



STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
*OFFICE OF MEDICAID SERVICES*

Jeffrey A. Meyers  
Commissioner

Henry D. Lipman  
Director

129 PLEASANT STREET, CONCORD, NH 03301  
603-271-9422 1-800-852-3345 Ext. 9422  
Fax: 603-271-8431 TDD Access: 1-800-735-2964  
www.dhhs.nh.gov

April 24, 2018

Ms. Judith Cash  
Director, State Demonstrations Program  
Center for Medicaid and CHIP Services (CMCS)  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Director Cash,

As part of a statewide effort to combat the ongoing opioid crisis, and in response to the nation's national public health emergency, the State of New Hampshire's application for a Section 1115(a) Demonstration Waiver, the "New Hampshire Substance Use Disorder Treatment and Recovery Access Section 1115 Research and Demonstration Waiver," was posted on the Department's web site on Thursday, April 12, 2018 upon formal application submission, and transparently addresses, in the budget neutrality analysis included, an estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures over the term of demonstration, including historic enrollment and budgetary data as applicable.

New Hampshire is requesting that CMS allow public comments on budget neutrality be submitted coincident with the federal comment process commencing April 26, 2018 to leverage a streamlined approval process allowing for full transparency.

The State of New Hampshire appreciates CMS' partnership on this application to improve access to and the quality of residential substance use disorder (SUD) treatment for Medicaid beneficiaries.

Sincerely,

Henry D. Lipman, FACHE  
Medicaid Director

cc: Timothy Hill, Acting Director, Center for Medicaid and CHIP Services  
Judith Cash, Director, State Demonstrations Group  
Mr. Richard McGreal, Associate Regional Administrator, CMS Boston Regional Office  
Commissioner Jeffrey A. Meyers, NH Department of Health and Human Services



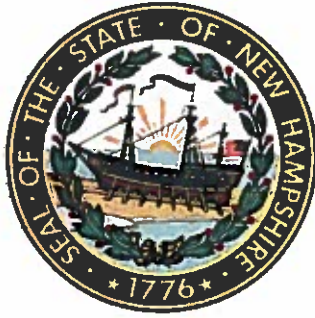
**Substance Use Disorder Treatment and Recovery Access Section 1115(a)  
Research and Demonstration Waiver Application**

**State of New Hampshire  
Department of Health and Human Services**

**April 9, 2018**

# Table of Contents

<b>Section I</b>	<b>Program Description/General</b>	<b>Page 2</b>
<b>Section II</b>	<b>Program Description/Eligibility</b>	<b>Page 10</b>
<b>Section III</b>	<b>Demonstration Benefits and Cost Sharing Requirements</b>	<b>Page 11</b>
<b>Section IV</b>	<b>Delivery System and Payment Rates for Services</b>	<b>Page 15</b>
<b>Section V</b>	<b>Implementation of Demonstration See Appendix A for Comprehensive Implementation Plan</b>	<b>Page 16</b>
<b>Section VI</b>	<b>Demonstration Financing and Budget Neutrality See Appendix B for Financing and Budget Neutrality Forms</b>	<b>Page 17</b>
<b>Section VII</b>	<b>List of Proposed Waivers and Expenditure Authorities</b>	<b>Page 18</b>
<b>Section VIII</b>	<b>Public Notice See Appendix C for Certification</b>	<b>Page 19</b>
<b>Section IX</b>	<b>Demonstration Administration</b>	<b>Page 22</b>
<b>Appendix A</b>	<b>Implementation Plan</b>	
<b>Appendix B</b>	<b>Budget Neutrality</b>	
<b>Appendix C</b>	<b>Public Notice Certification</b>	



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 Application*

---

April 9, 2018

# NEW HAMPSHIRE 1115 WAIVER APPLICATION

## 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 enrolled in fee-for-service, managed care, or covered by other Medicaid state waivers.

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).<sup>1</sup> Since 2010, the number of overdose deaths has increased and in 2016, it was reported that 485 people died from overdose.<sup>2</sup> In 2015 there were 439 total drug deaths, of which 397 deaths were caused by opiates/opioids.<sup>3</sup>*

<sup>1</sup> <https://www.cdc.gov/drugoverdose/data/statedeaths.html>

<sup>2</sup> <https://www.doh.nh.gov/medical-examiner/documents/drug-data-update.pdf>

<sup>3</sup> <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 naloxone (Narcan) more than tripled, from 877 to 2,793.<sup>4</sup> 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.<sup>5</sup> 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.<sup>6</sup>

*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.<sup>7</sup> 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.<sup>8</sup> 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

<sup>4</sup> <http://millvardcommunications.com/index.php?src=news&srcType=detail&category=News&refno=7449>

<sup>5</sup> <https://scholars.unh.edu/cgi/viewcontent.cgi?article=1330&context=carsey>

<sup>6</sup> <https://www.nhbar.org/publications/display-news-issue.asp?id=8377>

<sup>7</sup> 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/NSDUHIsacPercents2016/NSDUHIsacPercents2016.pdf>

<sup>8</sup> 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. Available at: <https://ndews.umd.edu/publications/hotspot-report-understanding-opioid-overdoses-new-hampshire>

treatment for illicit drug use in a specialty facility in the past year.<sup>9</sup> 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. ASAM is a patient placement criterion that reflects evidence-based clinical treatment guidelines for individuals with SUD. 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 (13) 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.<sup>10</sup>

*Table 1. NH Medicaid Substance Use Disorder Benefit*

<b>SUD Service Type</b>	<b>Description</b>
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.

<sup>9</sup> 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/NSDUHIsacTotal2016/NSDUHIsacTotals2016.pdf>

<sup>10</sup> <https://www.dhhs.nh.gov/dcbcs/bdas/documents/mid-year-commission.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*

<b>ASAM Level</b>	<b>Description</b>	<b>Waitlist (number of days)</b>
Level 3.5	Clinically Managed High-Intensity Residential Services for adults <ul style="list-style-type: none"> <li>• 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment.</li> </ul>	28



	<ul style="list-style-type: none"> <li>• Patients in this level are able to tolerate and use full active milieu or therapeutic communities.</li> <li>• 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.</li> </ul>	
Level 3.1	<p>Clinically Managed Low-Intensity Residential Services</p> <ul style="list-style-type: none"> <li>• 24 hour living support and structure with available trained personnel.</li> <li>• Offers at least 5 hours of clinical service a week.</li> <li>• 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</li> </ul>	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 IMD 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.

*The Demonstration is necessary to address critical unmet needs for inpatient SUD treatment for individuals with co-occurring disorders.* 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.*"<sup>11</sup>

### **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 which has no pre-determined length of stay.

### **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.

---

<sup>11</sup> [https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final\\_Report\\_Draft\\_11-1-2017.pdf](https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf)

Evaluation Question	Hypothesis	Waiver Component Being Addressed	Data Source
What are the impacts of the NH SUD waiver on access to SUD residential treatment services for Medicaid recipients age 21 to 64?	Adult Medicaid recipients, ages 21 to 64, will have equal to or better access to SUD residential and hospital rehabilitation treatment services in New Hampshire.	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 in New Hampshire.	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, ages 21 to 64, will have equal to or better access to acute inpatient hospital services for the treatment of MH and SUD co-occurring disorders when admitted for a primary SUD diagnosis.	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**

<b>Eligibility Group Name</b>	<b>Social Security and CFR Sections</b>	<b>Income Level</b>

**Optional State Plan Groups**

<b>Eligibility Group Name</b>	<b>Social Security and CFR Sections</b>	<b>Income Level</b>

**Expansion Populations**

<b>Eligibility Group Name</b>	<b>N/A</b>	<b>Income Level</b>

**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  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  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.medicicaid.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)  
 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  
 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 quality, 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**

<b>Eligibility Group</b>	<b>Delivery System</b>	<b>Authority</b>

**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       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.**

See Appendix A for Implementation Plan. 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) 03/14/2018 (day)
Accept Public Comments on Waiver	03/30/2018
Submit Application/Implementation Plan	04/09/2018
Submit Monitoring Protocol	05/30/2018
Receive Waiver/Implementation Plan Approval	06/30/2018
Launch Program with FFP Prospectively	07/01/2018
Evaluation Plan Submitted	10/1/2018

**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 ages 12-64 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**

See Appendix B.

**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.**

On Tuesday February 27, 2018, the Department of Health and Human Services released a draft of the *New Hampshire Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver*. This release coincided with the development of a publicly accessible web page, an email address for public input, and an announcement of two public hearings (one of which included teleconference capacity for those wishing to participate remotely), along with a United States Postal Service address, to provide for remote and in-person public comment to the proposed applications for waiver. The Department held a third opportunity for public input with the State’s Medical Care Advisory Committee on Monday, March 12, 2018, providing email notification to stakeholders and committee members. The Department accepted public comment until 12 noon (eastern) on Friday March, 30, 2018.

The 30-day public comment period for the waiver is from Tuesday, February 27, 2018 until Friday, March 30, 2018 at 12 Noon (Eastern).

The link to the State’s web site is <https://www.dhhs.nh.gov/sud-imd/index.htm>. The web site clarifies public process noting public hearings, options for providing input, slide deck for the public hearings, and a link to a press release noticing the application for waiver. The email address is [imsudwaiver@dhhs.nh.gov](mailto:imsudwaiver@dhhs.nh.gov). The United States Postal Service address is New Hampshire Department of Health and Human Services, *Attn: Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver, Leslie Melby*, 129 Pleasant Street, Concord, NH, 03301. Attached is a screen shot of the web site page (*See Appendix A*). The public notice appeared in New Hampshire’s statewide newspaper, *The Union Leader*, on 3/4/2018. Attached is proof of publication (*see Appendix A*).

### **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.**

See Appendix C.

### **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.**

See response to Section VIII (1) above.

### **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.)**

See response to Section VIII (1) above.

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

**Comment #1** – How does this 1115 waiver tie into the IDNs and the other 1115 waiver?

**Response #1** – The Department’s 1115 Delivery System Reform Incentive Program (DSRIP) waiver allows health care providers and community partners within a region to form relationships focused on transforming care. The DSRIP incentive funding also provides for prompt resources for combating the opioid crisis and strengthening the state's strained mental health delivery system. This waiver, the *New Hampshire Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver*, will compliment DSRIP efforts through increased in-state residential service capacity for Comprehensive SUD Treatment for adults and children. The Department expects that the waivers are in alignment to address New Hampshire’s opioid crisis and support efforts to implement a comprehensive and lasting response to this epidemic.

**Comment #2** – We have been doing this for years, is there a chance we won’t get this waiver?

**Response #2** – During the roll out 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 CMS clarification of 42 CFR 438.6 (e) in March 2016. As a result, residential treatment providers were advised that SUD facilities with more than (16) sixteen beds would not be considered an IMD in New Hampshire. The waiver is necessary to address the compliance issue with 42 CFR 438.3 (e) identified by CMS on March 13, 2017 and to ensure that publicly-funded SUD residential treatment is clinically appropriate and that the provider capacity continues to expand to address the opioid epidemic. New Hampshire is working with our federal partners at CMS to ensure that the waiver is expedited.

**Comment #3** – This is necessary for providers to support those with Medicaid. If we were limited to 15 or 16 beds, this not a viable business option. This is incredibly important for providers since nobody has less than 16 beds.

