Prepared by the New Hampshire
Department of Health and Human Services

New Hampshire Substance Use Disorder Treatment and Recovery Access
Section 1115(a) Research and Demonstration Waiver

February 27, 2018

Section I – Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act.

The New Hampshire Department of Health and Human Services (the "Department") is seeking a Substance Use Disorder Treatment and Recovery Access Section 1115(a) Demonstration Waiver that will allow New Hampshire to provide Medicaid payments for individuals receiving substance use disorder (SUD) services in an Institution for Mental Disease (IMD). Specifically, New Hampshire is requesting:

1) CMS waive Section 1905(a)(29)(B), 42 CFR 438.6(e), and 42 CFR 435.1010 to allow a waiver of the IMD exclusion for Medicaid-eligible individuals aged 21 to 64 receiving residential substance use disorder (SUD) treatment in an IMD for as long as is medically necessary.

2) CMS expand the exception to the IMD exclusion in 42 CFR 441.11(c)(5) to the provider type Comprehensive SUD program, as described in He-W 513.02 (b) to allow New Hampshire to claim federal financial participation (FFP) for individuals under 21 receiving residential substance use disorder treatment in these facilities for long as is medically necessary.

Expenditure authority is being requested for individuals who meet the criteria above who are either in fee-for-service or enrolled in Medicaid managed care.

This Demonstration will further the objectives of Title XIX by increasing access to residential SUD treatment services for adults and adolescents in New Hampshire.

2) Include the rationale for the Demonstration.

Rationale to allow waiver of IMD exclusion for Medicaid-eligible individuals receiving residential substance use disorder (SUD) in an IMD for as long as is medically necessary.

The Demonstration is necessary to address New Hampshire's opioid crisis and to support the state's effort to implement a comprehensive and lasting response to this epidemic. 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 impacting individuals, families, and communities throughout the state. New Hampshire currently has the third highest overdose death rate in the country (39 per 100,000).[1] Since 2010, the number of overdose deaths has increased and in 2016, it was reported that 485 people died from overdose.[2] In 2015 there were 439 total drug deaths, of which 397 deaths were caused by opiates/opioids.[3]

[1] https://www.cdc.gov/drugoverdose/data/statedeaths.html
[2] https://www.doj.nh.gov/medical-examiner/documents/drug-data-update.pdf
[3] https://www.dhhs.nh.gov/dcbcs/bdas/documents/state-response-opioid-crisis.pdf

Between 2012 and 2016, the number of times emergency medical personnel administered Narcan more than tripled, from 877 to 2,793.[4] As striking as these data are, the scope of the crisis is not conveyed only by numbers, but by data that describe the impact of the crisis on New Hampshire's children and families, public resources (law enforcement, judicial, corrections), public and private healthcare costs, and economic productivity. As with the rest of the country, New Hampshire has seen significant rises in neonatal abstinence syndrome (NAS) as a result of the opioid crisis facing the state. The rate of NAS births per 1,000 live hospital births in New Hampshire reached 24.4 per 1,000 in 2015. Babies born with NAS in NH require more complex medical care, with average hospital stays of twelve (12) days. The incidence of NAS is higher among Medicaid enrollees and Medicaid costs reflect these increased costs. In 2013, Medicaid paid for 78 percent of NAS births.[5] This impact to families and children is further supported by data from the state child welfare agency. 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.[6]

The Demonstration is necessary to address critical unmet needs for residential SUD treatment that 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 has invested more than thirty (30) million dollars over the last two years to build service capacity and invest in a full continuum of care to treat individuals with substance use disorder. 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 regional access points (RAPs). 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 major challenge.

In addition to the high rates of opioid use among the adult population, New Hampshire ranks in the top five (5) in the nation for binge drinking among 12-20 year olds.[7] According to the 2015-2016 National Survey on Drug Use and Health (NSDUH), illicit drug use among individuals aged 12-17 in NH is higher than New England and the United States. In 2015-2016, 8.98% (95% CI: 7.32-10.96) of NH individuals aged 12-17 reported illicit drug use in the past month.[8] With some of the highest rates of youth alcohol and drug use, New Hampshire lacks both the outpatient and residential capacity to serve youth who present with problems as a result of such use. The NSDUH reports that estimated 3,000 youth indicated they needed but did not receive

[4] http://millyardcommunications.com/index.php?src=news&srctype=detail&category=News&refno=7449
[5] https://scholars.unh.edu/cgi/viewcontent.cgi?article=1330&context=carsey
[6] https://www.nhbar.org/publications/display-news-issue.asp?id=8377
[7] 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/NSDUHsaePercents2016/NSDUHsaePercents2016.pdf
[8] 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 l National Drug Early Warning System l University of Maryland. [online] Ndews.umd.edu. Available at: https://ndews.umd.edu/publications/hotspot-report-understanding-opioid-overdoses-new-hampshire

treatment for illicit drug in a specialty facility in the past year.[9] Many adolescents are sent out of state to specialty treatment facilities or the progression of their disease leads them to involvement with the juvenile justice system, emergency departments, and other costly services to the state.

