DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-262
Baltimore, Maryland 21244-1850

June 16, 2021

Henry Lipman
Medicaid Director
Division of Medicaid Services
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-6521

Dear Mr. Lipman:

The Centers for Medicare & Medicaid Services (CMS) is approving New Hampshire's request to amend its section 1115(a) demonstration project titled, "Substance Use Disorder Treatment and Recovery Access" (SUD TRA) (Project number 11-W-00321/1) – in accordance with section 1115(a) of the Social Security Act ("the Act") – and in response to a required Corrective Action Plan (CAP), as modified through discussions with CMS. Approval of this amendment brings the state back into compliance with the SUD TRA's budget neutrality requirements and permits the state to continue operating this demonstration that is expected to assist the state in maintaining:

- Increased identification of and timely engagement in treatment for Medicaid beneficiaries diagnosed with SUD;
- Increased adherence to, and retention in, SUD treatment; and,
- Reduced inappropriate or preventable utilization of emergency departments and inpatient hospital settings through improved access to a continuum of care services – including services in additional settings that, absent this demonstration, would be ineligible for payment for most Medicaid enrollees.

This approval is effective June 16, 2021 through June 30, 2023, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS' approval of this demonstration amendment/CAP is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the Special Terms and Conditions (STCs) defining the nature, character and extent of anticipated federal involvement in the project.

Amendment Proposal

New Hampshire submitted an amendment as part of its required CAP, as the state was exceeding the SUD TRA's cumulative budget neutrality expenditure limit. In its August 21, 2020 amendment application, New Hampshire, due to lack of reliable and accurate historical data, proposed changes to the demonstration's per member per month (PMPM). As part of the CAP,

CMS is *prospectively* adjusting the state's hypothetical budget neutrality limits to more accurately reflect actual expenditure data reported under this demonstration. Additionally, CMS is updating, among others, sections III, XI and XII of the STCs to align with CMS's recent section 1115(a) demonstration approvals. No additional expenditure or waiver authorities are necessary. This amendment is being approved to meet the CAP requirement.

Consideration of the Public Comments

The state provided public notice for this amendment in accordance with the September 27, 1994 Federal Register notice (59 FR 49249) requirements for state notice. The New Hampshire Department of Health and Human Services posted public notice of the section 1115 SUD TRA demonstration amendment application on its website on August 7, 2020. Due to the COVID-19 public health emergency, in lieu of in-person public hearings, New Hampshire used alternative formats, such as video teleconference or telephone hearings, which permitted the public to participate in a public hearing and submit public input. New Hampshire held a public hearing on August 10, 2020 at its monthly Medical Care Advisory Committee meeting during which it accepted public comment. As a companion to the public hearing, the state provided additional time for the submission of input through mail or electronic mail from August 7, 2020 through August 11, 2020. New Hampshire does not have any federally recognized tribes and therefore did not send any tribal notice or consultation letters.

Consistent with federal transparency requirements, CMS reviewed all of the materials submitted by the state, when evaluating whether the demonstration project as a whole is likely to assist in promoting the objectives of the Medicaid program. New Hampshire received at least one comment in support of its amendment during its public comment period. After deeming the state's SUD TRA amendment application complete, CMS posted it on Medicaid.gov for a 30-day federal public comment period from August 27, 2020, through September 25, 2020. CMS received one written comment during the federal comment period that was not relevant to this amendment request.

After careful review of the public comments submitted during the federal comment period and the information received from the state public comment period, CMS has concluded that the demonstration, as amended, is likely to advance the objectives of Medicaid.

Other Information

The award of this approval is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. Your project officer for this demonstration is Kathleen O'Malley. She is available to answer any questions concerning your amendment. Ms. O'Malley's contact information is below:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850

Telephone: (410) 786-8987
E-mail: Kathleen.OMalley@cms.hhs.gov

If you have any questions regarding this approval, please contact Ms. Teresa DeCaro, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services at (410) 786-9686.

Sincerely,

[redacted]

Anne Marie Costello
Acting Deputy Administrator and Director

Enclosure

cc: William Pak, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00321/1

TITLE: Substance Use Disorder Treatment and Recovery Access

AWARDEE: New Hampshire Department of Health and Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by New Hampshire for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from July 10, 2018 through June 30, 2023, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

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

1. **Residential Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD).

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00321/1

TITLE: Substance Use Disorder Treatment and Recovery Access

AWARDEE: New Hampshire Department of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Substance Use Disorder Treatment and Recovery Access" (SUD – TRA) section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the New Hampshire Department of Health and Human Services (hereinafter "state"), to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted. The STCs are effective as of the date of the approval letter, unless otherwise specified.

On June 16, 2021 CMS approved an amendment that revised the SUD TRA's per member per month (PMPM) limits—as its required Corrective Action Plan (CAP)—pursuant to STC 64. The state's demonstration amendment application/CAP has been added to these STCs as Attachment F.

The STCs have been arranged into the following subject areas:

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

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

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

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements

of the Medicaid Program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to this demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs as needed to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STCs 6 and 7. CMS will notify the state within 30 days of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as

amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

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

    a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
    b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
    c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
    d. An up-to-date CHIP allotment worksheet, if necessary;
    e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the Evaluation Design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of

the demonstration, the Governor of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and phase- out plan consistent with the requirements of STC 9.

9. **Demonstration Transition and Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements;

    a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
    b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will redetermine Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
    c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to determining the individual ineligible as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid or CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e) and 457.350. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure

all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230.

d. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

e. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

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

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

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

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

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

13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

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

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

IV. ELIGIBILITY AND ENROLLMENT

16. **Eligibility Groups Affected by the Demonstration.** Under the demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan. The demonstration will allow Medicaid recipients under age 65 to receive OUD/SUD treatment services in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. Demonstration services are delivered through a managed care or fee for service (FFS) delivery system. FFS recipients are primarily those in their managed care plan selection period, except for a small number of recipient who are exempt from managed care. All affected groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable.

V. DEMONSTRATION PROGRAMS AND BENEFITS

17. Opioid Use Disorder/Substance Use Disorder Program. Effective upon CMS' approval of the OUD/SUD Implementation Protocol, the demonstration benefit package for Medicaid recipients will include OUD/SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. New Hampshire will aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in Section VIII below, to ensure short-term residential treatment stays. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

The extension of coverage to services for all recipients while they are in short-term residential treatment for OUD/SUD will expand the available settings and allow the state to offer a full continuum of care for recipients with OUD/SUD (see Table 1). Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 1: New Hampshire OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Expenditure Authority
Outpatient Services	State plan (Individual services covered)	Services provided to individuals in an IMD
Intensive Outpatient Services	State plan (Individual services covered)	Services provided to individuals in an IMD
Residential Treatment	State plan (Individual services covered)	Services provided to individuals in an IMD
Medically Supervised Withdrawal Management	State plan	Services provided to individuals in an IMD
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	State plan	Services provided to individuals in an IMD
Medication Assisted Treatment	State Plan	Services provided to individuals in an IMD
Partial Hospitalization	State plan	Services provided to individuals in an IMD
Recovery Support Services	State plan	Services provided to individuals in an IMD.

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

component of this demonstration program:

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

in STC 18; and

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

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

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

20. **Mid-Point Assessment.** The state must conduct an independent mid-point assessment of the demonstration by December 31, 2021. The assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The mid-point assessment will also provide a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors

that the state can influence that will support improvement. The assessor will provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. A copy of the report will be provided to CMS. CMS will be briefed on the report.

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

21. **SUD Health Information Technology (Health IT).** The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance will be included as a section of the state's "Implementation Plan" (see STC 18) to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.
    a. The SUD Health IT section of the Implementation plan will include implementation milestones and dates for achieving them.
    b. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.
    c. The SUD Health IT Plan will describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP).[1]
    d. The SUD Health IT Plan will address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.2 This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
    e. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state

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

will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

f. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.

g. In developing the Health IT Plan, states should use the following resources:
    i. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."
    ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.
    iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.

h. The state will include in its Monitoring Protocol (see STC 19) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.

i. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 27).

j. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.
    i. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.
    ii. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

[3] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

VI. COST SHARING

Cost sharing imposed upon individuals under the demonstration is consistent with the provisions of the approved state plan.

VII. DELIVERY SYSTEM

The state's SUD/OUD Medicaid delivery system is based on an integrated managed care model for physical and behavioral health. It utilizes Managed Care Organizations (MCO) to deliver integrated physical and behavioral health services, including SUD with a small number of members receiving services through FFS. Under the demonstration, Substance Use Disorder Treatment and Recovery Access will continue to operate as approved in Section 1932(a) state plan authority for managed care and concurrent 1915(b) and 1115 demonstrations.

22. Managed Care Requirements. The state must comply with the managed care regulations published at 42 CFR 438, except as explicitly provided to the contrary in this STC 22. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.4. The capitation rates shall be developed according to 42 CFR 438.5 and 438.6, and the certification submitted pursuant to 42 CFR 438.7.

The state must maintain:

a. Policies to ensure an increased stability among capitated managed care plans and minimize plan turnover. This could include a limit on the number of participating plans in the Medicaid Care Management (MCM) program. Plan selection and oversight criteria must include: confirmation that solvency requirements are being met; an evaluation of prior business operations in the state; and financial penalties for not completing a contract term.

b. These STCs provide additional refinements and detail on the state's existing obligations under 42 CFR Part 438 and are intended to be consistent with the requirements of 42 CFR Part 438; except where expressly noted otherwise, these STCs are not wholly new and distinct requirements on the state. The state must maintain policies to ensure network adequacy and access requirements which address travel time and distance, which are appropriate for the enrolled population. Policies must include documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations.

c. The state must ensure that each managed care entity calculates and reports a Medical Loss Ratio (MLR) for each contract and rating year. Such MLR calculation and reporting must be consistent with the standards specified in 42 CFR 438.8.

