PHPG

THE PACIFIC HEALTH POLICY GROUP

New Hampshire Substance Use Disorder Treatment and Recovery Access Section 1115 Medicaid Demonstration

(Project # 11-W-00321/1)

Mid-Point Assessment Report

Submitted to CMS: December 29, 2021

TABLE OF CONTENTS

1. SUD DEMONSTRATION OVERVIEW AND MID-POINT ASSESSMENT

The New Hampshire Substance Abuse Treatment and Recovery Access Section 1115 Demonstration was approved by CMS on July 10, 2018, for a five-year term ending June 30, 2023. Clarifying, non-substantive revisions were approved on August 3, 2018. On June 16, 2021, an amendment was approved to update the Demonstration's budget neutrality terms and conditions. CMS agreed to prospectively adjust the State's hypothetical budget neutrality limits to reflect actual expenditures more accurately. Additionally, CMS updated Sections III, XI, and XII of the Special Terms and Conditions (STCs) to align with recent CMS requirements for 1115(a) Demonstration approvals. No additional expenditure or waiver authorities were necessary.

New Hampshire's Demonstration was designed to maintain critical access to opioid use disorder (OUD) and other substance use disorder (SUD) treatment services and continue delivery system improvements to support coordinated and comprehensive OUD/SUD treatment for Medicaid enrollees. The Demonstration authorizes New Hampshire to provide high-quality, clinically appropriate SUD treatment services for short-term stays in residential and inpatient treatment settings that qualify as Institutions for Mental Disease (IMDs).

The Demonstration builds on New Hampshire's ongoing efforts to improve models of care that focus on supporting enrollees in the community and home and strengthen the 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. The CMS defined goals include:

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to, and retention in, treatment;
3. Reduced overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services;
5. Reduced 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.

As part of the Demonstration, New Hampshire submitted an SUD Implementation Plan that was approved by CMS. The Implementation Plan outlines State-specific steps to achieve CMS-defined milestones for SUD treatment. New Hampshire is required to conduct a Mid-Point Assessment of its progress in meeting SUD Implementation Plan goals and its performance based on CMS-identified metrics. The SUD Mid-Point Assessment includes an examination of:

- Progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan;

- Progress toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol;
- A determination of factors that affected the achievement of milestones and closure of performance measure gaps to date; and
- A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and the risk of missing those milestones and performance targets.

The assessment also requires a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the assessment will provide recommendations for revisions to the State's implementation plan or other pertinent factors that the State can influence to support improvement.

This SUD Mid-Point Assessment report is organized into seven sections. Each of the remaining sections is organized as outlined in Exhibit 1-1 below.

Exhibit 1-1. Remaining Report Sections

Section	Title	Content
2	New Hampshire SUD Coverage	An overview of the New Hampshire SUD Implementation Plan and proposed delivery system enhancements
3	SUD Mid-Point Assessment Methodology	A description of the methodology used to conduct the Mid-Point Assessment
4	SUD Milestones and Mid-Point Assessment Findings	An overview of progress to date toward meeting milestones and timeframes as described in the SUD Implementation Plan and a summary of performance based on Monitoring Protocol measures
5	SUD Information Technology Plan	An overview of progress to date on the State's SUD IT Plan
6	SUD Amendment Budget Neutrality	An assessment of the SUD Amendment Budget Neutrality
7	Assessment Summary and Recommendations	The evaluator's overall assessment of progress to date, identifying factors supporting achievement and those putting performance at risk, along with recommendations to support improvement in future performance

2. NEW HAMPSHIRE SUD COVERAGE

In August 2014, New Hampshire's expanded Medicaid program ("New Hampshire Health Protection Program") began offering comprehensive benefits for SUD treatment to the Medicaid Expansion population. As part of its Demonstration request to CMS, DHHS notes that prior to 2016, approximately 7,500 enrollees in the New Hampshire Health Protection Program received SUD treatment services each quarter. Beginning in July of 2016, SUD benefits, outlined in Exhibit 2-1 below, were made available to all Medicaid enrollees.

Exhibit 2-1. New Hampshire Medicaid Substance Use Disorder Benefits

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 are 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) provides state-funded SUD treatment and recovery services for individuals who are not Medicaid eligible or whose commercial benefit plan leaves them underinsured for the medically necessary level of care. These services are delivered through BDAS contracts with thirteen SUD treatment providers across New Hampshire.

Nearly all SUD residential treatment facilities that receive SAMHSA Supplemental Block Grant Funding through the State have more than sixteen beds and provide services to individuals aged 22-64. In addition, the State 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 included 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. In June of 2020, the adolescent treatment program closed when DHHS terminated the contract with the vendor. There are no current plans to reopen the program.

New Hampshire offers a comprehensive continuum of care for SUD, including Opioid Use Disorder (OUD). In addition to promoting access to all levels of care defined by ASAM, the State supports: public education and awareness activities with schools and other community groups; outreach through partnerships with corrections and law enforcement; specialized residential programs; case management services; recovery housing; and other recovery supports.

3. SUD MID-POINT ASSESSMENT METHODOLOGY

In May of 2021, PHPG was retained as the independent evaluator for the New Hampshire Demonstration and to conduct the SUD Mid-Point Assessment. In developing the SUD Mid-Point Assessment methodology, PHPG collaborated with DHHS, Medicaid stakeholders, and SUD treatment providers as required in the Special Terms and Conditions (STC 20). The following stakeholder information and input sessions were offered:

June 23, 2021	2:30 - 3:30 pm	BDAS, Medicaid, and other DHHS staff
August 16, 2021	2:00 - 3:00 pm	BDAS SUD Treatment Providers
August 31, 2021	12:00 - 1:00 pm	Medicaid and Managed Care Advisory Boards and General Stakeholders
September 1, 2021	5:00 - 6:00 pm	Medicaid and Managed Care Advisory Boards and General Stakeholders

In addition, PHPG offered attendees the option to provide input via email, phone, or with a 1:1 meeting through September 15, 2021.

PHPG performed the following evaluation activities to identify trends in performance and policy issues, as well as successes and potential barriers to progress:

- Analysis of SUD treatment program rules, audit tools, provider and Managed Care Organization (MCO) contract, and program requirements;
- Review of training and technical assistance (TA) topics and where available, participant feedback;
- Qualitative analysis of de-identified feedback from consumer interviews conducted during Independent Peer Reviews (IPR) of New Hampshire providers in 2019 and 2021;
- Interviews and discussions with Medicaid, BDAS, and Prescription Drug Monitoring Program (PDMP) staff; and
- Analysis of CMS-required SUD Monitoring Protocol metrics and monitoring reports.

An overview of New Hampshire's planned activities and the data sources used for the assessment is provided in Exhibit 3-1 on the following page.

