery supports and services for individuals identified with SUD as described: <i>[narrative response if applicable]</i></p> <p>(d) <u>Health IT Infrastructure/Capabilities</u></p> <p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to other aspects of its plan to develop health IT infrastructure/capabilities including its delivery system, health plan/MCO, and individual provider level.</p> <p><input type="checkbox"/> Yes, NH plans to make changes to the following aspects of its plan to develop health IT infrastructure/capabilities:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Delivery system as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Health plan/MCO as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Individual provider level as described: <i>[narrative response if applicable]</i> <p>(e) <u>Health IT Implementation Milestones</u></p> <p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to other aspects of its health IT implementation milestones.</p> <p><input type="checkbox"/> Yes, NH expects to make changes to the following aspects of its health IT implementation milestones as described: <i>[narrative response if applicable]</i></p>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<p>(f) <u>Health IT Implementation Timelines</u> <input type="checkbox"/> No, there are no changes and NH does not expect to make any changes to the timeline for achieving health IT implementation milestones. <input type="checkbox"/> Yes, NH expects to make the following changes to the timeline for achieving health IT implementation milestones as described: <i>[narrative response if applicable]</i></p> <p>(g) <u>Prescription Drug Monitoring Program (PDMP)</u> <input type="checkbox"/> No, there are no changes and NH does not expect to make any changes to planned activities to increase the use and functionality of its prescription drug monitoring program (PDMP). <input type="checkbox"/> Yes, NH expects to make the following changes to planned activities to increase the use and functionality of its prescription drug monitoring program (PDMP) as described: <i>[narrative response if applicable]</i></p> <p><input type="checkbox"/> No, NH does not anticipate any other program changes that may impact metrics related to SUD health IT monitoring. <input type="checkbox"/> Yes, NH expects to make the following program changes that may impact metrics related to SUD health IT monitoring as described: <i>[narrative response if applicable]</i></p>
<input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
9. Other SUD-Related Metrics		
NH proposes the use of a checklist format in the Summary Column		NH will not analyze relevant trends until Demonstration Year 2 Quarter 1. This request was previously approved by CMS at the September 21, 2018, SUD monitoring call to assure that NH has sufficient data to determine seasonality and common cause variation associated with the data (e.g., flu season impact).

Summary of proposed modification	Related metric (if any)	Justification for modification
		<p>NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:</p> <p>9.2.1 Metric Trend</p> <p><input type="checkbox"/> Trends have not been evaluated in this report as NH does not have sufficient data to analyze.</p> <p><input type="checkbox"/> No, NH reports no relevant metric trends greater than 2 percent related to the assessment of need and qualifications for SUD.</p> <p><input type="checkbox"/> Yes, NH reports the following metric trends greater or less than 2 percent for the assessment of need and qualifications for SUD as described: <i>[narrative response if applicable]</i></p> <p>9.2.2 Implementation Update</p> <p><input type="checkbox"/> No, NH does not anticipate any program changes that may impact the other SUD-related metrics.</p> <p><input type="checkbox"/> Yes, NH anticipates the following changes that may impact the other SUD-related metrics as described: <i>[narrative response if applicable]</i></p>
<input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
10. Budget Neutrality		
NH proposes the use of a checklist format in the Summary Column		<p>NH will use the following format in the Summary Column of the Quarterly Monitoring Report:</p> <p>10.2.1 Current Status and Analysis The following is a current status and analysis of budget neutrality:</p> <p>10.2.2 Implementation Update</p>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<input type="checkbox"/> No, NH does not anticipate any program changes that impact budget neutrality. <input type="checkbox"/> Yes, NH anticipates the following program changes that may impact budget neutrality as described: <i>[narrative response if applicable]</i>
<input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
11. SUD-Related Demonstration Operations and Policy		
NH proposes the use of a checklist format in the Summary Column		<p>NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:</p> <p>11.1.1 Considerations The following are operations or policy considerations that could positively or negatively impact:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Beneficiary enrollment as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Access to services as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Timely provision of services as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Budget neutrality as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Other provisions that have potential for beneficiary impacts as described: <i>[narrative response if applicable]</i> <p><input type="checkbox"/> No, NH does not identify any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives.</p> <p><input type="checkbox"/> Yes, NH identifies the following activities that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals and objectives as described: <i>[narrative response if applicable]</i></p> <p>11.1.2 Implementation Update</p>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<p>(a) <u>Delivery System Operations</u></p> <p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to how the delivery system operates under the demonstration.</p> <p><input type="checkbox"/> Yes, NH expects the following changes to how the delivery system operates under the demonstration as described: <i>[narrative response if applicable]</i></p> <p>(b) <u>Delivery Model</u></p> <p><input type="checkbox"/> No, there have been no changes and NH does not expect to make any changes to the delivery model affecting demonstration participants.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to the delivery model affecting demonstration participants as described: <i>[narrative response if applicable]</i></p> <p>(a) <u>Partners in Service Delivery</u></p> <p><input type="checkbox"/> No, there are no changes and NH does not expect to make any changes to partners involved in service delivery.</p> <p><input type="checkbox"/> Yes, NH expects to make the following changes to partners involved in service delivery as described: <i>[narrative response if applicable]</i></p> <p><input type="checkbox"/> No, NH has not experienced any significant challenges or performance issues in partnering with entities contracted to help implement the demonstration.</p> <p><input type="checkbox"/> Yes, NH has the following challenges and performance issues with entities contracted to help implement the demonstration as described: <i>[narrative response if applicable]</i></p> <p><input type="checkbox"/> No, NH is not currently working on any other initiatives related to SUD or OUD.</p> <p><input type="checkbox"/> Yes, NH is currently working on the following initiatives related to SUD or OUD.</p> <p style="padding-left: 40px;"><input type="checkbox"/> Similar to SUD/ODU as described: <i>[narrative response if applicable]</i></p> <p style="padding-left: 40px;"><input type="checkbox"/> Different from SUD/ODU as described: <i>[narrative response if applicable]</i></p>

Summary of proposed modification	Related metric (if any)	Justification for modification
<input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
12. SUD Demonstration Evaluation Update		
NH proposes the use of a checklist format in the Summary Column		<p>NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:</p> <p>12.2.1 Narrative Information</p> <p><input type="checkbox"/> No, NH has no updates to provide on the SUD evaluation work and timeline.</p> <p><input type="checkbox"/> Yes, NH has the following updates on the SUD evaluation work and timeline as described: <i>[narrative response if applicable]</i></p> <p>NH has the following updates to provide on the demonstration evaluation:</p> <p><input type="checkbox"/> No, NH does not anticipate any barriers in achieving deliverable goals and/or timelines.</p> <p><input type="checkbox"/> Yes, NH anticipates the following barriers in achieving deliverables goals as described: <i>[narrative response if applicable]</i></p> <p><input type="checkbox"/> No, NH has no SUD demonstration evaluation update to report.</p> <p><input type="checkbox"/> The following are the anticipated evaluation-related deliverables related to this demonstration as described: <i>[narrative response if applicable]</i></p>
<input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
13. Other Demonstration Reporting		

Summary of proposed modification	Related metric (if any)	Justification for modification
<p>NH proposes the use of a checklist format in the Summary Column</p>		<p>13.1.1 General Reporting Requirements</p> <p><input type="checkbox"/> No, there have been no changes to NH’s implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.</p> <p><input type="checkbox"/> Yes, the following are changes to NH’s implementation of the demonstration that might necessitate a change to approved:</p> <ul style="list-style-type: none"> <input type="checkbox"/> STCs as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Implementation plan as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Monitoring protocol as described: <i>[narrative response if applicable]</i> <p><input type="checkbox"/> No, NH does not anticipate the need to make future changes to the STCs, implementation plan, or monitoring protocol based on expected or upcoming implementation changes.</p> <p><input type="checkbox"/> Yes, based on expected or upcoming implementation changes, NH anticipates the need to make future changes to the approved:</p> <ul style="list-style-type: none"> <input type="checkbox"/> STCs as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Implementation plan as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Monitoring protocol as described: <i>[narrative response if applicable]</i> <p>(a) <u>Monitoring Report Schedule</u></p> <p><input type="checkbox"/> No, NH has not formally requested any changes nor does it expect to formally request any changes to the schedule for completing and submitting monitoring reports.</p> <p><input type="checkbox"/> Yes, NH expects to formally request the following changes to the schedule for completing and submitting monitoring reports as described: <i>[narrative response if applicable]</i></p> <p>(b) <u>Content of Monitoring Reports</u></p> <p><input type="checkbox"/> No, NH has not formally requested nor does it expect to formally request any changes to the content or completeness of submitted reports or future reports.</p> <p><input type="checkbox"/> Yes, NH expects to formally request the following changes to the content or completeness of:</p>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<p><input type="checkbox"/> Submitted reports as described: <i>[narrative response if applicable]</i></p> <p><input type="checkbox"/> Future reports as described: <i>[narrative response if applicable]</i></p> <p><input type="checkbox"/> No, NH has not identified any real or anticipated issues for submitting timely post-approval demonstration deliverables.</p> <p><input type="checkbox"/> Yes, NH has identified the following issues for submitting timely post-approval demonstration deliverables:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Deliverable as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Issue as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Plan for Remediation as described: <i>[narrative response if applicable]</i> <p>13.1.2 Post Award Public Forum</p> <p><input type="checkbox"/> No, this is not an annual report and NH did not host a post-award public forum during this reporting period.</p> <p><input type="checkbox"/> Yes, the following is NH’s summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues as described: <i>[narrative response if applicable]</i></p>
<p><input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.</p>		
<p><input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).</p>		
<p>14. Notable State Achievements and/or Innovations</p>		
<p>NH proposes the use of a checklist format in the Summary Column</p>		<p>NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:</p> <p>14.2.1 Narrative Information</p> <p><input type="checkbox"/> No, NH has no notable achievements or innovations to report for this reporting topic.</p>

Summary of proposed modification	Related metric (if any)	Justification for modification
		<input type="checkbox"/> Yes, the following is a summary of NH's relevant achievements and/or innovations in this reporting period: <ul style="list-style-type: none"> <input type="checkbox"/> Enrollment as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Benefits as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Operations as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Policies pursuant to the hypotheses of the SUD demonstration or that served to provide better care for individuals as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Policies pursuant to the hypotheses of the SUD demonstration or that served to provide better care for populations as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Reduced cost per capita as described: <i>[narrative response if applicable]</i> <input type="checkbox"/> Other significant impacts to beneficiary outcomes as described: <i>[narrative response if applicable]</i>
<input checked="" type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
<input type="checkbox"/> New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		

3. Acknowledgement of Budget Neutrality Reporting

New Hampshire has reviewed the Budget Neutrality workbook provided by the project officer and understands the expectations for quarterly and annual monitoring reports.

New Hampshire will provide the requested budget neutrality information with no modifications.

4. SUD Demonstration Monitoring Reporting Schedule

	Q1	Q2	Q3	Q4 & Annual Report
REPORTING PERIOD:	JUL-SEP	OCT-DEC	JAN-MAR	APR-JUN
	REPORT SUBMISSIONS DATES			
Demonstration Year 1 7/10/18 – 6/30/19	11/30/2018	2/28/2019	5/31/2019	9/30/2019
Demonstration Year 2 7/10/19 – 6/30/20	11/27/2019	2/28/2020	5/29/2020	9/30/2020
Demonstration Year 3 7/10/20 – 6/30/21	11/30/2020	2/26/2021	5/28/2021	9/30/2021
Demonstration Year 4 7/10/21 – 6/30/22	11/30/2021	2/28/2022	5/31/2022	9/30/2022
Demonstration Year 5 7/10/22 – 6/30/23	11/30/2022	2/28/2023	5/31/2023	9/29/2023

**ATTACHMENT F:
SUD Amendment/CAP Application**

New Hampshire Department of Health and Human Services
Division of Medicaid Services
Substance Use Disorder Treatment and Recovery Access Section 1115(a)
Demonstration (Project No. 11-W-00321/1)

Amendment I

August 21, 2020

Summary

The State of New Hampshire's Department of Health and Human Services (DHHS), Division of Medicaid Services is requesting approval from the Centers for Medicare & Medicaid Services (CMS) for an amendment to the state's Section 1115(a) Substance Use Disorder Treatment and Recovery Access (SUD TRA) Demonstration to prospectively adjust its per member per month (PMPM) budget neutrality limits to account for unanticipated retroactive enrollment under Fee-For-Service (FFS). Since the FFS population is so small, the Institution for Mental Disease (IMD) costs incurred during the retroactive eligibility period and spread over such a small population distorted the PMPMs. In addition, the budget neutrality limits need to be adjusted to account for the actual enrollment mix for individuals in IMDs that are weighted in more expensive rate cells than originally assumed. Finally, adjustments are needed to account for rate increases to most Medicaid providers, including residential providers that were approved by the Legislature to ensure beneficiary access to SUD services and implemented after the original SUD TRA demonstration submission.

New Hampshire's 1115 SUD TRA Demonstration was originally approved effective July 10, 2018 through June 30, 2023. The demonstration authority permits the DHHS to receive Federal Financial Participation (FFP) for the coverage of SUD treatment-related IMD stays for Medicaid-eligible individuals age 21-64 for a statewide average length of stay of 30 days in residential treatment settings. The SUD TRA demonstration also expands the IMD exception for the provider type Comprehensive SUD treatment, as described in New Hampshire's administrative rule He-W 513.02(c)⁴ to allow New Hampshire to claim FFP for individuals under age 21 receiving residential substance use disorder treatment in these facilities for a statewide average length of stay of 30 days in residential treatment settings.

Overview

Within the budget neutrality analysis provided for the initial 1115 SUD TRA demonstration application, New Hampshire developed the base year costs (SFY 2018) in the budget neutrality template separately for the three specific Medicaid eligibility groups (MEGs): Medicaid adult population, expansion adult population; and adolescent population. The modifications in this amendment reflect adjustments for items that were not originally anticipated during the initial budget neutrality development and later became known as claims were being reviewed during the quarterly monitoring report preparation. Attached as Appendix A to this amendment is a letter from our actuary, Milliman, detailing the adjustments to the original budget neutrality calculations. The amendment narrative provides a more general overview of the adjustments and notes that the proposed adjustments do not impact the services, eligibility, or service delivery system under the demonstration.

STC 64 of the demonstration approval requires the State to submit a corrective action plan (CAP) to CMS if the State exceeds the calculated cumulative target limit for any of the demonstration years by the percentage identified in the approval. As such, New Hampshire is requesting that CMS consider this amendment submission as addressing the CAP requirement in the STC.

Demonstration Eligibility

⁴ http://www.gencourt.state.nh.us/rules/state_agencies/he-w500.html

New Hampshire does not seek to amend the eligibility groups in the budget neutrality calculation, but rather to adjust the DY03-DY05 budget neutrality limits prospectively to account for the issues as described in the letter and in the following sequence:

- Updated assumed rate cell enrollment distribution within each MEG
- SUD provider rate increases
- HB4 provider rate increases
- Hospital directed payment
- Inclusion of IMD payments during retroactive eligibility

Demonstration Area

The demonstration will continue to operate statewide and the proposed amendment does not alter that.

Demonstration Timeframe

The approved demonstration is currently for five years from July 10, 2018 through June 30, 2023 and the proposed amendment does not alter the timeframe. New Hampshire is requesting the amendment be approved with an effective date of September 1, 2020.

Demonstration Cost Sharing Requirements

There is no beneficiary cost sharing required under this demonstration and the proposed amendment does not alter that.

Demonstration Delivery System

The delivery system will continue to be fee-for-service and Medicaid Care Management. The Medicaid Care Management program utilizes capitated Medicaid managed care plans to provide Medicaid state plan services to beneficiaries. New Hampshire's Care Management will continue to operate as approved under New Hampshire's approved Medicaid State plan and 1915(b) waiver authority. The proposed amendment does not alter the demonstration delivery system.

Demonstration Benefits

New Hampshire's Medicaid beneficiaries are covered by the State's Medicaid state plan benefit and the Alternative Benefit Plan for the provision of SUD treatment services provided under this demonstration. The proposed amendment does not alter that.

Evaluation Design

New Hampshire's 1115 SUD TRA demonstration evaluation design was approved on May 22, 2019. New Hampshire does not anticipate additional modifications to the evaluation design as a result of this amendment to the demonstration. The proposed amendment does not alter the demonstration program hypotheses or measures.