VIII. GENERAL REPORTING REQUIREMENTS

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

24. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)")) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

a. Thirty (30) calendar days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).
    i. CMS may decline the extension request.
    ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
    iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.
c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

    CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example, what quarter the deferral applies to and how the deferral is released.

25. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Protocol and the required performance measures in the Monitoring protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

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

work with CMS to:

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

IX. MONITORING

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

a. Operational Updates - Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post- award public forums regarding the progress of the demonstration.
b. Performance Metrics – Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.
c. Budget Neutrality and Financial Reporting Requirements- Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report

quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. SUD Health IT. The state will include a summary of progress made in regards to SUD Health IT requirements outlined in STC 18.

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

a. The draft report must comply with the most current guidance from CMS.
b. The state will present to and participate in a discussion with CMS on the close-out report.
c. The state must take into consideration CMS' comments for incorporation into the final close-out report.
d. The final close-out report is due to CMS no later than 30 calendar days after receipt of CMS' comments.
e. A delay in submitting the draft or final version of the close-out report may subject the state to penalties described in STC 24.

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

a. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.
b. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.
c. The state and CMS will jointly develop the agenda for the calls.

30. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

X. EVALUATION OF THE DEMONSTRATION

31. Independent Evaluator. Upon approval of the demonstration, the state must begin to

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

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

33. **Draft Evaluation Design.** The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state must use an independent evaluator to develop the draft Evaluation Design.

34. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in theses STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

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

36. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for

renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

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

37. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period, July 10, 2018 through June 30, 2023, within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

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

38. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

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

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

41. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 24.

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

42. Allowable Expenditures. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.[1]

43. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

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

a. Administrative costs, including those associated with the administration of the demonstration;
b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved demonstration; and

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

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the approved demonstration period, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

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

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

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

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to fund the demonstration. CMS will consider the submission and adequacy of documents formally requested under this subsection as subject to STC 24. If the state does not adequately respond to CMS requests for information within the timeframe delineated in STC 25, CMS will initiate a deferral.
b. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

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

a. All units of state or local government that furnish any non-federal share for expenditures under the demonstration, including health care providers that are such units of state or local government, certify that state or local funds have been expended as the non-federal share of funds under the demonstration.
b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of payments under the demonstration, the state has obtained CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state would identify those costs eligible for FFP under title XIX or title XXI or under section 1115 authority for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities certify to the state the amount of such state or local funds that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is used to claim federal Medicaid matching funds, the federal matching funds received cannot be used as the non-federal share needed to receive other federal matching funds, except as allowed by law. The entity or entities that certified the expenditure(s) must also provide cost documentation to support the state's claim for federal matching funds.
d. The state uses intergovernmental transfers (IGT) only to the extent that such funds are derived from state or local funds that are transferred by units of government within the state to the single state Medicaid agency to serve as the non-federal share for demonstration expenditures.
e. Under all circumstances, health care providers retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) exist between or among health care providers (or entities related to health care providers) and state and/or local government entities to return and/or redirect to the state any portion of the providers' Medicaid payments. This certification confirming Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, and payments in connection with business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.
f. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration accord with all applicable federal requirements and do not lead to the duplication of any other federal funds, unless permitted by law.

48. Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, with respect to any of the below-described financing mechanisms used to supply non-federal share for payments under the demonstration:

a. Except as provided in this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Social Security Act and 42 CFR § 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Social Security Act and 42 CFR § 433.68(c)

b. Except as provided in this STC, all health care-related taxes are uniform as defined by Section 1903 (w)(3)(C) of the Social Security Act and 42 CFR § 433.68(d)

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Social Security Act and 42 CFR § 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Social Security Act and 42 CFR § 433.68(f).

e. All provider related-donations as defined by Section 1903(w)(2)(B) of the Social Security Act and 42 CFR § 433.52 are bona fide and meet the requirements of 42 CFR § 433.66 and 42 CFR § 433.54.

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

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

Table 2: Master MEG Chart

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

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

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the

original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are not used to reduce the base expenditures used to determine the budget neutrality expenditure limit, the state should not report pharmacy rebates to reduce actual expenditures applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration.

d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER, using with the waiver name "ADM". Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in STC 27, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive coverage for services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date

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

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

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

Table 4: Demonstration Years

Demonstration Year 1	July 1, 2018 to June 30, 2019	12 months
Demonstration Year 2	July 1, 2019 to June 30, 2020	12 months
Demonstration Year 3	July 1, 2020 to June 30, 2021	12 months
Demonstration Year 4	July 1, 2021 to June 30, 2022	12 months
Demonstration Year 5	July 1, 2022 to June 30, 2023	12 months

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

[2] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states

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

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

a. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of any requirement of section 1903(w) of the Act or its implementing regulations.
b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.
c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures that the data are fully consistent with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to establish the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

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

58. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

59. Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. The federal share of any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

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

condition of CMS approval) to offset that excess spending by refunding the FFP to CMS.

61. **Hypothetical Budget Neutrality Test 1:** SUD Services (see Expenditure Authority #1). The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 5. PMPM Costs by MEG and Demonstration Year

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

62. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

63. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from July 1, 2020 to June 30, 2023. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

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

Table 6: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations

Demonstration Year	Cumulative Target Definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent

XIII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Date	Deliverable	STC
30 days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 days after SUD program approval date	SUD Implementation Protocol	STC 18
150 days after SUD program approval date	SUD Monitoring Protocol	STC 19
180 days after approval date	Draft Evaluation Design	STC 33
60 days after receipt of CMS comments	Revised Draft Evaluation Design	STCs 34
30 days after CMS Approval	Approved Evaluation Design published to state's website	STC 34
December 31, 2021	Mid-Point Assessment	STC 20
One year prior to the end of the demonstration, or with renewal application	Draft Interim Evaluation Report	STC 36(c)
60 days after receipt of CMS comments	Final Interim Evaluation Report	STC 36(d)
18 months of the end of the demonstration	Draft Summative Evaluation Report	STC 37
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 37(a)
30 calendar days of CMS approval	Approved Final Summative Evaluation Report published to state's website	STC 37(b)
Monthly Deliverables	Monitoring Calls	STC 29
Quarterly Deliverables Due 60 days after end of each quarter, except 4th quarter	Quarterly Monitoring Reports	STC 27
	Quarterly Expenditure Reports	STC 43

Annual Deliverables - Due 90 days after end of each 4th quarter	Annual Reports	STC 27
Within 120 calendar days after the expiration of the demonstration	Draft Close-out Operational Report	STC 28
30 calendar days after receipt of CMS comments	Final Close-out Operational Report	STC 28(d)

ATTACHMENT A
Developing the Evaluation Design

Introduction

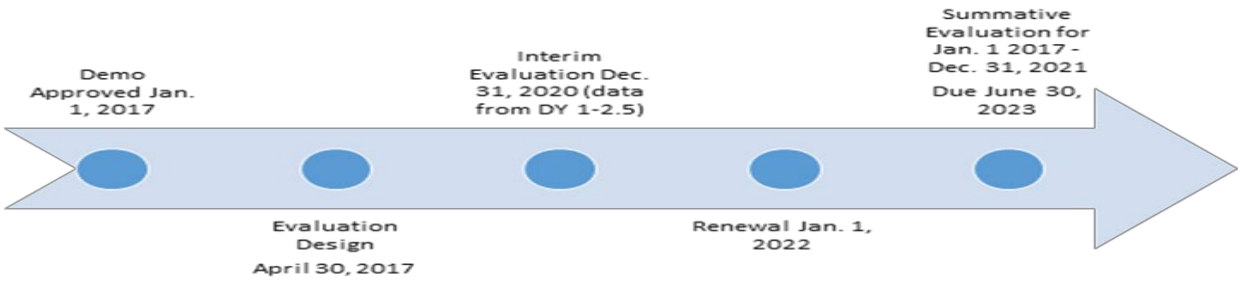
For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs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

Expectations for Evaluation Designs

All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals**.**

The format for the Evaluation Design is as follows:
General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

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



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

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

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

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

1. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
2. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3. Identify the state's hypotheses about the outcomes of the demonstration:

4. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;

5. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
    a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
    b. Qualitative analysis methods may be used, and must be described in detail.
    c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
    d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
    e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
    f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

    If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

    b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

    c. A discussion of how propensity score matching and difference in differences

design may be used to adjust for differences in comparison populations over time (if applicable).

d. The application of sensitivity analyses, as appropriate, should be considered.

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

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

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

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

1) When the state demonstration is:
   a. Long-standing, non-complex, unchanged, or
   b. Has previously been rigorously evaluated and found to be successful, or
   c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

a. Operating smoothly without administrative changes; and
b. No or minimal appeals and grievances; and
c. No state issues with CMS-64 reporting or budget neutrality; and
d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

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

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

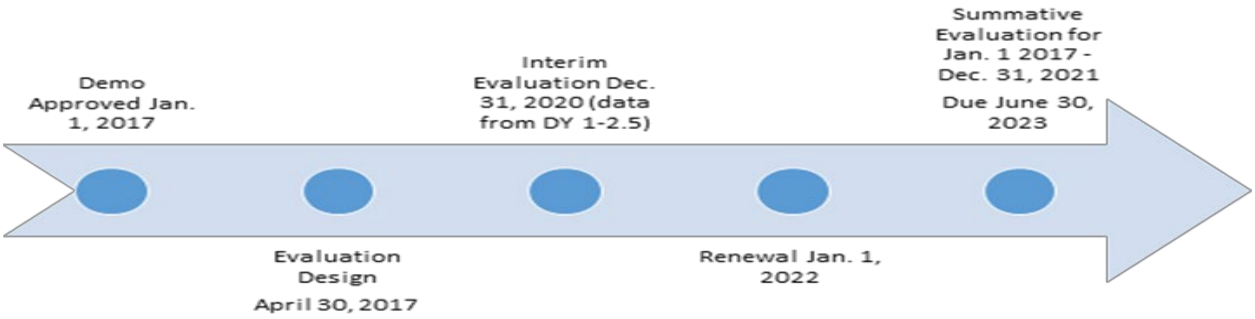
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved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

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

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

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



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the

implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

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

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

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

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
   a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
   b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
   c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

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

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. Evaluation Design – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. Target and Comparison Populations – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. Evaluation Period – Describe the time periods for which data will be collected
4. Evaluation Measures – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. Data Sources – Explain where the data will be obtained, and efforts to validate and clean the data.
6. Analytic methods – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. Other Additions – The state may provide any other information pertinent to the evaluation of the demonstration.