**Response #3** – The Department concurs with this comment.

**Comment #4** – How long is the waiver good for?

**Response #4** – The Department has applied for a five year waiver to begin on July 1, 2018.

**Comment #5** – Does this cover Medicaid and non-Medicaid for both adults and children?

**Response #5** – The waiver is specific to Medicaid, but by increasing capacity for Medicaid funded services, the Department is facilitating an opportunity for provides to receive payment through both public and private sources to increase overall capacity in the State.

**Comment #6** – How does this work with in lieu of services in the managed care contracts?

**Response #6** – The Department, with the authority granted through a waiver from CMS, does not need to exercise an in lieu of option in the managed care contracts since the authority waives the limitation on IMD service days for SUD treatment.

**Comment #7** – Will this allow for mental health services in IMDs? Is the Department considering a mental health IMD waiver?

**Response#7** – This demonstration authorizes FFP for covered/coverable Medicaid services provided to beneficiaries who are admitted to an IMD for the purpose of SUD treatment. The expenditure authority is not limited to the SUD-related treatments exclusively. If a participating SUD IMD provider renders mental health services to treat a beneficiary's co-occurring disorder,

that would be allowable; as would primary care, pharmacy, or other covered Medicaid services provided to the beneficiary by the IMD or other Medicaid provider. However, FFP for covered Medicaid services provided to beneficiaries who are admitted to IMDs primarily for mental health treatment (or for any reason other than for SUD) are not included in the 1115 SUD demonstration option. The Department is exploring mental health options in collaboration with our CMS federal partners. The Department's web site provides a link to the November 1, 2017 CMS guidance for the waiver.

**Comment #8:** Does this mean if you are between 18 and 21 years of age the waiver does not apply to you?

**Response #8:** The Department's request is to allow a waiver for IMD exclusion for Medicaid eligible individuals 21 to 64, as well as those under 21, receiving residential substance use disorder (SUD) treatment in an IMD for as long as is medically necessary. HB 517 requires the State to develop a 36-bed residential SUD treatment facility available to adolescents under 18 years old. The waiver will include services that are in alignment with the existing substance use disorder delivery system for residential treatment and expand availability of services in the state of NH for adolescents.

**Comment #9:** Who are the providers per ASAM? Is this outlined here in NH?

**Response #9:** The ASAM criteria is the medical necessity criteria that is used to determine appropriate level of care for individuals with SUD. All SUD providers that meet provider and facility qualifications in He-W 513 must follow these criteria. Provider eligibility for SUD services is outlined in He-W 513.

**Comment #10:** Is there a need to have this capacity for children?

**Response #10:** HB517 directed the Department to redevelop excess capacity at Sununu Youth Services Center for a SUD residential program for adolescents <18 years of age. There are no residential programs for this population in NH and therefore few claims to assess any historical utilization. HB517 also required outpatient capacity development for this population and the Department will review the timeline for those services once residential services at the facility are available beginning July 1, 2018.

**Comment #11:** What is the professional or hospital portion of the service? Is there facility type billing?

**Response #11:** Hospitals providing SUD services in accordance with He-W 513 are eligible service providers for the full array of benefits. Hospitals billing for SUD services would bill the DRG code as outlined in the rate spreadsheet available at

<https://www.dhhs.nh.gov/ombp/sud/documents/sud-billable-services.pdf>

**Comment #12:** Is there a bed listing by provider type based on what is noted in the slide deck?

**Response #12:** The list of state funded treatment providers can be found on the Bureau of Drug and Alcohol Services treatment resource guide available at:

<https://www.dhhs.nh.gov/dcbcs/bdas/documents/resource-guide-treatment.pdf>. The list of licensed residential facilities can be selected by selecting "Residential Treatment and Rehab" as the license type in the search function available at: <https://nhlicenses.nh.gov/verification/Search.aspx?facility='Y'>

**Comment #13:** There is a "stigma" noted around the Sununu Youth Center that may keep some



families from engaging in services. How will the Department address this since it is a service entirely separate from the Center?

**Response #13:** The Department has been very sensitive to the stigma concerns related to the population being served at Sununu Youth Services Center. Prior to designing the program, Department representatives met with youth at the facility to understand the needs for youth with SUD and built that feedback into the program design. To address this, the separate entry space for the SUD program is being constructed to reflect a rehabilitative environment and all programming is required to be delivered in accordance with clinically appropriate criteria. Additionally, specific program requirements regarding working with youth and families were built in the program design, specifically requiring alignment with the State Youth Treatment Strategic Plan available in Appendix G at: <https://www.dhhs.nh.gov/business/rfp/documents/rfp-2018-bdas-11-resid.pdf>

**Comment #14:** How will telehealth for SUD services be considered as part of this waiver?

**Response #14:** This waiver does not consider telehealth SUD services.

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

See responses in Section VIII (6) above.

**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.**

New Hampshire has made the determination that this demonstration application will not have a direct effect on Indians, tribes, Indian health programs, or urban Indian health organizations.

**Section IX – Demonstration Administration**

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

**Name and Title:** Deborah Scheetz, New Hampshire Medicaid Deputy Director

**Telephone Number:** 603-271-9459

**Email Address:** [Deborah.Scheetz@dhhs.nh.gov](mailto:Deborah.Scheetz@dhhs.nh.gov)

**Appendix A**  
**Implementation Plan**

**Section 1115 Substance Use Disorder (SUD) Demonstration:  
Guide for Developing Implementation Plan Protocols**

**Overview:** This template is meant to assist states that are developing an implementation plan for applications for a new section 1115 substance use disorder (SUD) demonstration project pursuant to the State Medicaid Directors' letter #17-003 issued on November 1, 2017, "Strategies to Address the Opioid Epidemic". States have the option of submitting their implementation plan as part of their application or as a post-approval protocol. If a state chooses to use a post-approval protocol, the timeframe for submitting the protocol will be specified in the Special Terms and Conditions (STCs) agreement between CMS and the state. Submission of the information provided in this template or the attachments does not guarantee approval of a state's demonstration request. CMS will work with states to identify any additional information necessary to consider approval of implementation plans and demonstration requests.

This template was designed to help states ensure demonstration implementation plans meet the goals and milestones established by CMS aimed at improving quality, accessibility, and outcomes of SUD treatment services in the most cost-effective manner. In addition, this template is intended to help states describe plans for improving the state's SUD Health Information Technology (IT) infrastructure to enhance the state's prescription drug monitoring program (PDMP). This template was also developed to facilitate an efficient review process. States should add narrative responses to the information requested in the sections below that are applicable to their specific plans for improving treatment, and complete the input boxes provided. We will continue to improve this guide based on input from states. The state's SUD Health IT Plan should be recorded in Attachment A.

The STCs developed for these demonstrations generally require states to submit an implementation plan within 90 calendar days after approval of the OUD/SUD demonstration. The state may not claim FFP for services provided in Institutions for Mental Diseases (IMDs), including residential treatment facilities, until CMS has approved a state's implementation plan.

As the state is developing its implementation plan, the state may access strategic design support through the Medicaid Innovation Accelerator Program (IAP). If your state is interested in receiving strategic design support through the Medicaid IAP related to implementation plan development, please contact [tyler.sadwith@cms.hhs.gov](mailto:tyler.sadwith@cms.hhs.gov).

Please submit completed implementation plans electronically to your CMS section 1115 Project Officer.

## **CMS' New Opioid and Other SUDs 1115 Demonstration Initiative:**

### **Goals and Milestones to be Addressed in State Implementation Plan Protocols**

CMS is committed to working with states to provide a full continuum of care for people with opioid use disorder (OUD) and other SUDs and in supporting state-proposed solutions for expanding access and improving outcomes in the most cost-effective manner possible.

#### **Goals:**

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD 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 readmissions is preventable or medically inappropriate for OUD and other SUD; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

#### **Milestones:**

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including MAT;
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

## **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>.

#### **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 Needed
State Medicaid programs must provide coverage of the following services: <ul style="list-style-type: none"> <li>• Outpatient Services;</li> <li>• Intensive Outpatient Services;</li> <li>• Medication assisted</li> </ul>	New Hampshire provides coverage for a robust array of substance use disorder services, including all of those outlined in the milestone requirement	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 authority will update the He-w 513 rule in collaboration with Bureau of Drug and Alcohol Services by November 30, 2018.

<p>treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state);</p> <ul style="list-style-type: none"> <li>• Intensive levels of care in residential and inpatient settings; and</li> <li>• Medically supervised withdrawal management</li> </ul>		<p>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>	
---	--	---	--

## 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 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. When ASAM is not applicable, both state contracted treatment providers and

all 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 Needed
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 program	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 Needed
--------------------	---------------	--------------	---------------------------

<p>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</p>	<p>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</p> <p>The Bureau of Drug and Alcohol Services has expired rules (He-A 300) governing the Certification and Operation of Alcohol and other Drug Disorder Treatment Programs</p>	<p>He-W 513 explicitly outlines the types of services and hours of clinically directed programming covered under each ASAM level of care.</p> <p>He-W 513 will outline required staffing ratios for residential programs.</p> <p>He-A 300 will be updated to outline required staffing ratios for residential programs.</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> <p>Bureau of Drug and Alcohol Services will update the He-A 300 rule by Fall 2019.</p>
---	--	---	---

***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 to operate in the State of NH
- 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</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</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>

	<p>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 regarding Certification and Operation of Alcohol and other Drug Disorder Treatment Programs have expired.</p>	Bureau of Drug and Alcohol Service staff on an annual basis.	
--	--	--	--

***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	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	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

	provider but is not a requirement for all Medicaid providers.	rule that requires on-site or facilitated access to MAT for all state funded SUD providers. This language will align with requirements updated in He-W 513.	be updated to include language around specific standards and requirements regarding offering MAT on-site or facilitating access off-site by Fall 2019.
--	---	---	--

#### 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 Needed
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	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	NH will establish an assessment process to identify Medicaid providers that are accepting new patients in critical levels of care. This will be accomplished through secret shopper quality activities conducted	Secret shopper planning to begin Spring 2018, assessment to begin by Summer 2018, assessment to be completed by early 2019.



participating regions of the state) including those that offer MAT:  Outpatient Services;  Intensive Outpatient Services;  Medication Assisted Treatment (medications as well as counseling and other services);  Intensive Care in Residential and Inpatient Settings;  Medically Supervised Withdrawal Management.	type and payers accepted.  A treatment capacity report was created in early 2014 prior to expansion of Medicaid.	by the NH DHHS EQRO  NH will explore the possibility of updating the 2014 treatment capacity report.  NH will work with the vendor supporting the treatment locator to determine opportunities to enhance the program.	Discuss opportunities of treatment capacity and treatment locator updates with current vendor by November 30, 2018
--	--	--	--

## 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_OHD	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)	<a href="https://medicaidquality.nh.gov/reports/use-of-opioids-at-high-">https://medicaidquality.nh.gov/reports/use-of-opioids-at-high-</a>

			<a href="#">dosage-ohd-cms-adult-core-set-1</a>
CMS_A_C UOB	Concurrent Use of Opioids and Benzodiazepines	Will start with FFY 2018 Reporting (for measurement year 2017)	N/A
PHA_RMQ 1.09	Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	Started with CY 2016 Quarter 2	<a href="https://medicaidquality.nh.gov/reports/safety-monitoring---opioid-prescriptions-meeting-nh-dhhs-morphine-equivalent-dosage-prior-authorization-compliance-1">https://medicaidquality.nh.gov/reports/safety-monitoring---opioid-prescriptions-meeting-nh-dhhs-morphine-equivalent-dosage-prior-authorization-compliance-1</a>
SUD_1115.01	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 Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	<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 (<a href="https://www.oplc.nh.gov/medicine/documents/med502-adopted.pdf">https://www.oplc.nh.gov/medicine/documents/med502-adopted.pdf</a>) Please see attached prior authorization criteria for</p>	NH will explore additional opportunities for enhancing opioid prescribing guidelines through Managed Care re-procurement	<p>Meet with PDMP by August 2018</p> <p>Meet with Governor's Commission on Opioid and</p>

	<p>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 (PHARMQI.09) to the Medicaid Quality Unit. The report is distributed to the subject matter experts (SMEs) for review.</p>	<p>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>Healthcare taskforces to discuss guidelines by August 2018</p> <p>Consult with vendor assisting with managed care re-procurement to develop language specific to opioid prescribing guidelines and associated reports.</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 21<sup>st</sup> 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 AWARe, 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 Needed
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 PDMP submitted to CMS by Spring 2019.