Estimated Impact Proposed Budget Neutrality Prospective Adjustments

By the end of the original demonstration period, (June 30, 2023) DHHS projects to be under the budget neutrality limit by approximately \$23 million cumulatively assuming the proposed prospective adjustments noted in this amendment are implemented. Further detail and supporting data are included in the attached Appendix A as noted above.

Table 1 below provides expected annual expenditures and caseloads by Medicaid Eligibility Group through the end of the demonstration.

Table 1 New Hampshire Department of Health and Human Services Substance Use Disorder Treatment and Recovery Access 1115 Demonstration Projected Annual Expenditures and Caseload					
	DY 01	DY 02	DY 03	DY 04	DY 05
	Projected Caseload				
Medicaid Adults	695	665	665	665	665
Expansion Adults	3,812	4,871	4,871	4,871	4,871
Adolescents	74	67	67	67	67
	Projected Expenditures				
Medicaid Adults	\$931,834	\$807,802	\$831,061	\$872,614	\$916,245
Expansion Adults	\$5,533,064	\$5,472,453	\$5,638,020	\$5,919,921	\$6,215,917
Adolescents	\$64,157	\$78,881	\$66,304	\$69,620	\$73,101

Waiver and Expenditure Authorities

The demonstration program provides New Hampshire with the expenditure authority to receive FFP for the coverage of SUD treatment-related stays in IMDs for adults age 21-64. The demonstration also expanded the IMD exception for the provider type Comprehensive SUD treatment, as described in administrative rule He-W 513.02(c) to allow New Hampshire to claim FFP for individuals under age 21 receiving residential substance use disorder treatment in these facilities for a statewide average length of stay of 30 days in residential treatment settings.

The proposed amendment does not alter the above listed approved demonstration expenditure authorities.

Public Notice and Tribal Consultation

New Hampshire provided Public Notice on the 1115 SUD TRA demonstration amendment at the August 10, 2020 Medical Care Advisory Committee (MCAC) meeting and public comments were accepted at that time, per the 1994 Federal Register Public Notice Requirements (59 FR 49249) and STC #7 and #15 of the demonstration. The Department accepted public comments through Tuesday, August 11, 2020 until 4:30 pm (Eastern).

The Department posted a public notice for the 1115 demonstration amendment on the Department’s website: <https://www.dhhs.nh.gov/sud-imd/> A copy of the public notice is also attached in Appendix B.

At the August 10, 2020 MCAC meeting the amendment to the demonstration was presented. The MCAC supported the amendment to the demonstration. Included in Appendix B is the MCAC agenda and it can also be found on the Department’s website. <https://www.dhhs.nh.gov/ombp/documents/mcacagenda81020.pdf>

Also included in Appendix B is an excerpt from the August 10, 2020 MCAC meeting minutes where the amendment was discussed by the Medicaid Director and the MCAC voted to support the amendment.

On August 11, 2020 the Department received an email from New Futures, also supporting the amendment to the demonstration. A copy of the e-mail is included in Appendix B.

New Hampshire does not have any federally recognized tribes.

New Hampshire SUD 1115 Demonstration Budget Neutrality

Current regulations at 42 CFR 438.3 permit MCOs to cover enrollees, services or settings that are in lieu of services or settings when: (i) the service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the state plan; (2) the enrollee is not required by the MCO to use the alternative service or setting; (iii) the approved in lieu of services are authorized and identified in the MCO contract and will be offered to enrollees at the option of the MCO; and (iv) the utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise. On July 10, 2018, New Hampshire DHHS received expenditure authority of the 15 day in lieu of period.

Milliman assisted DHHS in modeling the initial estimates of SUD IMD utilization changes and the resulting budget neutrality calculations that were submitted to CMS in April 2018. As noted previously, DHHS and Milliman recognized that adjustments were needed to the budget neutrality PMPM limits to account for items that were not originally anticipated, and were not realized until substantive review of the CMS 64 claims summary as part of the quarterly monitoring report preparations. Modifications to the budget neutrality limits also need to be made to account for provider rate increases implemented after the demonstration was implemented, and to account for the impact of a recently implemented hospital directed payment. The remainder of this section provides the general description of the adjustments that were outlined in the amendment overview. As stated previously, the attached Appendix A provides additional detail and supporting data tables.

Updated rate cell enrollment distribution within each MEG

The original budget neutrality development included an assumed distribution of demonstration enrollment by MCM rate cell, which allowed for the calculation of the budget neutrality limits to reflect the average capitation rate and fee-for-services (FFS) expenditures (i.e., LTSS services) at a granular level. We developed this original enrollment distribution by reviewing individuals with a SUD diagnosis as those individuals would most likely be included in the demonstration reporting. At this time, we now have actual enrollment patterns and find the actual demonstration recipients represent rate cells with higher capitation rates and higher FFS expenditures.

SUD provider rate increase

Effective January 1, 2019, DHHS increased reimbursement for high intensity residential treatment services for adults (H0018) to \$247.82 per day. Additionally, effective July 1, 2019, DHHS increased reimbursement for residential sub-acute detoxification (H0010) to \$340.32 per day to address member access issues to these services.

HB4 provider rate increases

New Hampshire House Bill 4 (HB4) implements a 3.1% provider rate increase applicable to nearly all Medicaid services. This rate increase went into effect January 1, 2020 and rates will increase again on January 1, 2021 by another 3.1%. This fee schedule increase was approved by the Legislature to help maintain beneficiary access by helping to support the cost increases that Medicaid providers have experienced over recent years.

Hospital directed payment

Effective July 1, 2020, the MCM capitation rates include a hospital directed payment to promote access to high-quality acute care services provided by critical access and non-critical access hospitals across New Hampshire.

Inclusion of IMD payments during retroactive eligibility

The original budget neutrality development included three categories of expenses: MCM capitation rates, FFS costs for services not covered by MCM (e.g., LTSS), and the newly covered SUD IMD services. The specific cost estimates for IMD stays were allocated to all MCM enrollees as these services would be covered as part of the MCM program. However, this approach did not take into account individuals with FFS SUD IMD costs during a retroactive eligibility period. As a result, the reporting during DY 01 and DY 02 showed a significant amount of FFS SUD IMD costs not included in the original budget neutrality limits. Therefore, we propose updating the budget neutrality limits to capture these costs. Since these individuals would essentially be in an IMD for every day of their eligibility, the effective cost or Medicaid per diem rate is the daily IMD rate.

Expenditure Estimate

The proposed changes will impact the per member per month budget neutrality calculations, and as a result, the aggregate expenditures by a proportional amount in DY 03 through DY 05. However, the adjustments do not impact program services, eligibility or service delivery.

Budget Neutrality Workbook

Attachment A of the Milliman letter provides the proposed updated budget neutrality workbook that reflects these adjustments going forward. As these are prospective adjustments, calculations for DY3, DY4, and DY5 will vary from the calculations in the workbooks we have already submitted to CMS as part of the quarterly reporting requirement of the demonstration. The workbooks submitted to-date reflect our original assumptions and understanding of the budget neutrality methodology.

New Hampshire Amendment Appendix B: Public Noticing

New Hampshire Department of Health and Human Services
Public Notice for Substance Use Disorder Treatment and Recovery Access Section 1115(a)
Research and Demonstration (Project No. 11-W-00321/1) Amendment I
Web Posting Date August 7, 2020

August 7, 2020

Notice is hereby given that the New Hampshire Department of Health and Human Services (DHHS) is seeking an amendment to its Substance Use Disorder Treatment and Recovery Access (SUD-TRA) 1115(a) demonstration (Project No. 11-W-00321/1) to prospectively adjust its per member per month (PMPM) budget neutrality limits. The prospective adjustments account for expenditures that were not originally anticipated, and were not realized during the initial budget neutrality development and later became known as claims were being reviewed as part of the quarterly monitoring report preparations.

Consistent with the notice requirements in the Special Terms and Conditions #15 and the procedure set forth in 59 Fed. Reg. 49249 (September 27, 1994), DHHS will convene one public hearing to seek public input on the demonstration amendment. Specifically, New Hampshire is requesting:

- To account for unanticipated retroactive enrollment under Fee-For-Service (FFS). Since the FFS population is so small, the Institution for Mental Disease (IMD) costs incurred during the retroactive eligibility period and spread over such a small population distorted the per member per month (PMPM);
- The budget neutrality targets be adjusted to account for the actual enrollment mix for individuals in IMD's that are weighted in more expensive rate cells than originally assumed; and
- Adjustments are needed to account for rating actions that were approved by the Legislature to ensure beneficiary access to SUD services and implemented after the original demonstration submission.

The complete amendment of the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration (Project No. 11-W-00321/1)* is available for public review at:
<https://www.dhhs.nh.gov/sud-imd/>

Due to the COVID-19 public health emergency, in-lieu of in-person public hearings, DHHS will use alternative formats, ZOOM or telephone, which permit the public to participate and permit submission of public input. **DHHS will host a public hearing at the monthly Medical Care Advisory Committee meeting on Monday, August 10, 2020 from 10:00 – 12:00 during which time DHHS will accept public comment.** All Medical Care Advisory Committee Meetings are open to the public.

To join by zoom:

Join Zoom Meeting

<https://nh-dhhs.zoom.us/j/92124210541?pwd=aVc1MnVzREZYUmRHS3M0S2dBYjE1QT09>

Meeting ID: 921 2421 0541

Passcode: 704376

One tap mobile

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration
[Demonstration Approval Date]
Submitted on September 3, 2021, Revised on April 19, 2022

+16465588656,,92124210541#,,,,,0#,,704376# US (New York)
+13017158592,,92124210541#,,,,,0#,,704376# US (Germantown)

To participate by phone, call in at 10:00 am to:

Dial by your location

+1 646 558 8656 US (New York)
+1 301 715 8592 US (Germantown)
+1 312 626 6799 US (Chicago)
+1 669 900 9128 US (San Jose)
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)

Meeting ID: 921 2421 0541

Passcode: 704376

Find your local number: <https://nh-dhhs.zoom.us/j/ab1FZAVnVw>

At the public hearing, you can give verbal or written comments to DHHS. Additional information about providing comments is noted below.

Public Comment

DHHS will accept public comments for the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration amendment through **Tuesday, August 11, 2020.*** All comments must be received by **4:30 pm (Eastern).**

Email comments to Dawn Landry at dawn.landry@dhhs.nh.gov or mail written comments to:

Dawn Landry

New Hampshire Department of Health and Human Services

129 Pleasant Street

Concord, NH 03301

When mailing or emailing please specify the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Amendment.*

Additional Information

Requests for a hard copy of the demonstration amendment may be submitted by mail to:

Dawn Landry

New Hampshire Department of Health and Human Services

Attn: *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Amendment*

129 Pleasant Street

Concord, NH 03301

All information regarding the IMD/SUD demonstration amendment can be found on the DHHS web site at <https://www.dhhs.nh.gov/> under "Quick Links." DHHS will update this website.

Medical Care Advisory Committee (MCAC)
Monday, August 10, 2020
10:00 am – 12:00 pm

Meeting will be held via Zoom
See email for instructions

MEETING AGENDA

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| Introductions/Announcements
5 min | Carolyn Virtue, Chair |
| Review/Approval: July 13, 2020 Minutes
5 min | Carolyn Virtue, Chair |
| DHHS Legislative Update
15 min | John Williams, Esq.
Director of Legislative Affairs |
| SUD Waiver Amendment of Budget Neutrality Target
Director 15 min | Henry Lipman, Medicaid |
| DRAFT New Hampshire State Triage Committee Crisis
15 min
Standards of Care Clinical Guidelines dated June 23, 2020 | Carolyn Virtue, Chair |

- [DRAFT New Hampshire State Long Term Care Crisis Standards of Care](#)  (June 21, 2020)
- [DRAFT New Hampshire State Triage Committee Crisis Standards of Care Clinical Guidelines](#)  (June 23, 2020)

- [DRAFT New Hampshire State Triage Committee Crisis Standards of Care Clinical Guidelines](#)  (May 27, 2020)

Managed Care Open Enrollment

10 min

Shirley Iacopino, Laura Ringelberg

Medicaid Managed Care Operations

Department Updates

10 min MCO DME coverage
Clarification on managed care entity
1135 Waivers/COVID-19
Department Website Improvement
Fee for Service NEMT Contract Award

Henry Lipman, Medicaid Director

Membership

10 min

Jonathan Routhier, Vice Chair

Agenda Items - September 14, 2020

min

Members

5

Materials Sent to MCAC: Minutes 7/13/20, Agenda 8/10/20; Legislative Update; 1135 Waivers/COVID-19 handout

August 7, 2020 MCAC Meeting Minutes re: Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration (Project No.11-W-00321/1)Amendment I

SUD Waiver Amendment of Budget Neutrality Target

Background: In July 2018, the State applied to CMS for the SUD waiver to go beyond the standard limit of 15 days of coverage for purposes of federal match. The goal was to provide SUD care in the least restrictive environment. The State will submit a future amendment to provide more flexibility and resources to deal with the psychiatric crisis.

The SUD waiver benefit and benchmark neutrality target that was approved and implemented was hypothetical as it had not previously existed. The original benchmark neutrality assumptions have not played out as projected. Therefore, the purpose of the amendment is to revise the benchmark budget neutrality limit to reflect actual utilization of the SUD benefit, legislatively

mandated rate increases, increased residential facility rates, and retroactive coverage previously not available in 2019.

It includes the fee-for-service component and retroactive coverage. It addresses the higher rate cells due to the distribution of those individuals accessing the benefit. The State is seeking this amendment to calibrate targets to actual expense.

A motion was made, seconded and approved to support the SUD waiver amendment of the benchmark neutrality target.

E-mail from New Futures to the Department in support of the Substance Use Disorder Treatment and Recovery Access (SUD TRA) Section 1115 Demonstration Amendment

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration
[Demonstration Approval Date]
Submitted on September 3, 2021, Revised on April 19, 2022

From: Landry, Dawn
Sent: Thursday, August 13, 2020 11:52 AM
To: 'Holly Stevens' <hstevens@new-futures.org>
Subject: RE: New Futures' support of SUD 1115a waiver amendment request

Dear Ms. Stevens,

The Department thanks you for your support of our proposed amendment to our SUD 1115 demonstration.

Dawn I. Landry, Policy Administrator
Division of Medicaid Services
New Hampshire Department of Health & Human Services
129 Pleasant Street, Concord, NH 03301
Phone: 603-271-9315
Email: dawn.landry@dhhs.nh.gov

From: Holly Stevens <hstevens@new-futures.org>
Sent: Tuesday, August 11, 2020 4:27 PM
To: Landry, Dawn <Dawn.Landry@dhhs.nh.gov>
Subject: New Futures' support of SUD 1115a waiver amendment request

EXTERNAL: Do not open attachments or click on links unless you recognize and trust the sender.

Dear Ms. Landry:

New Futures' strongly supports the amendment to the SUD 1115 waiver that allowed individuals to utilize 28 day treatment programs by waiving the IMD prohibition. It is our understanding that there were many unknown circumstances including a Medicaid rate increase, an increase in SUD provider rates, retroactive eligibility, along with the population with higher PMPMs are utilizing this benefit at a greater rate than originally anticipated. Therefore, the waiver is no longer budget neutral. Since it is extremely important that this waiver remain in place so that our state can continue to combat the addiction crisis using all the tools available. Because of that, New Futures supports this amendment to the SUD 1115 waiver so that it will have budget neutrality.

Thank you for the opportunity to comment on this amendment.

Holly

Holly A. Stevens, Esq.
Health Policy Coordinator
[New Futures](#)
100 North Main Street, Suite 400 | Concord, NH
603-225-9540 Ext. 127
[NewFuturesNH](#) | [@NewFuturesNH](#)

ATTACHMENT G:

SMI Implementation Plan

Section 1115 SMI/SED Demonstration Implementation Plan July 23, 2019

Overview: The implementation plan documents the state’s approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on “Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]” over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan
NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration
[Demonstration Approval Date]
Submitted on September 3, 2021, Revised on April 19, 2022

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding: The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

State Response: In accordance with New Hampshire’s approved Medicaid State Plan, the NH Department of Health and Human Services (DHHS) is the single State agency. The Division for Behavioral Health is within DHHS; therefore, no MOU is applicable to this demonstration amendment request.