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

B) Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

C) Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

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

E. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?

2. What would you recommend to other states which may be interested in implementing a similar approach?

F. Attachment

Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT C:
Evaluation Design

NEW HAMPSHIRE SUBSTANCE USE DISORDER TREATMENT AND RECOVERY ACCESS DEMONSTRATION

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

EVALUATION DESIGN
DEC 18, 2018

Table of Contents

I. General Background Information

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

A. Rationale for Demonstration

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

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

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

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

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

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

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

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

B. Purpose of Demonstration

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

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

C. SUD Benefits and Demonstration History

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

Table 1. New Hampshire Medicaid Substance Use Disorder Benefit

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

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

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

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

D. Demonstration Goals

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

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

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

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

E. Demonstration Population

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

II. Evaluation Questions and Hypotheses

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

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

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

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

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

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

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

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

Improvements in quality expected as a result of rule changes will be measured through structured provider interviews. Interviews will solicit provider feedback on their understanding of the DHHS rule changes and its impact relative to consistency in residential SUD programs and expanded discharge planning requirements.
Lastly, related to cost of care, the State is expected to maintain or reduce spending in comparison to what would have been spent absent the demonstration. In the case of adolescents, it is hypothesized that the cost of residential SUD treatment will be reduced as more youth access in-state treatment options in lieu of more costly out-of-state SUD treatment.

Quality Strategy and SUD Monitoring Plan

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

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

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

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

[i] https://www.cdc.gov/drugoverdose/data/statedeaths.html
[ii] New Hampshire Drug Monitoring Initiative, 2017 Final Overview Report, October 5, 2018: https://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-2017-overview.pdf
[iii] ibid
[iv] ibid
[v] https://scholars.unh.edu/cgi/viewcontent.cgi?article=1330&context=carsey
[vi] https://www.nhbar.org/publications/display-news-issue.asp?id=8377
[vii] Center for Behavioral Health Statistics and Quality (2016). 2015-2016 National Survey on Drug Use and Health: Model-Based Prevalence Estimates. Substance Abuse and Mental Health Services Administration, Rockville, MD.
https://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2016/NSDUHsaePercents2016.pdf
[viii] Meier, A., Moore, S., Saunders, E., Metcalf, S., McLeman, B., Auty, S. and Marsch, L. (2017). HotSpot Report: Understanding Opioid Overdoses in New Hampshire | NDEWS l National Drug Early Warning System l University of Maryland. [online] Ndews.umd.edu. Available at: https://ndews.umd.edu/publications/hotspot-report-understanding-opioid-overdoses-new-hampshire
[ix] https://www.dhhs.nh.gov/dcbcs/bdas/documents/mid-year-commmission.pdf

Figure 1: Access Driver Diagram

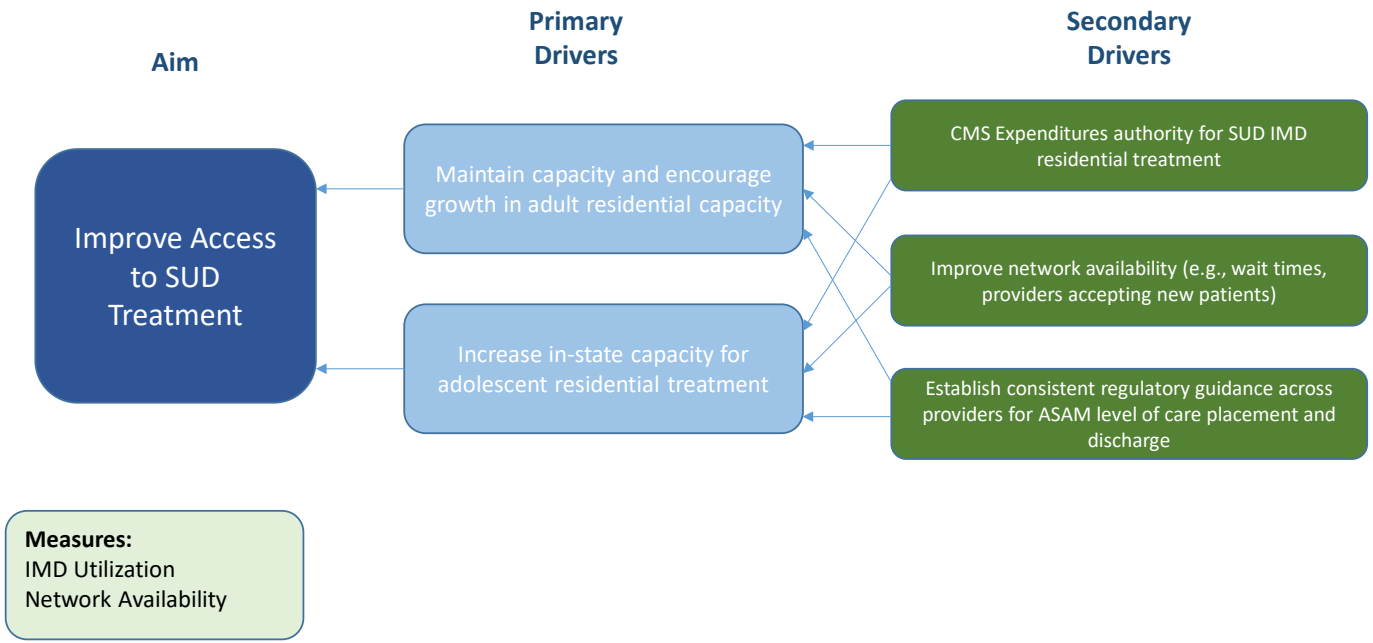


Figure 2: Quality Driver Diagram

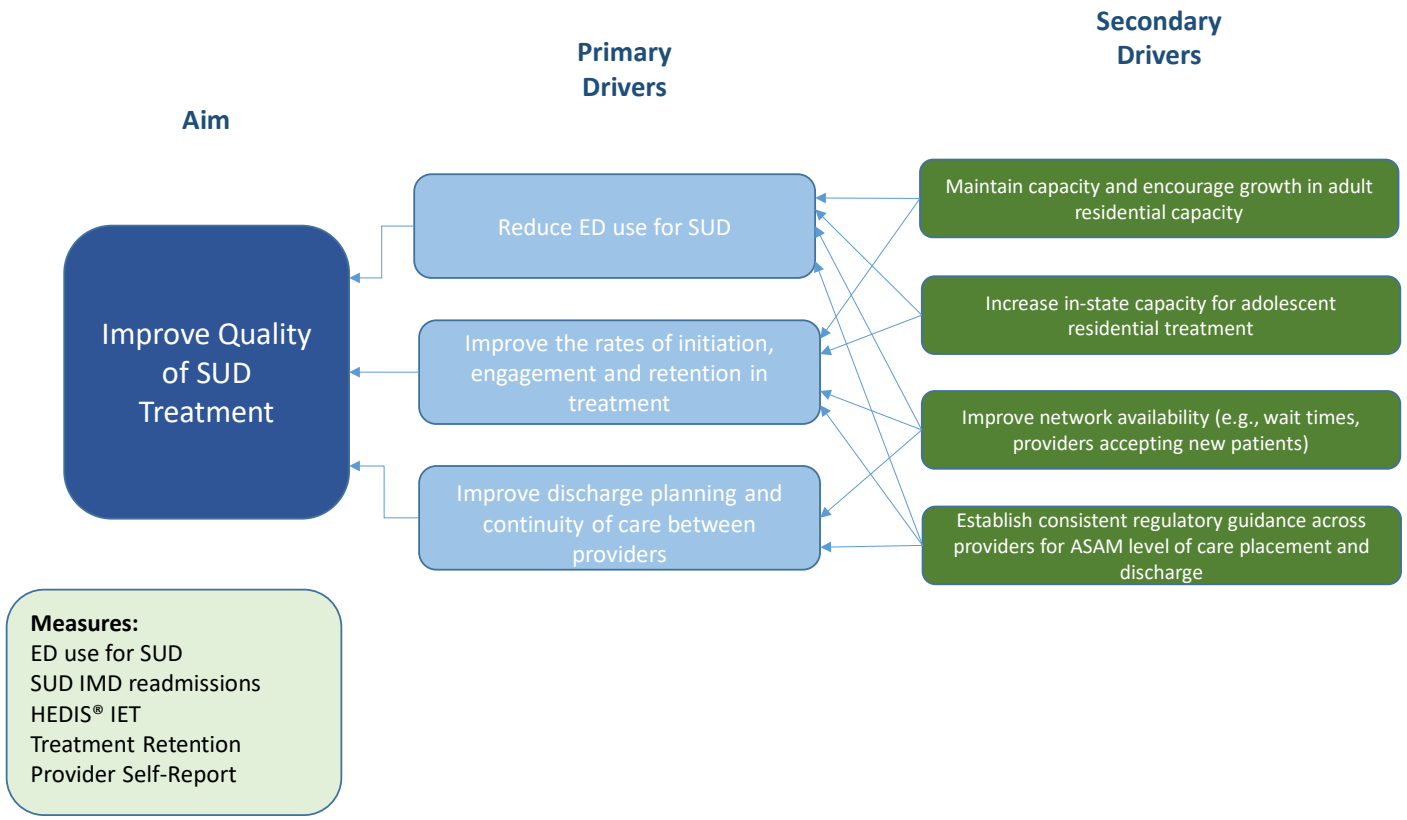
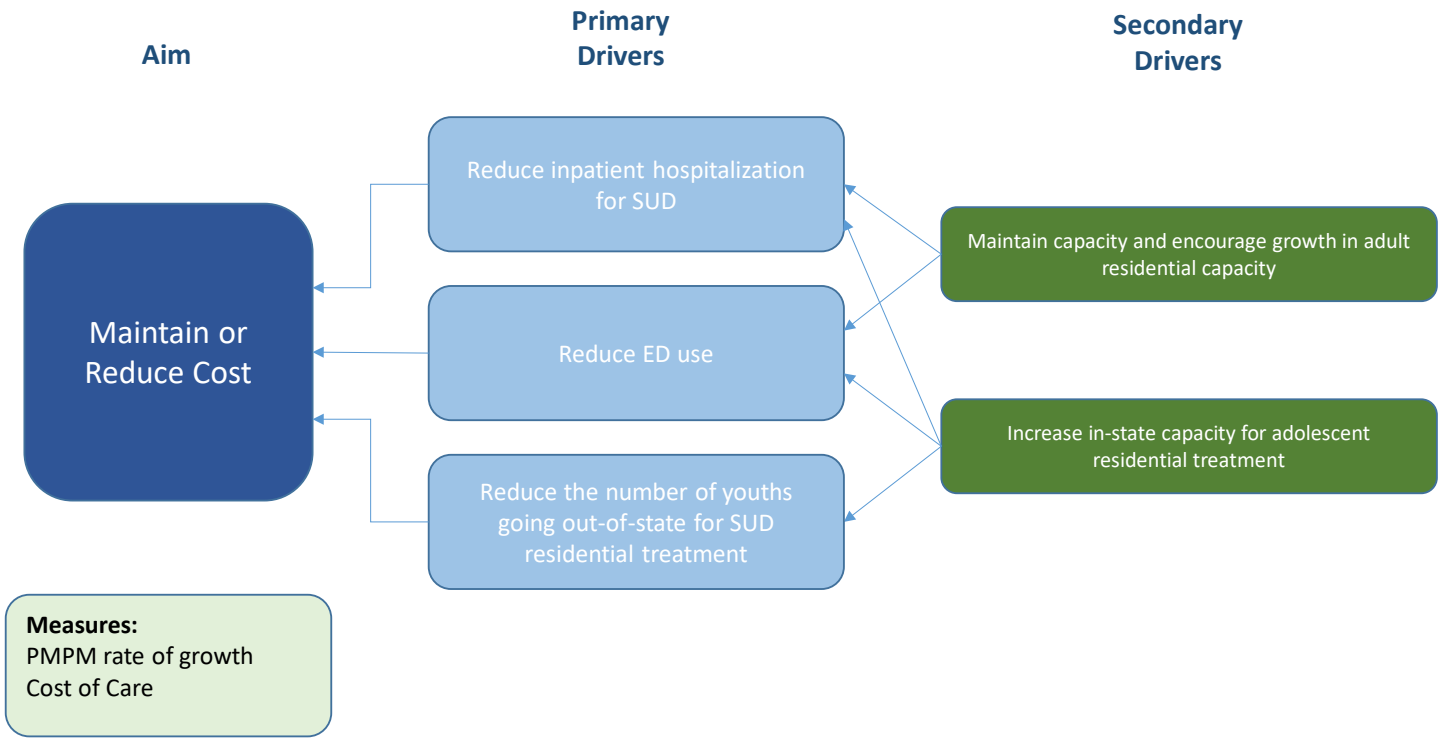