**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. 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 Needed
--------------------	---------------	--------------	---------------------------

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 Fall 2019
---	---	---	---

**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

Telephone Number: 603-271-9459

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 AWAARxE, 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."<sup>1</sup>
- 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

---

<sup>1</sup> Available at <https://www.healthit.gov/playbook/opioid-epidemic-and-health-it>.

IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.<sup>2</sup>

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.

**Table 1. State Health IT / PDMP Assessment & Plan**

Milestone Criteria	Current State	Future State	Summary of Actions Needed
--------------------	---------------	--------------	---------------------------

<sup>2</sup> Available at <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>.

<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>
---	---	--	--

**Prescription Drug Monitoring Program (PDMP) Functionalities**

<p>Enhanced interstate data sharing in order to better track patient specific prescription data</p>	<p>The New Hampshire Controlled Drug Prescription Health and Safety Program (PDMP) has advanced data sharing agreements with all of the other New England States (VT, ME, MA, CT, RI) and with New York and New Jersey.</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 system has ease of use features (3 clicks you're in) features built into the system. As an outcome of a provider survey conducted in 2016, 25% of respondents indicated that it takes less than 1 minute to access the NH PDMP, 38% 1 to 2 minutes and 31% 3 or more minutes, with (79%)</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>

	indicated that the information in the patient history report is presented in a clear and understandable manner.		
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 <sup>3</sup> (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		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.

<sup>3</sup> 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>include:</p> <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>		
<b>Current and Future PDMP Query Capabilities</b>			
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)	As a result to changes proposed in HB 1423 that passed in 2016, the law that outlines the requirements for the New Hampshire Controlled Drug Prescription Health and Safety Program (PDMP) requires prescribers to query the NH PDMP for an initial prescription of a Class II, III or IV opioids and at least twice per year thereafter.	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.
<b>Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes</b>			
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	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-

	when conducting a query. See additional information in the enhanced “ease of use” milestone		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 New Hampshire Controlled Drug Prescription Health and Safety Program (PDMP) offers trainings to providers and dispensers, including how to integrate accessing the NH PDMP into the work flow / business processes.	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.
<b>Master Patient Index / Identity Management</b>			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The Advisory Council of the New Hampshire Controlled Drug Prescription Health and Safety Program (PDMP) has proposed developing a protocol for practice boards and their societies to train prescribers on using PDMP data to identify patients that are at particular risk and for conducting SBIRT type interventions	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.
<b>Overall Objective for Enhancing PDMP Functionality &amp; Interoperability</b>			

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

The Office of Quality Assurance and Improvement at the New Hampshire Department of Health and Human Services has convened staff from the Department's its CDC supported Opioid Overdose Surveillance Programs, the Bureau of Emergency Medical Services at the Department of Safety, the Office of the Chief Medical Examiner and the New Hampshire Controlled Drug Prescription Health and Safety Program (PDMP), to initiate developing a strategy to cross reference their respective data sources in order to better target individuals at risk for opioid addiction and those at greatest risk for opioid overdose. In addition, the Department's Medicaid Pharmacy Program has a number of "utilization management tools" at its disposal, including prior authorization review, quantity and dosage limitations (< 100 combined daily MME) on opioid prescription, to make

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.

	<p>sure regulations are followed. Medicaid beneficiaries that have a history of possible misuse of opioids are “locked in” and then closely monitored and required to adhere to certain safety criteria (can only use one designated pharmacy, etc.). New Hampshire’s Medicaid Managed Care Organizations are required to institute similar safeguards.</p>		
--	---	--	--

The State has sufficient health IT infrastructure at the appropriate levels including state Medicaid and pharmacy systems, contracted managed care organizations, and provider electronic health records in order to achieve the goals of the demonstration. The State Medicaid Health IT Plan (SMHP) and Delivery System Reform Incentive Program (DSRIP) 1115 Waiver implementation will serve to support additional enhancements specific to Admit, Discharge and Transfer (ADT) feeds, infrastructure, and innovation to connect data, providers and systems.

The state will ensure that any appropriate revisions are made during the next managed care procurement to incorporate the necessary requirement to use health IT standards referenced in 45 CFR 170 Subpart B and the Interoperability Standards Advisory (ISA) as set forth by the Office of the National Coordinator of Health IT.

NH has statutory authority and corresponding health IT infrastructure to support electronic prescribing which is currently available statewide. Prescribers are granted the ability to obtain a patient’s medication history from the PDMP housed with the Board of Pharmacy. Per NH rules, prescribers must check the PDMP before prescribing an opioid, or any controlled substance, for new patients and thereafter, every six months that treatment continues.

Development is on-going, as part of the state’s Delivery System Reform Incentive Program (DSRIP) 1115 Waiver implementation, to document and share care plans as well as make strides in other HIT efforts based on a statewide gap analysis. NH provides oversight for the performance measurement plan, by identifying measures, goals, reporting timelines, and business owners, through on-going work with the state’s DSRIP partners. In regards to performance metrics in monitoring the progress of the health IT plan, the Department will coordinate efforts with DSRIP partners, the Board of Pharmacy, and MMIS Modernization initiatives under the Department’s Chief Information Officer.



**Attachment A, Section II – Implementation Administration**

Please provide the contact information for the state’s point of contact for the SUD Health IT Plan. Name and Title: Deborah Scheetz, New Hampshire Medicaid Deputy Director

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.

**Appendix B**  
**Budget Neutrality**



15800 Bluemound Road  
Suite 100  
Brookfield, WI 53005  
USA  
Tel +1 262 784 2250  
Fax +1 262 923 3680

milliman.com

Mathieu Doucet, FSA, MAAA  
Consulting Actuary

mathieu.doucet@milliman.com

April 6, 2018

Mr. Henry D. Lipman, FACHE  
Interim Medicaid Director  
New Hampshire Department of Health and Human Services  
129 Pleasant Street  
Concord, NH 03301

**Re: Substance Use Disorder Treatment and Recovery Access 1115 Demonstration Waiver – Budget Neutrality Projections**

Dear Henry:

At your request, this letter provides the New Hampshire Department of Health and Human Services (DHHS) with information related to budget neutrality projections for the Substance Use Disorder Treatment and Recovery Access 1115 Demonstration Waiver. The waiver will allow DHHS to provide Medicaid payments for individuals receiving substance use disorder (SUD) services in an Institution for Mental Disease (IMD) under the standard fee-for-service Medicaid or Medicaid managed care programs. Specifically, through this waiver application, DHHS is requesting:

- 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.
- CMS expand the exception to the IMD exclusion in 42 CFR 441.11(c)(5) to the provider type Comprehensive SUD Treatment, as described in He-W 513.02 (c) 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.

This waiver will apply to all Medicaid populations, including the expansion population, when they transition from the Premium Assistance Program (PAP) to the MCM program on January 1, 2019. This waiver will allow New Hampshire to claim FFP for adults residing in an IMD for SUD treatment and for the adolescents residing at the Sununu Youth Services Center.

As part of the waiver submission, CMS requires DHHS to submit the completed CMS budget neutrality template for review. This letter includes documentation of the budget neutrality methodology and provides CMS template forms and related worksheets. **The populated CMS budget neutrality template is attached to this letter.**

## **METHODOLOGY AND ASSUMPTIONS**

We developed the base year costs (SFY 2018) in the budget neutrality template separately for the three specific Medicaid Eligibility Groups (MEGs) representing the populations affected by the waiver: Medicaid adult population, expansion adult population, and adolescent population.

The bottom section of the 'SUD Historical' tab in the CMS budget neutrality template requires the input of the total estimated expenditures for SUD medical assistance services provided in an IMD, as well as a total estimated expenditure PMPM for non-SUD medical assistance services. We estimated the monthly SUD medical assistance cost per member residing in an IMD using the per diem rates shown below. We also estimated the monthly non-SUD medical assistance cost per member for capitated services through the MCM program, carved-out services from the MCM capitation rates paid on a FFS basis, waiver services not covered under MCM, and additional financial transactions not included in the Medicaid Management Information System (MMIS) claims data. We estimated the total number of eligible member months for all medical assistance provided in an IMD. Each component is detailed below.

### SUD IMD Service Unit Cost

The reimbursement for all services included in this waiver is structured around the current all-inclusive rehabilitative services per diem rates for each population. The per diem rate varies by the procedure code used to identify the level of services provided to a residential facility beneficiary. We also assume that a small portion of admissions for the adult populations would occur in a hospital setting. Table 1 below shows the per diem information provided by DHHS.

**Table 1**  
 New Hampshire Department of Health and Human Services  
 SUD IMD 1115 Waiver Budget Neutrality Analysis  
 List of Included Codes and Per Diem Rates

Code	Description	Current Per Diem Rate
H2034-HA	Low intensity adolescent behavioral health; short-term residential	\$128.00
H0018-HA	Medium intensity adolescent behavioral health; short-term residential	170.00
H0018	High intensity adult behavioral health; short-term residential	162.50
T1006	High intensity pregnant & parenting alcohol and / or substance abuse	230.00
H0010	Alcohol and / or drug services; sub-acute detoxification	230.00
DRG 894-897	Alcohol, Drug Abuse or Dependence	1,346.00

We reviewed historical MCO, FFS and expansion population experience data to understand the anticipated distribution of these services for the three populations included in the waiver. Table 2 below shows the estimated composite per diem rate for the Medicaid adults, expansion adults, and adolescents based on the historical distribution of these services. Please note, the adolescent population residing at the Sununu Youth Services Center does not have historical experience, but we understand they will provide low and medium intensity services to the adolescent population. The New Hampshire Bureau of Drug and Alcohol Services (BDAS) estimates that services will be provided in a 20% / 80% proportion for low and medium intensity services, respectively.

**Table 2**  
 New Hampshire Department of Health and Human Services  
 SUD IMD 1115 Waiver Budget Neutrality Analysis  
 Calculation of Composite Per Diem Rates for Adult Populations

Code	Per Diem Rate	Medicaid Adults	Expansion Adults	Adolescents
H2034-HA	\$128.00	0.0%	0.0%	20.0%
H0018-HA	170.00	0.0%	0.0%	80.0%
H0018	162.50	82.6%	74.8%	0.0%
T1006	230.00	8.5%	0.0%	0.0%
H0010	230.00	7.9%	24.2%	0.0%
DRG 894-897	1,346.00	1.0%	1.0%	0.0%
<b>Composite Rate</b>		<b>\$185.39</b>	<b>\$190.70</b>	<b>\$161.60</b>

**Estimated SUD IMD Monthly Cost per User**

We estimated the SUD IMD monthly cost per user based on the composite rates for each MEG calculated above and the average days per month. We assumed each user occupies a bed for the equivalent of an entire month, since the addiction recovery programs offered in these facilities are structured to receive patients for stays ranging from one month to six months. Table 3 below shows the calculation of the monthly cost per user.