Exhibit 3-1. SUD Mid-Point Assessment Activities

CMS Milestone	NH Implementation Activity	Data Source*
1. Access to critical levels of care for OUD and other SUDs	• Medicaid rule changes	• Required CMS metrics • Rule and policy review • MCO contract requirements
2. Widespread use of evidence-based, SUD-specific patient placement criteria	• Medicaid rule changes • Provider Training and TA	• Required CMS metrics • Rule and policy review • Training and TA activity and participant feedback • MCO and provider contract requirements • Compliance Tools • Consumer interview data
3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications	• Medicaid, BDAS, and Licensing rule changes	• He-W 513 rule changes • MCO and provider contract requirements • Compliance Tools
4. Sufficient provider capacity at each level of care	• Establish an assessment process such as the Secret Shopper method • Explore the use of the Treatment Locator Tool for routine assessment of provider availability	• Required CMS metrics • MCO contract requirements • MCO Network Adequacy Reports
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	• Work with the Board of Pharmacy to align planning	• Required CMS metrics • MCO contract requirements • Prescription Drug Monitoring Program (PDMP) Strategic Plan
6. Improved care coordination and transitions between levels of care.	• Medicaid and BDAS rule changes	• Required CMS metrics • Consumer interview data • MCO and provider contract requirements
Other SUD Monitoring Protocol Metrics	• Maintain or improve	• Required CMS Metrics
SUD IT Plan	• Work with the Board of Pharmacy to align planning	• Required CMS metrics • PDMP Strategic Plan and Annual Reports • PDMP and Opioid prescribing rules
Budget Neutrality (BN)	• Maintain expenditures at or below PMPM limits as defined in STCs	• BN amendment and workbook

* For all activities, PHPG also reviewed NH's quarterly and annual reports to CMS for analysis of policy issues, trends, and progress, as well as other State-specific documents as noted in each discussion section.

POLICY, RULE, CONTRACT, AND OPERATIONAL REVIEW

In assessing the State's progress in meeting SUD Implementation Plan Milestones, PHPG examined the following policy, rule, and contract documents:

- DHHS Final Proposal-Annotated Text (10/24/18) for He-W 513 substance use disorder (SUD) Treatment and Recovery Support Services
- DHHS Conditional Approval Request (11/09/18) for He-W 513 substance use disorder (SUD) Treatment and Recovery Support Services
- Public Testimony for He-W 513 substance use disorder (SUD) Treatment and Recovery Support Services
- NH Administrative Rule Medicaid He-W 513 substance use disorder (SUD) Treatment and Recovery Support Services
- NH Administrative Rule Chapter Ph 1500 NH Controlled Drug Prescription Health and Safety Program
- NH Administrative Rule Chapter He-P 800 Residential Care and Health Facility Rules Statutory Authority: Part He-P 826 Substance Use Disorder Residential Treatment Facilities
- NH Administrative Rule Med 502 Opioid Prescribing
- Treating Addiction Together ECHO: Evaluation Report 2019-2020
- SUD Treatment Community of Practice Training, participant feedback (1/4/19, 3/6/20, 3/29/19, 6/28/19, 9/27/19)
- BDAS Training and TA inventory
- DHHS Substance Use Disorder Treatment and Recovery Support Services Contract Exhibit B Scope of Services
- DHHS BDAS SUD Contract Compliance Tool
- Medicaid Care Management Services Contract Exhibit A – Scope of Services Amendment #6 May 2021
- 2021 MCO Network Adequacy Reports
- PDMP Strategic Plan (2019)
- PDMP Annual Reports for SFY 2018, 2019, 2020
- SUD Treatment and Recovery Access Section 1115(a) Demonstration Budget Neutrality (BN) amendment and final approval

CONSUMER INTERVIEW DATA

Funding for SUD treatment services provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) requires BDAS to arrange for an Independent Peer Review (IPR) of at least one SUD treatment provider annually. Each IPR includes interviews with program participants. Data from two interviews conducted in 2019 and five interviews in 2021 were examined. The 2020 IPR was suspended due to the novel coronavirus public health emergency (PHE).

Interviews consisted of a variety of questions related to the consumer's experience of care at each facility. One question related to patient placement and was used to assess Milestone 2 requirements. Three questions related to coordination with other support services (community and recovery) and were used to assess Milestone 6 requirements.

PHPG reviewed consumer responses for each of the following four questions.

Milestone 2:

1. Do you feel that you are currently in the right treatment program, or do you feel as if you would be better served in a different program? For example, if you are currently in residential treatment, do you feel as if you would do better in an intensive outpatient program (IOP).

Milestone 6:

2. Has the program helped you to connect to and build a recovery support network?
3. Has the staff made you aware of, and helped you access other community resources available to you, such as medical services like a primary care doctor, medication assisted treatment, psychiatric treatment, or mental health treatment?
4. Has staff coordinated with, or been in contact with your other providers, such as your PCP or psychiatrist?

CMS REQUIRED MONITORING METRICS

DHHS submits quarterly and annual progress reports to CMS for all required SUD Monitoring Protocol metrics. CMS approved the following modifications to the technical specification requirements in the Monitoring Protocol:

- Subpopulations are determined on the last day of the measurement period; and
- Dually eligible (Medicare and Medicaid) members are not included in the measure calculation for HEDIS and HEDIS-like measures.

To assess the State's performance in meeting its directional targets, PHPG analyzed results of the CMS-required metrics through the first two and one half years of the Demonstration (July 1, 2018 - December 31, 2020). Metrics were reviewed for changes in performance over time.

Guidance on the alignment of metrics under each milestone and the technical specifications was derived from CMS Manual, "Medicaid Section 1115 SUD Demonstrations Technical Specifications for Monitoring Metrics," Version 3.0, issued in August 2020.

PERFORMANCE ASSESSMENT

This SUD Mid-Point Assessment examines the progress of planned enhancements as well as the State's performance per CMS-defined metrics, as outlined in its SUD Monitoring Protocol. PHPG examined SUD Monitoring Protocol results for each year relative to the base year as well as year-over-year changes to assess performance related to CMS-defined metrics. PHPG assessed progress in each Implementation Plan area by evaluating Demonstration activities and their alignment with the approved plan and timeline. Exhibit 3-2 provides an overview of criteria used to assess performance.

Exhibit 3-2. Criteria for Assessing Performance

Finding	CMS-Defined Metrics	Implementation Plan
Meeting	• Results in the most recent year examined showed that the State was maintaining or improving over the base year	Approved steps and timelines are completed or progressing as planned
Low Risk	• Alternative timelines for data reporting were submitted as part of the State's quarterly or annual reports to CMS; Or • Performance metric results are moving away from the desired target, however, they appeared to be influenced by one or more of the following: ○ Measure construction (e.g., state-specific billing practices or claim codes diverge from the technical specifications); ○ The State's public health emergency (PHE) response (e.g., the PHE resulted in temporary program closures or other utilization anomalies); ○ Small sample size (e.g., a small change in numbers may cause a wide variation in results); Or • Performance moved away from the desired target but is at or above national benchmarks, where available	Approved steps and timelines are on hold or delayed, with a plan for completion by the end of the Demonstration
Medium Risk	• Results in the most recent year showed a decline of less than 2 percentage points from the base year with no known problems in metric construction or other factors in the low-risk category	Same as above, with a plan for completion after the end of the Demonstration
High Risk	• Results showed a two percentage point or more change from baseline, away from the desired target; or • A consistent year-over-year decline in performance with no known problems in metric construction or other factors in the low-risk category	Same as above, with no plan for completion available at the time of review

An overall score for each milestone was assigned, using each of the categories above, when 50 percent or more of the findings (metric results and implementation activities) fell in that category.