Figure 3: Cost Driver Diagram



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

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

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

III. Methodology

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

A. Evaluation Design

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

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

- Accept Medicaid enrollees
- Accept new patients
- Have timely appointment availability[3]

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

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

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

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

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

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

Target and Comparison Populations

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

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

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

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

Table 3. SUD Evaluation Enrollee Sub-Groups

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

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

Sampling Methodology

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

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

Comparison Groups

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

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

Evaluation Period

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

Table 4. Evaluation Period

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

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

Evaluation Measures

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

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

Hypothesis

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

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

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

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

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

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

Hypothesis

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

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

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

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

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

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

National Benchmark	N/A

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

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

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

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

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

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

Hypothesis

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

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

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

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

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

B. Data Sources

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

Table 5. SUD Evaluation Data Sources

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

C. Analytic Methods

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

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

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

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

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

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

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

Isolation from Other Initiatives

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

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

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

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

IV. Methodological Limitations

The SUD demonstration evaluation is limited by several factors including:

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

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

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

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

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

Attachments

A. Independent Evaluator

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

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

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

B. Evaluation Budget

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

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

C. Timeline and Major Milestones

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

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

	2018						2019					
Activity/Milestone	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun

Procure Independent Evaluation Design	X	X	X									
Draft Evaluation Design				X	X	X						
CMS Review (1/4-4/5 2019)							X	X	X	X		
Incorporate CMS Revisions									X	X		
Final Evaluation Design									X	X		
Publish Evaluation Design to Website (30-days after approval)									X	X		
Procure Independent Evaluator									X	X	X	X
Finalize Research Methods												X
Finalize Performance Measures												X

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

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

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

	2020	2021

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

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

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

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

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

Collect, Analyze, Interpret Data	X	X	X	X	X	X	X	X	X	X	X	X
Replicate Secret Shopper Tools	X	X	X	X	X	X						
Conduct Secret Shopper Assessment				X	X	X						

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

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

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

	2024						2025					
Activity/Milestone	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Incorporate CMS Comment (60 days after CMS comments)					X	X						
Submit Final Summative Evaluation Report to CMS							X					
Publish Final Summative Evaluation Report (within 30-days after approval)								X				

ATTACHMENT D:
SUD Implementation Plan Protocol

Section I – Milestone Completion

Milestones

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

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

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

Current state:

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

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

Table 1. NH Medicaid Substance Use Disorder Benefit

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

Future state:

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

Support Systems

In Level 2.1 programs, necessary support systems include:

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

Therapies

Therapies offered by Level 2.1 programs include:

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

Milestone Criteria	Current State	Future State	Summary of Actions
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 levels of care with codes covering	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 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.	Medicaid authority will update the He-w 513 rule in collaboration with Bureau of Drug and Alcohol Services by November 30, 2018.

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

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

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

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

Current state:
Patient Placement Criteria

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

a. The service shall be included as an evidence-based mental health and substance abuse intervention on the SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP), available at http://www.nrepp.samhsa.gov/AllPrograms.aspx;

b. The services shall be published in a peer-reviewed journal and found to have positive effects; or

c. The SUD treatment and recovery support service provider shall be able to document the services' effectiveness based on the following:

1. The service is based on a theoretical perspective that has validated research; or

2. The service is supported by a documented body of knowledge generated from similar or related services that indicate effectiveness.

Future State

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

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

Current state:

Utilization management

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

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

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

(b) Supporting documentation shall include:

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

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

a. The treatment modality and duration;

b. The signature of the primary therapist for each entry;

c. The primary therapist's professional discipline; and

d. The date of each treatment session; and

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

a. Updated at least every 4 sessions or 4 weeks, whichever is less frequent;

b. Signed by the provider and the recipient prior to treatment being rendered; and

c. Signed by the clinical supervisor, prior to treatment being rendered, if the service is an outpatient or comprehensive SUD program.

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

(1) The recipient's name, date of birth, address, and phone number; and

(2) A copy of the evaluation described in He-W 513.05(p)(4).

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

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

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

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

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

Residential treatment provider qualifications

Current state:

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

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

The selected vendor must meet minimum staffing requirements that include:

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

- Receive an orientation within the first three (3) days of work, or prior, to direct contact with clients, which includes;
    - The vendor's code of ethics, including ethical conduct and reporting of unprofessional conduct;
    - The vendor's policies on client rights and responsibilities and complaint procedures;
    - Confidentiality requirements;
    - Grievance procedures for both clients and staff;
    - The duties and responsibilities and the policies, procedures and guidelines of the position they were hired for;
    - Topics covered by both the administrative and personnel manuals;
    - The vendor's infection prevention program;
    - The vendor's fire, evacuation and other emergency plans, which outline the responsibilities for personnel in an emergency; and
    - Mandatory reporting requirements for abuse or neglect, such as those found in RSA 161-F and RSA 169-C:29; and
    - Sign and date documentation that they have taken part in an orientation;
    - Complete a mandatory annual in-service education, which includes a review of all orientation elements.

- The selected vendor must ensure all unlicensed staff providing treatment, education and/or recovery support services shall be under the direct supervision of a licensed supervisor.
- The selected vendor must ensure no licensed supervisor supervises more than eight (8) unlicensed staff, unless the Department has approved an alternative supervision plan.
- The selected vendor must provide a minimum of one (1) Certified Recovery Support Worker (CRSW) for every 50 clients or portion thereof.
- The selected vendor must ensure unlicensed staff providing clinical or recovery support services obtain a CRSW certification within 6 months of hire or contract effective date, whichever is later.
- The selected vendor shall ensure a staff to resident ratio that is more stringent than the required staff to resident ratios stated above, when required by the resident's treatment plan.
- The selected vendor must provide ongoing clinical supervision that occurs at regular intervals. The selected vendor must ensure clinical supervision includes, but is not limited to:
    - Receipt of, at least, one (1) hour of supervision for every twenty (20) hours of direct client contact;
    - Weekly discussion of cases with suggestions for resources or therapeutic approaches, co-therapy, and periodic assessment of progress;
    - Group supervision to help optimize the learning experience, when enough candidates are under supervision;
    - Training on:

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

Future state:

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

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

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

Reviewing compliance to standards

Current state:

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

Future state:

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

1) The update of Bureau of Health Facilities rules specific to SUD residential treatment facilities to include requirements related to staffing, physical space expectations, programmatic design, and compliance requirements.