Table 3 New Hampshire Department of Health and Human Services SUD IMD 1115 Waiver Budget Neutrality Analysis Calculation of Monthly Cost Per User			
	Standard	Expansion	Adolescents
Composite Per Diem Rate	\$185.39	\$190.70	\$161.60
Days per Month	30.42	30.42	30.42
Monthly Cost per User	\$5,638.95	\$5,800.46	\$4,915.33

**Estimated non-SUD IMD PMPM**

The CMS budget neutrality template requires all beneficiary costs associated with an individual in an SUD IMD bed to be included. We estimated the non-SUD month costs per member based on the following components:

- **Capitated services through the MCM program:** We estimated the costs of capitated services using the SFY 2018 MCM capitation rates, SFY 2018 Medically Frail capitation rates, SFY 2018 NHHPP Transitional capitation rates, and estimated CY 2018 Premium Assistance Program costs under a Medicaid managed care delivery system.
- **Carved-out services from the MCM capitation rates paid on a FFS basis:** High cost drugs such as Hepatitis C drugs, hemophilia drugs, Carbaglu, and Ravicti are carved out of the MCM program and paid for by DHHS on a FFS basis. Other carved-out costs include Applied Behavioral Analysis (ABA) services, among others. We estimated the cost for these carved-out costs using FFS claims in the MMIS.
- **Waiver services not covered under MCM:** Medicaid long-term supports and services including nursing home and Choices for Independence (CFI) services are not covered under the MCM program and are paid for by DHHS on a FFS basis. We estimated costs for these long-term supports and services using FFS claims in the MMIS. This component also includes a small allowance for the Medicaid Quality Incentive Program (MQIP) and Proportionate Share (ProShare) payments related to nursing facility stays. These services are only included for the portion of IMD eligible months where a member is not residing in the IMD.
- **Financial transactions:** We estimated an allowance for payable and receivable transaction amounts attributable to a specific member using financial transaction files provided by DHHS.

Table 4 below shows each component of the non-SUD IMD cost PMPM by MEG.

Table 4 New Hampshire Department of Health and Human Services SUD IMD 1115 Waiver Budget Neutrality Analysis Non-SUD IMD Costs PMPM			
	Standard	Expansion	Adolescents
Capitated Services	\$783.40	\$554.68	\$315.42
Carved-Out Services	29.38	12.63	133.97
Waiver Services	78.81	0.25	102.06
Financial Transactions	0.02	0.00	0.01
<b>Total</b>	<b>\$891.61</b>	<b>\$567.56</b>	<b>\$551.45</b>

### Estimated Member Months

We calculated the number of member months for members while residing in an SUD IMD in SFY 2019, or Demonstration Year (DY) 01. To estimate the caseloads for each MEG, which populate the 'SUD Caseloads' tab of the CMS template, we relied on the following assumptions provided by DHHS:

- There are currently 320 SUD beds available from Medicaid enrolled providers in New Hampshire, with roughly 60% occupied by the adult Medicaid population. This translates into 192 beds occupied by these individuals.
- When the expansion population transitions to Medicaid managed care on January 1, 2019, there will be an estimated 500 beds available, with roughly 80% of these beds occupied by the total adult Medicaid population. The expected increase in the number of available beds is due to more residential facilities enrolling as Medicaid providers when the PAP population transitions to Medicaid managed care. These resulting 400 Medicaid beds will have 192 occupied by the Medicaid adult population (calculated above) and the remaining 208 occupied by the expansion adult population.
- The newly constructed Sununu Youth Services Center scheduled to open July 1, 2018 will have 36 beds, of which 75%, or 27 beds, are expected to be occupied by Medicaid adolescent patients. Of the 36 beds, 16 are set to be operational on July 1, 2018, with the remaining 20 beds opening upon Federal Waiver approval. For the purpose of the budget neutrality calculations, we assumed that the waiver would be approved prior to July 1, 2018 for all 36 beds to be available on implementation day.
- Individuals can enter the SUD IMD at any point in the month. Assuming an even distribution of admissions during the month, members would, on average, enter the IMD on the 15<sup>th</sup> of each month, providing for one-half of an IMD eligible member month, during which they do not reside in an IMD at the beginning of each IMD stay. Similarly, we assumed that treatment would occur in increments of one month, which means there is an additional one-half of an IMD eligible member month post-discharge. We adjusted the total IMD eligible member months to account for the extra partial month when the individuals enter and leave the SUD IMD facility.

Using these assumptions, we estimated the total member months in the SUD waiver for DY 01 as shown in Table 5 below.

**Table 5**  
**New Hampshire Department of Health and Human Services**  
**SUD IMD Waiver Budget Neutrality Analysis**  
**Calculation of DY01 Member Months**

	<b>Medicaid Adults</b>	<b>Expansion Adults*</b>	<b>Adolescents</b>
Number of Medicaid beds	192	208	27
Occupancy rate	100%	100%	100%
Eligible months in DY01	12	6	12
Partial Month Adjustment	2.0	2.0	1.5
<b>Total DY 01 member months</b>	<b>4,608</b>	<b>2,496</b>	<b>486</b>

\* Scheduled to transition to Medicaid managed care on January 1, 2019.

The partial month adjustment is based on an estimated average treatment length of 30 days for adults and 60 days for adolescents. As discussed above, each admission into an IMD for SUD services generates an additional IMD eligible member month. Therefore, the total number of an IMD eligible month should be adjusted by a factor of 2.0 for adults (one month of treatment, plus the additional IMD eligible month divided by the one month of treatment) and 1.05 for adolescents (two months of treatment, plus the additional IMD eligible month divided by the two months of treatment).

### SUD Without Waiver Projections

As mentioned above, the product of the DY 01 member months and the estimated cost per user produces the aggregate costs contained in the 'SUD Historical' tab of the budget neutrality template. Both the 'with waiver' and 'without waiver' projections use the same values. Our projections assume that Medicaid recipients who get treatment in an IMD will remain in the facilities for one or more entire months.

Per CMS' guidance, we used an annual per user cost trend of 4.9% consistent with the President's Budget PMPM cost trend, since no historical data is available to develop a New Hampshire-specific trend estimate. Per conversations with CMS, we understand the final PMPM cost trend will be provided by CMS when they review DHHS' initial waiver filing.

In estimating the future caseloads, we assumed a 2.0% annual enrollment trend. **Please note, we adjusted the DY 02 formula for the expansion adult population on the 'SUD Caseloads' tab to account for the expansion population receiving the waiver services for only 6 months in DY 01 and 12 months in all future years.** During previous conversations, CMS indicated we could modify certain formulas included in the budget neutrality template.

### CAVEATS AND LIMITATIONS ON USE

This letter is intended for the internal use of the New Hampshire Department of Health and Human Services (DHHS) and it should not be distributed, in whole or in part, to any external party without the prior written permission of Milliman. We do not intend this information to benefit any third party, even if we permit the distribution of our work product to such third party.

This information is designed to provide DHHS with a budget neutrality projections for the Substance Use Disorder Treatment and Recovery Access 1115 Demonstration Waiver. This information may not be appropriate, and should not be used, for other purposes.

It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected.



Mr. Henry D. Lipman  
New Hampshire Department of Health and Human Services  
April 6, 2018  
Page 6 of 7

In preparing this information, we relied on information from DHHS and CMS. We accepted this information without audit, but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate.

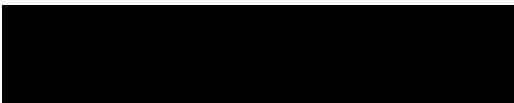
I am a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

The terms of Milliman's contract with DHHS effective July 1, 2017 apply to this letter and its use.



Please call me at 262 784 2250 if you have any questions.

Sincerely,



Mathieu Doucet, FSA, MAAA  
Consulting Actuary

MD/tel

Attachments





**EXHIBITS (provided in Excel)**

**How To Use This Spreadsheet:**

Consult the tables below for a high level overview of the IMD Cost Limit and SUD Hypothetical CNOM Services Limit in Scenario 1 and Scenario 2. The tables provide basic concepts for establishment of the budget neutrality limits, and reporting requirements for monitoring. The notes below the table provide additional information related to allowable SUD IMD medical assistance services, estimation of the various budget neutrality limits, trend rates and other details of estimation. (see glossary below table for definition of abbreviations)

**Scenario 1**

<b>Situation:</b> Demonstration CNOM is limited to expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are residents in facilities that meet the definition of an IMD (i.e., IMD exclusion related MA)	IMD Cost Limit	SUD IMD Hypothetical CNOM Services Limit
Without Waiver (i.e., budget neutrality limit)	<p><u>PMPM Cost</u></p> <ul style="list-style-type: none"> <li>Estimated average of all MA costs incurred during IMD MMs.</li> <li>Est. total MA cost in IMD MMs ÷ est. IMD MMs</li> </ul> <p><u>Member Months</u></p> <ul style="list-style-type: none"> <li>IMD MM: Any <i>whole</i> month during which a Medicaid eligible is inpatient in an IMD at least 1 day</li> </ul> <p><u>BN Expenditure Limit</u></p> <ul style="list-style-type: none"> <li>PMPM cost × IMD MMs</li> </ul>	
With Waiver	<p><u>Expenditures Subject to Limit</u></p> <ul style="list-style-type: none"> <li>All MA costs with dates of service during IMD MMs</li> </ul> <p><u>Reporting Requirements</u></p> <p>State must be able to identify and report:</p> <ul style="list-style-type: none"> <li>IMD MMs separate from other Medicaid months of eligibility</li> <li>MA costs during IMD MMs separate from other MA costs</li> </ul>	

**Scenario 2**

<b>Situation:</b> Demonstration CNOM include both CNOM for IMD exclusion related MA to <i>and</i> CNOM for additional hypothetical services that can be provided outside the IMD.	IMD Cost Limit	SUD IMD Hypothetical CNOM Services Limit
Without Waiver (i.e., budget neutrality limit)	<p><u>PMPM Cost</u></p> <ul style="list-style-type: none"> <li>Estimated average of all MA costs incurred during IMD MMs.</li> <li>Est. total MA cost in IMD MMs ÷ est. IMD MMs</li> </ul> <p><u>Member Months</u></p> <ul style="list-style-type: none"> <li>IMD MM: Any <i>whole</i> month during which a Medicaid eligible is inpatient in an IMD at least 1 day</li> <li>Can exclude months with ≤ 15 IMD inpatient days under managed care</li> </ul> <p><u>BN Expenditure Limit</u></p> <ul style="list-style-type: none"> <li>PMPM cost × IMD MMs</li> </ul>	<p><u>PMPM Cost</u></p> <ul style="list-style-type: none"> <li>Estimate of average SUD CNOM service cost during Non-IMD MMs</li> <li>Est. total SUD CNOM service cost ÷ est. Non-IMD MMs</li> <li>SUD CNOM service cost can include capitated cost of IMD services</li> </ul> <p><u>Member Months</u></p> <ul style="list-style-type: none"> <li>Non-IMD MM: Any month of Medicaid eligibility in which a person <i>could</i> receive a SUD CNOM service that is not an IMD MM</li> </ul> <p><u>BN Expenditure Limit</u></p> <ul style="list-style-type: none"> <li>PMPM cost × Non-IMD MMs</li> </ul>
With Waiver	<p><u>Expenditures Subject to Limit</u></p> <ul style="list-style-type: none"> <li>All MA costs with dates of service during IMD MMs</li> </ul> <p><u>Reporting Requirements</u></p> <p>State must be able to identify and report:</p> <ul style="list-style-type: none"> <li>IMD MMs separate from other Medicaid months of eligibility</li> <li>MA costs during IMD MMs separate from other MA costs</li> </ul>	<p><u>Expenditures Subject to Limit</u></p> <ul style="list-style-type: none"> <li>All SUD CNOM service costs with dates of service during Non-IMD MMs</li> </ul> <p><u>Reporting Requirements</u></p> <p>State must be able to identify and report:</p> <ul style="list-style-type: none"> <li>Non-IMD MMs separate from IMD MMs</li> <li>SUD CNOM costs separate from other MA costs</li> </ul>