State Point of Contact: Please provide the contact information for the state’s point of contact for the implementation plan.

Name and Title: Carolyn Richards
Telephone Number: 603.271.9439
Email Address:
Carolyn.S.Richards@dhhs.nh.gov

1. Title page for the state’s SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

State	State of New Hampshire
Demonstration name	New Hampshire Department of Health and Human Services Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Amendment #2 Request: Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness
Approval date	<i>Enter approval date of the demonstration as listed in the demonstration approval letter.</i> TBD
Approval period	<i>Enter the entire approval period for the demonstration, including a start date and an end date.</i> TBD
Implementation date	<i>Enter implementation date(s) for the demonstration.</i> July 1, 2022

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state’s SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place “NA” in the summary cell if a prompt does not pertain to the state’s demonstration. Answers are meant to provide details beyond the information provided in the state’s special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic 1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
<p>To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk.</p> <p>To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.</p>	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	<p><i>Current Status:</i></p> <p>The two hospitals that will participate in the demonstration—New Hampshire Hospital and Hampstead Hospital—are authorized by the state to treat mental illness, enrolled in Medicaid / Medicare and are in compliance with the Conditions of Participation. Both hospitals are also Joint Commission accredited.</p> <p>NH Administrative Code details licensure requirements for acute settings:</p> <ul style="list-style-type: none"> • NH Administrative Code He-P 802 Rules for Hospitals and RSA 151:2 Residential Care and Health Facility Licensing: License or Registration Required requires licensure for hospitals. • NH Administrative Code He-M 405.04 Application Procedure and Designation/Redesignation Criteria states that hospital-based Designated Receiving Facilities (DRFs) which submit an application for (re-)designation shall include a certificate of compliance with the Conditions of Participation (CoPs) for hospital-based psychiatric services set by CMS, obtained from either DHHS on behalf of CMS or by a national accrediting organization deemed by CMS as having standards and a survey process that meets the Medicare CoPs and federal survey requirements.

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- New Hampshire Hospital is state-owned and authorized to provide care and treatment to persons who have mental illness by RSA 135-C:4 rather than facility licensure.

In accordance with NH administrative code, upon the initial enrollment in NH Medicaid, the licensure requirement is a mandatory field and verified with the appropriate licensing entity for the Provider. This information displays the end date of the license and the MMIS staff have an overdue license report that is worked weekly to update and record license dates to maintain current information. This function is done upon expiration of the license and at the time of revalidation every 5 years.

Future Status:

In addition to continuing operation of current requirements, New Hampshire (the State) plans to require all IMDs to verify that they are accredited by a nationally recognized accreditation entity as part of the Medicaid enrollment process.

Summary of Actions Needed:

DHHS will draft new administrative rule language to specify that all hospitals participating in the demonstration must be accredited by a nationally recognized accreditation entity. Once the new administrative rule language is drafted, DHHS will coordinate with the Administrative Rules Unit to finalize rule language and submit the rule for publication. Following a public comment period, the Rules Unit will bring the proposed rule change(s) in front of Joint Legislative Committee Rules for approval.

After the administrative rule is formally filed with the Office of Legislative Services, DHHS will conduct outreach to providers and MCOs. DHHS updates the provider and other stakeholder communities, and the public on the progress of the IMD Demonstration, inclusive of public comment periods at key moments through its website. The promulgation of administrative rules includes public notice and hearings to allow agency adoption through Joint Legislative Committee on Administrative Rules (JLCAR). DHHS will specifically issue guidance to the MCOs regarding these administrative rule changes, along with any billing and coding instructions. These efforts will be joined with aligned approaches for DHHS' provider relations team's work at the individual provider level.

This entire process will take approximately 12-18 months. DHHS has set an internal goal to complete draft language by October 2022 and to begin public review and comment of the proposed rules by Jan 1, 2023. These specific dates are subject to change based on internal staff capacity and timing with other ongoing internal processes.

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<p>1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state’s licensing or certification and accreditation requirements</p>	<p><i>Current Status:</i> The Program Integrity Unit performs on-site visits of every moderate and high-risk provider during the initial enrollment process and revalidation every 5 years to assess the meeting of the requirements for each provider type. Additionally, Program Integrity may increase a limited risk provider to moderate or high based on the risk to the Medicaid program.</p> <p>The State also completes a full designation review of DRFs once every five years.</p> <p>Bureau of Licensing and Certification (BLC) reviews are conducted pursuant to federal regulations requiring the periodic inspection of all CMS certified hospitals by the NH DHHS Licensing and Certification Unit, specifically the CMS contracted certification unit or the accrediting organization. Pursuant to RSA 151:5-b Deemed Licensed, all CMS certified hospitals are deemed licensed and are exempt from inspections required by RSA 151:6 Investigations and Consultations and NH Administrative Rule He-P 802 Rules for Hospitals.</p> <p>NH Administrative Code He-P 405.04 Application Procedure and Designation/Redesignation Criteria requires that DHHS assign staff to review the application materials and conduct a site visit of any DRF applying for designation or redesignation.</p> <p>The BLC conducts the onsite visits for licensed facilities, pursuant to NH RSA 151. BLC’s federal CMS team conducts onsite surveys for licensed facilities that are CMS certified. These surveys are conducted as defined in <u>CMS SOM</u>, depending on the provider type.</p> <p>The State BLC exempts hospitals which are accredited and CMS certified from its site visits. These facilities are instead subject to unannounced visits from their accrediting entity, including at minimum an unannounced audit visit every three years. NH Hospital and Hampstead Hospital are both Joint Commission accredited and subject to unannounced visits from this accreditation entity.</p> <hr/> <p><i>Future Status:</i> Continued operation of current requirements.</p> <hr/> <p><i>Summary of Actions Needed:</i> N/A – Milestone met.</p>
<p>1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and</p>	<p><i>Current Status:</i> NH Administrative Code He-W 543.11 Utilization Review requires evaluations of the quality, medical necessity, appropriateness of care, and length of stay determinations for all inpatient hospital services at in-state and border hospitals in accordance with 42 CFR 456.100.</p>

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<p>types of care and to provide oversight on lengths of stay</p>	<p>Operationally, the program area or their designated contractor reviews whether individual beneficiaries are receiving appropriate services. NH DHHS contracts with managed care organizations (MCOs) who employ or contract with licensed health care personnel to perform utilization review activities. These activities are outlined in the written Utilization Management policies included in each MCO contract. At a minimum, MCOs must outline policies which address Second Opinion programs, pre-hospitalization admission certification, pre-inpatient service eligibility certification, concurrent hospital review to determine appropriate lengths of stay, and the process for preserving confidentiality of patient information.</p> <p>Each MCO also maintains a collaborative agreement specific to New Hampshire Hospital (NHH) that includes mutually-developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to NHH. This requirement is further outlined by MCM Section 41.11.5.18.1.3, “The collaborative agreement shall also include mutually developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to New Hampshire Hospital.”</p> <p>New Hampshire Hospital employs Utilization Review as a key function in determining clinical necessity for levels of psychiatric care that patients receive. This process closely follows CMS guidelines outlined in Chapter 2, section 30.2.1 of the Medicare Benefit Policy Manual and Pub 100-01- Medicare General Information, Eligibility, and Entitlement, from the CMS Manual System. Throughout a patient’s stay, utilization review is employed to determine a patient’s continued medical necessity for inpatient psychiatric care, and when medical necessity is no longer met, Utilization Review staff members partner with Social Workers, Clinicians, and a variety of community-based and step-down facility providers in finalizing a safe and effective discharge plan for patients.</p> <p>New Hampshire’s focus on ensuring patients are served in the most appropriate and least restrictive environment possible is a key reason the state invested in and opened the Philbrook Adult Transitional Housing (PATH) program, a 16-bed transitional housing facility, owned and operated by the State of New Hampshire, that ensures a timely transition to a more appropriate level of care for patients who no longer require acute psychiatric hospitalization.</p> <p>In its oversight capacity, NH DHHS’s External Quality Review Organization conducts annual MCO contract compliance reviews. NH DHHS also conducts annual contract compliance audits for all state funded treatment facilities to ensure adherence to clinical standards when determining level of care placement.</p> <p>NH Administrative Code He-W 520.04 Surveillance and Utilization Review and Control requires DHHS to perform utilization reviews directly or through contracted organizations for the purposes of assessing quality of care, including through random reviews of claims. In the last two years, the Program Integrity Unit (PIU) has internalized its Quality Improvement Organization (QIO) function to perform utilization reviews for inpatient fee-</p>
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	<p>for-service hospital claims only.</p> <p><i>Future Status:</i> DHHS is in the process of amending the existing utilization management language in the MCM contract that requires MCOs to have an agreement with NHH which, "...shall also include mutually developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to New Hampshire Hospital". The amended MCM contract will strengthen and expand this existing requirement for NHH to explicitly state that MCOs must include admission and utilization review criteria in all IMD contracts, not just NHH.</p> <p><i>Summary of Actions Needed:</i> The State will amend MCO contracts to explicitly require MCOs to include admission and utilization review criteria in all IMD contracts. This process will be completed by June 30, 2022.</p>
<p>1.d Compliance with program integrity requirements and state compliance assurance process</p>	<p><i>Current Status:</i> In order to receive reimbursement under Medicaid, participating psychiatric hospitals must be enrolled to participate in New Hampshire Medicaid. Provider enrollment processes fully comply with 42 CFR Part 455 Subparts B&E. PIU performs audits and investigations when an allegation of fraud, waste, or abuse is reported. PIU also uses data analytic reports to determine whether there are anomalies in billing and/or reimbursement. Further, Program Integrity will investigate an allegation that the program area reports to Program Integrity that includes questions about the accuracy of claim information or questions surrounding utilization. DHHS has also recently hired a waiver manager to oversee compliance and requirements of all NH waivers.</p> <p><i>Future Status:</i> In addition to the continued operation of current requirements, PIU will enhance provider monitoring during the period of the requested demonstration amendment.</p> <p><i>Summary of Actions Needed:</i> PIU will implement a formal approach to monitoring the providers that will include a six month random sampling of paid claims from the Fee-for-Service and MCO populations to determine if there are any patterns of irregularity or utilization practices including excessive high coding procedures. This process will begin in 12-18 months due to claims run out time. The State will meet internally in March of 2023 to review initial claims received and refine the sampling process. The State will target completion of this initial review within six months of the March 2023 meeting (by November 2023).</p>

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	<p>As it identifies additional best-practice safeguards over the normal course of business, PIU will work with BMHS to assure integration into the rule-making process.</p>
<p>1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions</p>	<p><i>Current Status:</i> New Hampshire Hospital and Hampstead Hospital are both Joint Commission accredited. Joint Commission standards PC 01.02.03 EP 4 include policies that address screening requirements for co-morbid physical health conditions. The policies require that a medical health history and physical examination must be completed within 24 hours of admission.</p> <p>DHHS monitors MCO performance relative to the contract requirements, and if necessary, takes corrective action and/or assesses liquidated damages to enforce compliance.</p> <p>During a PIU review, the required documentation will be requested from the provider so that PIU may review claims for compliance with the plan of care and ensure that the provider is following proper qualifications for the staff performing the functions. If there were a screening requirement as part of a service, PIU would request the documentation specific to the screening.</p> <p><i>Future Status:</i> To reinforce the impact of accreditation standards, the State plans to create new administrative rule language ensuring that all participating hospitals screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions.</p> <p><i>Summary of Actions Needed:</i> DHHS will draft new administrative rule language to specify that all hospitals participating in the demonstration must screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions. Once the new administrative rule language is drafted, DHHS will coordinate with the Administrative Rules Unit to finalize rule language and submit the rule for publication. Following a public comment period, the Rules Unit will bring the proposed rule change(s) in front of Joint Legislative Committee Rules for approval.</p> <p>After the administrative rule is formally filed with the Office of Legislative Services, DHHS will conduct outreach to providers and MCOs. DHHS updates the provider and other stakeholder communities, and the public on the progress of the IMD Demonstration, inclusive of public comment periods at key moments through its website. The promulgation of administrative rules includes public notice and hearings to allow agency adoption through Joint Legislative Committee on Administrative Rules (JLCAR). DHHS will specifically issue guidance to the MCOs regarding these administrative rule changes, along with any billing and coding instructions. These efforts will be joined with aligned approaches for DHHS' provider management team's work at the individual provider level.</p>

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	<p>This entire process will take approximately 12-18 months. DHHS has set an internal goal to complete draft language by October 2022 and to begin public review and comment of the proposed rules by Jan 1, 2023. These specific dates are subject to change based on internal staff capacity and timing with other ongoing internal processes.</p>
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Prompts	Summary
<p>1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.</p>	<p><i>Current Status:</i> The Division of Program Quality and Integrity (DPQI) requires and reviews provider submissions of sentinel event reports pertaining to individuals receiving services in residential settings operated by a provider agency receiving DHHS funding, or to individuals in residential treatment directly receiving Community Mental Health Center (CMHC) - or other DHHS-funded services.</p> <p>DPQI offers a website open to the public that tracks Healthcare Effectiveness Data & Information Set (HEDIS) and other commonly used healthcare quality measures.</p> <p>In addition, PIU provides ongoing monitoring and oversight for adherence to administrative rules in the normal course of provider audits.</p> <p>There are also MCO requirements to ensure quality care across the network. Under the terms of its contract with the State, the MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. (MCO Contract Exhibit A, Section 4.12.1.1) In contracts with its providers, the MCOs are required to ensure the providers' compliance with the health plan's clinical practices guidelines. (MCO Contract Exhibit A, Section 4.13.5.2.1) In addition, under terms of their contracts with the MCO, there is a requirement of the provider to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority. (MCO Contract Exhibit A, Section 4.13.5.15.1.3)</p> <p><i>Future Status:</i> PIU will develop a sampling of the enrolled sites to perform program integrity reviews at certain intervals to assess programs for compliance and claim submissions for accuracy. Further, PIU will then inform the Program area of any potential issues.</p> <p>PIU will develop the sampling methodology and review program during the first 12 months. During year two, PIU</p>

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	<p>will conduct a pilot review process with a limited sample size. From years three to five, PIU will transition monitoring review to the appropriate Program area.</p> <p>As part of its monitoring capacity, DHHS plans to track several of the SMI Demonstration Monitoring Metrics identified by CMS as focusing on serious mental illness, such as <i>30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)</i>.</p> <p><i>Summary of Actions Needed:</i> Program Integrity will become part of the on-going monitoring plan for these providers.</p>
<p>SMI/SED. Topic 2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care</p>	
<p><i>Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.</i></p>	
<p>Improving Care Coordination and Transitions to Community-based Care</p>	
<p>2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.</p>	<p><i>Current Status:</i> Psychiatric Hospitals: NH Administrative Code He-P 802.18 Required Services requires hospitals to complete discharge planning on all patients admitted to a hospital. Discharge planning shall include, as applicable:</p> <ul style="list-style-type: none"> • The patient's medication needs upon discharge; • The need for medical equipment, special diets, or potential food-drug interactions; • The need for further placement in another health care hospital; • The need for home health services upon discharge; and • Discharge instructions and education shall be provided to the patient in writing. <p>New Hampshire Hospital (NHH) and Hampstead Hospital comply with He-M 311.06 Rights of Persons in State Mental Health Facilities (a.) (3-7), which states that patients have the right to quality treatment in the least restrictive setting in accordance with the timeframe set forth in their individual service plan developed under RSA 135-C:19 and the Joint Commission Comprehensive Accreditation Manual for Hospitals (January 2015) published by Joint Commission Resources, Inc. Joint Commission PC.04.01.03 EP 1-4, 10 requires discharge planning begins early in the patient's episode of care, treatment and services. The hospital identifies any needs the patient may have for psychosocial or physical care, after discharge or transfer.</p> <p>NHH's Social Work Discharge Planning standard requires that NHH's communication with the outpatient CMHC begin the first business day following admission. Transition Care plans are initiated at admission and updated as</p>

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required based on assessment and as treatment planning progresses. CMHCs are expected to provide an appointment within 7 days of discharge for all discharged individuals and within 48 hours to those who were receiving Assertive Community Treatment (ACT) services prior to the most recent admission.