Where applicable (e.g., medium, and high-risk areas) PHPG examined factors that may have impacted performance negatively and developed recommendations for performance improvement.

4. SUD MILESTONES AND MID-POINT ASSESSMENT FINDINGS

At the outset of the Demonstration, New Hampshire's existing service array, program requirements, and delivery system were in alignment with the majority of the milestones identified by CMS. In addition, the State identified efforts to enhance the quality of SUD treatment services. An overview of the State's Implementation Plan and CMS milestones is presented in Exhibit 4-1.

Exhibit 4-1. Overview of NH's SUD Implementation Plan and Milestones

CMS Milestone	Planned Enhancements
1. Access to critical levels of care for OUD and other SUDs	• Update Rule He-W 513 to align with updated State Plan services and include explicit ASAM level of care service expectations
2. Widespread use of evidence-based, SUD-specific patient placement criteria	• Update Rule He-W 513 to reflect updated reference for Substance Abuse and Mental Health Services Agency (SAMHSA) and other evidence-based practices
3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications	• Reissue expired rule He-A 300 (Certification and Operation of Alcohol and Drug Disorder Treatment Programs) and include specific staffing ratios in alignment with ASAM and He-W 513 rule revisions • Update NH Health Facilities Licensing Rule for SUD providers to include specific staffing, physical space, program design, and compliance requirements in alignment with He-W 513 and He-A 300, including annual compliance audits • Update He-W 513 and He-A 300 to explicitly require MAT access
4. Sufficient provider capacity at each level of care	• Establish an assessment process to identify Medicaid providers who are accepting new patients in critical levels of care, including MAT and adolescent treatment services • Assess whether the SUD Treatment Locator Tool can be enhanced to include an assessment of provider availability that is routinely reported to DHHS
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	• Explore opportunities to enhance current efforts through managed care re-procurement, including developing language-specific to opioid prescribing guidelines and associated reports • Explore additional PDMP report functionality • Work with the PDMP staff and Board of Pharmacy to identify opportunities to increase PDMP use and submit a plan to CMS
6. Improved care coordination and transitions between levels of care.	• Expand discharge planning requirements to all providers through He-W 513 and He-A 300 rule updates

The remainder of Section 4 presents findings for each milestone, including Monitoring Protocol metrics and the State's progress in meeting its action steps and timelines outlined in the SUD Implementation Plan.

MILESTONE 1 ACCESS TO CRITICAL LEVELS OF CARE

Milestone 1 requirements outline expectations for states to improve access to OUD and SUD treatment services for Medicaid beneficiaries. States must offer a range of services at varying levels of intensity across a continuum of care to address the needs of beneficiaries. 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.

New Hampshire provides coverage for a robust array of substance use disorder services, including all of those outlined above. Additional services covered by New Hampshire Medicaid include peer and non-peer recovery support services and continuous recovery monitoring. Where applicable, covered services are in alignment with the American Society for Addiction Medicine (ASAM) patient placement criteria.

As part of the SUD Implementation Plan, Medicaid rules were enhanced to provide greater clarity regarding provider standards, service types and amounts, and member assessment protocols. The State completed Milestone 1 planned activities in November of 2018. In addition, Medicaid MCO contract requirements include SUD-specific access to care provisions and network adequacy standards for members who meet ASAM guidelines for services.

Milestone 1. Performance Metrics

The following performance metrics, as defined in the SUD Monitoring Protocol, were examined related to access to SUD treatment.

> ***#6 Any SUD Treatment***: Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period.
>
> ***#7 Early Intervention***: Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period.

#8 Outpatient Services: Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step-down care, and monitoring for stable patients) during the measurement period.

#9 Intensive Outpatient and Partial Hospitalization Services: Number of unique beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period.

#10 Residential and Inpatient Services: Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period.

#11 Withdrawal Management: Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period.

#12 Medication Assisted Treatment (MAT): Number of beneficiaries who have a claim for MAT for SUD during the measurement period.

#22 Continuity of Pharmacotherapy for Opioid Use Disorder: Percentage of adults in the denominator with pharmacotherapy for OUD who have at least 180 days of continuous treatment.

In addition, PHPG reviewed the following performance measures associated with the CMS topic area "Assessment of Need":

#3 Medicaid Beneficiaries with SUD Diagnosis (monthly): Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement period.

#4 Medicaid Beneficiaries with SUD Diagnosis (annually): Number of beneficiaries annually who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period.

DHHS set an annual target to increase access to SUD treatment services at all levels of care (Metric #6-12) and continuity of pharmacotherapy (Metric #22) for Milestone 1 and to increase in the related topic area of "Assessment of Need" (Metrics #3-4).

In examining the State's progress relative to Milestone 1, the State is meeting its goals for improving access to care and in the related area of Assessment of Need. Measure #22, continuity of pharmacotherapy, is on an alternative reporting schedule.

From DY1 to DY2, the overall use of SUD treatment services rose 27.6 percent. Outpatient treatment showed the highest increase of 26.3 percent and residential and inpatient services showed the smallest increase of 19.3 percent.

A decline of 5 percent was seen for the use of early intervention services. However, the reported figures for early intervention are small. For example, there were an average of 52 reports per month in DY1; 49 in DY2; and 37 in the first six months of DY3. The limited availability of data is because New Hampshire does not include a separate billing code for Screening, Brief Intervention, and Referral to Treatment (SBIRT); rather, services are billed as part of routine assessment and treatment services.

When assessing performance from DY1 through the first half of DY3, intensive outpatient services showed over a 90 percent increase in use, followed by 32.8 percent for outpatient service and 33.9 percent for MAT services. A decline of 28.2 percent was seen for early intervention services and a decline of 8.7 percent was observed for withdrawal management services. As noted above, small reporting numbers contribute to the wide variation seen in the early intervention measures. In addition, the impact of COVID-19 may have limited the use of withdrawal management services. During this period, one residential facility was closed to address lead mitigation from mid-November 2020 to the end of January 2021 and two facilities merged resulting in a small decrease in bed capacity.

Exhibit 4-2 provides an overview of year-over-year change for Milestone 1 metrics.

Exhibit 4-2. Year-Over-Year Change for Milestone 1 Metrics

#	Metric Name	Percent Change DY1-DY2	Percent Change DY1-DY3 (6-mos)
6	Any SUD Treatment	27.6%	25.7%
7	Early Intervention	-5.3%	-28.2%
8	Outpatient Services	26.3%	32.8%
9	Intensive Outpatient and Partial Hospitalization	20.2%	90.9%
10	Residential and Inpatient Services	19.3%	8.5%
11	Withdrawal Management	22.4%	-8.7%
12	Medication Assisted Treatment (MAT)	21.9%	33.9%

In the area of "Assessment of Need" (Exhibit 4-3), the State saw a 9.3 percent increase in the average monthly count of beneficiaries with an SUD diagnosis from DY1 to DY2. From DY1 through the first half of DY3, the State saw a 19.4 percent increase in the average monthly count. The annual count of beneficiaries diagnosed with an SUD rose 7.1 percent from DY1 to DY2. (Annual data for DY3 is not yet available.)