#### Glossary of Abbreviations

CNOM = expenditure authority (cost not otherwise matchable)

Hypo = hypothetical, i.e., optional services that could be included in the state plan but are instead being authorized in the 1115 using CNOM

IMD = institution for mental diseases

MA = medical assistance

MM = member month

SUD = substance abuse disorder

#### Notes

1. Date of service for capitation payments is the month of coverage for which the capitation is paid.
2. The IMD Cost Limit and SUD Hypothetical CNOM Services Limit are intended to be two distinct budget neutrality tests separately and independently enforced.
3. SUD IMD Services may include all approved services provided to Medicaid beneficiaries while residing in an IMD; however, *they may not include costs associated with room and board payments* in those facilities unless they qualify as inpatient facilities under section 1905(a) of the Social Security Act.

#### Estimation for the IMD Cost Limit

The IMD Cost Limit represents the projected cost of medical assistance during months in which Medicaid eligible are patients at the IMD. These are the acceptable ways for the state to determine the PMPMs for the IMD Cost Limit.

- States should present 5 years of historical data on overall MA costs for individuals with a SUD diagnosis (or proxy) who received inpatient treatment for SUD (or could have received inpatient treatment if such services were available), to determine average MA cost per user of SUD inpatient services for each historical year. The per user per month costs are then projected forward using the lower of historical per user month cost trend or the President's Budget PMPM cost trend. The projected per user per month costs will become the PMPMs for the IMD Cost Limit.

- If the state has an existing comprehensive Medicaid demonstration with already calculated without waiver PMPMs, the state should incorporate those PMPMs in the IMD Cost Limit PMPMs (see Historical tab).
- State can top off IMD Cost Limit PMPMs with an additional estimated amount representing any additional CNOM services that affected individuals may also receive during IMD months.
- State may use Alternate PMPM Development in Historical tab for estimating expenditures to be included in the PMPM(s)/IMD Cost Limit (see 'Supplemental Methodology Document' requirement below).

#### Estimation of the SUD Hypothetical CNOM Services Limit

The SUD Hypothetical CNOM Services Limit represents the projected average PMPM cost of additional expenditure authority services for the population eligible to receive them. This can include the estimated average cost of IMD services, if these costs are being averaged out across an entire covered population through inclusion in capitated payment rates to Medicaid managed care plans.

- Since states are unlikely to have actually covered these services in the past, they will not have historical data for projecting future costs.
- The PMPM cost estimate should be an average expected cost of hypothetical additional expenditure authority services for individuals who are eligible to receive those services. It should not be a cost per month of service use.

#### Supplemental Methodology Document

The 'Historical Spending Data' and/or 'Alternate PMPM Development' in the SUD Historical tab must be accompanied by a supplemental methodology and data sources document that fully describes, for each MEG, a full breakout of all SUD services - with descriptions of accompanying expenditures and caseloads. There should also be sections/headings in the methodology document which describe all other state data inputs (see 'State Data Inputs' below).

#### Trends

PMPM trends should be the lower of the state's historical trend and the smoothed trend from the 2018 President's Budget (in the absence of historical data, CMS will apply the President's Budget trend). The President's Budget trends should be for the eligibility groups that are participating in the SUD demonstration. Most often, these will be the Current Adults, New Adults, or a blend of Current Adults and New Adults.

#### Multiple MEGs

There should be one set of MEGs for the current Medicaid state plan IMD Cost Limit(s) with associated PMPMs and member months, and one for the SUD Hypothetical CNOM Services Limit (and *non*-Hypothetical CNOM), as applicable.

#### Member Month Non-Duplication

IMD Cost Limit member month must be non-duplicative of SUD Hypothetical CNOM Services Limit member months, and must also be non-duplicative of general comprehensive demonstration budget neutrality limit member months. This means that month of Medicaid eligibility for an individual cannot appear as both an IMD Cost Limit member month and a SUD Hypothetical CNOM Services Limit member month; it has to be one or the other, and likewise for IMD Cost Limit member month and general comprehensive demonstration budget neutrality limit member months. SUD Hypothetical CNOM Services Limit member months can be duplicative of general comprehensive demonstration budget neutrality limit member months.

#### State Data Inputs

States must add their data to the yellow highlighted cells for CMS review and discussion - and choose the appropriate drop-downs corresponding to their data inputs. CMS will provide template instructions with this spreadsheet.

SUD Historical Spending Data - 5 Years

Medicaid Adults	Historical Years Definition:			State Fiscal Year		
	2012	2013	2014	2015	2016	5-YEARS
TOTAL EXPENDITURES						
ELIGIBLE MEMBER MONTHS						
PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
TREND RATES						
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Expansion Adults						
TOTAL EXPENDITURES						
ELIGIBLE MEMBER MONTHS						
PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
TREND RATES						
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Adolescents						
TOTAL EXPENDITURES						
ELIGIBLE MEMBER MONTHS						
PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
TREND RATES						
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Alternate SUD IMD MEG PMPM Development & C	Medicaid Adults	Non-SUD/IMD Title XIX PMPM:			Choose "Included" from Drop-Down(s) to Link Services with MEG(s)				
		Expansion Adults	Adolescents		CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
		Estimated Total Expenditures for SUD Medical Assistance Provided in an IMD	Estimated Total Expenditures for All Other non-SUD/IMD Title XIX State Plan Medical Assistance	Estimated Eligible Member Months for All Medical Assistance Provided in an IMD	Estimated PMPM Cost	Medicaid Adults	Expansion Adults	Adolescents	SUD IMD Hypothetical Services CNOM MEG
		\$891.61							
		\$567.56							
		\$551.45							
<i>Medicaid Adults all inclusive per diem</i>	\$12,992,131	\$395,502,368	443,582	\$920.90	Included				
<i>Expansion Adults all inclusive per diem</i>	\$7,238,972	\$317,013,190	558,554	\$580.52		Included			
<i>Adolescents all inclusive per diem</i>	\$1,592,568	\$573,562,186	1,040,098	\$552.98			Included		
<i>Service 4</i>		\$0		#DIV/0!					
<i>Service 5</i>		\$0		#DIV/0!					
<i>Service 6</i>		\$0		#DIV/0!					
<i>Service 7</i>		\$0		#DIV/0!					
<i>Service 8</i>		\$0		#DIV/0!					
<i>Service 9</i>		\$0		#DIV/0!					
<i>Service 10</i>		\$0		#DIV/0!					
<i>Service 11</i>		\$0		#DIV/0!					
<i>Service 12</i>		\$0		#DIV/0!					
<i>Add additional services, as necessary</i>		\$0		#DIV/0!					
<b>Totals</b>					\$920.90	\$580.52	\$552.98	\$0.00	\$0.00

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	PB Trend:		DEMONSTRATION YEARS (DY)					TOTAL WOW
			BASE YEAR DY 00	4.9%	DY 01	DY 02	DY 03	DY 04	DY 05	
			TREND RATE 2	TREND RATE 2						

**Medicaid Adults**

Eligible Member Months	n.a.	n.a.	0	n.a.	4,608	4,700	4,794	4,890	4,988	
PMPM Cost	n.a.	0	\$920.90	4.9%	\$966	\$1,013	\$1,063	\$1,115	\$1,170	
Total Expenditure					\$4,451,420	\$4,762,907	\$5,096,195	\$5,452,842	\$5,834,435	\$25,597,799

**Expansion Adults**

Eligible Member Months	n.a.	n.a.	0	n.a.	2,496	5,092	5,194	5,298	5,404	
PMPM Cost	n.a.	0	\$580.52	4.9%	\$609	\$639	\$670	\$703	\$737	
Total Expenditure					\$1,519,989	\$3,252,718	\$3,480,335	\$3,723,913	\$3,984,488	\$15,961,443

**Adolescents**

Eligible Member Months	n.a.	n.a.	0	n.a.	486	496	506	516	526	
PMPM Cost	n.a.	0	\$552.98	4.9%	\$580	\$609	\$638	\$670	\$702	
Total Expenditure					\$281,919	\$301,646	\$322,757	\$345,344	\$369,511	\$1,621,177

**SUD IMD Hypothetical Services CNOM MEG**

Eligible Member Months	n.a.	n.a.	n.a.	n.a.	0	0	0	0	0	
PMPM Cost	n.a.		\$0.00	4.9%	\$0	\$0	\$0	\$0	\$0	
Total Expenditure					\$0	\$0	\$0	\$0	\$0	\$0

ELIGIBILITY GROUP	DY 00	TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01	DY 02	DY 03	DY 04	DY 05	

**Medicaid Adults**

Eligible Member Months			4,608	4,700	4,794	4,890	4,988	
PMPM Cost	\$921	4.9%	\$966	\$1,013	\$1,063	\$1,115	\$1,170	
Total Expenditure			\$4,451,420	\$4,762,907	\$5,096,195	\$5,452,842	\$5,834,435	\$25,597,799

**Expansion Adults**

Eligible Member Months			2,496	5,092	5,194	5,298	5,404	
PMPM Cost	\$581	4.9%	609	639	670	703	\$737	
Total Expenditure			1,519,989	3,252,718	3,480,335	3,723,913	\$3,984,488	\$15,961,443

**Adolescents**

Eligible Member Months			486	496	506	516	526	
PMPM Cost	\$553	4.9%	580	609	638	670	702	
Total Expenditure			281,919	301,646	322,757	345,344	369,511	\$1,621,177

**SUD IMD Hypothetical Services CNOM MEG**

Eligible Member Months	n.a.		0	0	0	0	0	
PMPM Cost	\$0	4.9%	0	0	0	0	0	
Total Expenditure			0	0	0	0	0	\$0

**SUD IMD Non-Hypothetical Services CNOM MEG**

Eligible Member Months			0	0	0	0	0	
PMPM Cost	\$0	4.9%	\$0	\$0	\$0	\$0	\$0	
Total Expenditure			\$0	\$0	\$0	\$0	\$0	\$0