CMHCs are also engaged in a directed payment program authorized through CMS and operating through DHHS MCO agreements. The directed payment arrangement is anticipated to advance the goals of the New Hampshire Quality Strategy by improving CMHP⁵ payments which will help ensure and promote continued access to care. A focused measure for these payments targets those individuals discharged from a psychiatric stay who are seen the same day of, or the next day after, discharge. If a CMHC sees an individual within these times frames, they receive a payment.

Each of the 10 regionally-based CMHCs have NHH liaisons. They receive notifications of an individual being admitted to NHH and engage in discharge planning and any other communications that need to be signed off on.

Hampstead Hospital currently has policies and procedures in place to assure that discharge planning begins at the time of admission and that every patient leaves with access to a safe and appropriate discharge plan. Within 24 hours of admission every patient meets with a qualified Master's level social worker. As part of that initial meeting discharge planning is discussed with a focus on accessing quality services upon discharge. The social worker then begins collaborating with the patient, family members, community mental health supports and other resources to assure that upon discharge the patient has an appropriate aftercare plan.

Upon discharge every patient and/or guardian receives a copy of the aftercare plan and a copy is also retained for the medical record. This is also reviewed verbally with the patient and/or guardian. The aftercare plan contains a list of all aftercare services being provided as well as contact information for these agencies. With the patient and/or guardian's consent aftercare providers may then receive additional information including but not limited to the following: discharge summary, psychiatric history, medication lists, assessments and the aftercare plan itself. The aftercare plan also includes discharge instructions and education. Every aftercare plan contains the patient's diagnosis and a list of all scheduled appointments. It allows the patient the opportunity to access services for substance use disorders services and tobacco cessation services. It also reviews advanced directives. In addition, at the time of discharge every patient and/or guardian meets with a member of the nursing staff. Both verbal and written instructions are given for medications. The need for medical equipment, special diets or potential food-drug interactions may also be discussed as relevant. If a patient is being transferred to another facility this is also written on the aftercare plan as well as discussed verbally with the patient and/or guardian.

⁵ The terms Community Mental Health Programs (CMHPs) and Community Mental Health Centers (CMHCs) are used interchangeably in this Implementation Plan in order to preserve historical references in statute or regulation.

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Hampstead Hospital currently has at least one discharge liaison from each of New Hampshire’s community mental health centers. The liaisons are notified of every admission within 2 business days of admission.

Additionally, MCOs play an important role in care transitions. Under the MCM Agreement, the MCO is required to maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. (MCO Contract Exhibit A, Section [4.10.9.2](#)) The MCO works with DHHS and the applicable Community Mental Health Provider to review Member cases that New Hampshire Hospital has indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community. (MCO Contract Exhibit A, Section 4.11.5.18.2.17)

Future Status:

New Hampshire Hospital and Hampstead Hospital will continue operation of current practices which already meet this milestone. The State plans to create new administrative rule language ensuring that all participating facilities in the demonstration also carry out intensive pre-discharge planning, and include community-based providers in care transitions. This will ensure that any new hospitals which join the demonstration must meet this milestone.

Summary of Actions Needed:

DHHS will draft new administrative rule language to specify that all hospitals participating in the demonstration must carry out intensive pre-discharge planning, and include community-based providers in care transitions. Once the new administrative rule language is drafted, DHHS will coordinate with the Administrative Rules Unit to finalize rule language and submit the rule for publication. Following a public comment period, the Rules Unit will bring the proposed rule change(s) in front of Joint Legislative Committee Rules for approval.

After the administrative rule is formally filed with the Office of Legislative Services, DHHS will conduct outreach to providers and MCOs. DHHS updates the provider and other stakeholder communities, and the public on the progress of the IMD Demonstration, inclusive of public comment periods at key moments through its website. The promulgation of administrative rules includes public notice and hearings to allow agency adoption through Joint Legislative Committee on Administrative Rules (JLCAR). DHHS will specifically issue guidance to the MCOs regarding these administrative rule changes, along with any billing and coding instructions. These efforts will be joined with aligned approaches for DHHS’ provider management team’s work at the individual provider level.

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	<p>are subject to change based on internal staff capacity and timing with other ongoing internal processes.</p>
<p>2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.</p>	<p><i>Current Status:</i></p> <p>As part of NH Administrative Code He-M 802.18 Required Services, hospitals are required to complete discharge planning that includes, as applicable:</p> <ul style="list-style-type: none"> • The need for further placement in another health care hospital; and • The need for home health services upon discharge. <p>NH Administrative Code He-M 613.09 Admission to Transitional Housing Service provides a path from NHH to Transitional Housing Service (THS) admission as long as applicants:</p> <ul style="list-style-type: none"> • Have been referred from NHH or have been discharged from the THS within the 30 days immediately preceding application; • Are 18 years of age or older and have a primary diagnosis of: <ul style="list-style-type: none"> • Psychiatric disorder or severe personality disorder; or • Intellectual disability or pervasive developmental disorder as defined in DSM-5 with a secondary diagnosis of psychiatric disorder or severe personality disorder; and • Have an individual service plan specifying that he or she: <ul style="list-style-type: none"> • No longer needs the level of care provided by NHH; • Requires the degree of care and supervision available from the THS; and • Has an identified goal of community placement. <p>NH Administrative Code He-M 403.06 CMHP Services and Programs requires CMHPs to provide outreach to persons with mental illness who are homeless for the purpose of engaging such persons in the service system, provide individuals with services at emergency shelters, provide services within an individual's home, and collaboration with state and local housing agencies and providers to promote access to existing housing and the development of housing for persons with mental illness, including home ownership and rental options.</p> <p>NHH employs a full time Housing Specialist to assist social work staff with locating permanent independent housing for patients who are homeless. Social Work staff collaborate with Housing Specialists at the appropriate CMHC to refer patients who are being discharged to either temporary housing or to assist with locating permanent housing. Social Work staff are also required to provide assessment of each patient's need for level of supervision post-discharge and make</p>

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appropriate referrals to programs offering those supports which may include independent apartments, community residences, transitional housing or long-term care (LTC) facilities.

The State provides several supported housing programs to meet the targeted population need. The primary program, Housing Bridge Subsidy Program (HBSP), has established supported, subsidized housing for over 1,000 individuals under the Community Mental Health Agreement (CMHA). The HBSP prioritizes individuals ready for discharge from NHH, Glenclyff Home, and Transitional Housing Programs. Additional prioritized individuals include those being served by ACT teams in the community who are homeless or at risk of becoming homeless due to their economic circumstances, and individuals served by CMHPs currently in community residences who are ready to transition into independent living.

HBSP provides individuals with 1:1 assistance with locating and applying for rental opportunities, landlord-tenant relationship management, financial subsidy towards rent, and ongoing supports and access to mental health services (if desired by the individual). At least 400 individuals receive a State subsidy at any one time that, combined with the individual's own contribution toward rent, fulfill monthly rent payments and maintains the individual's access to the apartment. This also allows the individual to remain on a waiting list for traditional Housing and Urban Development (HUD) funded programs, other municipally administered programs, or until the individual's own income exceeds the HBSP's financial eligibility guidelines.

Additionally, the State supports individuals who need more intensive supports and services to return to the community post psychiatric hospitalization through transitional housing programs (THP). These programs combine residential, therapeutic, vocational and other services and supports to further prepare individuals for independent living.

Lastly, the State provides opportunities for individuals to live as independently as possible through the coordination of voluntary services and providing a choice of subsidized, integrated housing options. The Section 811 Project Rental Assistance (PRA) program provides project-based rental assistance for extremely low income persons within the target population linked with long-term services. The grant is administered in partnership with the DHHS and the NH Housing Finance Authority.

Future Status:

The State plans to create new administrative rule language ensuring that all participating hospitals assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.

Further, on June 21, 2021, the State submitted a 1915(i) Supportive Housing Waiver request to provide transitional

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and/or sustaining supportive housing services to eligible homeless and at-risk of homelessness HCBS individuals. The State responded to CMS' Request for Additional Information (RAI) questions on November 19th and is currently waiting for CMS feedback. If approved, the 1915(i) Supportive Housing Waiver is planned to go into effect on July 1, 2022.

Summary of Actions Needed:

DHHS will draft new administrative rule language to specify that all hospitals participating in the demonstration must assess beneficiaries' housing situations and coordinate with housing services providers when needed and available. Once the new administrative rule language is drafted, DHHS will coordinate with the Administrative Rules Unit to finalize rule language and submit the rule for publication. Following a public comment period, the Rules Unit will bring the proposed rule change(s) in front of Joint Legislative Committee Rules for approval.

After the administrative rule is formally filed with the Office of Legislative Services, DHHS will conduct outreach to providers and MCOs. DHHS updates the provider and other stakeholder communities, and the public on the progress of the IMD Demonstration, inclusive of public comment periods at key moments through its website. The promulgation of administrative rules includes public notice and hearings to allow agency adoption through Joint Legislative Committee on Administrative Rules (JLCAR) vote. DHHS will specifically issue guidance to the MCOs regarding these administrative rule changes, along with any billing and coding instructions.

This entire process will take approximately 12-18 months. DHHS has set an internal goal to complete draft language by October 2022 and to begin public review and comment of the proposed rules by Jan 1, 2023. These specific dates are subject to change based on internal staff capacity and timing with other ongoing internal processes.

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<p>2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge</p>	<p><i>Current Status:</i> MCOs conduct follow-up calls with their members who were admitted for a psychiatric stay. NHH previously had a follow-up call process that was ineffective as the number of patients reached was very low and duplicated efforts with MCOs.</p> <p>As part of their scope of services, the MCOs are obligated to maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management (TCM), including appropriate discharge planning for short-term and long-term hospital and institutional stays. [42 CFR 438.208(b)(2)(i)]</p> <p>TCM is further required in the contracts to include, at minimum:</p> <ul style="list-style-type: none"> • Obtaining a copy of the discharge plan/summary prior to the day of discharge, if available, otherwise, as soon as it is available, and documenting that a follow-up outpatient visit is scheduled, ideally before discharge; • Communicating with the Member's PCP about discharge plans and any changes to the care plan; • Conducting medication reconciliation within forty-eight (48) business hours of discharge; • Ensuring that a Care Manager is assigned to manage the transition; • Follow-up by the assigned Care Manager within forty-eight (48) business hours of discharge of the Member; • Determining when a follow-up visit should be conducted in a Member's home; • Supporting members to keep outpatient appointments; and • A process to assist with supporting continuity of care for the transition and enrollment of children being placed in foster care, including children who are currently enrolled in the plan and children in foster care who become enrolled in the plan, including prospective enrollment so that any care required prior to effective date of enrollment is covered. <p>In addition, MCOs are required under Exhibit O – Reporting Reference SUD.42 “Emergency Department Discharges for SUD: MCO Contacts and Contact Attempts” to provide a count and percent of members discharged from an Emergency Department (ED) with a substance use disorder (SUD) diagnosis during the measurement period, where the MCO either successfully contacted the member, or attempted to contact the member at least 3 times, within 3 business days of discharge by subpopulation.</p> <p>The MCOs produce a quarterly report that outlines all of their members who have been re-admitted during the quarter within a 30-day and 180-day window. This report is reviewed with the BMHS and cases with high re-admissions and low service utilization are identified, case-consulted with the MCO, and the MCO is required to conduct targeted</p>

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	<p>follow up to decrease the likeliness of re-admission. MCOs have also developed algorithms to identify those cases that may be at high risk for a psychiatric admission or re-admission and work to engage these individuals in care coordination ensuring appropriate services are being utilized.</p> <p>The MCOs have contracted with a vendor to help provide intensive in home service to youth waiting for psychiatric hospital beds. This is in effort to redirect care away from EDs and potentially avoid the need for a psychiatric hospital stay.</p>
	<p><i>Future Status:</i> The State plans to create new administrative rule language ensuring that all participating hospitals contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge.</p>
	<p><i>Summary of Actions Needed:</i> DHHS will draft new administrative rule language to specify that all hospitals participating in the demonstration must contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge. Once the new administrative rule language is drafted, DHHS will coordinate with the Administrative Rules Unit to finalize rule language and submit the rule for publication. Following a public comment period, the Rules Unit will bring the proposed rule change(s) in front of Joint Legislative Committee Rules for approval.</p> <p>After the administrative rule is formally filed with the Office of Legislative Services, DHHS will conduct outreach to providers and MCOs. DHHS updates the provider and other stakeholder communities, and the public on the progress of the IMD Demonstration, inclusive of public comment periods at key moments through its website. The promulgation of administrative rules includes public notice and hearings to allow agency adoption through Joint Legislative Committee on Administrative Rules (JLCAR). DHHS will specifically issue guidance to the MCOs regarding these administrative rule changes, along with any billing and coding instructions.</p> <p>This entire process will take approximately 12-18 months. DHHS has set an internal goal to complete draft language by October 2022 and to begin public review and comment of the proposed rules by Jan 1, 2023. These specific dates are subject to change based on internal staff capacity and timing with other ongoing internal processes.</p>

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<p>2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission</p>	<p><i>Current Status:</i> Division for Behavioral Health (DBH) receives a daily ED waitlist from NHH identifying all individuals – not just Medicaid beneficiaries – awaiting psychiatric beds in the State (self-pay, private insurance, etc.), which is distributed to an array of stakeholders including the MCOs. MCOs are required to review the daily ED waitlist to identify alternative bed solutions and intensive community treatment options for their members. They also have weekly meetings with DBH to report out on the status of members waiting.</p> <p>MCOs also engage in single-case agreements for providers out of network to support alternative bed solutions when necessary.</p> <p>MCOs are required to provide a monthly report on the number of its members awaiting placement in the ED or in a hospital setting for twenty-four (24) hours or more; the disposition of those awaiting placement; and the average length of stay in the ED and medical ward for both children and adult members, and the rate of recidivism for Psychiatric Boarding.</p> <hr/> <p><i>Future Status:</i> DBH is working to increase the number of non-hospital-based psychiatric beds such as Recovery-Oriented Step Up and Step Down beds. These beds can be used to support an individual in need of increased supports in order to avoid a psychiatric stay or to step down from a psychiatric stay. DBH is contracted with all 10 of the regionally based CMHCs to increase the number of community-based supported housing beds in each region.</p> <p>Critical Time Intervention. CTI is a time-limited, evidence- and community-based practice that mobilizes support for individuals with serious mental illness during vulnerable periods of transition (e.g., discharge from a psychiatric hospital). CTI providers will work with transitioning individuals to ensure they successfully reintegrate into their home communities. This can entail a broad range of assistance, from helping an individual secure employment, housing, or food; to identifying and accessing mental or physical health care; to reconnecting with family, friends, and peers to ensure strong, supportive relationships.</p> <p>Transitional Bed Capacity. By increasing transitional bed capacity in the State, the Hospital will be able to discharge individuals who no longer require hospital LOC and therefore accept more individuals from the ER into the Hospital.</p> <p>First Episode Psychosis (FEP) Programs. The state is targeting workforce development to support the staffing of the 3 newly established programs as well as maintaining the Nashua region based program for FEP. By increasing the availability of FEP programs throughout the state, NH increases the likelihood of identifying an individual during their first psychotic episode and providing intense, targeted services that lead to a decrease in psychiatric hospital stays.</p>
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	<p><i>Summary of Actions Needed:</i> DBH plans to increase the number of community-based supported housing beds in each region as contracted.</p> <p>Critical Time Intervention. The State is working to implement CTI statewide, with the near-term goal of mitigating the overflowing demand on the State hospital system. Phase one CMHCs are in the process of finalizing their content, staffing, and training materials and will launch CTI services in January 2022. Strategy development for contracts with the phase two CMHCs has begun, and CTI will be launched across all 10 CMHCs by July 2022</p> <p>Transitional Bed Capacity. Funding was provided in the SFY 20-21 State budget to construct 40 new transitional housing beds. Philbrook Adult Transitional Housing (PATH) accepted its first client on September 14, 2020 and has served 58 clients as of August 25, 2021. The State is in the process of executing a contract amendment with the ten community mental health centers to stand up a minimum of 6 new supported housing beds per region including, but not limited to, transitional or community residential beds. It is anticipated that these beds will become available between April-December 2022.</p> <p>First Episode Psychosis (FEP) Programs. Starting in July of 2021 three (3) additional FEP programs within the Derry, Seacoast, and Monadnock regions began standing up their services. Standing up these programs is a lengthy process due to the extensive training required to implement this evidence-based practice (EBP). These programs began accepting clients in January 2022, and are now continuing with the intensive EBP training and consultation process which typically runs for 8-12 months.</p>
<p>2.e Other State requirements/policies to improve care coordination and connections to community-based care</p>	<p><i>Current Status:</i> Administrative Code He-M 405.12 Services to be Provided requires case coordination services from either the CMHC or DRF staff upon admission to a DRF and continuing through discharge.</p> <p>NH is undergoing the early stages of an Event Notification System (ENS) implementation, which connects a patient’s entire care team — including hospitals, primary and specialty care, post-acute care, behavioral health providers, community service organizations, and health plans — by offering real-time patient insights that power better decision-making for improved patient outcomes.</p> <p>DHHS encourages education on safe practices for discharging of mental health individuals between clinical teams and mental health professionals.</p> <p>MCO contracts have quality and oversight reporting requirements for “member discharges from a community hospital with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a</p>