New Hampshire's Development and Implementation of a Comprehensive Benefit for SUD Services.

In August 2014, New Hampshire's expanded Medicaid program ("NH Health Protection Program") began offering a comprehensive benefit for SUD services to the Medicaid Expansion population. This benefit (*Table 1*) provides a full array of substance use services, which are closely aligned with American Society of Addiction Medicine (ASAM) level of care guidelines, which is a patient placement criteria that reflects evidence-based clinical treatment guidelines. On a quarterly basis, 7,500 individuals in the NH Health Protection Program receive treatment services for SUD. Beginning in July 2016, this robust SUD benefit was made available to all Medicaid enrollees, not just those in the New Hampshire Health Protection Program. In addition to expanding coverage for SUD services through Medicaid, the DHHS' Bureau of Drug and Alcohol Services ("BDAS") contracts with fifteen (15) SUD treatment providers across the state to provide substance use disorder 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.[10]

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.

[9] Center for Behavioral Health Statistics and Quality (2016). 2015-2016 National Survey on Drug Use and Health: National Surveys on Drug Use and Health: Model-Based Estimated Totals (in Thousands) . Substance Abuse and Mental Health Services Administration, Rockville, MD. https://www.samhsa.gov/data/sites/default/files/NSDUHsaeTotal2016/NSDUHsaeTotals2016.pdf

[10] https://www.dhhs.nh.gov/dcbcs/bdas/documents/mid-year-commmission.pdf

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 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

New Hampshire's Required Use of ASAM Criteria

SUD residential treatment facilities and managed care organizations in New Hampshire are required to provide services and treat patients in accordance with the current criteria adopted by ASAM. RSA 420-J:16, I and N.H. Admin. R. He-W 513.04(f). SUD providers apply ASAM criteria to determine the level of care that is medically necessary for the patient. Patients may only receive residential treatment if they are determined to meet ASAM criteria based on a clinical evaluation conducted by a qualified practitioner.

SUD Residential Treatment Resources Are Still Not Adequate

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. This is reflected in *Table 2*, which describes the current wait time for individuals seeking residential treatment at state funded treatment providers in New Hampshire.

Table 2. Wait times for ASAM Levels of Care in New Hampshire, as of February 2018

ASAM Level	Description	Waitlist (number of days)
Level 3.5	Clinically Managed High-Intensity Residential Services for adults • 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment.	28

	• Patients in this level are able to tolerate and use full active milieu or therapeutic communities. • Co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour treatment setting.	
Level 3.1	Clinically Managed Low-Intensity Residential Services • 24 hour living support and structure with available trained personnel. • Offers at least 5 hours of clinical service a week. • Co-occurring capable, co-occurring enhanced, and complexity capable services, which are staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour living support setting	28

While the table above reflects the capacity challenges faced by the entire SUD treatment system, this limitation is even more evident for the adolescent (under 18) population. In 2016, the legislature passed HB517, which sought to address the capacity challenges related to substance use services for the youth population. The legislation required the state to redevelop excess capacity at the existing Sununu Youth Services Center to allow for expansion to a 36-bed residential SUD treatment facility available for adolescents under 18 years old in New Hampshire. The facility is in the process of undergoing construction for the treatment program and programming is anticipated to begin by July 1, 2018. This facility will be recognized as a comprehensive SUD program, as outlined in NH rule He-W 513. The services provided will include both low and medium intensity adolescent residential treatment for adolescents under 18

years of age who qualify for such a level of care using the ASAM patient placement criteria. The initial sixteen beds for the program will be available immediately upon opening in July 2018, with the remaining 20 beds opening upon Federal Waiver approval. This program in this facility was intentionally designed as a comprehensive SUD facility, to be in alignment with the existing SUD service delivery system in NH.

Despite New Hampshire's commitment to strengthening community supports for those with mental illness in hopes of mitigating psychiatric crises exacerbated by substance use disorder that requires hospitalization, the state observes an increasing number of individuals who present in hospital emergency rooms. Many of these individuals are experiencing acute psychiatric crises with co-occurring substance use disorders. These individuals remain in emergency departments throughout the state without appropriate mental health and substance use treatment because there are no available inpatient psychiatric beds for admissions. This is reflected in *Table 3*, which describes the current number of adults in emergency rooms waiting for treatment at NH Hospital.