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

3) The update of He-W 513 rules through the Office of Medicaid to outline specific requirements around staffing, licensing, and service expectations for all SUD Medicaid services.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	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. 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. The DHHS Medicaid Program Integrity Unit oversees compliance with He-W 513 as part of their pre and post enrollment site visits and re-validation processes. The Bureau of Drug and Alcohol Service He-A 300 rules regarding	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. Additional controls will be put in place through updates to He-W 513 and He-A 300 rules to ensure compliance checks from Medicaid Program Integrity and Bureau of Drug and Alcohol Service staff on an annual basis.	Health Facilities rule updated and effective by December 31, 2018 He-W 513 rules will be updated to include language regarding annual compliance checks by Fall 2018 He-A 300 rules will be updated to include language regarding specific standards and annual compliance by Fall 2019.

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

Current state:

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

Future state:

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

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

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

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

Current state:

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

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

Future state:

NH will establish an assessment process to meet this milestone.

Milestone Criteria	Current State	Future State	Summary of Actions
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT: Outpatient Services; Intensive Outpatient Services; Medication Assisted Treatment (medications as well as counseling and other services); Intensive Care 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 type and payers accepted. A treatment capacity report was created in early 2014 prior to expansion of Medicaid.	NH will establish an assessment process to identify Medicaid providers that are accepting new patients in critical levels of care, including those who offer MAT and those who offer adolescent-specific programming. This will be accomplished through secret shopper quality activities conducted by the NH DHHS EQRO NH will explore the possibility of updating the 2014 treatment capacity report. NH will work with the vendor supporting the	Secret shopper planning to begin Spring 2018, assessment to begin by Summer 2018, assessment to be completed by early 2019. 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)	https://medicaidquality.nh.gov/reports/use-of-opioids-at-high-dosage-ohd-
CMS_A_CUOB	Concurrent Use of Opioids and Benzodiazepines	Will start with FFY 2018 Reporting (for measurement year	N/A
PHARMQI.09	Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	Started with CY 2016 Quarter 2	https://medicaidquality.nh.gov/reports/safety-monitoring---opioid-prescriptions-meeting-nh-dhhs-morphine-equivalent-dosage-prior-
SUD_111	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
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	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. The Opioid Prescribing Guidelines from the NH Board of Medicine went into effect on January 1, 2017 (https://www.oplc.nh.gov/medicine/documents/med 502- adopted.pdf) Please see attached prior authorization criteria for Methadone, Long Acting Narcotics, Short Acting Fentanyl and Morphine Milligram Equivalence (MME). 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 The MCOs are required to submit a quarterly report	NH will explore additional opportunities for enhancing opioid prescribing guidelines through Managed Care re-procurement efforts NH will further enhance implementation of existing laws related to opioid prescribing in collaboration with the OPLC and Board of Medicine.	Meet with PDMP by August 2018 Meet with Governor's Commission Opioid and Healthcare taskforces to discuss guidelines by August 2018 Consult with vendor assisting with managed care re-procurement to develop

Expanded coverage of and access to naloxone for overdose reversal

Current state:

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

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

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

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

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

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

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

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

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

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

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

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

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

Current state:

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

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

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

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

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

Future state:

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

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

6. Improved Care Coordination and Transitions between Levels of Care

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

Improved Care Coordination and Transition between Levels of Care

Current state:

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

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

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

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

Future state:

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

1) Continuing Care and Discharge

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

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

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

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

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

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

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

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

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

substance use disorder treatment, and long-term care services, as well as linkages to other community supports and resources
- Transitional care coordination across settings, including from the hospital to the community
- Robust patient engagement process around information sharing consent
- Coordination with other care coordination/management programs or resources that may be following the same patient so that to the extent possible, only one care coordinator/manager is playing a lead role in managing the patient's care plan.

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

Section II – Implementation Administration

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

Name and Title: Deborah Scheetz, New Hampshire Medicaid Deputy Director
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 AWARxE, is a web-based program that facilitates the collection, analysis, and reporting of information on the prescribing, dispensing, and use of controlled substances.

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

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

Section I.

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

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

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

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

As the state develops its SUD Health IT Plan, it may also request technical assistance to conduct an assessment and develop its plan to ensure it has the specific health IT infrastructure with regards to the state's PDMP plan and, more generally, to meet the goals of the demonstration.
Contacts for technical assistance can be found in the guidance documents.

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

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

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

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

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

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

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[4] Available at https://www.healthit.gov/playbook/opioid-epidemic-and-health-it.
[5] Available at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html.

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is: *--Enhance the state's health IT functionality to support its PDMP; and* *--Enhance and/or support clinicians in their usage of the state's PDMP.*	*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.*	*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.*	*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*
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data	NH does not have access or grant access to other state PDMPs	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 “ease of use” for prescribers and other state and federal stakeholders	The NH PDMP is web-based and has been assessed for ease of use, requiring approx. 3 clicks for providers to navigate through the program when conducting a query	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 connectivity between the state's PDMP and any statewide, regional or local health information exchange	There is no connectivity between the PDMP and other local HIE	NH DHHS will develop a plan to identify the future state within 60 days of waiver submission on April 9, 2018	The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress towards future state goals.
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns[6] (see also "Use of PDMP" #2 below)	NH is continuing to invest in the capacity of the PDMP to identify data points that will enable the PDMP to aid in combating opioid and substance use. At this time, there are no formal processes for using the PDMP for this purpose given that NH is still working to build staffing and program capacity. Metrics being considered for identifying outliers that need intervention include:		The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress towards future state goals.

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

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

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

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

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 current state of this milestone is unknown at this time.	NH DHHS will submit the current state of this milestone to CMS within 30 days of waiver submission to CMS on April 9, 2018 and NH DHHS will develop a plan to identify the future state within 60 days of waiver submission on April 9, 2018	The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress towards future state goals.

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.

ATTACHMENT E:
SUD Monitoring Protocol

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

State	New Hampshire (NH)
Demonstration Name	Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver
Approval Date	July 10, 2018
Approval Period	July 10, 2018 – June 30, 2023
SUD (or if broader demonstration, then SUD Related) Demonstration Goals and Objectives	The goal of this demonstration is for NH to maintain critical access to opioid use disorder (OUD) and other substance use disorder (SUD) services and continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid beneficiaries. During the demonstration, NH seeks to achieve the following: 1 . Increased rates of identification, initiation, and engagement in treatment. 2. Increased adherence to and retention in treatment. 3. Reductions in overdose deaths, particularly those due to opioids. 4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate through improved access to other continuum of care services. 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate. 6. Improved access to care for physical health conditions among Medicaid beneficiaries.

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

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

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

Summary of proposed modification	Related metric (if any)	Justification for modification
		2.2.2 Implementation Update (a) Access Across the Continuum of Care ☐No, there have been no changes and NH does not expect to make any changes to planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries. ☐Yes, NH expects to make the following changes to planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries as described: *[narrative response if applicable]* (b) Benefit Coverage Under Medicaid State Plan/Expenditure Authority ☐No, there have been no changes and NH does not expect to make any changes to planned activities to SUD benefit coverage under the Medicaid state plan or the Expenditure Authority. ☐Yes, NH expects to make the following changes to planned activities to SUD benefit coverage under the Medicaid state plan or the Expenditure Authority for: ☐Residential Treatment as described: *[narrative response if applicable]* ☐Medically supervised withdrawal management as described: *[narrative response if applicable]* ☐Medication Assisted Treatment to individuals in IMDs as described: *[narrative response if applicable]* ☐No, NH does not anticipate making any program changes that may impact metrics related to access to critical levels of care of OUD and other SUDs. ☐Yes, NH anticipates making the following program changes that may impact metrics related to access to critical levels of care of OUD and other SUDs as described: *[narrative response if applicable]*
☒ New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		

Summary of proposed modification	Related metric (if any)	Justification for modification
☐ New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
3. Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)		
NH proposes the use of a checklist format in the Summary Column		**NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:** **3.2.1 Metric Trend** There are no monitoring metrics associated with Milestone #2. As a result, NH will not be reporting trends. **3.2.2 Implementation Update** (a) <u>Placement Criteria</u> ☐No, NH does not expect to make any changes to planned activities to improve providers' use of evidence-based, SUD-specific placement criteria. ☐Yes, NH expects to make the following changes to planned activities to improve providers' use of evidence-based, SUD-specific placement criteria as described: *[narrative response if applicable]* (b) <u>Utilization Management Approach</u> ☐No, NH does not expect to make any changes to implement a utilization management approach. ☐Yes, NH expects to make the following changes to implement a utilization management approach to ensure: ☐Beneficiaries have access to SUD services at the appropriate level of care as described: *[narrative response if applicable]* ☐Interventions are appropriate for the diagnosis and level of care as described: *[narrative response if applicable]* ☐Use of independent process for reviewing placement in residential treatment settings as described: *[narrative response if applicable]*

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

Summary of proposed modification	Related metric (if any)	Justification for modification
		☐No, there have been no changes, and NH does not expect to make any changes to implement the state review process for residential treatment providers' compliance with qualification standards. ☐Yes, NH expects to make the following changes to implement the state review process for residential treatment providers' compliance with qualification standards as described*: [narrative response if applicable]* (c) Medication Assisted Treatment (MAT) ☐No, there have been no changes, and NH does not expect to make any changes to the availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site. ☐Yes, NH expects to make the following changes to the availability of medication assisted treatment at residential treatment facilities: ☐On-site as described: *[narrative response if applicable]* ☐Facilitated access to services off site as described: *[narrative response if applicable]* ☐No, NH does not anticipate any other program changes that may impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities. ☐Yes, NH anticipates the following program changes that may impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities as described: *[narrative response if applicable]*
☒ New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☐ New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
5. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)		