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	<p>mental health practitioner within 7 calendar days of discharge”.</p>
	<p><i>Future Status:</i> The ENS implementation requires more complete engagement from all stakeholders in the state to fully utilize the benefits to coordinate care. All EDs, DRFs, CMHCs, and NHH will enter data necessary to expedite care as patients move between levels of care.</p>
	<p><i>Summary of Actions Needed:</i> The State has drafted and is conducting final review of an advanced planning document to support the design, development, and implementation of the event notification system as a statewide initiative to support improved care coordination. As part of this implementation, DHHS plans to leverage the Contractor for provider engagement and interoperability. This will also include the implementation of a steering committee for the network of event notification and outcome-based referrals. This committee will provide governance and approvals for enhancements. A provider network user group committee will also support the continued growth and enhancement recommendations.</p>

Prompts	Summary
<p>SMI/SED. Topic 3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services</p>	<p><i>Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.</i></p>
<p>Access to Continuum of Care Including Crisis Stabilization</p> <p>3.a The state’s strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization,</p>	<p><i>Current Status:</i> Since 2013 the State has operated a Medicaid Managed Care Program for Medicaid eligible beneficiaries delivered through commercial MCOs with several minor carve-out populations. Currently, DHHS contracts with three MCOs that provide Medicaid benefits, including behavioral health services, to recipients in exchange for a monthly payment from the state. In addition to providing Medicaid benefits to eligible recipients, the MCOs are also required to ensure the availability of mental health providers. MCOs manage and ensure all members receive primary behavioral health care through PCPs and other practitioners connected with a variety of community-based providers. MCOs are required by contract to meet network adequacy</p>

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<p>residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state’s demonstration application. The content of annual assessments should be reported in the state’s annual demonstration monitoring reports.</p>	<p>standards for all geographic regions and provider types (e.g. PCPs, specialists, family planning providers, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), hospitals, and mental health and SUD providers).</p> <ul style="list-style-type: none"> • Each MCO is required to prepare and submit a Participating Provider report during the Readiness Review period in a format prescribed by DHHS for determination of the MCO’s network adequacy. The report identifies fully credentialed and contracted providers and prospective participating providers. • MCOs are required to confirm their provider networks with DHHS and post them to their websites within 30 days of the member enrollment period. • MCOs are subject to corrective action plans to restore network adequacy. • MCOs are required to provide the count and percent of member requests for assistance accessing MCO Designated Primary Care Providers per average 1,000 members by county on a quarterly basis. • Should providers give notice, have been issued notice, or left the MCO network, MCOs are required to provide the number of members impacted, impact to network adequacy, and transition plan if necessary. <p>The network adequacy standards in the State are outlined in the MCO contracts, including but not limited to:</p> <ul style="list-style-type: none"> • Requirements regarding having Participating Providers in sufficient numbers, and with sufficient capacity and expertise for all covered services. • Requirements to maintain an adequate network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. <p><i>Future Status:</i> DHHS will monitor the provider network through the annual completion of the CMS-designated Provider Availability Assessment Template.</p> <p><i>Summary of Actions Needed:</i> By completing the CMS-designated Provider Availability Assessment, the State will fulfill the requirements of this milestone.</p>
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Prompts	Summary
<p>3.b Financing plan</p>	<p><i>Current Status:</i> Please refer to Financing Plan below.</p> <p><i>Future Status:</i> Please refer to Financing Plan below.</p>

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	<p><i>Summary of Actions Needed:</i> Please refer to Financing Plan below.</p>
<p>3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds</p>	<p><i>Current Status:</i> DHHS currently tracks psychiatric beds in a public daily, point-in-time report of DRF. Information tracked includes the following:</p> <ul style="list-style-type: none"> • Facility name; • Total number of Involuntary Emergency Psychiatric Beds; • Current Unit cap; • Available Involuntary Emergency Psychiatric Beds; and • Number of Adults or Individuals Waiting for a DRF Bed. <p>In addition to the public report, DHHS also maintains a Bed Inventory that tracks hospital-based voluntary beds. The State of NH also currently utilizes a web-based portal for bed tracking.</p> <p>NHH admissions staff play a key role in bed tracking and communicate with Emergency Departments (ED), Emergency Services Clinicians, and DRFs multiple times throughout the day regarding queue updates. NHH staff call every ED several times each day to confirm if patients referred to NHH are still waiting for a DRF bed. Staff also call all DRFs each day to determine unit census and bed availability, and update this data daily on the DHHS website.</p> <p><i>Future Status:</i> The State of NH will continue utilizing a web-based portal for bed tracking to monitor various types of bed capacity throughout the state. In the short-term, NHH and Hampstead Hospitals will be the only IMDs participating in the demonstration and will continue to communicate daily with EDs and DRFs regarding the waitlist and bed availability.</p> <p><i>Summary of Actions Needed:</i> DHHS is exploring options with one or more additional IMD provider(s) to build a facility in the State and anticipates that this additional capacity will mitigate the need for waitlisting individuals.</p>
<p>3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay</p>	<p><i>Current Status:</i> DHHS requires an Adults Needs and Strengths Assessment (ANSA), or an equivalent evidence-based tool, to be completed for every adult. These requirements are incorporated into MCO and CMHC contracts, which require initial and updated care plans to be based on a comprehensive assessment conducted using an evidenced-based assessment tool such as the NH version of the Child and Adolescent Needs and Strengths (CANS) and the ANSA.</p> <p>These assessments inform individualized treatment planning and level of care decision making. Individuals are</p>

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	<p>reassessed on a routine basis with adjustments to level of care and or treatment plan being made accordingly. The ANSA also informs individual service needs and level of care that could include inpatient and/or residential services.</p> <p>As part of the State’s rollout of the federal 9-8-8 behavioral health crisis number, BMHS launched an initiative (described further in 3.e) to redesign and centralize the State’s crisis response system into a program called the Rapid Response Access Point. Part of this program’s responsibilities is to provide an initial assessment for each individual who calls to determine the nature of crisis. The operator engages each individual in brief phone-based counseling and intervention to determine the individual’s appropriate level of need, and to attempt to resolve each situation using tools such as the Patient Health Questionnaire 9 for Depression (PHQ-9), the Mood Disorder Questionnaire (MDQ), the Adverse Childhood Experiences (ACEs) questionnaire, a lethality assessment tool, the Drug Abuse Screening Test (DAST-10), an alcohol use disorder identification test, and other recognized tools for determining the nature of a behavioral health crisis.</p> <p>In addition to the tools above, the state has also contracted with a vendor to provide Comprehensive Assessments for Treatment (CATs) to determine whether children, youth, or young adults are in need of behavioral health residential treatment services and the least restrictive and most appropriate level of care. The vendor is required to conduct interviews using other behavioral health screening tools including, but not limited to: Columbia Suicide Severity Rating Scale (C-SSRS); Patient Health Questionnaire-9 (PHQ-9); Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT); and Juvenile Sex Offender Protocol (JSOP).</p> <p><i>Future Status:</i> The State plans to complete 9-8-8 integration by the national integration date of July 16, 2022.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone met.</p>
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Prompts	Summary
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	<p><i>Current Status:</i> Currently only three regions operate mobile crisis response teams for adults with mental illness. As referenced in Topic 5. Financing Plan, DHHS has entered into a contract to establish and operate a centralized access and crisis call center via a single, statewide telephone number for individuals experiencing a mental health and/or substance use disorder crisis. The Rapid Response Access Point (RRAP) is now live. RRAP receives telephone calls, text messages, and two-way real-time chat, provides clinical crisis resolution services, and acts as a triage center for mental health and/or substance use disorders crises. The Access Point operates twenty-four hours per day, seven days per week. The</p>

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	<p>contractor performs centralized triage of incoming calls, texts, and chat messages, conducts initial assessments, brief interventions, and deploys mobile response teams to the caller’s location when necessary. The contractor also coordinates with regional crisis services, develops training curriculum, trains the Rapid Response workforce, and provides data collection services to promote consistency and quality.</p> <p>The Rapid Response Access Point serves NH residents of any age, statewide, who may be experiencing a mental health and/or substance use disorder crisis. Approximately 30,000 callers to the Access Point are expected to be served in SFY22 and SFY23.</p> <p><i>Future Status:</i> DHHS has recently included a statewide integrated mobile crisis response teams in crisis services. These teams will be expanded from three (for adults) to ten for all ages. All ten CMHCs will enhance their crisis services to ensure the delivery of integrated mobile crisis response services to individuals experiencing mental health.</p> <p><i>Summary of Actions Needed:</i> The State signed a contract with all ten CMHCs in June 2021 to provide statewide enhanced mobile crisis services. CMHCs have begun accepting deployments as of 1/1/2022 and are expected to fulfill the contract requirements for the mobile crisis services from this point on. Going forward, the Bureau of Mental Health Services will continue to monitor these services and issue corrective action plans if necessary.</p>
<p>SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration</p>	
<p><i>Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.</i></p>	
<p>Earlier Identification and Engagement in Treatment</p>	
<p>4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs</p>	<p><i>Current Status:</i> NH DHHS has several strategies to engage beneficiaries with and at risk of SMI/SED in treatment sooner. The State, CMHCs, and private providers work together to provide a comprehensive system of care for early identification and engagement in treatment. A summary of strategies and initiatives across integrated service delivery, special education, supported employment, vocational rehabilitation, and supported housing is outlined below.</p> <p>System of Care Strategy / Initiatives. In 2016, New Hampshire passed Senate Bill 534, the System of Care (SOC) law, a major policy initiative of the Children's Behavioral Health Collaborative, which embedded the system of care approach and accompanying values in RSA 135-F System of Care for Children’s Mental Health. The law requires the State to develop and maintain an</p>

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integrated and comprehensive service delivery system for children with behavioral health needs. Ten CMHCs and other BH providers participate in the SOC initiative. Major initiatives under SoC include, but are not limited to:

- **DHHS Initiatives**
 - **NH Families and Systems Together (FAST) Forward for Children and Youth:** Awarded by SAMSHA to DHHS in 2012, this program supports the expansion and sustainability of a state-level SOC for children, youth, and their families in seven school districts. As of 2017, FAST Forward has been supported by a Care Management Entity (CME) that provides services for the FAST forward program including, but not limited to: oversight and care coordination for children and youth entering/exiting psychiatric hospitalization and/or residential treatment, wraparound coordination and coordinator training, provision of youth peer support, and provision of stipends for customizable goods and services. The CME also contracts with many qualifying provider agencies to ensure children, youth and families have what they need when they need it. In the past year, DHHS has expanded from one contracted CME to two.
- **Department of Education (DOE) Initiatives**
 - Adoption of NH DOE's MTSS-B model⁶ through a SOC grant (awarded 2016), which includes comprehensive early access screening, an integrated delivery system, a tiered prevention network, and other non-Medicaid billable services.
 - **Project Aware (2014-2020)**⁷ which expanded MTSS-B to an additional 12 schools and early childhood settings in NH's North Country and Lakes Region.
 - **School Climate Transformation Grant (2019-2024):** The NH Department of Education, through its SEA School Climate Transformation Grant, has two primary goals: 1) to develop, enhance, and expand a statewide system to support the use of NH's MTSS-B model by Local Education Agencies (LEAs) to improve school climate and 2) to support the use of best practices to promote positive school culture and climate across the state through partnerships between local communities and Office of Social & Emotional Wellness staff, especially MTSS-B consultants, and local communities. During the reporting period, considerable progress was made in advancing these goals including developing and launching the

⁶ Multi-Tiered System of Support for Behavioral Health and Wellness Model. <https://www.education.nh.gov/who-we-are/division-of-learner-support/bureau-of-student-wellness/office-of-social-and-emotional-wellness/mtssb>.

⁷ NH Department of Education's Project AWARE initiative shared with the NH SOC the same school-based intervention framework, bringing MTSS-B to an additional set of 12 schools (later reduced to 10 by school closings) in three North Country Local Educational Agencies: Berlin, Franklin, and SAU 7. Funded by a 5-year grant from the federal Substance Abuse and Mental Health Services Administration, AWARE concluded in 2019 after serving more than 2500 children per year of its implementation, however an additional 4 year award was provided by to continue and expand this work. Like NH SOC, NH AWARE made significant advances in the capacity to support the social-emotional well-being of students, linking 76 organizations in formal interagency agreements, providing training to assist teachers and other school staff better understand student behavior and respond with trauma-informed strategies, and training more than 4600 school staff and community members in Youth Mental Health First Aid. Interviews with key informants from each district attested to AWARE resulting in less stigma attributed to emotional distress, less punitive discipline, and more supportive and trauma responsive interventions.

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first ever train-the-trainer for NH's MTSS-B model, recruiting and hiring state-level MTSS-B consultants, and delivering evidence-based external coaching support to numerous local school districts.

Special Education. Under the provision of the Individuals with Disabilities Education Act (IDEA) youth who are placed in a special education program because of a SED must have an Individual Education Plan (IEP). Many CMHC staff and programs affiliated with systems of care are actively involved in supporting families and children for whom an IEP is needed.

In addition, DHHS supports DOE with supported employment and programs:

Supported Employment. NH CMHCs deliver the following employment-related services:

- Rehabilitation for Empowerment, Education, and Work (RENEW) intervention with fidelity to transition-aged youth who qualify for state-supported community mental health services, in accordance with the UNH Institute on Disability model.
- CMHCs provide the following Evidence Based Supported Employment (EBSE) services, in accordance with the SAMHSA/Dartmouth Individual Placement and Support (IPS) model, to eligible individuals:
 - Job development;
 - Work incentive counseling;
 - Rapid job search; and
 - Follow along supports for employed clients.

The NH Bureau of Vocational Rehabilitation (BVR), under NH DOE, assists eligible NH citizens with disabilities to secure suitable competitive integrated employment and financial and personal independence by providing rehabilitation services. Services are provided through seven BVR offices. Vocational rehabilitation has a long history of providing direct and indirect services to youth with disabilities as they transition from school to work. The Bureau is committed to increasing access and improving the overall quality of services offered to school age youth.

Additionally, BVR has established a partnership with CMHCs and funded a full-time Work Incentive Benefits Counselor at each of the 10 CMHCs. The benefits counselors assist individuals with mental illness who are pursuing employment to complete applications for vocational rehabilitation services and engage in EBSE. The counselors conduct comprehensive incentives counseling to inform individuals of the impact different levels of income will have on existing benefits and what specific work incentives options individuals might use to increase financial independence, accept pay raises, or increase earned income.