Exhibit 4-3. Year-Over-Year Change for Assessment of Need

#	Metric Name	Percent Change DY1-DY2	Percent Change DY1-DY3 (6-mos)
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	9.3%	19.4%
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	7.1%	N/A

Exhibit 4-4, below and 4-5, and 4-6 on the following pages, provide the results for each measure, along with the status of progress to date.

Exhibit 4-4. Milestone 1 Demonstration Year Metrics (Converted to Average Monthly Enrollment for Each Year)

#	Name	Description	Goal	DY1	DY2	DY3 (6-Months)	Status
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Increase	6,622	8,451	8,325	Meeting
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Increase	52	49	37	Low Risk
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Increase	4,122	5,208	5,475	Meeting
9	Intensive Outpatient and Partial Hospitalization Services	Number of unique beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Increase	252	303	481	Meeting
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Increase	442	528	480	Meeting
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Increase	120	147	110	Low Risk
12	Medication Assisted Treatment (MAT)	Number of beneficiaries who have a claim for MAT for SUD during the measurement period*	Increase	3,817	4,651	5,111	Meeting

Exhibit 4-5. Milestone 1 Metrics for Calendar Year Reporting

#	Name	Description	Goal	CY2018	CY2019	CY2020	Status
22	Continuity of Pharmacotherapy for Opioid Use Disorder	Percentage of adults in the denominator with pharmacotherapy for OUD who have at least 180 days of continuous treatment.	Increase	N/A	39.67%	N/A	Low Risk*

**Alternative reporting timeline established with CMS*

Exhibit 4-6. Demonstration Year Results for Assessment of Need (Monthly and Annual)

#	Name	Description	Goal	DY1	DY2	DY3 (6-months)	Status
3	Medicaid Beneficiaries with SUD Diagnosis	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement period *(converted to average monthly enrollment)*	Increase	14,989	16,387	17,904	Meeting
4	Medicaid Beneficiaries with SUD Diagnosis	Number of beneficiaries annually who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period (annual)	Increase	21,414	22,927	N/A	Meeting

Milestone 1. Assessment

Overall, the State is meeting expected performance for Milestone 1. All Implementation Plan activities have been accomplished and 75 percent of the performance metrics are trending in the desired direction. Three metrics are at low-risk. One of the three due to the adoption of an alternative reporting schedule and two potentially due to the impact of the recent public health emergency. In the topic area of "assessment of need", 100 percent of the metrics are trending in the desired direction.

MILESTONE 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.

Patient Placement Criteria

As of January 1, 2017, all SUD treatment programs and insurance carriers in New Hampshire are required to utilize The ASAM Criteria for placement, per State law RSA 420-J:16. In addition, all State-funded treatment providers are contractually obligated to use evidence-based screening and assessment tools.

As part of the Medicaid rule revision in November 2018, DHHS updated references to nationally recognized evidence-based practice by removing the reference to SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP) which was retired. The NREPP reference was replaced with a reference to the SAMHSA Evidence-Based Practices Resource Center. All covered services must align with nationally recognized best practices, as defined in He-W 513.05 (b)(3), (7), and (8), below.

> *(3) Be 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 Evidence-Based Practices Resource Center available at https://www.samhsa.gov/ebp-resource-center*

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

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

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

(7) Be provided in accordance with the ASAM Level of Care service descriptions, as applicable, noted in He-W 513.11; and

(8) Be provided at a length of time and frequency of care based on individual client need in accordance with ASAM Criteria (2013), available as noted in Appendix A, and not on predetermined time or frequency limits.

Although the sample size was small (N=7), qualitative data from consumer interviews conducted in 2019 and 2021 indicated that 100 percent of consumers interviewed felt their SUD residential treatment program was the best fit for their needs.

Utilization Management (UM) Requirements

The SUD Implementation Plan, approved at the outset of the Demonstration, indicated that New Hampshire policies were already meeting Milestone 2 requirements related to utilization management (UM). UM takes place between MCOs and providers based on contractual agreements. MCO UM policies are initially approved by DHHS and changes must be reviewed and approved by DHHS prior to implementation. The timeliness and volume of UM decisions are monitored by DHHS quarterly. The Department's External Quality Review Organization (EQRO) conducts annual contract compliance reviews, which periodically include MCO compliance with the UM standards. In addition, 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.

BDAS also conducts annual contract compliance audits for all State-funded treatment facilities to ensure adherence to clinical standards when determining the level of care placement. This is done through randomized chart audits conducted by licensed professionals with experience using The ASAM Criteria. All BDAS funded providers submit client placement data to the State-sponsored Web Information Technology System (WITS) when billing the Department for State-funded services. WITS data is audited at the time of billing to ensure that adequate information and documentation is presented for the level of care of the services rendered.

Medicaid documentation standards are outlined in New Hampshire rule He-W 513 for all Medicaid SUD providers. The DHHS Program Integrity Unit reviews documentation as part of their pre- and post-enrollment site visits and re-validation processes for SUD providers.

To support the use of ASAM criteria for patient placement and treatment planning, the SUD Implementation Plan included a commitment to ongoing provider training and technical assistance (TA).

During CY2019 and CY2020, thirty training and TA sessions were conducted. Eighteen sessions were conducted between October 2019 and June 2020 as part of a collaboration with JSI Research & Training Institute, Inc. JSI implemented training for New Hampshire SUD treatment providers using the evidence-based Project ECHO (Extension for Community Healthcare Outcomes) model to improve knowledge, skills, and confidence utilizing The ASAM Criteria.

In addition, nine general training sessions were offered by BDAS in 2019 and 2020 for interested providers and three sessions were conducted in response to provider requests for TA. Exhibit 4-7 offers an overview of training topics, dates training were conducted, and type of training during the Demonstration period.

Exhibit 4-7. Provider Training Opportunities During the Demonstration

Training Topic	Date	Type of Training
Prior Authorization for SUD Treatment	1/4/19	General
Treatment Planning for SUD Treatment	3/29/19	General
ASAM Transfer/Discharge, Continued Care Criteria	6/28/19	General
Social Determinants of Health	3/6/20	General
Understanding and Using ASAM Criteria and Engaging People into Collaborative Addiction Treatment	7/10/19	General
Improving Skills in Assessment, Placement, and Treatment Planning to Implement The ASAM Criteria and Person-Centered Services	7/11/19	General
The Basic Framework of The ASAM Criteria	11/7/19	ECHO
ASAM Levels of Care Part 1	11/21/19	
ASAM Levels of Care Part 2	12/5/19	
All Paths to Recovery	12/19/19	
Harm Reduction Strategies	1/2/20	
Intro to MAT	1/16/20	
Assessment Part 1: Intro to Assessment	1/30/20	
Assessment Part 2: Imminent Danger	2/13/20	
The Basics of Treatment Planning	2/27/20	
Treatment Considerations Part I: NH Treatment System	3/12/20	
Treatment Considerations: The NH Treatment System Pt. 2	3/26/20	
Providing Addiction Care During COVID-19	4/9/20	
COVID-19: Implications for People with SUD	4/23/20	
COVID-19 from an ASAM Dimensional Perspective	5/7/20	
Peer Recovery Support Services	5/21/20	
Clinical Supervision and Self Care	6/4/20	
Continuing Care, Transfer/Discharge Criteria	6/18/20	
ASAM Training and consultation for all NE Phoenix House Staff	6/18/20	TA Request
ASAM Criteria Training at Home Base Collaborative	6/2/20	