Table 3. New Hampshire Hospital Waitlist as of February 23, 2018

NH Hospital Admitting Queue	Source of Referral	Number of Adults
50	Emergency Department	44

The Demonstration is necessary to address the compliance issue with 42 CFR 438.3(e) identified by CMS in its letter of March 13, 2017 to Commissioner Jeffrey A. Meyers and to ensure that publicly-funded SUD residential treatment is clinically appropriate and that the provider capacity expanded to address the opioid epidemic is not reduced at this time of ongoing crisis. During the rollout of the SUD benefit for the Medicaid Expansion population, New Hampshire determined that residential SUD providers could not be classified as an IMD pursuant to 42 CFR 1009. This determination was made in 2015, prior to the release of the CMS clarification on 42 CFR 438.6(e) in March of 2016. As a result, residential treatment providers were advised that SUD facilities with more than sixteen (16) beds would not be considered an IMD in New Hampshire. As a result of this investment in capacity and guidance from the state, nearly all of the state-funded SUD residential treatment facilities in New Hampshire have more than sixteen (16) beds and provide services to individuals ranging from age 22-64. It is critical that this waiver be granted so that current practices comply with federal guidance without risking the loss of still critically needed residential treatment beds for SUD.

Although Medicaid has been paying for residential SUD treatment, there is still a significant shortage of providers. Many attribute lack of plans for expansion to market uncertainties. Given the uncertainty about federal reimbursement following the release of the updated managed care rule, several providers have decided not to invest in increasing the number of beds for fear that they may have to eliminate beds to stay below sixteen (16) in order to avoid classification as an IMD. Without this waiver, providers could not treat Medicaid beneficiaries for more than fifteen (15) days. *See* 42 CFR 438.6(e).

Providers who choose to limit their capacity to sixteen (16) beds may be inclined to discharge Medicaid patients prematurely to comply with the rule and avoid providing uncompensated care, which would place them in violation of ASAM criteria.

The Demonstration is consistent both with President Trump's August 11, 2017 declaration that the opioid crisis is a national emergency and the recommendation set forth in the Report of the President's Commission on Combating Drug Addiction and the Opioid Crisis which specifically proposed that CMS should take "*immediate action to grant waiver approvals for all 50 states to quickly eliminate barriers to treatment resulting from the federal Institutes for Mental Diseases (IMD) exclusion within the Medicaid program."*[11]

Parity Alignment

The Medicaid managed care final rule also includes provisions related to compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2010 regulations. Specifically, those related to quantitative treatment limitations *see* 42 CFR 438.910(c). CMS's commitment to ensuring parity between behavioral health and physical health is crucial to ensuring that Medicaid beneficiaries have access to quality, timely behavioral health services, much like they experience when seeking treatment for a somatic disorder. Expenditure authority for stays in an IMD will further New Hampshire's efforts to achieve parity by ensuring that Medicaid enrollees do not have more restrictive access to residential SUD services than their counterparts covered by qualified health plans (QHPs).

Particularly in the case of substance use disorder services, the IMD exclusion puts managed care organizations at risk of choosing between compliance with federal regulations or risking parity violations should they not authorize treatment beyond fifteen (15) days due to IMD restrictions. The latter would be a violation of state law that requires carriers to utilize the ASAM criteria for placement in services.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to them.

The Demonstration will authorize FFP to be claimed for Medicaid payments made to IMDs for the treatment of Medicaid enrollees with SUD. The following hypotheses will be tested during the approval period:

Evaluation Question	Hypothesis	Waiver Component Being Addressed	Data Source

[11] https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf

What are the impacts of the NH SUD waiver on access to SUD residential treatment services for Medicaid recipients age 21 through 64?	Adults Medicaid recipients will have equal to or better access to SUD residential and hospital rehabilitation treatment services.	Access to SUD residential treatment services.	Encounter and claims data. Number of SUD residential beds.
What are the impacts of the NH SUD waiver on adolescent Medicaid recipient's access to SUD residential treatment services?	Adolescent Medicaid recipients will have better access to SUD residential treatment services.	Access to SUD residential treatment services.	Encounter and claims data. Number of SUD residential beds for adolescents.
What are the impacts of the NH SUD waiver on access to inpatient acute psychiatric services for the treatment of co-occurring MH and SUD disorders for Medicaid recipients age 21 through 64?	Adult Medicaid recipients age 21 through 64 will have equal to or better access to inpatient acute psychiatric services for the treatment of co-occurring MH and SUD disorders.	Access to inpatient services for the treatment of co-occurring MH and SUD disorders.	Encounter and claims data.