Supported Housing. CMHCs complete eligibility for individuals in accordance with **He-M 401 Eligibility**

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	<p>Determination and Individual Service Planning⁸ and complete applications for Public Housing, Section 8 subsidy, and Project Rental Assistance (PRA) 811, according to their respective rules, requirements, and filing deadlines. Housing staff are located in all regions of the state to provide housing support services. This includes coordinating with and developing relationships with landlords and other vendors that provide services to individuals receiving the Housing Bridge Subsidy and coordinating housing efforts with DHHS and the New Hampshire Housing Finance Authority. CMHCs also provide supported housing services through a variety of options that range from independent apartments to community residences.</p> <p>DHHS has contracted with a Community Mental Health Center to expand the Housing Bridge program for individuals with mental illness who transitioned out of the criminal justice system. The contract enables these individuals to access the Housing Bridge program for a longer period than individuals would typically remain on the program based on their anticipated entrance into long term housing subsidy programs, such as HUD’s Section 8. It has been in place for more than two years and approximately 20 individuals had received housing subsidies to occupy their own leased apartment.</p> <p>Transitional Housing / Continuum of Care Program. The NH Division of Economic and Housing Stability (DEHS), in collaboration with Housing and Urban Development (HUD), have established a Continuum of Care (COC) program designed to assist individuals (including unaccompanied youth) and families experiencing homelessness and to provide the services needed to help such individuals move into transitional and permanent housing with the goal of long-term stability. NH has three (3) COCs: Harbor Homes (Greater Nashua), Families in Transition (FIT; Manchester) and Bureau of Housing Supports (BHS; Balance of State).</p> <p>Transitional Housing / PATH. NH DEHS also receives federal funding for SAMHSA Projects for Assistance in Transition from Homelessness (PATH) that provides homeless street outreach for individuals experiencing homelessness who have a diagnosis of SMI.</p>
	<p><i>Future Status:</i> NH DHHS will continue operation of existing services.</p> <p>System of Care Strategy. In accordance with both RSA 135-F, which established the SOC, and RSA 132:13, which supports services for maternal and infant needs, NH DHHS and stakeholders participated in an infant and early childhood finance strategy technical assistance group through the Zero to Three national policy organization. This work</p>

⁸ Through a psychiatrist, psychologist, pastoral psychotherapist, clinical social worker, a certified nurse or registered nurse, clinical mental health counselor, or marriage and family therapist.

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	<p>included a work plan on how NH would address and finance these initiatives. The goals are to develop a comprehensive Medicaid benefit to address the needs of infants and young children who have been identified as at risk and who require treatment and support for themselves and their primary caregiver.</p> <p>This Medicaid Benefit will amend NH’s current 1915i State Plan Amendment to include the 0-5 age group and their caregivers (known as Fast Forward in NH). There are 2 proposed amendments to the current Care Management Entity (CME) contracts, which will serve as the intermediary to deliver this new programming. The components of the Infant Mental Health Programming will include Enhanced Care Coordination (ECC), and Evidence based practices (EBP)- such as Child Parent Psychotherapy (CPP). There is a training schedule to increase the ability for the workforce to appropriately diagnose this age group and more effectively meet their targeted treatment needs with both Diagnostic Criteria (DC 0-5) and CPP. There will be an additional component within the program for an in-home/home visiting model for the highest level of need within the enrolled clients. The CME contracts amendments are targeted for approval by May 2022. This will allow for services to begin with clients by July 2022.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone met.</p>
<p>4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment</p>	<p><i>Current Status:</i></p> <p>Currently, the State operates the ProHealth NH grant (2019 through 2024) which aims to improve primary and behavioral health service delivery in NH with the following highlights (as of September 2020) related to integration of behavioral health care in non-specialty settings:</p> <ul style="list-style-type: none"> • Integrated primary and behavioral health care is available at community mental centers for youth and young adults in three of ten regions in NH, with nearly 250 (249) individuals ages 16 to 39 years served in the first year and half of enrollment. • All individuals enrolled and receiving integrated services through ProHealth NH are receiving mental health services. • The CMHCs and FQHCs collect individual health and demographic information to improve outcomes. • The BMHS, CMHCs, and FQHCs have 20 additional full time equivalents of staff time collectively to augment Medicaid and insurance reimbursement in support of integration activities. • Staff are cross-trained in evidence-based whole-person health. Over 1,200 (1,201) staff from health settings across NH participated in 115 training opportunities, including two conferences in collaboration with the Integrated Delivery Network. • Integrated teams continuously improve services with peer experts and quality improvement staff.

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- State and regional plans, policies, and procedures include language to support integrated care. Efforts to sustain integration have resulted in 46 policy-related changes throughout the partnerships and at the state.
- Tobacco interventions are available, including web-based motivational enhancement for tobacco and vaping prevention, Breathe Well Live Well in person or virtually, Quitline NH by phone, and Mylifemyquit via the web.
- Fitness and nutrition interventions are available, including Healthy Choices Health Changes in person and virtually and the Weight Watchers and Myfitnesspal web apps.
- An integrated care sustainability plan has been drafted by the ProHealth NH Administrator in collaboration with the partnerships and is being used to inform ongoing sustainability. Each partnership has completed their own individual sustainability plans, which are actively being utilized for their individual sites.
- The CMHCs and FQHCs deliver high quality integrated care, including evidence-based screening, collocation, team meetings, health and wellness goals in treatment plans, integrated shared plans, population health initiatives, and evidence-based interventions.
- The CMHCS and FQHCs provide whole health services in person and virtually using telehealth technology.
- The CMHCs staff peer experts and community health workers that represent the diverse individuals served.

Behavioral Health Integration in School Settings. Funding opportunities through DOE have worked to expand the number of mental health staff integrated in school settings. The presence of community mental health providers as a “regular” part of the school community and culture was viewed as reducing mental health stigma. Students openly talked with each other about seeing school-based mental health providers. NH AWARE was also credited, along with other MTSS-B and SOC initiatives, with contributing to a more supportive community and state policy environment. Stakeholders reported that these projects, by bringing together schools and communities via Community Management Teams and other collaborations, improved community awareness and support for social and emotional learning (SEL) and children’s behavioral health. This, in turn, was viewed as supporting passage of the “System of Care” bill (**RSA 135-F**), which requires NH DOE and DHHS to work together to create a better, more cohesive system of care for NH youth with behavioral health needs.

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	<p>The State contracts with MCOs that are required by contract to screen for mental health conditions:</p> <ul style="list-style-type: none"> • MCOs are required to make a Welcome Call to new members within 30 calendar days, which should include a screening for depression, mood, suicidality, and Substance Use Disorder (SUD). • In addition, MCOs are required to ensure that providers under contract to provide SUD services shall conduct an Initial Eligibility Screening for services as soon as possible, ideally at the time of first contact with the member / beneficiary. If screened positive, members will receive an ASAM LOC Assessment and a clinical evaluation. • MCOs are required to conduct a Health Risk Assessment (HRA) Screening of all existing and newly enrolled members within 90 calendar days to identify members with unmet health care needs and/or special health care needs. Part of this health screen must include, at minimum, questions about behavioral health needs including “depression or other Substance Use Disorders” [<i>sic</i>].⁹ The State’s MCO contracts include rewards (incentives) for high performance and penalties (liquidated damages) for low performance on completion of the HRA Screening. • MCOs are also required to help members arrange Wellness Visits with the members’ PCPs which include a) appropriate assessments of both physical and behavioral health and b) screening for depression, mood, suicidality, and SUD. <p><i>Future Status:</i> In addition to the continued operation of the same programs above with participating centers, the State also plans to explore implementing the Certified Community Behavioral Health Clinic (CCBHC) model across NH as part of an approach to extend ProHealth-like capabilities across the state in a sustainable way. The State issued an RFP on March 7, 2022 seeking a vendor to study the readiness, capability, and cost-effectiveness of implementing a CCBHC model of services across the NH community mental health system. Responses are due on April 19, 2022.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone met.</p>
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Prompts	Summary
4.c Establishment of specialized settings and services, including crisis	<p><i>Current Status:</i> NH Crisis Response System. As referenced in the Provider Availability Assessment Template and in F.a, the State presently has crisis stabilization services which include but is not limited to:</p>

⁹ As described in sections, including but not limited to, Section 4.11.1.16 (Comprehensive Assessment and Care Plans for Behavioral Health Needs), Section 4.11.5.4 (Comprehensive Assessment and Care Plans), and Section 4.11.6.6 (Provision of Substance Use Disorder Services).

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<p>stabilization, for young people experiencing SED/SMI</p>	<ul style="list-style-type: none">• 33 Crisis Call Centers – Including emergency services hotlines at the CMHCs, Mobile Crisis Response Team hotlines, Lifeline Hotlines, Doorway Numbers, and National Hotlines advertised in NH (Veterans Crisis, Trevor Project, Crisis Text Line, Translifeline, Disaster Distress Helpline, LGBT National Help Center, and 9-1-1).• 3 Mobile Crisis Units (MCU) – There are three mobile crisis units in Nashua, Concord, and Manchester with ongoing plans to expand to all 10 CMHCs within the next year. Each unit is staffed with 24/7 available teams that may receive referrals, and respond to/with, first responders and law enforcement staff of the applicable community. This communication is bidirectional; each unit can support, or be supported by, local law enforcement.• Drug and Mental Health Courts – The State has specialty court programs for offenders with substance abuse or mental health diagnoses, which are available in various Superior and Circuit Court District Division locations in New Hampshire. These treatment courts combine community-based treatment programs with strict court supervision and progressive incentives and sanctions. By linking offenders to treatment services, these programs aim to address offender's substance abuse and mental health diagnoses that led to criminal behavior, thereby reducing recidivism, and protecting public safety. These treatment court programs are designed to promote compliance with treatment programs as an alternative to jail time.• 4 Crisis Observation/Assessment Centers – Each MCU has four corresponding crisis apartment beds. Additionally, one standalone Behavioral Health Crisis Treatment Center (BHCTC) provides emergency services with limited walk-in capacity.• 1 Coordinated Community Crisis Response Teams – The State maintains a Disaster Behavioral Health Response Team. The Governor or designee at the Department of Health and Human Services-Emergency Services Unit activates this team during Federal or State Emergencies. If an emergency is not declared, local municipalities or emergency response systems may request assistance in order to meet the behavioral health needs of communities in local crises. <p>NH Rapid Response Model. The State is in the process of implementing a Rapid Response Model with one statewide access point & call center that provides initial assessments, de-escalation and resolution services, mobile rapid response dispatch services, referrals to location-based face-to-face rapid response services, post-crisis support, and referrals for ongoing services through the Doorways and outpatient mental health and SUD providers. In this model, staff are mobile/deployed to facilitate community-based face-to-face interventions. This would ensure availability of a location-based, drop-in behavioral health treatment location, allowing for stays of up to 23 hours for crisis intervention. The State has contracted with a vendor that was selected through a competitive Request for Proposals (RFP) process.</p> <p>NH COVID-19 Rapid Crisis Response Program (NH Rapid Response). As mentioned below in F.a, in April 2020 NH was awarded temporary funding due to COVID-19 from SAMHSA to expand crisis response services for children, youth, and adults.</p>
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Future Status:

Statewide Mobile Crisis Services for Children. The State has amended all ten CMHC contracts to expand mobile crisis services statewide for all ages. As of January 2022, the new CMHC contracts are in effect, including statewide mobile crisis services in all ten regions, inclusive of all age groups. This expansion is in alignment with the statewide New Hampshire Rapid Response crisis transformation plan which includes integrated crisis services for all populations across the state.

Expansion of Residential Treatment. From June – September 2021, DHHS signed contracts with 16 vendors to provide behavioral health residential treatment services for children, youth and young adults to stabilize their behavioral health. The Residential Treatment programs are contracted and/or certified for the provision of residential treatment for children from DCYF or BCBH. Programs certified prior to the September 2021 contracts already have established licensing. Newly contracted programs, including programs which were previously licensed that have been awarded contracts and are seeking certification, as well as the newly established programs, are currently in the process of being certified as a part of the initial stages of implementation.

There are:

83 certified programs,
of those 83 programs 44 are contracted (16 vendors) and
of those 44 contracted programs,
32 are in New Hampshire and
12 are in New England.

There are two new programs which are seeking licensure in New Hampshire and those will encompass two 12 bed programs; the remainder of the New Hampshire and New England contracted programs have existing licenses.

The procurement of the residential treatment contracts was intended to reduce the use of psychiatric, emergency room or national providers. There were 496 beds contracted for in the last procurement, with 16 beds already under contract in a separate procurement, resulting in 512 total beds under contract with DHHS.

Residential treatment in New Hampshire has historically been available only through DCYF and school districts. The system itself has focused on the concept of placement and education with a lower level of care for the treatment aspect of this service. By aligning the delivery with the Families First Prevention Services Act (FFPSA) guidance, residential treatment in New Hampshire can be transitioned to a model of effective shorter-term treatment and stabilization in the system of care that is available to all children and youth who require that level of care without engaging with DCYF. This

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	<p>is also intended to help children and youth avoid or decrease the use of psychiatric hospitals or emergency rooms.</p> <p><i>Summary of Actions Needed:</i> In general, NH DHHS will need to conduct ongoing monitoring to ensure that the contracts for the new structures and programs described above are implemented in a high-quality manner.</p> <p>Residential treatment services shall be licensed and certified within 6 months from contract approval, unless otherwise agreed upon by DHHS.</p>
<p>4.d Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people</p>	<p><i>Current Status:</i> Aside from the programs, strategies, and initiatives already mentioned, NH DHHS has implemented the following state strategies.</p> <p>The First Episode Psychosis (FEP)/Early Serious Mental Illness (ESMI) Initiative. Bureau for Children's Behavioral Health (BCBH) and BMHS are in the process of planning a needs assessment and work with stakeholders to identify a model for statewide implementation of a First Episode Psychosis specialty care program. In the meantime, the State maintains the Nashua region based program for First Episode Psychosis (FEP). Starting in July of 2021 three (3) additional programs within the Derry, Seacoast, and Monadnock regions began standing up their services. By increasing the availability of FEP programs throughout the state, the State will increase the likelihood of identifying an individual during their first psychotic episode and providing intense, targeted services that lead to a decrease in psychiatric hospital stays.</p> <p>Creating Connections NH: A treatment and recovery system of care for youth and young adults with substance use disorders (SUD) or SUD with co-occurring mental health disorders. This initiative is funded through a Cooperative Agreement between BCBH and the Adolescent and Transitional Aged Youth Treatment Implementation grant program administered by SAMHSA. Awarded in 2017, the grant supports evidence-based SUD assessment, treatment, and recovery services for youth aged 12-25. The NH Bureau for Children's Behavioral Health leads the project in collaboration with family, youth, research, and content experts.</p> <p>Launch Manchester. Coordinated by a local FQHC, Launch (Linking Actions for Unmet Needs in Children's Health) promotes the well-being of children (birth through age 8) and their families in collaboration with multiple local child and family serving agencies. The primary strategies employed by Launch are: improving access to high-quality early education and care; empowering families; identifying and mitigating the effects of Adverse Child Experiences; and improving access to health, behavioral health, and specialized medical services. In 2019, Launch Manchester developed an Early Learning Collaborative of 12 early childhood programs and the Manchester School District to support transitions</p>

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	<p>into kindergarten, implement developmental screenings, and facilitate access to appropriate supports. The hope is that coordinating transitions will maximize the preservation and expansion of academic and developmental skills these children have attained in early childhood settings. Also in 2019, Launch laid the groundwork for a public awareness campaign through early childhood settings, primary care offices, hospitals and other public spaces.</p> <p>Mobile App GoodLife. DOE has partnered with a technology company to begin the planning and development of GoodLife, a mobile application designed to build and strengthen student social and emotional resilience. The GoodLife app’s design will ensure that all students across New Hampshire and their families have access to evidence-based resilience cultivation tools. It aligns with the SOC values by providing a youth-driven platform where adolescents are empowered to set goals, join communities of support, and share positive messages with their peers.</p> <p>The app will additionally be trauma-informed in accordance with the SOC values, and builds resilience skills in youth such as empowerment, support, commitment to learning, and positive identity. The app will allow students to join communities, set physical and emotional development goals, and send and receive positive feedback. The GoodLife app is built on the Search Institute’s 40 Developmental Assets for Adolescents, a list of research-based, positive experiences and qualities that influence young people’s development, helping them become caring, responsible, and productive adults. GoodLife anonymizes the identity of users, and does not collect any personally-identifiable information. GoodLife is available free to all NH youth and their families through Google Play and the Apple App Store.</p> <p>Project GROW. Through a Learning Community effort known as Project GROW (Generating Resilience, Outcomes, and Wellness), the NH DOE’s Bureau of Student Wellness – Office of Social Emotional Wellness (OSEW) has been providing expert training, consultation, and technical assistance to school districts in MTSS-B aligned, trauma-responsive practices, including district-wide systems change, school-level adoption of new practices and procedures, classroom-level instructional and student support techniques, and individual teacher and specialist professional development. These Project GROW efforts are all designed to promote student social and emotional safety, and thus contribute to the Children’s SOC ecosystem.</p> <p><i>Future Status:</i> N/A – milestone met.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone met.</p>
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Prompts	Summary
SMI/SED.Topic_5. Financing Plan	

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State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.