Training Topic	Date	Type of Training
ASAM Criteria and Treatment Planning for FIT	8/15/19	
Application of ASAM Criteria for MAT Practices	8/8/19	General
Discovery, Recovery, Relapse Prevention: Treatment Planning for MAT Care Models	10/10/19	General
Introduction to ASAM Levels of Care for MAT Providers	12/12/19	General

Post-session surveys were available for five BDAS training sessions. Over 185 providers participated in these sessions (in-person and remotely). One hundred percent of survey respondents in each session indicated that the session was valuable. Respondents who indicated that the sessions' goals were met ranged from 93 to 100 percent. Exhibit 4-8 provides a summary of post-session feedback.

Exhibit 4-8. SUD Provider Training Goals and Post-session Feedback Summary

Training Date/Goals	Participants Completing Post Session Survey	Respondents who agree/strongly agree all goals were met	Respondents who found the training valuable
January 2019: Applying prior authorization tools and best practices for UM, including ASAM criteria	71%	93%	100%
March 2019: Importance of and how to develop patient-driven treatment plans	82%	96%	100%
June 2019: Importance of ASAM and using the criteria in case reviews and discharge planning	82%	100%	100%
September 2019: Importance of emerging trends of marijuana, kratom, and stimulants	82%	100%	100%
March 2020: Opportunities to incorporate the social determinants of health into substance use disorder treatment and recovery	75%	100%	100%

The "Treating Addiction Together ECHO Project" engaged a cohort of community clinicians from geographically diverse regions of New Hampshire, representing five of the eight ASAM levels of care and withdrawal management services. The ECHO evaluators reported that 92% of participants said their knowledge of The ASAM Criteria had increased. Clinicians provided self-assessments of their confidence using the information learned in their practice. The highest increase in clinician self-ratings of confidence was in using the six dimensions of The ASAM Criteria. Among other items, clinicians also were asked to rate their likelihood of using:

- Training recommendations following the ECHO session; and
- The ASAM Criteria in clinical decision making.

An average of 98% of clinicians said they were very likely or somewhat likely to use the recommendations discussed and 100% of clinicians reported they were very likely or somewhat likely to use The ASAM Criteria for clinical decision making. Clinicians reported improved skills in the areas related to patient care and The ASAM Criteria. This included:

- Providing patients with care in line with their treatment goals;
- Determining the accurate level of care determination based on patients' clinical needs;
- Providing appropriate quality care utilizing services across the New Hampshire substance use and mental health treatment system; and
- Incorporating holistic client needs (e.g., transportation, insurance, childcare, etc.) into treatment plans.

Milestone 2. Performance Metrics

CMS identified two measures for Milestone 2. Both relate to IMD use. Overall, the State experienced a slight decrease (4.5%) from DY1 to DY2 in the number of members treated in an IMD. The average length of stay increased 2.5% during that same period.

DY2 includes the first six months of the novel coronavirus public health emergency (PHE). Utilization may have been impacted by enrollees remaining in quarantine, being reluctant to leave programs once placed, and/or programs suspending or otherwise modifying admission and discharge practices. In addition to the impact of COVID-19, one residential facility was closed to address lead mitigation from mid-November 2020 to the end of January 2021 and two facilities merged, resulting in a small decrease in bed capacity.

Exhibit 4-9 illustrates metric performance and progress status for Milestone 2.

Exhibit 4-9. Milestone 2 Metrics

#	Name	Description	Goal	DY1	DY2	Status
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for residential or inpatient treatment for SUD in IMDs during the measurement period (annual)	Increase	2,580	2,462	Low Risk
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient or residential treatment for SUD	Decrease	17.06	17.50	Low Risk

Milestone 2. Assessment

Overall, the State is meeting expected performance for Milestone 2. Implementation Plan activities have been accomplished. Both metrics associated with Milestone 2 were assessed as low-risk, with a slight decline in performance potentially due to the impact of the novel coronavirus public health emergency.

MILESTONE 3 USE OF NATIONALLY RECOGNIZED SUD-SPECIFIC PROGRAM STANDARDS

Through the Section 1115 SUD Demonstration initiative, states 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 (IMD). Milestone 3 requires that the following residential treatment criteria be 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
- Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off-site.

Residential Treatment Provider Qualifications

Residential programs are required to be licensed by the Bureau of Health Facilities, Licensing Division. During the first 6 months of the Demonstration, effective November 1, 2018, the Bureau of Health Facilities adopted Part He-P 826 titled "Substance Use Disorder Residential Treatment Facilities." These licensing rules for SUD residential treatment facilities are in alignment with the updated Medicaid rule (Part He-W 513) and CMS requirements.

New Hampshire Medicaid rule (He-W 513) includes specific provider qualifications for delivery of SUD services, including required credentials, hours of clinical care, and services covered under each ASAM level of care. He-W 513 also outlines required staffing ratios for residential programs. In addition, both rules outline expectations for the use of ASAM criteria for placement, and as guidance for service planning, discharge planning, and transitions of care between settings.

All residential treatment provider qualifications (in licensure requirements, policy manuals, managed care contracts, or other guidance) meet The ASAM Criteria regarding the types of services, hours of clinical care, and credentials of staff for residential treatment settings.

The BDAS has expired rules (He-A 300) governing requirements for SUD treatment providers receiving State funds. The SUD Implementation Plan included action steps for BDAS to update He-A 300 by the fall of 2019. Due to competing priorities and the onset of the novel coronavirus public health emergency (PHE), the timeline for BDAS rulemaking has been revised to CY2022. However, BDAS provider contracts and Medicaid MCO contracts require adherence to ASAM criteria for SUD-specific program standards regarding the types of services, hours of clinical care, and credentials of staff for residential treatment settings.

Compliance Reviews

Medicaid rules, Bureau of Licensing requirements, BDAS, and MCO contract requirements are enforced by the State through periodic audits, including site visits and/or annual contract compliance reviews.

The BDAS Contract Compliance Tool includes 77 items specific to ASAM criteria and best practices in SUD treatment and service planning. Compliance items are assessed for each provider in the areas of:

- Client rights and program orientation;
- Referral and care coordination, including obtaining proper consents and assessing for self-harm and withdrawal at all phases of treatment;
- Treatment planning, including client involvement and adherence to ASAM guidance;
- Client education on addiction, recovery, and health issues;
- Service documentation; and
- Transfers/discharge including planning in all ASAM domains and continuity of care.

To support effective and efficient compliance monitoring, DHHS convened a workgroup to integrate Medicaid, BDAS, and MCO provider audit activities. In July of 2021, New Hampshire's three Medicaid MCOs began piloting a provider compliance tool designed to streamline current processes between BDAS and MCOs and to minimize administrative burden for the providers. Based on the results of this pilot, DHHS and the MCOs are refining the tool and will implement a revised compliance process.