SUD IMD Supplemental BN Tests

**IMD Cost Limit**  
**Without-Waiver Total Expenditures**

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Adults	\$4,451,420	\$4,762,907	\$5,096,195	\$5,452,842	\$5,834,435	\$25,597,799
Expansion Adults	\$1,519,989	\$3,252,718	\$3,480,335	\$3,723,913	\$3,984,488	\$15,961,443
Adolescents	\$281,919	\$301,646	\$322,757	\$345,344	\$369,511	\$1,621,177
<b>TOTAL</b>	<b>\$6,253,328</b>	<b>\$8,317,271</b>	<b>\$8,899,287</b>	<b>\$9,522,099</b>	<b>\$10,188,434</b>	<b>\$43,180,419</b>
<b>With-Waiver Total Expenditures</b>						
	DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
Medicaid Adults	\$4,451,420	\$4,762,907	\$5,096,195	\$5,452,842	\$5,834,435	\$25,597,799
Expansion Adults	\$1,519,989	\$3,252,718	\$3,480,335	\$3,723,913	\$3,984,488	\$15,961,443
Adolescents	\$281,919	\$301,646	\$322,757	\$345,344	\$369,511	\$1,621,177
<b>TOTAL</b>	<b>\$6,253,328</b>	<b>\$8,317,271</b>	<b>\$8,899,287</b>	<b>\$9,522,099</b>	<b>\$10,188,434</b>	<b>\$43,180,419</b>
<b>Net Overspend</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**SUD IMD Hypothetical CNOM Services Limit**  
**Without-Waiver Total Expenditures**

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Hypothetical Services CNOM MEG	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>With-Waiver Total Expenditures</b>						
	DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
SUD IMD Hypothetical Services CNOM MEG	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Overspend</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

**SUD IMD Non-Hypothetical Services Limit**  
**With-Waiver Total Expenditures**

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Non-Hypothetical Services CNOM MEG	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>

Add Trend Rates & PMPMs from Table Below to 'SUD IMD Supplemental Budget Neutrality Test(s)' STC

SUD MEG(s)	Trend Rate	DY 01	DY 02	DY 03	DY 04	DY 05
Medicaid Adults	4.9%	\$966	\$1,013	\$1,063	\$1,115	\$1,170
Expansion Adults	4.9%	\$609	\$639	\$670	\$703	\$737
Adolescents	4.9%	\$580	\$609	\$638	\$670	\$702
SUD IMD Hypothetical Services CNOM MEG	4.9%	\$0	\$0	\$0	\$0	\$0



Projected SUD IMD Member Months/Caseloads

	Trend Rate	DEMONSTRATION YEARS (DY)				
		DY 01	DY 02	DY 03	DY 04	DY 05
Medicaid Adults	2.0%	4,608	4,700	4,794	4,890	4,988
Expansion Adults	2.0%	2,496	5,092	5,194	5,298	5,404
Adolescents	2.0%	486	496	506	516	526
SUD IMD Hypothetical Services CNOM MEG			0	0	0	0
SUD IMD Non-Hypothetical Services CNOM MEG			0	0	0	0

**Appendix C**  
**Public Notice Certification**

# New Hampshire Public Notices

Powered by MyPublicNotices.com

[Home](#)

Monday, March 05, 2018

## NEW HAMPSHIRE DEPARTMENT OF HEALTH AND HUMAN SER

New Hampshire Department of Health and Human Services Proposed Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver As part of its overall approach to addressing the substance use disorder crisis, the New Hampshire Department of Health and Human Services (DHHS) is applying for a Section 1115(a) Demonstration Waiver from the Centers for Medicare and Medicaid Services (CMS). This Waiver will enable DHHS to reimburse residential substance use disorder (SUD) treatment providers with more than 16 beds and expand access to adolescent residential treatment. The Department of Health and Human Services is interested in public input on the Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver. DHHS is convening two public hearings to seek public input on this Waiver that will enable New Hampshire to provide Medicaid payments for individuals receiving substance use disorder (SUD) services at certain residential SUD treatment providers. The hearings will be held: \* Tuesday, March 6, 2018 - Manchester 6:00 - 7:30 pm Manchester Health Department 1528 Elm St Manchester, NH Snow Date Thursday, March 8, 2018, 6 - 7:30 pm, Manchester Health Department \* Tuesday, March 13, 2018 - Nashua 1:00 - 2:30 pm Harbor Homes - Partnership for Successful Living 77 Northeastern Blvd. Nashua, NH Snow Date Wednesday, March 14, 2018, 1-2:30 pm, Harbor Homes Partnership for Successful Living The Substance Use Disorder Treatment and Recovery Access Waiver is available for public review at: <https://www.dhhs.nh.gov/sud-imd/index.htm> . The services proposed within the Waiver include those that are in alignment with the existing substance use disorder delivery system for residential treatment and expand availability of services for individuals with co-occurring mental health disorders. All public comments must be received by 12 Noon (Eastern) on Friday, March 30, 2018. Comments will be accepted: (1) at either of the two scheduled public hearings referenced above; (2) emailed to [imdsudwaiver@dhhs.nh.gov](mailto:imdsudwaiver@dhhs.nh.gov) ; or (3) mailed to Leslie Melby, NH Department of Health and Human Services, Attn: Substance Use Disorder Treatment and Recovery Access Waiver, 129 Pleasant St, Concord NH 03301.

Appeared in: *The Union Leader* on Sunday, 03/04/2018



[Printer-friendly version](#)



[E-mail to a friend](#)

[Home](#) | [Privacy Policy](#) | [Terms of Use](#) | [About Us](#) | [Contact Us](#)

© Copyright 2001-2018 Legacy.com All Rights Reserved



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

***Public Notice for Proposed***  
**Substance Use Disorder Treatment and Recovery Access Section 1115(a)**  
**Research and Demonstration Waiver**  
**February 27, 2018**

Notice is hereby given that the New Hampshire Department of Health and Human Services (DHHS) is convening two public hearings to seek public input on a Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver that will enable 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:

- The Center for Medicare and Medicaid Services (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 ages 21-64 receiving residential substance use disorder (SUD) treatment in an IMD as long as is medically necessary.
- 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 as long as is medically necessary.

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

The Demonstration will further the objectives of Title XIX of the Social Security Act by increasing access to, stabilizing, and strengthening providers and provider networks, available to serve Medicaid and low-income populations in the state. This will be accomplished by ensuring continuity of care for individuals receiving SUD treatment, increasing access to residential treatment services for adolescents with SUD, and ensuring consistency between public and private coverage for SUD services in New Hampshire.

The complete version of the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver* is available for public review at: <https://www.dhhs.nh.gov/sud-imd/index.html>

DHHS will host two public hearings during the public comment period:

- **Tuesday, March 6, 2018 – Manchester**  
6:00 - 7:30 pm  
Manchester Health Department  
1528 Elm St  
Manchester, NH  
**Call-in option:** To participate by phone, call in at 6:00 pm to:  
1-866-470-8024  
When prompted, use this code: 965 412 0884  
**Snow Date – Thursday, March 8, 2018, 6 - 7:30 pm, Manchester Health Department**
- **Tuesday, March 13, 2018 – Nashua**  
1:00 - 2:30 pm  
Harbor Homes - Partnership for Successful Living  
77 Northeastern Blvd.

Nashua, NH

**Snow Date – Wednesday, March 14, 2018, 1-2:30 pm, Harbor Homes Partnership for Successful Living**

If accommodations are needed for communication access such as interpreters, CART (captioning), assistive listening devices, or other auxiliary aids and/or services, please contact Leslie Melby at [Leslie.Melby@dhhs.nh.gov](mailto:Leslie.Melby@dhhs.nh.gov) or 603-271-9074 no later than March 1, 2018. Every effort will be made to accommodate needs identified with advance notice.

### **Public Comment**

The 30-day public comment period for the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver* is from **Tuesday, February 27, 2018 until Friday, March 30, 2018 at 12 Noon (Eastern)**. All comments must be received by **12 Noon (Eastern) on Friday, March 30, 2018**.

DHHS would like to hear your comments about the changes it is proposing. After hearing the public's ideas and comments about the proposed changes, DHHS will make final decisions about what changes to make to the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver* and then submit to CMS. The summary of comments will be posted for public viewing at <https://www.dhhs.nh.gov/> along with the waiver application when it is submitted to CMS.

There are several ways to give your comments to DHHS:

- Attend either of the two public hearings held at the dates/locations noted above. At the public hearings, you can give verbal or written comments to DHHS. Additional information about providing comments is noted below.
- Email comments to [imsudwaiver@dhhs.nh.gov](mailto:imsudwaiver@dhhs.nh.gov) or mail written comments to:

Ms. Leslie Melby

New Hampshire Department of Health and Human Services

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

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 Waiver*.

### **Additional Information**

Requests for a hard copy of the Waiver application should be submitted by mail to:

Ms. Leslie Melby

New Hampshire Department of Health and Human Services

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

129 Pleasant Street

Concord, NH 03301

A hard copy of the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver* can also be picked up at DHHS, which is located at:

New Hampshire Department of Health and Human Services

Fred H. Brown Building

129 Pleasant Street

Concord, NH 03301

All information regarding the IMD/SUD Waiver can be found on the DHHS web site at <https://www.dhhs.nh.gov/> under "Quick Links." DHHS will update this website throughout the public comment and application process.

[DHHS Home >](#)

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

The State of New Hampshire Department of Health and Human Services (DHHS), as the single-state Medicaid agency, is seeking 1115(a) Demonstration Waiver authority to support Medicaid payments for individuals receiving Substance Use Disorder (SUD) services in an Institution for Mental Disease (IMD).

### February 27, 2018 Notice

Notice is hereby given that the DHHS is seeking public input on a *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver* [↗](#) that will enable New Hampshire to provide Medicaid payments for individuals receiving SUD services in an IMD.

Specifically, New Hampshire is requesting:

The Center for Medicare and Medicaid Services (CMS) waive Section 1905(a)(29)(B), 42 CFR 438.6(a), and 42 CFR 435.1010 to allow a waiver of the IMD exclusion for Medicaid-eligible individuals ages 21-64 receiving residential SUD treatment in an IMD as long as is medically necessary.

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 as long as is medically necessary.

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

The Demonstration will further the objectives of Title XIX of the Social Security Act by increasing access to, stabilizing, and strengthening providers and provider networks, available to serve Medicaid and low-income populations in the state. This will be accomplished by ensuring continuity of care for individuals receiving SUD treatment, increasing access to residential treatment services for adolescents with SUD, and ensuring consistency between public and private coverage for SUD services in New Hampshire.

[Read the DHHS Press Release](#)

[View Public Notice ↗](#)

[Read CMS Guidance: Strategies to Address the Opioid Epidemic ↗](#)

### 30-Day Public Comment Period and Waiver

The 30-day public comment period for the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver* [↗](#) is from Tuesday, February 27, 2018 until Friday, March 30, 2018 at 12 Noon (Eastern). All comments must be received by 12 Noon (Eastern) on Friday, March 30, 2018.

Written comments may be submitted to [imsudwaiver@dhhs.nh.gov](mailto:imsudwaiver@dhhs.nh.gov).

[Public Comment and DHHS Responses ↗](#)

[Comments: National Alliance on Mental Illness \(NAMI\) New Hampshire ↗](#)

### Public Hearings

DHHS will host two public hearings during the public comment period.