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

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

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

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

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

Summary of proposed modification	Related metric (if any)	Justification for modification
		☐No, there have been no changes and NH does not expect to make any changes to demonstrate how health IT is being used to effectively treat individuals identified with SUD. ☐Yes, NH expects to make the following changes to demonstrate how health IT is being used to effectively treat individuals identified with SUD as described*: [narrative response if applicable]* (c) Health IT Used to Monitor Recovery ☐No, there have been no changes and NH does not expect to make any changes to demonstrate how health IT is being used to effectively monitor recovery supports and services for individuals identified with SUD. ☐Yes, NH expects to make the following changes to demonstrate health IT is being used to effectively monitor recovery supports and services for individuals identified with SUD as described: *[narrative response if applicable]* (d) Health IT Infrastructure/Capabilities ☐No, there have been no changes and NH does not expect to make any changes to other aspects of its plan to develop health IT infrastructure/capabilities including its delivery system, health plan/MCO, and individual provider level. ☐Yes, NH plans to make changes to the following aspects of its plan to develop health IT infrastructure/capabilities: ☐Delivery system as described: *[narrative response if applicable]* ☐Health plan/MCO as described: *[narrative response if applicable]* ☐Individual provider level as described: *[narrative response if applicable]* (e) Health IT Implementation Milestones ☐No, there have been no changes and NH does not expect to make any changes to other aspects of its health IT implementation milestones. ☐Yes, NH expects to make changes to the following aspects of its health IT implementation milestones as described: *[narrative response if applicable]*

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

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

Summary of proposed modification	Related metric (if any)	Justification for modification
		☐No, NH does not anticipate any program changes that impact budget neutrality. ☐Yes, NH anticipates the following program changes that may impact budget neutrality as described: *[narrative response if applicable]*
☒ New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☐ New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
11. SUD-Related Demonstration Operations and Policy		
NH proposes the use of a checklist format in the Summary Column		**NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:** **11.1.1 Considerations** The following are operations or policy considerations that could positively or negatively impact: ☐Beneficiary enrollment as described: *[narrative response if applicable]* ☐Access to services as described: *[narrative response if applicable]* ☐Timely provision of services as described: *[narrative response if applicable]* ☐Budget neutrality as described: *[narrative response if applicable]* ☐Other provisions that have potential for beneficiary impacts as described: *[narrative response if applicable]* ☐No, NH does not identify any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives. ☐Yes, NH identifies the following activities that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals and objectives as described: *[narrative response if applicable]* **11.1.2 Implementation Update**

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

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

Summary of proposed modification	Related metric (if any)	Justification for modification
NH proposes the use of a checklist format in the Summary Column		**13.1.1 General Reporting Requirements** ☐No, there have been no changes to NH's implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol. ☐Yes, the following are changes to NH's implementation of the demonstration that might necessitate a change to approved: ☐STCs as described: *[narrative response if applicable]* ☐Implementation plan as described: *[narrative response if applicable]* ☐Monitoring protocol as described: *[narrative response if applicable]* ☐No, NH does not anticipate the need to make future changes to the STCs, implementation plan, or monitoring protocol based on expected or upcoming implementation changes. ☐Yes, based on expected or upcoming implementation changes, NH anticipates the need to make future changes to the approved: ☐STCs as described: *[narrative response if applicable]* ☐Implementation plan as described: *[narrative response if applicable]* ☐Monitoring protocol as described: *[narrative response if applicable]* (a) <u>Monitoring Report Schedule</u> ☐No, NH has not formally requested any changes nor does it expect to formally request any changes to the schedule for completing and submitting monitoring reports. ☐Yes, NH expects to formally request the following changes to the schedule for completing and submitting monitoring reports as described: *[narrative response if applicable]* (b) <u>Content of Monitoring Reports</u> ☐No, NH has not formally requested nor does it expect to formally request any changes to the content or completeness of submitted reports or future reports. ☐Yes, NH expects to formally request the following changes to the content or completeness of:

Summary of proposed modification	Related metric (if any)	Justification for modification
		☐Submitted reports as described: *[narrative response if applicable]* ☐Future reports as described: *[narrative response if applicable]* ☐No, NH has not identified any real or anticipated issues for submitting timely post-approval demonstration deliverables. ☐Yes, NH has identified the following issues for submitting timely post-approval demonstration deliverables: ☐Deliverable as described: *[narrative response if applicable]* ☐Issue as described*:* *[narrative response if applicable]* ☐Plan for Remediation as described: *[narrative response if applicable]* **13.1.2 Post Award Public Forum** ☐No, this is not an annual report and NH did not host a post-award public forum during this reporting period. ☐Yes, the following is NH's summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues as described: *[narrative response if applicable]*
☒ New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☐ New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
14. Notable State Achievements and/or Innovations		
NH proposes the use of a checklist format in the Summary Column		**NH will use the following checklist format in the Summary Column of the Quarterly Monitoring Report:** **14.2.1 Narrative Information** ☐No, NH has no notable achievements or innovations to report for this reporting topic.

Summary of proposed modification	Related metric (if any)	Justification for modification
		☐Yes, the following is a summary of NH's relevant achievements and/or innovations in this reporting period: ☐Enrollment as described: *[narrative response if applicable]* ☐Benefits as described: *[narrative response if applicable]* ☐Operations as described: *[narrative response if applicable]* ☐Policies pursuant to the hypotheses of the SUD demonstration or that served to provide better care for individuals as described: *[narrative response if applicable]* ☐Policies pursuant to the hypotheses of the SUD demonstration or that served to provide better care for populations as described: *[narrative response if applicable]* ☐Reduced cost per capita as described: *[narrative response if applicable]* ☐Other significant impacts to beneficiary outcomes as described: *[narrative response if applicable]*
☒ New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☐ New Hampshire has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		

3. Acknowledgement of Budget Neutrality Reporting

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

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

4. SUD Demonstration Monitoring Reporting Schedule

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

ATTACHMENT F:
SUD Amendment/CAP Application

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

Amendment I

August 21, 2020

Summary

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

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

Overview

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

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

Demonstration Eligibility

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

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

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

Demonstration Area

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

Demonstration Timeframe

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

Demonstration Cost Sharing Requirements

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

Demonstration Delivery System

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

Demonstration Benefits

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

Evaluation Design

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

Estimated Impact Proposed Budget Neutrality Prospective Adjustments

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

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

Table 1
New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Access 1115 Demonstration
Projected Annual Expenditures and Caseload

	DY 01	DY 02	DY 03	DY 04	DY 05
	Projected Caseload				

Medicaid Adults	695	665	665	665	665
Expansion Adults	3,812	4,871	4,871	4,871	4,871
Adolescents	74	67	67	67	67
	Projected Expenditures				
Medicaid Adults	$931,834	$807,802	$831,061	$872,614	$916,245
Expansion Adults	$5,533,064	$5,472,453	$5,638,020	$5,919,921	$6,215,917
Adolescents	$64,157	$78,881	$66,304	$69,620	$73,101

Waiver and Expenditure Authorities

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

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

Public Notice and Tribal Consultation

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

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

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

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

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

New Hampshire does not have any federally recognized tribes.

New Hampshire SUD 1115 Demonstration Budget Neutrality

Current regulations at 42 CFR 438.3 permit MCOs to cover enrollees, services or settings that are in lieu of services or settings when: (i) the service or setting is a medically appropriate and cost

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

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

Updated rate cell enrollment distribution within each MEG

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

SUD provider rate increase

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

HB4 provider rate increases

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

Hospital directed payment

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

Inclusion of IMD payments during retroactive eligibility

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

Expenditure Estimate

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

Budget Neutrality Workbook

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

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August 7, 2020

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

[Sent via email: henry.lipman@dhhs.nh.gov]

Re: APPENDIX A - Budget Neutrality Limit Analysis – SUD IMD 1115 Demonstration

Dear Henry:

At your request, we are working with the New Hampshire Department of Health and Human Services (DHHS) to review the budget neutrality limits in New Hampshire's Substance Use Disorder Treatment and Recovery Access (SUD TRA) 1115 Demonstration. Based on prior discussions with DHHS and CMS, this letter provides the detail and calculations supporting revised budget neutrality limits effective July 1, 2020. In conversations with CMS, we understand retro-active changes to the budget neutrality limits are not allowed.

This letter includes preliminary estimates of the additional modifications to the original budget neutrality methodology. These modifications are consistent with previous conversations with CMS and reflect adjustments for items that were not originally anticipated during the budget neutrality development and later became known during monitoring report preparation. We are happy to provide additional details to CMS to help them understand our proposed adjustments and methodology.

Please note, we understand there are ongoing reporting issues related to this demonstration. We relied on the enrollment and cost information provided by DHHS for this review rather than the populated demonstration monitoring document. It is our understanding that the provided data does include all IMD providers and their clients.

Table 1 below shows the projected five year demonstration results using the current limits, as well as the proposed limits, which include adjustments for the following items:

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

Table 1 New Hampshire Department of Health and Human Services Substance Use Disorder Treatment and Recovery Access 1115 Demonstration Summary of SUD IMD Budget Neutrality Estimates					
	DY 01	**DY 02**	**DY 03**	**DY 04**	**DY 05**
Projected Member Months	4,581	5,603	5,603	5,603	5,603
Estimated Actual Costs (PMPM)	$1,425	$1,135	$1,166	$1,225	$1,286
Budget Neutrality Limit - Current (PMPM)	$661	$679	$711	$744	$778
Budget Neutrality Limit - Proposed (PMPM)	$661	$679	$2,813	$2,958	$3,096
Cumulative Over / (Under) - Current (millions)	$3.5	$6.1	$8.6	$11.3	$14.1
Cumulative Over / (Under) - Proposed (millions)	$3.5	$6.1	-$3.2	-$12.9	-$23.0

In this table, the estimated actual costs represent the reported costs during DY 01 (SFY 2019) and DY 02 (SFY 2020), and the SFY 2020 PMPM costs trended to subsequent years using a 5% annual trend. As shown, the proposed adjustments result in estimated costs below the budget neutrality limits. Exhibit 1 contains the member months, estimated costs, and budget neutrality limits by year for each MEG.