F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.

Current Status:
NH Crisis Response System. As referenced in the Provider Availability Assessment Template and in 4.c (in greater detail), the State presently has crisis stabilization services which include but is not limited to:

- 33 Crisis Call Centers
- 3 Mobile Crisis Units (MCU)
- Drug and Mental Health Courts
- 4 Crisis Observation/Assessment Centers
- 1 Coordinated Community Crisis Response Teams

To build upon the existing system, the State has recently invested in the following coordinated crisis response initiatives:

1. **NH COVID-19 Rapid Crisis Response Program (NH Rapid Response).** In April 2020, NH was awarded temporary funding due to COVID-19 from SAMHSA to expand crisis response services for children, youth, and adults. The \$2M Rapid Response grant award addresses the needs of uninsured or underinsured individuals with SMI/SED or SUD through the State's existing community mental health system which includes the 10 CHMCs. The program also provided crisis services for other individuals in need of behavioral health supports, including health care personnel.
2. **Centralized Access and Crisis Call Center.** The State has allocated \$9.2M through SFY23 in support of establishing and operating a centralized access and crisis call center via a single, statewide telephone number for individuals experiencing a mental health and/or substance use disorder crisis.
3. **Mobile Crisis Teams.** The State has allocated \$13.2M annually toward the statewide expansion of mobile crisis teams from three to ten teams for SFY22 and SFY23. The expanded statewide service will serve all populations to address all behavioral health needs.

The state has promoted access and coordination through the following changes in funding and reimbursement:

1. **Directed Payments.** NH DHHS received authorization from CMS to pay interim enhanced rates to eligible CMHPs for select adult services to improve access and coordination. These directed payments were effective in SFY19 and SFY 20 and subject to the following limits in each state fiscal year:
 - a. \$3M – Assertive Community Treatment (ACT) Services – payments to improve access and support ACT program fidelity.
 - b. \$1.2M – NHH Discharges – payments for a face-to-face service the same-day/next-day of discharge

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- from NHH to enhance care coordination for transitions.
 - c. \$200K – Specialty Residential Services – to support specialized services for individuals who have co-occurring mental health and developmental disabilities.
 - d. \$600K – Mobile Crisis Teams – to support face-to-face crisis response services provided by mobile crisis teams (e.g., MCUs).
2. For SFY21, the directed payments were as follows:
- a. \$3M– ACT – to strengthen and maintain fidelity to enhance quality of care.
 - b. \$1.2M – NHH Discharges – to reduce the 30-day and 90-day readmission rates.
 - c. \$200K – Specialty Residential Services – to improve quality of care by encouraging inpatient discharge when medically appropriate for patients with co-occurring disorders and DD who need a less acute level of care.
 - d. \$600K – Mobile Crisis Teams – crisis intervention for adults with primary mental health but also those with co-occurring mental health and substance use disorders.
3. For SFY22, the directed payments are as proposed (subject to CMS approval):
- e. \$2.4M – ACT – to strengthen and maintain fidelity to enhance quality of care.
 - f. \$1.2M – NHH Discharges – reduce the 30-day and 90-day readmission rates to a DRF or NHH.
 - g. \$650K – Timely Prescriber Services Following Intake – to reduce ED visits and readmissions by emphasis on early contact upon intake.
 - h. \$600K – Illness Management and Recovery Services (IMR) – to reduce ED visits and readmissions.
 - i. \$200K – Specialty Residential Services – to improve quality of care by encouraging inpatient discharge when medically appropriate for patients with co-occurring disorders and DD who need a less acute level of care.

Future Status:

The State has implemented a system transformation for statewide integrated crisis response services (NH Rapid Response). This transformation includes two core components: a singular NH Rapid Response Access Point, which is a crisis call center with 1 statewide number (screen calls, complete initial assessments, triage, deploy mobile response, and provide information and referral services) that launched January 1, 2022; and regional Rapid Response/Mobile Crisis Response Teams (RR/MCRT; at least one team in each CMHC region in the State), which launched July 1, 2021 with teams initially responding to calls coming from within their applicable regional crisis hotlines. This legislatively-approved and -funded transformation fundamentally shifts NH’s crisis response services from primarily being a hospital-based ED- delivered system to a mobile crisis team-delivered service provided directly to individuals within the community where they are at (e.g. home, work, etc.). This transformation incorporates an approach that meets the requirements necessary to draw down enhanced federal funding envisioned in the American Rescue Plan Act, as well as expanded community-based stabilization supports. These expanded stabilization supports include: capacity for walk-in stabilization and peer living room models that may also serve as a drop-off location for first responders, crisis apartment

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	<p>beds, follow-up phone contact for all who interact with the crisis system, in-home and out-of-home options for brief services after the crisis response, and access to 60 new community-based supported housing beds (six per region) for those who may need longer term supported housing.</p> <p>DHHS is working on training for first responders to better understand responses to behavioral health emergencies. First Responders are close partners on the NH 988 Planning and Implementation Coalition as well as having a specific First Responder subcommittee. First Responders are also involved in regional meetings with the Community Mental Health Centers and the Rapid Response Access Point. Additionally, DHHS is working with first responders; including 911, state and local police, fire, and EMS; in close partnership with the Department of Justice and Department of Safety, to better collaborate on when mobile crisis response teams deploy and when a first responder response is needed. With the approval of increased funding for mental health services in the state, including statewide mobile crisis services, CMHCs in New Hampshire will be better equipped to implement a vision that is: recovery-oriented, trauma-informed, integrates peer staff, aligned with suicide care best practices, committed to safety, available to children and adults, includes integrated mental health and substance use care, and has collective and cooperative coverage.</p> <p>In addition, the State has secured an additional \$2.6M and an extension of the NH COVID-19 Rapid Crisis Response Program and anticipates continuing providing crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for youth and adults impacted by the COVID-19 pandemic.</p> <p>Finally, the crisis response system transformation includes transitioning 33 crisis call lines, which are currently maintained by various providers in regions across the state, to an integrated call model that will meet the federal mandate to shift to 9-8-8 in July 2022. This effort maximizes collaboration between the National Suicide Prevention Lifeline, with the State’s provider also being empowered to directly connect callers with the Veterans Crisis Line or the Rapid Response Access Point, as applicable to the caller’s needs, and ensuring real-time linkage to meet their behavioral health crisis response needs, whether child or adult.</p> <p><i>Summary of Actions Needed:</i> The Rapid Response Access Point call center launched January 1, 2022, and the Rapid Response Access Point and all crisis call center lines will be integrated with 9-8-8 on July 16, 2022.</p>
<p>F.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment,</p>	<p><i>Current Status:</i> Increased CMHC and Mobile Crisis Funding. As noted throughout this template, and as outlined in the Provider Availability Assessment, NH offers a comprehensive continuum of community-based services. For the SFY22 / SFY23 biennium, DHHS received funding to allocate \$52.4M (Federal and General Funds) to the ten CMHCs. This represents a \$24.5M increase over the prior contract. Part of this funding will be for statewide mobile crisis services. As part of their contract, CMHCs are required to stand up an additional six beds per region (60 statewide) for supported housing</p>

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<p>assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.</p>	<p>for individuals with SMI.</p> <p>Assertive Community Treatment. The State continues to support ACT services through the existing CMHC contracts. There were 1,234 unique clients receiving ACT services at CMHCs between 4/1/2020 and 3/31/2021. In addition, the CMHCs screened 8,935 unique clients not already receiving ACT services from 10/2020-12/2020 and 8,899 from 07/2020-09/2020. The CMHCs provided ACT services to 95 new clients between 10/2020-12/2020 and 132 new clients between 1/2021-3/2021.</p> <p>Partial Hospitalization / Day Treatment. The State is exploring ways to assess more precisely which providers currently offer Intensive Outpatient Programs (IOPs)/Partial Hospitalization Programs (PHPs). The State’s current understanding is that five of the ten CMHCs currently maintain, or partner with hospitals to maintain, IOPs/PHPs with behavioral health services. This is an area of continued interest and potential expansion.</p> <ul style="list-style-type: none"> • Intensive Outpatient Treatment – There are three intensive outpatient treatment programs in New Hampshire. • Partial Hospitalization – There are three restorative partial hospitalization programs in New Hampshire. <p>Certified Community Behavioral Health Clinics. The Mental Health Center of Greater Manchester (MHCGM) is the recipient of a \$4 million grant from SAMHSA, to implement a comprehensive mental health and substance use treatment program by becoming a Certified Community Behavioral Health Clinic (CCBHC). The population of MHCGM’s service area makes up about 15% of the population of NH, while 56% of clients are from medically underserved areas.</p> <p>The State issued an RFP on March 7, 2022 seeking a vendor to study the readiness, capability, and cost-effectiveness of implementing a CCBHC model of services across the NH community mental health system. The State received responses on April 19, 2022.</p> <p><i>Future Status:</i></p> <p>In addition to the continued operation and expansion of existing programs, the State is currently implementing Critical Time Intervention. CTI is a time-limited, evidence- and community-based practice that mobilizes support for individuals with serious mental illness during vulnerable periods of transition (e.g., discharge from a psychiatric hospital). CTI providers work with transitioning individuals to ensure they successfully reintegrate into their home communities. This can entail a broad range of assistance, from helping an individual secure employment, housing, or food; to identifying and accessing mental or physical health care; to reconnecting with family, friends, and peers to ensure strong, supportive relationships. CTI is backed by \$4.2M in state and federal funding for SFY22 and SFY23.</p> <p>CMHCs are contractually required to stand up 54 of the 60 transitional beds by April 2, 2022. The final 6 beds are contractually required by 12/2022.</p>
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	<p>DBH will also assess which providers offer IOP and PHP services and create an inventory.</p>
	<p><i>Summary of Actions Needed:</i> The State plans to monitor the operations of existing programs and ensure oversight over the implementation of new programs like CTI.</p> <p>Phase one CMHCs are in the process of finalizing their content, staffing, and training materials and launched CTI services in January 2022. Strategy development for contracts with the phase two CMHCs has begun, and CTI will be launched across all 10 CMHCs by July 2022.</p> <p>DHHS will select a vendor to study the readiness, capability, and cost-effectiveness of implementing a CCBHC model of services across the NH community mental health system by April 26, 2022. Once a vendor has been selected, DHHS will commence negotiating definitive terms of the contract, the final version of which will require approval by the Governor & Executive Council (G&C). The vendor will approach the study in two phases, with Phase 1 being the analysis of the NH service system which is projected to last nine months from the date of contract approval by G&C. Contingent upon the outcome of Phase 1, Phase 2 will continue into year two and support the development and implementation planning of the CCBHC model.</p> <p>DBH will survey CMHC and hospital providers to create an inventory of IOP and PHP services by 12/30/2022.</p>

Prompts	Summary
<p>SMI/SED. Topic_6. Health IT Plan</p>	<p><i>As outlined in State Medicaid Director Letter (SMDL) #18-011, “[s]tates seeking approval of an SMI/SED demonstration ... will be expected to submit a Health IT Plan (“HIT Plan”) that describes the state’s ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration’s goals.”¹ The HIT Plan should also describe, among other items, the:</i></p> <ul style="list-style-type: none"> • <i>Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and</i> • <i>Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.</i> <p><i>Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state’s demonstration proposal.</i></p>
<p>Statements of Assurance</p>	

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<p>Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period</p>	<p>The State of New Hampshire has an established health IT infrastructure that supports the continuum of care and measurement of the health care system. The State’s health IT infrastructure includes, but is not limited to, three managed care organizations (Well Sense, NH Health Families and AmeriHealth Caritas), an Event Notification System (ENS) for admissions, discharges and transfers (ADTs) to/from inpatient care, a statewide closed loop referral (CLR) system, an All Payer Claims Database (APCD), an aging and disability resource center (ADRC), and an integrated eligibility system (NH EASY).</p> <p>Managed Care Organizations. The State contracts with three Managed Care Organizations that file claims, perform medical necessity, and share encounter information with the State. They are responsible for managing or conducting the utilization review of health and medical records.</p> <p>Event Notification System. In partnership with seven geographically established Integrated Delivery Networks, the ENS system was implemented in New Hampshire to coordinate admission, discharge and transfer event notification to improve shared care planning for individuals. Currently, 19 of 26 hospitals’ systems and 9 of 10 Community Mental Health Centers’ (CMHC) systems have access to a platform to access and contribute to an electronic plan of care for their patients.</p> <p>Closed Loop Referral System. DHHS is planning to conduct an RFP process to secure and contract with a third-party vendor to maintain a service referral care coordination network. This network encompasses DHHS, federally qualified health centers, 10 CMHCs, nine Doorway locations, and relevant social service organizations providing single points of entry for people seeking help for substance use and/or mental health crises.</p> <p>All Payer Claims Database. The State’s APCD provides access to the majority of the claims from the commercially insured adult population in New Hampshire and provides a comparative resource for monitoring change in rates of hospitalization, emergency department visits, and community services in the Medicaid population.</p> <p>Aging and Disability Resource Center. ADRCs are a collaborative effort of the Administration on Community Living and the Centers for Medicare & Medicaid Services (CMS). ADRCs serve as single points of entry into the long-term supports and services system (LTSS) for older adults and people with disabilities of all income levels. In New Hampshire, ADRCs are called ServiceLink and are state contracted, regionally based offices and partners to help individuals: a) access and make connections to long term services and supports, b) access family caregiver information and supports, c) explore options, and d) understand and access Medicare and Medicaid. Presently, the ServiceLink contractors access New HEIGHTS and NH EASY. At this time, ServiceLink does not push eligibility information to the MMIS system or to the MCOs for enrollment.</p>
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	<p>New HEIGHTS and NH EASY. New HEIGHTS is the integrated eligibility system for NH DHHS. Eligibility programs determined within New HEIGHTS include Medicaid, TANF, SNAP, Child Care, Foster Care and more. Eligibility information such as demographics, income, resources, family composition and relationships, disability information, and much more is collected and stored in New HEIGHTS. In addition, LTSS, including eligibility for the various waiver programs, is contained within New HEIGHTS. New HEIGHTS is also the MCO enrollment broker for Medicaid. Eligibility, enrollment and client demographic information is sent to the MMIS via a nightly interface. The MMIS passes this information on to the MCOs.</p> <p>NH EASY is the online portal for clients to manage their accounts. Functionality within NH EASY includes applications for all programs in New HEIGHTS, redeterminations, change reports, etc. In addition, clients can upload documentation for their case, see what is due, read their notices, change their MCO, etc. NH EASY is tightly integrated with New HEIGHTS, so information entered in NH EASY is immediately available in New HEIGHTS.</p> <p>NH EASY also is used by providers and other community partners for a variety of reasons. Providers are able to (with client permission) act on behalf of their clients and assist them with upcoming events such as redeterminations, providing assistance with understanding notices, etc. Community partners who assist DHHS with determination for the Choices for Independence (CFI) waivers do so within NH EASY. The functionality allows both community partners within NH EASY as well as DHHS LTSS workers within New HEIGHTS to manage medical determinations for clients, as well as services they need when eligible. Dashboards are available in both systems so that there is transparency regarding the list of next steps and the key personnel assigned to each step. When services are approved by both entities, New HEIGHTS sends this information to the MMIS. This information is then passed to the MCOs.</p>
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Prompts	Summary
<p>Statement 2: Please confirm that your state’s SUD Health IT Plan is aligned with the state’s broader State Medicaid Health IT Plan and, if applicable, the state’s Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.</p>	<p>The SUD Health IT planning effort is aligned with DHHS IT planning efforts. DHHS leverages common platforms for reporting, data analytics, and analysis; is working on a standard case management platform; and, where necessary, is working towards interoperability between systems.</p>