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate.

This Demonstration will operate statewide.

5) Include the proposed timeframe for the Demonstration.

NH is seeking a five (5) year Demonstration.

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.

No. The demonstration will not modify the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost-sharing or delivery systems.

Section II – Program Description

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included).

Please refer to Medicaid Eligibility Groups: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf when describing Medicaid State Plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

The Demonstration will not affect any of the eligibility categories or criteria that are set forth in the New Hampshire Medicaid State Plan (hereinafter "State Plan").

Eligibility Chart

Mandatory State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Optional State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Expansion Populations

Eligibility Group Name	N/A	Income Level

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.

When determining whether an individual is eligible for Medicaid, the Department will apply the same eligibility standards and methodologies as those articulated in the State Plan.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

There are no caps on enrollment in the Demonstration.

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

Any Medicaid enrollee ages 12-64 with SUD requiring residential treatment based on ASAM criteria will be eligible for the Demonstration. In 2018, the estimated number of potentially eligible enrollees is 74,000. In 2019, the estimated number of potential eligible enrollees is 115,000. The increase from 2018 to 2019 is attributed to the transition of premium assistance program (PAP) enrollees to the state Medicaid Care Management (MCM) program discussed in Section III, 7(a) below. Currently approximately 320 Medicaid enrollees receive a residential SUD service each quarter. This is based on current use of state programs for SUD residential treatment services available in the Medicaid state plan and the NH Health Protection Program-Premium Assistance Program through the 1115(a) waiver authority.

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).

The Demonstration will have no impact on long term services and supports, and in particular will not impact post-eligibility treatment of income or spousal impoverishment rules.

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

This Demonstration will not change any eligibility procedures. The State will not institute continuous eligibility or express lane eligibility.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

N/A

Section III – Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

____ Yes __X___ No (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

____ Yes _X__ No (if no, please skip questions 8 - 11)

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

Benefit Package Chart

Eligibility Group	Benefit Package

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

___ Federal Employees Health Benefit Package
___ State Employee Coverage
___ Commercial Health Maintenance Organization
__ Secretary Approved

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

Benefit Chart

Benefit	Description of Amount, Duration, and Scope	Reference

Benefits Not Provided

Benefit	Description of Amount, Duration, and Scope	Reference

6) Indicate whether Long Term Services and Supports will be provided.

___ Yes (if yes, please check the services that are being offered) _X_ No

In addition, please complete the: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf, and the: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf.)

- ☐ **Homemaker**
- ☐ **Case Management**
- ☐ **Adult Day Health Services**
- ☐ **Habilitation – Supported Employment**
- ☐ **Habilitation – Day Habilitation**
- ☐ **Habilitation – Other Habilitative**
- ☐ **Respite**
- ☐ **Psychosocial Rehabilitation**
- ☐ **Environmental Modifications (Home Accessibility Adaptations)**
- ☐ **Non-Medical Transportation**
- ☐ **Home Delivered Meals Personal**
- ☐ **Emergency Response**
- ☐ **Community Transition Services**
- ☐ **Day Supports (non-habilitative)**
- ☐ **Supported Living Arrangements**
- ☐ **Assisted Living**
- ☐ **Home Health aide**
- ☐ **Personal Care Services**
- ☐ **Habilitation – Residential Habilitation**
- ☐ **Habilitation – Pre-Vocational**
- ☐ **Habilitation – Education (non-IDEA Services)**
- ☐ **Day Treatment (mental health service)**
- ☐ **Clinic Services**
- ☐ **Vehicle Modifications**
- ☐ **Special Medical Equipment (minor assistive devices)**
- ☐ **Assistive Technology**
- ☐ **Nursing Services**
- ☐ **Adult Foster Care**
- ☐ **Supported Employment**
- ☐ **Private Duty Nursing**
- ☐ **Adult Companion Services**
- ☐ **Supports for Consumer Direction/Participant Directed Goods and Services**
- ☐ **Other (please describe)**

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

___ Yes (if yes, please address the questions below)
_X__ No (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program.

The state has a PAP for employer-sponsored coverage that is currently in place, and the Demonstration will not affect that program. Residential SUD treatment is currently covered in commercial plan benefits accessed by the PAP enrollees. There is currently legislation that requires the Department to transition its PAP members to our MCM program effective January 1, 2019. The members would be transitioning into the existing program.

b) Include the minimum employer contribution amount.

N/A

c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing.