We performed sensitivity testing to ensure the revised budget neutrality limits would produce a budget neutral cost under the demonstration, consistent with CMS instructions.

METHODOLOGY

As noted above, we include five proposed adjustments to the existing budget neutrality limits. Table 2 below identifies the proposed PMPM change for each MEG. The adjustments for all subsequent years reflect the existing demonstration trend rates approved by CMS applied to these amounts. We show the HB4 provider increase for DY 03 and DY 04 to specifically account for the January 1, 2020 and January 1, 2021 rate increases that is not fully captured in DY 03 and DY 04, respectively.

Table 2 New Hampshire Department of Health and Human Services Substance Use Disorder Treatment and Recovery Access 1115 Demonstration Proposed Adjustments by MEG			
	Medicaid Adult	**Expansion Adults**	**Adolescent**
Enrollment Distribution Change (DY 03)	$382.42	$368.58	$103.66
SUD Provider Rate Increase (DY 03)	13.07	13.22	1.19
HB4 Provider Rate Increase (DY 03)	54.90	37.05	27.92
HB4 Provider Rate Increase (DY 04)	77.02	52.13	38.90
Hospital Directed Payment (DY 03)	20.62	26.60	7.56
Inclusion of Retroactive Payments (DY 03)	635.07	1,800.97	1,312.59

Enrollment Distribution Change

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

find the actual demonstration enrollees represent rate cells with higher capitation rates and higher FFS expenditures. The adjustment shown in Table 2 results from updating the underlying enrollment distribution to align with the July 2018 to June 2020 reporting period.

SUD Provider Rate Increase

Effective January 1, 2019, DHHS increased reimbursement for high intensity residential treatment services for adults (H0018) to $247.82 per day. The new fee was set to align with the Massachusetts fee schedule for the same service. Additionally, effective July 1, 2019, DHHS increased reimbursement for residential sub-acute detoxification (H0010) to $340.32 per day to align with the Massachusetts fee schedule for the same service.

HB4 Provider Rate Increase

New Hampshire House Bill 4 (HB4) implements a 3.1% provider rate increase applicable to nearly all Medicaid services. This rate increase went into effect January 1, 2020 and will again increase rates on January 1, 2021 by another 3.1%. The adjustment in Table 2 accounts for the inclusion of these rate increases.

Hospital Directed Payment

Effective July 1, 2020, the MCM capitation rates include a hospital directed payment to promote access to high-quality acute care services provided by critical access and non-critical access hospitals across New Hampshire. The adjustment in Table 2 accounts for the inclusion of this new directed payment.

Inclusion of Retroactive Payments

The original budget neutrality development included three categories of expenses: MCM capitation rates, FFS costs for services not covered by MCM (e.g., LTSS), and the newly covered SUD IMD services. The specific cost estimates for IMD stays were allocated to all MCM enrollees as these services would be covered as part of the MCM program. However, this approach did not take into account individuals with FFS SUD IMD costs during a retroactive eligibility period. As a result, the reporting during DY 01 and DY 02 showed a significant amount of FFS SUD IMD costs not included in the original budget neutrality limits.

As a result, we propose updating the budget neutrality limits to capture these costs. Since these individuals would essentially be in an IMD for every day of their eligibility, the effective cost is the daily IMD rate. Table 3 below shows the development of the proposed adjustment, calculated as the daily rate applicable to the percent of demonstration individuals expected to have retroactive eligibility. We developed the percentage estimate by reviewing the average and range of this percentage by month during DY 01 and DY 02.

Table 3
New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Access 1115 Demonstration
Development of Retroactivity PMPM Adjustment

	Daily Rate	% of MMs	PMPM
Medicaid Adult	$264.63	7.9%	$635.07
Expansion Adults	$281.17	21.0%	$1,800.97
Adolescent	$282.34	15.3%	$1,312.59

BUDGET NEUTRALITY WORKSHEET

Attachment A includes an updated budget neutrality worksheet in the CMS format. This worksheet includes the specific breakout of the items described in this letter.

CAVEATS AND LIMITATIONS ON USE

This letter is designed to assist DHHS with adjusting the budget neutrality limits for the SUD TRA 1115 Demonstration. This information may not be appropriate, and should not be used, for other purposes.

The information contained in this letter has been prepared for DHHS. To the extent that the information contained in this letter is provided to third parties, this letter should be distributed in its entirety. Any user of this information must possess a certain level of expertise in actuarial science and healthcare modeling, so as not to misinterpret the information presented.

Actual results will vary from estimates due to actual experience under the demonstration being higher or lower than expected. DHHS should monitor emerging results and take corrective action when necessary.

In preparing this information, we relied on information from DHHS regarding historical expenditures, historical enrollment, projected costs under the demonstration, and the expected return on investment for certain initiatives. 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.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this letter.

The terms of Milliman's contract with the New Hampshire Department of Health and Human Services effective July 1, 2017, apply to this letter and its use.

❖ ❖ ❖ ❖ ❖

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

Sincerely,

Gregory J. Herrle

Greg J. Herrle, FSA, MAAA
Consulting Actuary

GJH/jf

Attachments

EXHIBIT 1

Exhibit 1
New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Access 1115 Demonstration
Summary of SUD IMD Budget Neutrality Limit

	DY 01	DY 02	DY 03	DY 04	DY 05
Member Months					
Medicaid Adults	695	665	665	665	665
Expansion Adults	3,812	4,871	4,871	4,871	4,871
Adolescent	74	67	67	67	67
Total	**4,581**	**5,603**	**5,603**	**5,603**	**5,603**
PMPM - Actual					
Medicaid Adults	$1,341	$1,214	$1,249	$1,312	$1,377
Expansion Adults	1,451	1,124	1,158	1,215	1,276
Adolescent	867	1,183	995	1,044	1,097
Total	**$1,425**	**$1,135**	**$1,166**	**$1,225**	**$1,286**
Budget Neutrality Limit - Current					
Medicaid Adults	$961	$1,004	$1,048	$1,094	$1,142
Expansion Adults	608	636	666	698	730
Adolescent	573	595	617	639	663
Total	**$661**	**$679**	**$711**	**$744**	**$778**
Incremental Over / (Under)	$3,501,063	$2,553,731	$2,553,119	$2,691,955	$2,845,666
Cumulative Over / (Under)	$3,501,063	$6,054,793	$8,607,913	$11,299,868	$14,145,533
Budget Neutrality Limit - Proposed					
Medicaid Adults	$961	$1,004	$2,154	$2,268	$2,368
Expansion Adults	608	636	2,913	3,063	3,207
Adolescent	573	595	2,070	2,156	2,236
Total	**$661**	**$679**	**$2,813**	**$2,958**	**$3,096**
Incremental Over / (Under)	$3,501,063	$2,553,731	-$9,222,481	-$9,709,350	-$10,139,177
Cumulative Over / (Under)	$3,501,063	$6,054,793	-$3,167,688	-$12,877,038	-$23,016,215

ATTACHMENT A

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

Situation: 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)	PMPM Cost · Estimated average of all MA costs incurred during IMD MMs. · Est. total MA cost in IMD MMs ÷ est. IMD MMs Member Months · IMD MM: Any *whole* month during which a Medicaid eligible is inpatient in an IMD at least 1 day BN Expenditure Limit · PMPM cost × IMD MMs	
With Waiver	Expenditures Subject to Limit · All MA costs with dates of service during IMD MMs Reporting Requirements State must be able to identify and report: · IMD MMs separate from other Medicaid months of eligibility · MA costs during IMD MMs separate from other MA costs	

Scenario 2

Situation: Demonstration CNOM include both CNOM for IMD exclusion related MA to *and* 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)	PMPM Cost · Estimated average of all MA costs incurred during IMD MMs. · Est. total MA cost in IMD MMs ÷ est. IMD MMs Member Months · IMD MM: Any *whole* month during which a Medicaid eligible is inpatient in an IMD at least 1 day · *Can* exclude months with ≤ 15 IMD inpatient days under managed care BN Expenditure Limit · PMPM cost × IMD MMs	PMPM Cost · Estimate of average SUD CNOM service cost during Non-IMD MMs · Est. total SUD CNOM service cost ÷ est. Non-IMD MMs · SUD CNOM service cost can include capitated cost of IMD services Member Months · Non-IMD MM: Any month of Medicaid eligibility in which a person *could* receive a SUD CNOM service that is not an IMD MM BN Expenditure Limit · PMPM cost × Non-IMD MMs
With Waiver	Expenditures Subject to Limit · All MA costs with dates of service during IMD MMs Reporting Requirements State must be able to identify and report: · IMD MMs separate from other Medicaid months of eligibility · MA costs during IMD MMs separate from other MA costs	Expenditures Subject to Limit · All SUD CNOM service costs with dates of service during Non-IMD MMs Reporting Requirements State must be able to identify and report: · Non-IMD MMs separate from IMD MMs · SUD CNOM costs separate from other MA costs

SUD Historical Spending Data - 5 Years

	Historical Years Definition:		State Fiscal Year			
Medicaid Adults	**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!