**Tuesday, March 6, 2018 – Manchester**

8:00 - 7:30 pm

Manchester Health Department

1528 Elm Street Manchester, NH

Call-in option: To participate by phone, call in at 6:00 pm to: 1-866-470-8024

When prompted, use this code: 965 412 0884

Snow Date: Thursday, March 8, 2018, 6 - 7:30 pm, Manchester Health Department

**Tuesday, March 13, 2018 - Nashua**

POSTPONED TO MARCH 14 (same time and location)

1:00 - 2:30 pm

Harbor Homes - Partnership for Successful Living

77 Northeastern Blvd, Nashua, NH

Snow Date: Wednesday, March 14, 2018, 1-2:30 pm, Harbor Homes Partnership for Successful Living

View Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration\* public hearing presentation ↗

If accommodations are needed for communication access such as interpreters, CART (captioning), assistive listening devices, or other auxiliary aids and/or services, please contact Leslie Melby at [Leslie.Melby@dhhs.nh.gov](mailto:Leslie.Melby@dhhs.nh.gov) or 603-271-9074, no later than March 1, 2018. Every effort will be made to accommodate needs identified with advance notice.

Comments will also be considered at the Monday, March 12, 2018 Medical Care Advisory Committee Meeting, from 10-12 p.m. All Medical Care Advisory Committee Meetings are open to the public.

Medical Care Advisory Committee Meeting location:  
NH Hospital Association  
125 Airport Rd, Conference Room 1  
Concord NH 03301

### Ways to Submit Comments

DHHS would like to hear your comments about the changes it is proposing. After hearing the public's ideas and comments about the proposed changes, DHHS will make final decisions about what changes to make to the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver* and then submit to CMS. The summary of comments will be posted for public viewing on this page, along with the waiver application when it is submitted to CMS.

There are several ways to submit your comments to DHHS:

Attend either of the two public hearings to be held at the dates/locations noted above. At the public hearings, you may give verbal or written comments to DHHS.

Email comments to [imsudwaiver@dhhs.nh.gov](mailto:imsudwaiver@dhhs.nh.gov); or

Mail written comments to:

Ms. Leslie Melby

New Hampshire Department of Health and Human Services

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

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 Waiver*.

### Additional Information

Requests for a hard copy of the Waiver application should be submitted by mail to:

Ms. Leslie Melby

New Hampshire Department of Health and Human Services

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

129 Pleasant Street

Concord, NH 03301

A hard copy of the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver* can also be picked up at DHHS, which is located at:

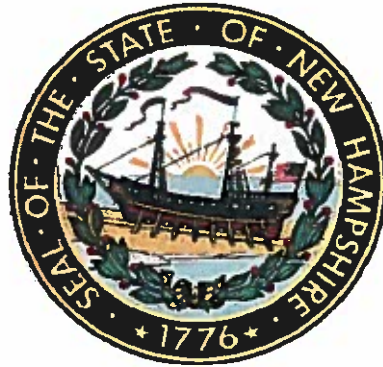
New Hampshire Department of Health and Human Services

Fred H. Brown Building

129 Pleasant Street

Concord, NH 03301

↗ Adobe Acrobat Reader format. You can download a free reader from Adobe (<http://get.adobe.com/reader/>) .



## **New Hampshire Department of Health and Human Services**

**Public Hearing for NH's "*Substance Use Disorder Treatment and Recovery Access*"  
Section 1115(a) Research and Demonstration Waiver**

**Public Forums: March 6, 2018, Manchester  
March 13, 2018, Nashua**



# Background

- ***New Hampshire is experiencing one of the most significant public health crises in its history***
  - Third highest overdose death rate in the country (39 per 100,000).
  - In 2016, 485 people died of overdose.
  - Between 2012 and 2016, the number of times emergency medical personnel administered Narcan more than tripled, from 877 to 2,793.
- ***Major impacts to communities and families***
  - Rate of NAS births per 1,000 live hospital births reached 24.4 per 1,000 in 2015.
  - In 2015, DHHS' Division for Children, Youth, and Families reported that it received 504 reports of children born drug-exposed, an increase of 37% from 2014.
- ***Alarming trends in youth substance use***
  - New Hampshire ranks in the top five (5) in the nation for binge drinking among 12-20 year olds.
  - 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.
  - Estimated 3,000 youth indicated they needed but did not receive treatment for illicit drug in a specialty facility in the past year.



# Waiver Request

- As part of its overall approach to addressing the substance use disorder crisis, the New Hampshire Department of Health and Human Services (DHHS) is applying for a Section 1115(a) Demonstration Waiver from the Centers for Medicare and Medicaid Services (CMS).
- This waiver will enable the Department to reimburse residential SUD treatment providers with more than 16 beds.
- The services proposed within the “Substance Use Disorder Treatment and Recovery Access” Waiver will include those that are in alignment with the existing substance use disorder delivery system for residential treatment and expand availability of services for individuals with co-occurring mental health disorders.
- The adolescent residential treatment program outlined in the waiver will begin operations on July 1, 2018.
- 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.
- DHHS will submit its “Substance Use Disorder Treatment and Recovery Access” Waiver application to CMS by April 9, 2018.



# Current Substance Use Disorder System

## Benefit Coverage:

- 1) **NH Health Protection Program-** Effective August 2014. These members are currently served through the Premium Assistance Program (PAP), receiving coverage on the exchange through commercial carriers. Each commercial carrier covers substance use disorder services, but scope of benefits vary.
- 2) **Medicaid-** Effective July 2016. Medicaid recipients in the state's fee-for-service plan or enrolled with managed care, are eligible to access SUD benefits listed below.

SUD Service Type	Description
<b>Screening, by Behavioral Health practitioner</b>	Screening for a substance use disorder
<b>SBIRT</b>	Screening, Brief Intervention, Referral to Treatment
<b>Crisis Intervention</b>	Crisis services provided in an office or community setting
<b>Evaluation</b>	Evaluation to determine the level of care and/or other services needed.
<b>Medically Managed Withdrawal Management</b>	Withdrawal management in a hospital setting, with or without rehabilitation therapy
<b>Medically Monitored Withdrawal Management</b>	Withdrawal management provided in an outpatient or residential setting
<b>Opioid Treatment Program</b>	Methadone or Buprenorphine treatment in a clinic setting
<b>Office based Medication Assisted Treatment</b>	Medication Assisted Treatment in a physician's office provided in conjunction with other substance use disorder counseling services.

SUD Service Type	Description
<b>Outpatient Counseling</b>	Individual, group, and/or family counseling for substance use disorders
<b>Intensive Outpatient</b>	Individual and group treatment and recovery support services provided at least 3 hours per day, 3 days per week.
<b>Partial Hospitalization</b>	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.
<b>Rehabilitative Services</b>	Low, Medium, and High Intensity residential treatment provided by Comprehensive SUD Programs.
<b>Recovery Support Services</b>	Community based peer and non-peer recovery support services provided in a group or individual setting.
<b>Case Management</b>	Continuous Recovery Monitoring



# Current Substance Use Disorder System

- DHHS' Bureau of Drug and Alcohol Services contracts with fifteen SUD treatment providers across the state to provide substance use disorder treatment and recovery services.
  - Covers those who are not Medicaid eligible or,
  - Commercial benefit plan leaves individual underinsured for the medically necessary level of care.
- SUD residential treatment facilities and insurance carriers 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)).
- Increasing number of individuals in emergency rooms in acute psychiatric crisis presenting with co-occurring substance use disorder.

*Table 3. New Hampshire Hospital Waitlist as of March 5, 2018*

NH Hospital Admitting Queue	Number of Children	Number of Adults
45	4	41



# Adult Residential SUD

- New Hampshire is requesting that 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.
- 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 prior to the release of the CMS clarification on 42 CFR 438.6(e) in March of 2016.
  - Waiver allows the Department to come into compliance with the managed care reg. while continuing to provide payments to SUD providers that are classified as an IMD.
  - Potential for additional SUD residential programs to expand to >16 beds with waiver in place.
  - This is inclusive of inpatient mental health facilities serving individuals with co-occurring SUD.
  - All residential SUD programs must:
    - Be enrolled with Medicaid as a Comprehensive SUD Program,
    - Comply with He-W 513 rules for Comprehensive SUD Program,
    - Comply with He-P 807 for Residential Facilities, and
    - Utilize ASAM Criteria for determining appropriate level of care.



# Current Substance Use Disorder System Adult Access

ASAM Level	Description	Waitlist as of February 2018
Level 3.5	Clinically Managed High-Intensity Residential Services for adults	28
Level 3.1	Clinically Managed Low-Intensity Residential Services	28

- NH DHHS has invested more than \$30M to enhance and expand service capacity in a full continuum of care to treat individuals with substance use disorder.
- Residential treatment access for substance use disorder continues to be limited:
  - 15 state funded entities
  - 18 licensed residential facilities (511 beds), of which 13 are enrolled as Medicaid providers (379 beds).



# Adolescent Residential SUD

- New Hampshire is requesting that CMS expand the exception to the IMD exclusion in 42 CFR 441.11(c)(5) to the provider type Comprehensive SUD program to allow New Hampshire to claim federal financial participation (FFP) for individuals under 21 receiving residential substance use disorder treatment in these facilities.
  - Specifically NH is proposing that any facility serving adolescents with SUD will:
    - Be enrolled with Medicaid as a Comprehensive SUD Program,
    - Comply with He-W 513 rules for Comprehensive SUD Program,
    - Comply with He-P 807 for Residential Facilities, and
    - Utilize ASAM Criteria for determining appropriate level of care.



# Current Substance Use Disorder System

## **Adolescent Access**

- Currently no residential treatment programs specifically for youth in NH.
- HB 517 (2017) 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.





# Adolescent Residential SUD

- ***Sununu Youth Services Center SUD Program***
  - Designed as Comprehensive SUD Program
    - Providing low intensity and medium intensity residential services for adolescents in accordance with ASAM.
    - Providing services to adolescents with co-occurring mental health disorders.
  - 36 beds for adolescent SUD treatment
    - 16 beds available on July 1, 2018, additional 20 beds available on August 1, 2018 or 30 days following notification of waiver approval.



# Budget Neutrality

- DHHS is working with the Department's actuary to develop a budget neutrality approach for its "Substance Use Disorder Treatment and Recovery Access" Waiver.