Access to MAT

Medicaid rule He-W 513, the Bureau of Licensing requirements, MCO contract requirements, and BDAS contract requirements all require providers to assist in accessing MAT either on-site or off-site when clinically indicated for members receiving residential services.

Milestone 3. Assessment

Overall, the State is meeting expected performance for Milestone 3. Implementation Plan activities have been accomplished apart from reissuing BDAS provider rule He-A 300. However, the elements necessary to align with CMS SUD requirements are contained in NH statute, related Medicaid rules, MCO and BDAS provider contracts. Contract compliance monitoring is routinely conducted by both BDAS and the MCOs. Evidence of compliance with CMS requirements was found in a review of State audit tools and activities, MCO and provider contract requirements, rules, and statutes. In addition, BDAS has a plan to re-issue its expired rules by the end of the Demonstration period. There are no performance metrics associated with Milestone 3.

MILESTONE 4 SUFFICIENT PROVIDER CAPACITY AT CRITICAL LEVELS OF CARE

To meet Milestone 4, 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 the availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as the availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in the availability of services for beneficiaries in the critical levels of care.

DHHS includes specific SUD provider network and accessibility standards in their Medicaid MCO contracts. MCOs are required to report annually and when needed, submit a corrective action plan for addressing availability and access to SUD treatment.

The MCO reports represent point-in-time assessments of SUD network adequacy each year. In January of 2021, all MCOs were at or above the contract standard for enrolling Master Licensed Alcohol and Drug Counselors (MLADC), Opioid Treatment Programs, and Buprenorphine prescribers. Seventy-five percent of the MCOs met the contract standard for enrolling residential providers and peer recovery programs. One MCO reported that contracts were in process for enrolling the remaining peer recovery programs. DHHS is in the process of reviewing feedback from one MCO related to potential discrepancies between the SUD residential list for 2020 and the number of programs currently operating. An overview of SUD network adequacy reports is provided in Exhibit 4-10.

Exhibit 4-10. MCO SUD Network Adequacy Report January 2021

SUD Provider Type	MCO Contract Standard	Network 1	Network 2	Network 3	Networks at or Above Standard
MLADCs	70%	78%	96%	84%	100%
Opioid Treatment Programs	75%	100%	100%	100%	100%
Buprenorphine Prescribers	75%	81%	93%	89%	100%
Residential Treatment	50%	64%	46%	64%	75%
Peer Recovery Programs	100%	100%	54%*	100%	75%*

**Enrollment was reported as 'in process' for remaining providers, bringing this total to 100%*

In addition to the network adequacy reports, DHHS explored the feasibility of including additional processes 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. These included:

- Conducting a periodic secret shopper assessment conducted by the DHHS EQRO vendor;
- Updating the 2014 treatment capacity report; and
- Working with the vendor supporting the treatment locator system to determine if quarterly or annual assessment data can be produced.

Following a review of the additional assessment options outlined above, DHHS concluded that the MCO contract requirements and Medicaid managed care quality strategy provided sufficient oversight for access and availability to SUD treatment.

DHHS also has made considerable investments in provider rate increases in each year between 2019 and 2021 to support SUD treatment services at all levels of care. Effective January 1, 2019, DHHS increased reimbursement for high-intensity residential treatment services for adults (H0018) to $247.82 per day. Effective July 1, 2019, DHHS increased reimbursement for residential sub-acute detoxification (H0010) to $340.32 per day to address member access issues. New Hampshire House Bill 4 (HB4) implemented a 3.1% provider rate increase applicable to nearly most other Medicaid services, effective January 1, 2020, and a second 3.1% rate increase with an effective on January 1, 2021, excluding residential treatment rates, which were increased as part of previous initiatives. These increases were approved by the Legislature to help maintain beneficiary access and support providers in the State.

Milestone 4. Performance Metrics

PHPG examined the following performance metrics, as defined in the SUD Monitoring Protocol, related to Milestone 4:

> ***#13 SUD provider availability***: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period.
>
> ***#14 SUD MAT provider availability***: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT.

Results show nearly a 180-percent increase in Medicaid enrolled SUD providers from DY1 to DY2 and a 379-percent increase in SUD MAT providers. Data for DY3 is not yet available. Although rate increases may have spurred some provider enrollment, DHHS reported a notable change in the methodology and data sets used to count SUD providers enrolled in Medicaid. During DY2, DHHS began using the All-Payer Claims Database to identify providers serving Medicaid enrolled members. Providers along the bordering states were added to the counts as well other SUD practitioners serving Medicaid members.

In 2020, DHHS also issued a more detailed SUD provider reporting structure and uniform workbook for MCOs to report compliance with SUD network adequacy standards. While DY3 data for the CMS monitoring report is not yet complete, point-in-time MCO data for January 2021 suggests SUD provider enrollments have risen to include over 1,300 providers.

Exhibit 4-11 offers an overview of the results for Milestone 4 metrics.

Exhibit 4-11. Milestone 4 Metrics

#	Name	Description	Goal	DY1	DY2	Status
13	SUD provider availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Increase	446	1,244	Meeting
14	SUD provider availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Increase	224	1,074	Meeting

Milestone 4. Assessment

Overall, the State is meeting expected performance for Milestone 4. Implementation Plan activities have been accomplished. CMS requirements are contained in MCO contracts and provider rate increases have been implemented throughout the Demonstration period. Both metrics associated with Milestone 4 are trending in the desired direction.

MILESTONE 5 IMPLEMENTATION OF COMPREHENSIVE TREATMENT AND PREVENTION STRATEGIES

Milestone 5 requires states to implement opioid prescribing guidelines along with other interventions to prevent prescription drug misuse. This includes:

- Expanded coverage of and access to naloxone for overdose reversal; and
- Implementation of strategies to increase utilization and improve the functionality of prescription drug monitoring programs (PDMP).

Opioid Prescribing Guidelines and Other Interventions to Prevent Misuse

Opioid Prescribing Guidelines: Rules from the New Hampshire Board of Medicine went into effect on January 1, 2017. For acute pain management, these guidelines require prescribers to:

- Complete a comprehensive physical exam and assess the patient's risk for opioid misuse or diversion. The assessment must include the completion of a board-approved risk assessment tool, such as the evidence-based screening tool Screener and Opioid Assessment for Patients with Pain (SOAPP);
- Document an appropriate pain treatment plan and the consideration of non-pharmacological modalities and non-opioid therapy;
- Prescribe the lowest effective opioid dose for a limited duration; and
- Ensure that patients understand the risks, benefits and proper medication use associated with opioids.

The rules for use of opioids for chronic pain management include additional requirements such as treatment planning with the patient and a written treatment agreement that specifies conduct that will trigger the discontinuation or tapering of opioids; random and periodic urine drug testing at least annually for all patients using opioids for longer than 90 days; and providing clinical coverage available for 24 hours per day, 7 days per week, to assist in the management of patients. Documentation must also include the consideration of a consultation with an appropriate specialist when the patient:

1. Receives a 100 mg morphine equivalent dose daily for longer than 90 days; or
2. Is at high risk for misuse or substance use disorder; or
3. Has a co-morbid psychiatric disorder.