		Non-SUD/IMD Title XIX PMPM:
	Medicaid Adults	$891.61
	Expansion Adults	$567.56
Alternate SUD IMD MEG PMPM Development & C	Adolescents	$551.45

					Choose "Included" from Drop-Down(s) to Link Services with MEG(s)				
					CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
SUD IMD Services	**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**	**SUD IMD Non-Hypothetical Services CNOM MEG**
Medicaid Adults all inclusive per diem	$12,992,131	$395,502,368	443,582	$920.90	Included				
Expansion Adults all inclusive per diem	$7,238,972	$317,013,190	558,554	$580.52		Included			
Adolescents all inclusive per diem	$1,592,568	$573,562,186	1,040,098	$552.98			Included		
Service 4				#DIV/0!					
Service 5				#DIV/0!					
Service 6				#DIV/0!					
Service 7				#DIV/0!					
Service 8				#DIV/0!					
Service 9				#DIV/0!					
Service 10				#DIV/0!					
Service 11				#DIV/0!					
Service 12				#DIV/0!					
Add additional services, as necessary				#DIV/0!					
Totals					**$920.90**	**$580.52**	**$552.98**	**$0.00**	**$0.00**

			PB Trend:	4.9%						
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 01 SFY19	DY 02 SFY20	DY 03 SFY21	DY 04 SFY22	DY 05 SFY23	TOTAL WOW
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	4.4%	$961.42	$1,003.72	$1,047.88	$1,093.99	$1,142.13	
Enrollment Distribution Change			n/a	4.4%	$0.00	$0.00	$382.42	$399.25	$416.82	
SUD Provider Rate Increases			n/a	4.4%	$0.00	$0.00	$13.07	$13.65	$14.25	
HB4 Provider Rate Increase			n/a	4.4%	$0.00	$0.00	$54.90	$77.02	$80.41	
Hospital Directed Payment			n/a	4.4%	$0.00	$0.00	$20.62	$21.53	$22.48	
Inclusion of Retroactive Payments			n/a	4.4%	$0.00	$0.00	$635.07	$663.01	$692.18	
Total Expenditure					$4,430,223	$4,717,645	$10,326,457	$11,092,820	$11,812,569	$42,379,714
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	4.7%	$607.80	$636.37	$666.28	$697.60	$730.39	
Enrollment Distribution Change			n/a	4.7%	$0.00	$0.00	$368.58	$385.90	$404.04	
SUD Provider Rate Increases			n/a	4.7%	$0.00	$0.00	$13.22	$13.84	$14.49	
HB4 Provider Rate Increase			n/a	4.7%	$0.00	$0.00	$37.05	$52.13	$54.58	
Hospital Directed Payment			n/a	4.7%	$0.00	$0.00	$26.60	$27.85	$29.16	
Inclusion of Retroactive Payments			n/a	4.7%	$0.00	$0.00	$1,800.97	$1,885.61	$1,974.23	
Total Expenditure					$1,517,069	$3,240,294	$15,127,623	$16,226,004	$17,328,434	$53,439,424
Adolescents										
Eligible Member Months	n.a.	n.a.	0	n.a.	48	49	50	51	52	
PMPM Cost	n.a.	0	$552.98	3.7%	$573.44	$594.66	$616.66	$639.48	$663.14	
Enrollment Distribution Change			n/a	3.7%	$0.00	$0.00	$103.66	$107.50	$111.48	
SUD Provider Rate Increases			n/a	3.7%	$0.00	$0.00	$1.19	$1.23	$1.28	
HB4 Provider Rate Increase			n/a	3.7%	$0.00	$0.00	$27.92	$38.90	$40.34	
Hospital Directed Payment			n/a	3.7%	$0.00	$0.00	$7.56	$7.84	$8.13	
Inclusion of Retroactive Payments			n/a	3.7%	$0.00	$0.00	$1,312.59	$1,361.15	$1,411.51	
Total Expenditure					$27,525	$29,115	$103,353	$109,827	$116,169	$385,989
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) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Medicaid Adults								
Eligible Member Months			4,608	4,700	4,794	4,890	4,988	
PMPM Cost	$921	4.4%	$961	$1,004	$1,048	$1,094	$1,142	
Enrollment Distribution Change		4.4%	$0	$0	$382	$399	$417	
SUD Provider Rate Increases		4.4%	$0	$0	$13	$14	$14	
HB4 Provider Rate Increase		4.4%	$0	$0	$55	$77	$80	
Inclusion of Retroactive Population		4.4%	$0	$0	$635	$663	$692	
Total Expenditure			$4,430,223	$4,717,645	$10,326,457	$11,092,820	$11,812,569	$42,379,714
Expansion Adults								
Eligible Member Months			2,496	5,092	5,194	5,298	5,404	
PMPM Cost	$581	4.7%	608	636	666	698	$730	
Enrollment Distribution Change		4.7%	0	0	369	386	$404	
SUD Provider Rate Increases		4.7%	0	0	13	14	$14	
HB4 Provider Rate Increase		4.7%	$0	$0	$37	$52	$55	
Inclusion of Retroactive Population		4.7%	$0	$0	$1,801	$1,886	$1,974	
Total Expenditure			1,517,069	3,240,294	15,127,623	16,226,004	$17,328,434	$53,439,424
Adolescents								
Eligible Member Months			48	49	50	51	52	
PMPM Cost	$553	3.7%	573	595	617	639	663	
Enrollment Distribution Change		3.7%	0	0	104	108	111	
SUD Provider Rate Increases		3.7%	0	0	1	1	1	
HB4 Provider Rate Increase		3.7%	$0	$0	$28	$39	$40	
Inclusion of Retroactive Population		3.7%	$0	$0	$1,313	$1,361	$1,412	
Total Expenditure			27,525	29,115	103,353	109,827	116,169	$385,989
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	$4,430,223	$4,717,645	$10,326,457	$11,092,820	$11,812,569	$42,379,714
Expansion Adults	$1,517,069	$3,240,294	$15,127,623	$16,226,004	$17,328,434	$53,439,424
Adolescents	$27,525	$29,115	$103,353	$109,827	$116,169	$385,989
TOTAL	$5,974,817	$7,987,053	$25,557,432	$27,428,652	$29,257,173	$96,205,127

With-Waiver Total Expenditures

	DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
Medicaid Adults	$4,430,223	$4,717,645	$10,326,457	$11,092,820	$11,812,569	$42,379,714
Expansion Adults	$1,517,069	$3,240,294	$15,127,623	$16,226,004	$17,328,434	$53,439,424
Adolescents	$27,525	$29,115	$103,353	$109,827	$116,169	$385,989
TOTAL	$5,974,817	$7,987,053	$25,557,432	$27,428,652	$29,257,173	$96,205,127
Net Overspend	$0	$0	$0	$0	$0	**$0**

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
TOTAL	$0	$0	$0	$0	$0	$0

With-Waiver Total Expenditures

	DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
SUD IMD Hypothetical Services CNOM MEG	$0	$0	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0	$0	$0
Net Overspend	$0	$0	$0	$0	$0	**$0**

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
TOTAL	$0	$0	$0	$0	$0	**$0**

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	4.4%	$961	$1,004	$2,154	$2,268	$2,368
Expansion Adults	4.7%	$608	$636	$2,913	$3,063	$3,207
Adolescents	3.7%	$573	$595	$2,070	$2,156	$2,236
SUD IMD Hypothetical Services CNOM MEG	4.9%	$0	$0	$0	$0	$0

Projected SUD IMD Member Months/Caseloads		DEMONSTRATION YEARS (DY)				
	Trend Rate	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%	48	49	50	51	52
SUD IMD Hypothetical Services CNOM MEG			0	0	0	0
SUD IMD Non-Hypothetical Services CNOM MEG			0	0	0	0

New Hampshire Amendment Appendix B: Public Noticing

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

August 7, 2020

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

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

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

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

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

To join by zoom:

Join Zoom Meeting
https://nh-dhhs.zoom.us/j/92124210541?pwd=aVc1MnVzREZYUmRHS3M0S2dBYjE1QT09

Meeting ID: 921 2421 0541
Passcode: 704376
One tap mobile
+16465588656,,92124210541#,,,,,,0#,,704376# US (New York)
+13017158592,,92124210541#,,,,,,0#,,704376# US (Germantown)

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

Dial by your location

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

Meeting ID: 921 2421 0541
Passcode: 704376
Find your local number: https://nh-dhhs.zoom.us/u/ab1FZAVnVw

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

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

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

Dawn Landry
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301
When mailing or emailing please specify the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Amendment*.

Additional Information
Requests for a hard copy of the demonstration amendment may be submitted by mail to:
Dawn Landry
New Hampshire Department of Health and Human Services
Attn: *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Amendment*
129 Pleasant Street
Concord, NH 03301

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

Medical Care Advisory Committee (MCAC)

Monday, August 10, 2020
10:00 am – 12:00 pm

Meeting will be held via Zoom
See email for instructions

MEETING AGENDA

Introductions/Announcements Carolyn Virtue, Chair
5 min

Review/Approval: July 13, 2020 Minutes Carolyn Virtue, Chair
5 min

DHHS Legislative Update John Williams, Esq.
15 min
Director of Legislative Affairs

SUD Waiver Amendment of Budget Neutrality Target Henry Lipman, Medicaid Director 15 min

DRAFT New Hampshire State Triage Committee Crisis Carolyn Virtue, Chair
15 min
Standards of Care Clinical Guidelines dated June 23, 2020

- DRAFT New Hampshire State Long Term Care Crisis Standards of Care (June 21, 2020)
- DRAFT New Hampshire State Triage Committee Crisis Standards of Care Clinical Guidelines (June 23, 2020)
- DRAFT New Hampshire State Triage Committee Crisis Standards of Care Clinical Guidelines (May 27, 2020)

Managed Care Open Enrollment Shirley Iacopino, Laura Ringelberg
10 min
Medicaid Managed Care Operations

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

Membership Jonathan Routhier, Vice Chair
10 min

Agenda Items - September 14, 2020 Members 5 min

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

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

SUD Waiver Amendment of Budget Neutrality Target

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

The SUD waiver benefit and benchmark neutrality target that was approved and implemented was hypothetical as it had not previously existed. The original benchmark neutrality assumptions have not played out as projected. Therefore, the purpose of the amendment is to revise the benchmark budget neutrality limit to reflect actual utilization of the SUD benefit, legislatively mandated rate increases, increased residential facility rates, and retroactive coverage previously not available in 2019.

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

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

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

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

Dear Ms. Stevens,

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

Dawn I. Landry, Policy Administrator
Division of Medicaid Services
New Hampshire Department of Health & Human Services
129 Pleasant Street, Concord, NH 03301

Phone: 603-271-9315
Email: dawn.landry@dhhs.nh.gov

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

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Dear Ms. Landry:

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

Thank you for the opportunity to comment on this amendment.

Holly

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