N/A

d) Indicate how the cost-effectiveness test will be met.

N/A

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

No enrollees will pay premiums under the Demonstration.

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

The Demonstration does not require any copayments, coinsurance and/or deductibles that differ from the Medicaid State plan.

Copayment Chart

Eligibility Group	Benefit	Copayment Amount

10) Indicate if there are any exemptions from the proposed cost sharing.

This Demonstration does not propose any cost sharing.

Section IV – Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

_ Yes

X_ No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals of improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on qualify, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- ☐ **Managed care**
  - ☐ **Managed Care Organization (MCO)**
  - ☐ **Prepaid Inpatient Health Plans (PIHP)**
  - ☐ **Prepaid Ambulatory Health Plans (PAHP)**
- ☐ **Fee-for-service (including Integrated Care Models) Primary Care Case Management (PCCM)**
- ☐ **Health Homes**
- ☐ **Other (please describe)**

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:

Delivery System Chart

Eligibility Group	Delivery System	Authority

5) If the Demonstration will utilize a managed care delivery system:

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state).

d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

e) Describe how the managed care providers will be selected/procured.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration

___ Yes _X_ No

The Demonstration will not provide long-term services and supports or personal care.

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality makers that will be measured and the data that will be collected.

New Hampshire Medicaid will not make supplemental payments directly to providers through the Demonstration.

Section V – Implementation of Demonstration

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

Coverage under the Demonstration will be effective 07/01/2018. A proposed implementation timeframe is included below:

Milestone	Timeframe
Issue public notice of waiver	02/27/2018
Hold public hearings on waiver	03/06/2018 (night) 03/13/2018 (day)
Accept public comments on waiver	03/30/2018
Submit waiver application to CMS	04/09/2018
Receive waiver approval	06/30/2018
Launch program	07/01/2018

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

Client Notices
The Department does not anticipate that Medicaid enrollees will need to be notified of the changes made under this demonstration. Notices to enrollees will go out that updates information regarding provider networks for residential SUD services as more services become available as predicted by this waiver.

The Department will work with managed care organizations to notify them of changes being made to allow for payments to IMDs for:

- Medicaid-eligible individuals receiving residential SUD treatment or hospital withdrawal management rehabilitation services in an IMD for as long as is medically necessary.

There are no anticipated changes expected to the managed care operations regarding reimbursement for residential SUD programs, as the managed care organizations are currently following the guidance issued to them in 2015 by the Department.

Notification of these changes will be made to the managed care organizations both in person and in writing ahead of the final demonstration effective date to ensure that reimbursement to providers can begin as soon as the demonstration begins.

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

The Department will provide a rate refresh through contract amendment to support the Demonstration.

Section VI – Demonstration Financing and Budget Neutrality

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion.

Section VII – List of Proposed Waivers and Expenditure Authorities

1) Provide a list of proposed waivers and expenditure authorities.

The state requests authority to waive Section 1905(a)(29)(B) and 42 CFR 435.1009 to permit the state to make payments for/provide coverage to Medicaid eligible individuals who are receiving residential substance use disorder treatment in an IMD, as defined in 1905(i) and 42 CFR 435.1010 for as long as medically necessary, consistent with relevant ASAM criteria.

In addition, for those Medicaid eligible individuals referred to above who are enrolled in Medicaid Managed Care Organizations, the state requests authority to waive Section 42 CFR 438.6(e), and by reference 42 CFR 438.3(e)(2), to ensure that these individuals receive substance use disorder treatment in an IMD for as long as medically necessary, consistent with relevant ASAM criteria.

The state also requests that CMS expand the exception to the IMD exclusion in 42 CFR 441.11(c)(5) to the provider type Comprehensive SUD Program, as described in He-W 513.02 (b) to allow New Hampshire to claim federal financial participation (FFP) for individuals under 21 receiving residential substance use disorder treatment in these facilities for long as is medically necessary.

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1905(a)(29)(B)	To permit the state to make payments to Medicaid-eligible individuals receiving residential substance use disorder (SUD) treatment in an IMD for as long as is medically necessary	This waiver authority is requested to address the shortage of residential substance use disorder treatment beds for adults and adolescents, as reflected in lengthy waitlists for such residential treatment services and to ensure that these individuals receive residential substance use disorder treatment in an IMD for as long as medically necessary, consistent with relevant ASAM criteria; and to support the implementation by New Hampshire of a comprehensive system for the treatment for substance use disorders.

Section VIII – Public Notice

1) Start and end dates of the state's public comment period.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)

5) Comments received by the state during the 30-day public notice period.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

Section IX – Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

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