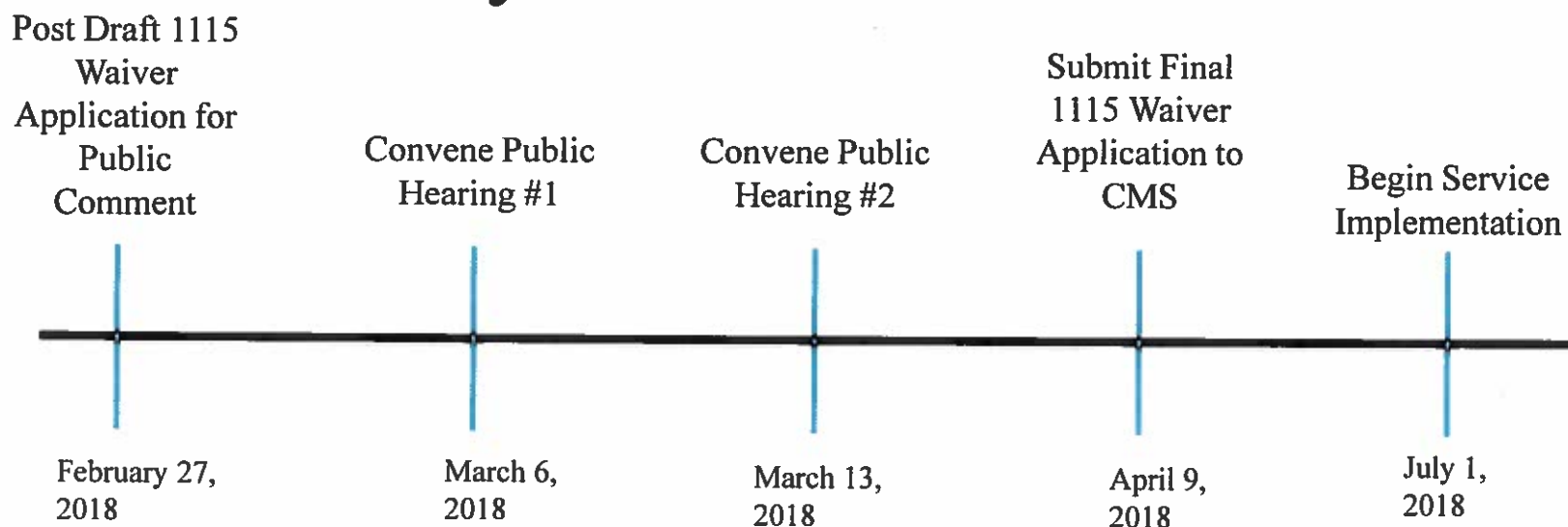


# Evaluation

- DHHS will submit an evaluation design for its “Substance Use Disorder Treatment and Recovery Access” Waiver no later than 120 days after CMS approves the Waiver.
- The State will test the following research hypotheses through its “Substance Use Disorder Treatment and Recovery Access” Waiver:
  - Adult Medicaid recipients, ages 21 through 64, will have equal to or better access to SUD residential and hospital rehabilitation treatment services in New Hampshire.
  - Adolescent Medicaid recipients will have better access to SUD residential treatment services in New Hampshire.
  - Adult Medicaid recipients, ages 21 through 64, will have equal to or better access to acute inpatient hospital services for the treatment of MH and SUD co-occurring disorders when admitted for a primary SUD diagnosis.



# Substance Use Disorder Treatment and Recovery Access Waiver Timeline



# Opportunities for Public Input – Public Hearings

- **Tuesday, March 6, 2018 – Manchester**  
6:00 – 7:30pm  
Manchester Health Department  
1528 Elm Street  
Manchester NH  
Call-in option: To participate by phone, call in at 6:00 pm to:  
1-866-470-8024  
When prompted, use this code: 965 412 0884  
**Snow Date** – Thursday, March 8, 2018, 6-7:30 pm, Manchester Health Department
- **Tuesday, March 13, 2018 – Nashua**  
1:00 – 2:30pm  
Harbor Homes – Partnership for Successful Living  
77 Northeastern Blvd  
Nashua, NH  
**Snow Date** – Wednesday, March 14, 2018, 1-2:30 pm, Harbor Homes Partnership for Successful Living
- **MCAC Meeting: Monday, March 12, 2018**  
10:00am – Noon  
New Hampshire Hospital Association  
125 Airport Rd  
Concord, NH



## Email or Mail

- Comments may be submitted by email to [imdsudwaiver@dhhs.nh.gov](mailto:imdsudwaiver@dhhs.nh.gov) or by regular mail to:  
Ms. Leslie Melby, New Hampshire Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301  
Attn: Substance Use Disorder Treatment and Recovery Access  
Section 1115(a) Research and Demonstration Waiver

## Current Draft Waiver Application

- The complete version of the current draft of the demonstration waiver application can be found at:  
<https://www.dhhs.nh.gov/sud-imd/index.htm>



## Web Site

- Notice, waiver documents, and information about the waiver are available on the DHHS web site at <https://www.dhhs.nh.gov/>
- To reach all stakeholders, non-electronic copies of all the aforementioned documents are available by contacting Leslie Melby at the Department at 603-271-9074.

Public Comments may be submitted until 12 noon (Eastern) on Friday, March 30, 2018.





March 23, 2018

Ms. Leslie Melby  
New Hampshire Department of Health and Human Services  
129 Pleasant Street  
Concord, NH 03301

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

Dear Ms. Melby:

On behalf of NAMI NH the National Alliance on Mental Illness and our Board of Directors, NAMI NH is submitting this letter as our formal comment and support of the New Hampshire Department of Health and Human Services request for a Substance Use Disorder and Recovery Access Section 1115(a) Demonstration Waiver. The proposed waiver will allowing the State to receive federal funds for adults and adolescents who are Medicaid-eligible and receive residential substance use disorder treatment in an Institution for Mental Disease (IMD) for as long as is medically necessary.

NH is in the midst of an addiction crisis with the third highest per capita overdose death in the country. The Department of Health and Human Services together with Governor Sununu, our Legislature and the Congressional delegation have all been working thoughtfully and tirelessly to support individuals and families impacted by this crisis and to provide a full array of treatment, services and supports. This 115(a) waiver will be an important component to getting affected individuals timely access to lifesaving treatment services.

Thank you for your consideration and please feel free to contact me if you have any questions regarding our support.

Respectfully,

  
Kenneth Norton, LICSW  
Executive Director

*Find Help, Find Hope*

NAMI New Hampshire • 85 North State Street • Concord, NH 03301  
InfoLine: 800-242-6264 • Tel. 603-225-5359 • Fax 603-228-8848 • [info@naminh.org](mailto:info@naminh.org) / [www.NAMINH.org](http://www.NAMINH.org)



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

**Public Comment and Responses from NH DHHS**

**Comment #1** – How does this 1115 waiver tie into the IDNs and the other 1115 waiver?

**Response #1** – The Department’s 1115 Delivery System Reform Incentive Program (DSRIP) waiver allows health care providers and community partners within a region to form relationships focused on transforming care. The DSRIP incentive funding also provides for prompt resources for combating the opioid crisis and strengthening the state's strained mental health delivery system. This waiver, the *New Hampshire Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver*, will compliment DSRIP efforts through increased in-state residential service capacity for Comprehensive SUD Treatment for adults and children. The Department expects that the waivers are in alignment to address New Hampshire’s opioid crisis and support efforts to implement a comprehensive and lasting response to this epidemic.

**Comment #2** – We have been doing this for years, is there a chance we won’t get this waiver?

**Response #2** – During the roll out 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 CMS clarification of 42 CFR 438.6 (e) in March 2016. As a result, residential treatment providers were advised that SUD facilities with more than (16) sixteen beds would not be considered an IMD in New Hampshire. The waiver is necessary to address the compliance issue with 42 CFR 438.3 (e) identified by CMS on March 13, 2017 and to ensure that publicly-funded SUD residential treatment is clinically appropriate and that the provider capacity continues to expand to address the opioid epidemic. New Hampshire is working with our federal partners at CMS to ensure that the waiver is expedited.

**Comment #3** – This is necessary for providers to support those with Medicaid. If we were limited to 15 or 16 beds, this not a viable business option; this is incredibly important for providers since nobody has less than 16 beds.

**Response #3** – The Department concurs with this comment.

**Comment #4** – How long is the waiver good for?

**Response #4** – The Department has applied for a five year waiver.

**Comment #5** – Does this cover Medicaid and non-Medicaid for both adults and children?

**Response #5** – The waiver is specific to Medicaid, but by increasing capacity for Medicaid funded services, the Department is facilitating an opportunity for provides to receive payment through both public and private sources to increase overall capacity in the State.

**Comment #6** – How does this work with in lieu of services in the managed care contracts?

**Response #6** – The Department, with the authority granted through a waiver from CMS, does not need to exercise an in lieu of option in the managed care contracts since the authority waives the limitation on IMD service days for SUD treatment.

**Comment #7** – Will this allow mental health services? Is the Department considering a mental health IMD waiver?

**Response#7** – This demonstration authorizes FFP for covered/coverable Medicaid services provided to beneficiaries who are admitted to an IMD for the purpose of SUD treatment. The expenditure authority is not limited to the SUD-related treatments exclusively. If a participating SUD IMD provider renders mental health services to treat a beneficiary's co-occurring disorder, that would be allowable; as would primary care, pharmacy, or other covered Medicaid services provided to the beneficiary by the IMD or other Medicaid provider. However, FFP for covered Medicaid services provided to beneficiaries who are admitted to IMDs primarily for mental health treatment (or for any reason other than for SUD) are not included in the 1115 SUD demonstration option. The Department is exploring mental health options in collaboration with our CMS federal partners. The Department's web site provides a link to the November 1, 2017 CMS guidance for the waiver.

**Comment #8:** Does this mean if you are between 18 and 21 years of age the waiver does not apply to you?

**Response #8:** The Department's request is to allow a waiver for IMD exclusion for Medicaid eligible individuals 21 to 64, as well as those under 21, receiving residential substance use disorder (SUD) treatment in an IMD for as long as is medically necessary. HB 517 requires the State to develop a 36-bed residential SUD treatment facility available to adolescents under 18 years old. The waiver will include services that are in alignment with the existing substance use disorder delivery system for residential treatment and expand availability of services in the state of NH for adolescents.

**Comment #9:** Who are the providers per ASAM? Is this outlined here in NH?

**Response #9:** The ASAM criteria is the medical necessity criteria that is used to determine appropriate level of care for individuals with SUD. All SUD providers that meet provider and facility qualifications in He-W 513 must follow these criteria. Provider eligibility for SUD services is outlined in He-W 513.

**Comment #10:** Is there a need to have this capacity for children?

**Response #10:** HB517 directed the Department to redevelop excess capacity at Sununu Youth Services Center for a SUD residential program for adolescents <18 years of age. There are no residential programs for this population in NH and therefore few claims to assess any historical utilization. HB517 also required outpatient capacity development for this population and the Department will review the timeline for those services once residential services at the facility are available targeted to begin July 1, 2018.

**Comment #11:** What is the professional or hospital portion of the service? Is there facility type billing?

**Response #11:** Hospitals providing SUD services in accordance with He-W 513 are eligible service providers for the full array of benefits. Hospitals billing for SUD services would bill the DRG code as outlined in the rate spreadsheet available at <https://www.dhhs.nh.gov/ombp/sud/documents/sud-billable-services.pdf>

**Comment #12:** Is there a bed listing by provider type based on what is noted in the slide deck?

**Response #12:** The list of state funded treatment providers can be found on the Bureau of Drug and Alcohol Services treatment resource guide available at:

<https://www.dhhs.nh.gov/dcbcs/bdas/documents/resource-guide-treatment.pdf>. The list of licensed residential facilities can be selected by selecting “Residential Treatment and Rehab” as the license type in the search function available at:

<https://nhlicenses.nh.gov/verification/Search.aspx?facility='Y'>

**Comment #13:** There is a “stigma” noted around the Sununu Youth Center that may keep some families from engaging in services. How will the Department address this since it is a service entirely separate from the Center?

**Response #13:** The Department has been very sensitive to the stigma concerns related to the population being served at Sununu Youth Services Center. Prior to designing the program, Department representatives met with youth at the facility to understand the needs for youth with SUD and built that feedback into the program design. To address this, the separate entry space for the SUD program is being constructed to reflect a rehabilitative environment and all programming is required to be delivered in accordance with clinically appropriate criteria. Additionally, specific program requirements regarding working with youth and families were built in the program design, specifically requiring alignment with the State Youth Treatment Strategic Plan available in Appendix G at:

<https://www.dhhs.nh.gov/business/rfp/documents/rfp-2018-bdas-11-resid.pdf>

**Comment #14:** How will telehealth for SUD services being considered as part of this waiver?

**Response #14:** This waiver does not consider telehealth SUD services.