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<p>Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)² and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state’s Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.</p>	<p>New Hampshire has reviewed the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B and, as a result, the MCOs who operate in New Hampshire are required by contract to develop and implement a strategy to address how the Interoperability Standards Advisory standards, from the Office of the National Coordinator for Health Information Technology, informs the MCO system development and interoperability.</p>
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Prompts	Summary
	<p><i>To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states “for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers.” For more on the availability of this “HITECH funding,” please contact your CMS Regional Operations Group contact.³</i></p> <p><i>Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established “No Wrong Door System.”⁴</i></p>
<p>Closed Loop Referrals and e-Referrals (Section 1)</p>	
<p>1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider</p>	<p><i>Current State:</i> All 10 CMHCs are utilizing EHRs. Additionally, the CMHCs are utilizing an ENS implemented statewide for shared care plan coordination and secure messaging associated with EDT functions. DHHS implemented a CLR system (through a third-party vendor) and the 10 CMHCs, and an additional 40 behavioral health service providers, are engaged in utilizing the secure messaging of outcome-based referrals in conjunction with their in house EHR for clinical care.</p>

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	<p><i>Future State:</i> DHHS is planning to conduct an RFP process to secure and contract with a third-party vendor to maintain the CLR system that encompasses behavioral health providers; hospitals; federally qualified health centers (FQHCs); community-based organizations; local government, education, and justice systems; and MCOs.</p>
	<p><i>Summary of Actions Needed:</i> Additional funding to maintain the CLR system is being sought. DHHS anticipates the following preliminary target milestones for delivery:</p> <ol style="list-style-type: none"> 1. Allocation of funds – September 2021 2. Procurement and Contracting – October 2021 through July 2022 3. Finalization of network governance – September through October 2022 4. Finalization of Interoperability Standards – January 2023 5. Integration of targeted providers (CBOs, FQHC, Hospitals) geographically – September 2022 through June 2023 6. Integration of Local Government, Education and Justice systems – September 2022 through June 2023 7. Integration of Managed Care Organizations – July 2024

Prompts	Summary
<p>1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider</p>	<p><i>Current State:</i> In December 2020, DHHS implemented a CLR system (through a third-party vendor) for the community based organizations, FQHCs, CMHCs, the nine Doorways locations providing a receiving location for Substance Use Disorder (SUD) treatment, and relevant social service organizations. The CLR system was deployed and currently has over 90 providers utilizing it to obtain client consent and submit electronic referrals to providers of clinical and social services. The CLR not only supports referrals, but also focuses on ensuring the provider receives, accepts, and provides an outcome for the referral. This allowed DHHS and the network of participating providers to track the health of the network and follow up with clients when a referral was not accepted or completed. Additionally, the hospitals, institutions, clinics and mental health providers are all using an ENS with secure messaging to support ADT referrals between the EHRs employed at each provider.</p> <p><i>Future State:</i> Milestones are met for ADTs; however, the long-term goal of DHHS is to integrate the CLR system with hospitals, local government, education systems, and MCOs to complete the circle of services and opportunities to send and receive referrals, thereby eliminating labor intensive manual processes.</p> <p><i>Summary of Actions Needed:</i></p>

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	See section 1.1 summary of actions needed.
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	<p><i>Current State:</i> The CLR, described above in section 1.2, Current State, is inclusive of physician/mental health provider to community-based supports referrals.</p>
	<p><i>Future State:</i> The CLR, described above in section 1.2, Future State, is the same for section 1.3.</p>
	<p><i>Summary of Actions Needed:</i> See section 1.1 summary of actions needed.</p>
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	<p><i>Current State:</i> The current state-operated psychiatric hospital, New Hampshire Hospital (NHH), the CMHC’s systems, and the New Hampshire’s acute care hospitals (required to have event notification) can each create and use electronic care plans. NHH’s electronic care plan is accessible by the patient’s care team, including mental health providers where there is a treating relationship and the patient has consented to sharing data. NHH providers currently enter care insights to the patient care plan. These insights include level of certainty of diagnosis, treatments including medications that work well for the patient, and the insights a provider gained during the hospitalization that would have been helpful to know at admission.</p> <p>Event Notification System. In addition, the State is in the early stages of implementing ENS which is capable of supporting event notification and shared care plans. Providers can access and/or contribute to an electronic SCP and receive ADTs related to ED, urgent/immediate care, and inpatient visits through the system. Currently, 19 of 26 hospitals’ systems and 9 of 10 CMHCs’ systems have access to a platform to access and contribute to an electronic plan of care for their patients. In 2020, this includes NHH, which is a major contributor of information to the system and whose entry brings value to the rest of the partners. Also as of 2020, key accomplishments regarding ENS implementation include:</p> <ul style="list-style-type: none"> • Addition of 2 hospitals, including NHH, added to the network, bringing the total to 19 hospitals connected and contributing ADT data. • Increase of 69 ambulatory facilities on the network, bringing the total to 115 (additional facilities may have been added in the past year). Ambulatory facilities, include behavioral health clinics, Skilled Nursing Facilities (SNFs), CMHCs, and primary care providers (PCPs). • 3.66% increase in patient records viewed by ambulatory providers.

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	<ul style="list-style-type: none"> • More than 2,800 logins per months to the platform. • ED utilization dropped 2% and inpatient utilization dropped 10% statewide, March 2019-March 2020 (pre COVID-19). <p>Medicaid EHR Incentive Program. For several years, NH DHHS has also provided incentive payments to eligible professionals and eligible hospitals as they adopted, implemented, upgraded, or demonstrated meaningful use of certified EHR technology. The program, which began in 2012 and ends in 2021, encourages Certified Electronic Health Record Technology (CEHRT) for use in a meaningful manner to improve public health. From 2012 to 2017, DHHS has disbursed 45 payments to 26 eligible hospitals, the most that were eligible to participate. In the same time period, the State disbursed 445 incentive payments to 667 eligible professionals.</p> <p><i>Future State:</i> DHHS and the intended healthcare stakeholders will work to agree to promote a statewide strategy for consistent use for clinical outcome improvement and realized value. DHHS will also onboard to the platform, where there is a beneficiary HIPAA-covered treatment, payment, or operations relationship to use and contribute to electronic care plans in collaboration with providers. This strategy will include any future IMDs and psychiatric providers.</p> <p><i>Summary of Actions Needed:</i> DHHS will seek to ensure continuation of the platform and implement it further statewide. DHHS also needs to plan and execute a statewide implementation to include all providers, a strategy to standardize key components of a plan of care, and workflows that leverage the information to improve patient care.</p>
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Prompts	Summary
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	<p><i>Current State:</i> The current state is outlined in section 2.1. The early stages of ENS implementation key in on the following relationships between systems:</p> <ul style="list-style-type: none"> • NHH EHR and ENS: NHH staff manually enter record data into its EHR. NHH staff download extracts from the EHR and submit the extracts to the ENS, at least once a day. • Eligibility System and ENS: There is currently no interface between NEW HEIGHTS and ENS. NH Medicaid beneficiaries are in New Heights, and Medicaid claims are processed through MMIS. If a beneficiary seeks treatment at an emergency department (ED), the care is attributed to that hospital and both the hospital and the ED have access to the same record; MMIS will eventually

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	<p>receive data regarding received services that are paid under either Fee-for-Service or MCO. ENS, being patient focused, restricts access only to those providers who have attestation.</p> <p>The NH Medicaid program is in compliance with the current in-force CMS Interoperability and Patient Access rule requirements.</p> <p><i>Future State:</i> The State’s providers have begun leveraging the Interoperability Standards to implement ENS within the EHRs of hospitals and CMHCs, and other ambulatory systems that have joined the network. This integration will make ENS more accessible by providers, as they will not need to go through multiple systems to access the data. Providers are using the actual EHR system to pull in relevant data (SCP notes, ADT detail, etc.). Including ENS as part of their EHR allows for smoother communication between providers in a real time environment.</p> <p>More broadly, the State seeks to ensure consistent documentation in care plans for patients discharged from NHH and additions to plan of care by other providers, adding value for NH providers to access. The goal for the State is to consolidate and build an interoperable E-plan of care system to allow for the accessibility and streamlined services to be performed to include a single state network for E-referrals for services, including outcomes and a centralized resource coordination center to manage shared care plans for the State’s clients.</p> <p><i>Summary of Actions Needed:</i> Execution on a statewide plan to address key pieces of information that provide high value for continuity of care for patients. In general, there is a need to inventory the disparate systems, build an interoperability standard from/to which all systems can connect and share data, create data sharing agreements with all providers, implement an informed consent process to protect the privacy of individual’s data, implement and replace existing systems where needed (specifically the Behavioral Health SUD Treatment system), update contracts for services to leverage the new interoperability standards and systems.</p>
<p>2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications</p>	<p><i>Current State:</i> CMHCs and inpatient facilities serve both children and adults. As a result, they have an EHR that provides medical records and treatment plans to the care teams serving the individual, including during transitions from youth services to adult behavioral health services. If an individual is being served by a different provider as an adult than as a youth, then releases of information would need to be employed.</p> <p><i>Future State:</i> N/A – milestone met.</p>

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	<p><i>Summary of Actions Needed:</i> N/A – milestone requirement already met.</p>
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	<p><i>Current State:</i> See response for section 2.3 above.</p>
	<p><i>Future State:</i> N/A – milestone met.</p>
	<p><i>Summary of Actions Needed:</i> N/A – milestone requirement already met</p>

Prompts	Summary
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	<p><i>Current State:</i> All CMHCs have electronic health records that serve both children and adults. As individuals transition between systems, information pertaining to the transition can be shared between providers on an individual, case-by-case basis.</p>
	<p><i>Future State:</i> See responses for 1.1 and 1.2.</p>
	<p><i>Summary of Actions Needed:</i> See responses for 1.1 and 1.2.</p>
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42	<p><i>Current State:</i> Consent is captured on providers EHR systems as well as on the CLR system.</p>
	<p><i>Future State:</i> N/A – milestone met.</p>
	<p><i>Summary of Actions Needed:</i> N/A – milestone met.</p>

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CFR part 2 and state laws)	
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	<i>Current State:</i> All documentation is included in the provider’s EHR and, as defined in the template (notes field) for information that is agreed to be shared, is interoperable via ENS.
	<i>Future State:</i> Future interoperability between providers EHR systems and the CLR system will connect the referrals with the rest of the HIT ecosystem; the goal of the State is to take the CLR system and expand it to hospitals, local government, education systems, and MCOs to complete the circle of services and opportunities to send and receive referrals, thereby eliminating arduous manual processes.
	<i>Summary of Actions Needed:</i> See section 1.1 summary of actions needed.

Prompts	Summary
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	<p><i>Current State:</i> In July 2020, the State Legislature passed HB 1623, which greatly expanded how care providers interact with telehealth technologies. The bill:</p> <ul style="list-style-type: none"> • Ensured reimbursement parity, expands site of service, and enables all providers to provide services through telehealth for Medicaid and commercial health coverage, with limited exceptions. • Enabled access to medication assisted treatment (MAT) in specific settings by means of telehealth services. • Amended the Physicians and Surgeons Practice Act to expand the definition of telemedicine. • Amended the relevant practice acts to expand the definition of telemedicine. • Enabled the use of telehealth services to deliver Medicaid reimbursed services to schools. <p>According to RSA 167:4-d Medicaid Coverage of Telehealth Services, Medicaid provides coverage and reimbursement for health care services provided through telemedicine on the same basis as the Medicaid program provides coverage and reimbursement for health care services provided in person, with limited exceptions.</p> <p>Medicaid providers are allowed to perform health care services through all modes of telehealth, including video and audio, audio-only, or other electronic media. This includes mental health practitioners governed by RSA 330-A and psychologists governed by RSA 329-B and community mental health providers employed by CMHPs pursuant to RSA 135-C:7.</p>

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	<p>American Rescue Plan Act funds were used to pay for increased broadband connectivity for rural and HRSA-defined medically underserved areas of New Hampshire.</p> <p><i>Future State:</i> Continued operation of telehealth policy, and continued promotion of telehealth technologies, in accordance with statutes. Expansion of outreach to support medication assisted treatment providers for the treatment of opioid use / mental health disorders via telehealth.</p> <p><i>Summary of Actions Needed:</i> Evaluate long-term uptake of telehealth service provision, particularly in rural areas of the State. Evaluate the evidence to provide coverage for remote patient monitoring and store-and-forward billing codes, and consider the need for submitting a State Plan Amendment.</p>
Alerting/Analytics (Section 6)	
<p>6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment⁵)</p>	<p><i>Current State:</i> NH Administrative Code He-M 405.05 Collaboration with Community Mental Health Programs require the joint development of discharge plans and referrals for clients whom CMHPs and Designated Receiving Facilities (DRFs) both serve. The discharge plan must include information about community supports, such as peer support agencies, and the availability of family support and education, and CMHPs must offer an appointment to a discharged client to occur within 7 days of discharge.</p> <p><i>Future State:</i> As part of its Critical Time Intervention (CTI) implementation, DHHS will be working with CTI providers to ensure transitioning individuals successfully reintegrate into their home communities. This can entail a broad range of assistance, from helping an individual secure employment, housing, or food; to identifying and accessing mental or physical health care; to reconnecting with family, friends, and peers to ensure strong, supportive relationships. DHHS has developed CTI metrics for CMHCs to track key information such as appointments, readmissions, and other health and treatment metrics. CMHCs are responsible for routinely updating their clients' EHRs and should help the State better track individuals who are discharged from NHH and DRFs to ensure proper follow-up is provided.</p> <p>In addition to better visibility into discharges and follow-up, the State plans to improve linkages between its eligibility system and the CLR/ENS systems mentioned above to better identify whether patients: 1) are eligible for services, 2) have a referral, 3) have been discharged from treatment, and 4) have received follow-up. Doing so will provide the State better visibility into patient care.</p> <p>Finally, the State has recently discussed examining data from assessment tools like CANS and ANSA, which may help</p>

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	<p>identify patients who are at risk of discontinuing engagement in their treatment.</p> <p>The analytics described in this response will be used to notify the centralized resource coordination system and care teams (outlined in the Future State section of 2.2) for outreach.</p> <p>All patients have the right to consent to treatment, to their release of information, and the State will leverage the best programs and services possible in order to provide the treatment consented to by each individual. In doing so, the State will leverage the systems of care to not only analyze the information the State has, but to also provide a notification process to update the client as to their eligibility for services and how the State can help them.</p> <p><i>Summary of Actions Needed:</i> The State will need to stand up a trend-based analytics environment platform to extract the data sources outlined above, and to establish a process for care team notification.</p>
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Prompts	Summary
<p>6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis</p>	<p><i>Current State:</i> The Bureau of Children’s Behavioral Health and Bureau of Mental Health Services is in the process of planning a needs assessment and work with stakeholders to identify a model for statewide implementation of a First Episode Psychosis (FEP) specialty care program. In the meantime, the State maintains the Nashua region based program for FEP.</p> <p><i>Future State:</i> Starting in July of 2021, three additional programs within the Derry, Seacoast, and Monadnock regions began implementing FEP programs. By increasing the availability of FEP throughout the State, NH increases the likelihood of identifying an individual during their first psychotic episode and providing intense, targeted services that lead to a decrease in psychiatric hospital stays. The coordination of care is a key requirement in this effort.</p> <p>Because Nashua is the only region that has an FEP program, they currently accept clients from other regions for this specific program.</p> <p>The State anticipates CMHCs will utilize their EHRs for the coordination of care with the SCPs already implemented in the ENS. The State will leverage referrals in the CLR.</p> <p><i>Summary of Actions Needed:</i> The State is currently contracting with a technical assistance and consultation resource to assist the applicable CMHCs in implementing FEP. Any other IT needs would be identified as the State embarks upon those additional programs. In</p>

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	addition, see 1.1 for summary of actions needed.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	<i>Current State:</i> If appropriate and needed, the State is capable of linking a child's electronic medical record with that of their respective parent's or caretaker's medical record.
	<i>Future State:</i> The State's goal is to build interoperability standards to allow for providers to consume the standards subsequent to creation of necessary data sharing agreements to allow for the linkage of child's electronic medical records with their respective parent/caretaker medical records.
	<i>Summary of Actions Needed:</i> N/A – milestone met.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	<i>Current State:</i> NHH's EHR is reliable in capturing all episodes of care. When NHH's EHR links to other data systems, it is capable of providing detail at the admissions and discharge level from NHH. Episodes of care can be aggregated and summarized by individual. NHH's EHR validates data with NHH and updates old data periodically to ensure information is up-to-date.
	<i>Future State:</i> N/A – milestone met.
	<i>Summary of Actions Needed:</i> N/A – milestone met.

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Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

ATTACHMENT H:
Reserved for SMI Monitoring Protocol