Under these rules, all prescribers are required to register with the PDMP and query (directly or through a delegate) the PDMP to obtain a history of schedule II-IV controlled substances dispensed to the patient prior to prescribing an initial schedule II, III, and IV opioids for the management or treatment of pain. The PDMP must be checked periodically and at least twice per year for continued treatment.

In 2020, the Legislature passed HB 1639 which includes a requirement that boards regulating the prescribing, administering, and dispensing of controlled substances adopt rules for the management of chronic pain to ensure the individual needs of patients are endorsed and that determinations made by their treating physician (in collaboration with other specialists) are not hindered. The statutes further clarify the definition of chronic pain and the role of the treating practitioner.

Warning Labels and Risk Mitigation: In 2019, the Legislature passed HB 359 relative to warning labels on prescription drugs containing opiates. This statute requires any drug which contains an opiate dispensed by a health care provider or pharmacy to have an orange sticker on the cap or dispenser and a warning label regarding the risks of the drug. The statute also requires the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery to develop a handout on the risks of opioids and how to mitigate them for persons who are receiving prescriptions for opioids.

Pharmacy Point of Sale Alerts: The pharmacy point of sale (POS) system has a cumulative morphine milligram equivalence (MME) calculator. DHHS has a system edit in place that will not allow claims to process once the cumulative MME is equal to or greater than 100mg. Beneficiaries that require doses that are equal to or greater than 100mg MME are required to get prior authorization. The 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 an MME calculator built into the pharmacy POS system and to prior authorize all prescriptions where the dose is equal to or greater than 100mg MME.

MCO Drug Utilization Review: New Hampshire's MCO contracts require compliance with Section 1004 provisions of the SUPPORT for Patient and Communities Act. These provisions are designed to reduce opioid-related fraud, misuse, and abuse. MCO contract requirements include:

- Safety edits on days' supply, early refills, duplicate fills, and quantity limitations on opioids and claims review automated process that indicates fills with opioids in excess of limitations identified by the State;
- Safety edits on the maximum daily morphine equivalent for the treatment of pain and claims review automated process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the State;
- Automated claims review processes that monitor when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;
- A program to monitor and manage the appropriate use of antipsychotic medications by all children, including foster children enrolled under the State plan; and
- Fraud and misuse identification processes that identify potential fraud or misuse of controlled substances by beneficiaries, health care providers, and pharmacies.

Continuing Medical Education: Physicians who possess a NH-DEA license need to include 3 hours of Continuing Medical Education (CME) in the area of pain management and addiction disorder or a combination thereof as part of the regular every-other-year CME reporting cycle that coincides with license renewal.

Expanded Coverage of Naloxone

At the outset of the Demonstration, New Hampshire was meeting this requirement. The approved SUD Implementation Plan did not include action steps beyond the State's existing commitment to harm reduction. In 2020, the State purchased 3,950 Naloxone kits for distribution to community providers. Distribution efforts were targeted at hard-to-reach populations who may be at the highest risk of overdose. This included distribution to agencies not involved with prior efforts. The distribution included opioid treatment providers, Federally Qualified Health Centers, Recovery Community Organizations, Recovery Houses, Outreach Workers, Food Pantries, Shelters, and Churches.

Strategies to Increase Utilization and Improve Functionality of the PDMP

The New Hampshire Controlled Drug Prescription Health and Safety Program was authorized in June 2012 to: enhance patient care; curtail the misuse of controlled substances; combat illegal trade in and diversion of controlled substances; and enable access to prescription information by practitioners, dispensers, and other authorized individuals and agencies.

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 must submit the information required by New Hampshire law to the PDMP database within seven (7) days of the date the prescription was dispensed. New Hampshire continues to work on strategies and policies associated with the PDMP.

New Hampshire's SUD Implementation Plan anticipated the assessment of the current state and the development of a proposed future state for PDMP enhancements. DHHS engaged in discussions with the PDMP staff and Board of Pharmacy to identify opportunities to align the PDMP Strategic Plan with CMS Medicaid requirements.

During the first quarter of the Demonstration, the Division of Medicaid collaborated with the New Hampshire Board of Pharmacy under the Office of Professional Licensure (the entity charged with overseeing the operations of the PDMP) to discuss the development of a PDMP Strategic Plan and the CMS PDMP requirements. During this same period, the New Hampshire Board of Pharmacy and the PDMP Advisory Council convened a collaborative planning team (including DHHS staff and policy leaders) to determine how the PDMP could contribute and achieve a positive impact for the State. The group agreed on a collective mission and strategic goals for the PDMP:

> *Mission: To promote the quality of patient care and appropriate use of controlled substances for legitimate medical purposes, including deterrence of misuse and diversion of schedule II-IV controlled substances by:*
>
> - *Inclusion of more accurate and complete data tracking of opioids and other scheduled drug prescriptions;*
> - *Helping prescribers and pharmacists make safe prescribing and dispensing decisions; and*
> - *Improving the identification and education of high-risk indicators (e.g., overdose and SUD).*
>
> *PDMP Strategic Goals*
>
> 1. *Provide an easy and accurate tool that improves prescribing and dispensing decisions;*
> 2. *Develop advanced analytics to improve patient outcomes; and*
> 3. *Support initiatives through a multi-disciplinary leadership collaborative.*

<u>Milestone 5. Monitoring Protocol Metrics</u>

PHPG examined the following performance metrics, as defined in the SUD Monitoring Protocol, related to the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD:

#18 Use of Opioids at High Dosage in Persons Without Cancer: Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids with a daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer.

#21 Concurrent Use of Opioids and Benzodiazepines: Percentage of beneficiaries with concurrent use of prescription opioids and benzodiazepines.

#23 Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries: Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period.

#27 Overdose Deaths (rate): Rate of overdose deaths during the measurement period per 1,000 adult Medicaid beneficiaries affected by the Demonstration.

DHHS set an annual target of "decrease" for all Milestone 5 metrics. The performance showed improvements from CY2018 to CY2019 for all metrics reported to date. One metric, overdose death rates, has not yet been reported for DY2. CMS and DHHS agreed on an alternative reporting schedule for overdose death counts and Medicaid overdose death rates; to date, the rates have been compiled for DY1. The metric was assessed as low-risk pending the production of additional data.

Two measures, #18 (Use of Opioids at High Dosage in Persons Without Cancer) and # 21 (Concurrent Use of Opioids and Benzodiazepines) are reported by calendar year. From 2018 to 2019, DHHS reported a 15.23 percent decrease in the use of opioids at high doses and an 11.69 percent decrease in concurrent use of opioids and benzodiazepines. Data for 2020 has not yet been reported.

Emergency Department use (Metric 23) is reported monthly. In assessing progress, PHPG examined the average monthly rates for each DY. From DY1 to DY2, DHHS experienced a 4.84 percent decrease in ED use. From DY1 to DY3, a 12.40 percent decrease in ED use was reported. However, it should be noted that the DY2 and DY3 results include observations reported during the novel coronavirus PHE and ED utilization was likely impacted by the quarantine mandates and/or members being reluctant to use the ED.

Exhibit 4-12 provides an overview of year-over-year change.

Exhibit 4-12. Year-over-Year Change for Milestone 5 Metrics

#	Metric Name	Percent Change DY1 – DY2*	Percent Change DY1-DY3 (6-mos)
18	Use of Opioids at High Dosage in Persons Without Cancer (*decrease is preferred)*	-15.23%	N/A
21	Concurrent Use of Opioids and Benzodiazepines (*decrease is preferred)*	-11.69%	N/A

#	Metric Name	Percent Change DY1 – DY2*	Percent Change DY1-DY3 (6-mos)
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries *(converted to average monthly rates – decrease is preferred)*	-4.84%	-12.40%
27	Overdose death rate	N/A	N/A

** Metrics 18 and 21 are reported by CY; metrics 23 and 27 are reported by DY*

Exhibits 4-13 and 4-14 provide an overview of Milestone 5 results.

Exhibit 4-13. Milestone 5 Calendar Year Metrics Results

#	Name	Description	Goal	2018	2019	Status
18	Use of Opioids at High Dosage in Persons Without Cancer	Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids with a daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer *(lower rates are preferred)*	Decrease	15.69%	13.30%	Meeting
21	Concurrent Use of Opioids and Benzodiazepines	Percentage of beneficiaries with concurrent use of prescription opioids and benzodiazepines *(lower rates are preferred)*	Decrease	32.12%	28.36%	Meeting

Exhibit 4-14. Milestone 5 Demonstration Year Metrics Results

#	Name	Description	Goal	DY1	DY2	2020	Status
23	Emergency Department Utilization	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period *(converted to average monthly for each year lower rates are preferred)*	Decrease	4.51	4.29	3.95	Meeting
27	Overdose deaths (rate)	Rate of overdose deaths during the measurement period per 1,000 adult Medicaid beneficiaries affected by the Demonstration	Decrease	1.67	N/A	N/A	Low Risk*

**Alternative reporting timeline established with CMS*

Milestone 5. Assessment

Overall, the State is meeting expected performance for Milestone 5. Implementation Plan activities have been accomplished; CMS requirements are contained in statute, rule, and MCO

contracts. One metric is identified as low-risk due to an alternative reporting schedule. The remaining three performance metrics (100 percent) are trending in the desired direction.

MILESTONE 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 support following stays in these facilities.

New Hampshire's SUD Implementation Plan anticipated updates for two rules, Medicaid (He-W 513) and BDAS (He-A 300), related to discharge planning and continuity of care. BDAS contract agreements include requirements specific to discharge planning for all State-contracted treatment facilities. In November of 2018, Medicaid rules were finalized to adopt these enhanced standards and expand discharge planning requirements to all SUD treatment providers. The State is planning to place requirements in BDAS administrative rules in CY2022.

PHPG reviewed the results of consumer interviews for three questions:

1. Has the program helped you to connect to and build a recovery support network?
2. Has the staff made you aware of, and helped you access other community resources available to you, such as medical services like a primary care doctor, medication assisted treatment, psychiatric treatment, or mental health treatment?
3. Has staff coordinated with, or been in contact with your other providers, such as your PCP or psychiatrist?

Although the sample size was small (N=7), qualitative data from consumer interviews conducted in 2019 and 2021 indicated that 100 percent of consumers interviewed felt their SUD residential treatment providers helped to connect them to and build a recovery support network and that staff informed them and helped them gain access to other community resources. When asked if staff have coordinated with other providers, five individuals said yes, one person said no, and one person did not know.

MCO Contract Requirements and Incentives

A recent amendment to New Hampshire's MCO contracts implements a membership auto-assignment incentive for high-performing MCOs, effective January 2021. As part of the incentive program, DHHS will reward MCOs for ensuring continuity of care as measured by the percent of members who are discharged from the ED for a SUD condition who are connected to treatment. Performance will be measured for connecting members to SUD treatment beginning with the quarter ending December 31, 2022.

Milestone 6. Performance Metrics

PHPG examined the following performance metrics, as defined in the SUD Monitoring Protocol, related to improved care coordination and transitions between levels of care:

#15 Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET): total scores and sub-population breakouts reported for:

- Initiation of AOD Treatment - Percentage of beneficiaries 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; and
- Engagement of AOD Treatment - The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.

#17 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence: results reported for four sub-groups:

- Percentage of ED visits for beneficiary's diagnosis of AOD abuse or dependence and who had a follow-up visit for AOD within 7-days of the ED visit;
- Percentage of ED visits for which the beneficiary received a follow-up visit for AOD within 30 days of the ED visit;
- Percentage of ED visits for beneficiary's diagnosis of mental illness which the beneficiary received a follow-up visit for mental illness within 7 days of the ED visit;
- Percentage of ED visits for which the beneficiary received a follow-up visit for mental illness within 30 days of the ED visit.

#25 Readmissions Among Beneficiaries with SUD: Total number of inpatient discharges per 1,000 beneficiaries in the measurement period.

All measures are reported by calendar year. Data for 2020 has not been reported. From 2018 to 2019, DHHS showed an improvement in initiation and engagement in SUD treatment, readmissions among members with an SUD, and follow-up after ED visits for SUD.

The total score for initiation in treatment (Metric 15a) rose by 17.80 percent, with a range of 11.84 for the initiation of treatment for other drugs to 26.77 percent for treatment for alcohol abuse and dependence. The total score for engagement in treatment (Metric 15b) rose by 23.44 percent, with a range of 12.99 percent for treatment for opioids to 49.87 percent for treatment for alcohol abuse and dependence.

From 2018 to 2019, 7-day follow-up after an ED visit for SUD rose 27.99 percent and 30-day follow-up rose 22.19 percent. During that same period, 7-day follow-up after an ED visit for mental illness rates declined 3.91 percent and 30-day follow-up declined by 3.30 percent. In reviewing the results in the context of Medicaid plans nationally, the national Medicaid benchmark at the 50th percentile showed a similar decline for both the 7- and 30-day follow-up after hospitalization for mental illness. However, New Hampshire's performance exceeded the national benchmark at the 75th percentile in each year. For this reason, the measures were assessed as low-risk.

Readmission rates among members with an SUD improved by 5.68 percent from 2018 to 2019. Exhibit 4-15 provides an overview of the year-over-year changes for Milestone 6 metrics.

Exhibit 4-15. Year-Over-Year Change Milestone 6 Metrics

#	Metric Name	Percent Change DY1-DY2
15a	Initiation of AOD Treatment (Total Score)	17.80%
	Alcohol Abuse or Dependence - Sub-Group Score	26.77%
	Opioid Abuse or Dependence - Sub-Group Score	15.36%
	Other Drug Abuse or Dependence- Sub-Group Score	11.84%
15b	Engagement of AOD Treatment (Total Score)	23.44%
	Alcohol Abuse or Dependence- Sub-Group Score	49.87%
	Opioid Abuse or Dependence - Sub-Group Score	12.99%
	Other Drug Abuse or Dependence- Sub-Group Score	22.99%
17a	Follow-up after ED visit for AOD (7-days)	27.99%
	Follow-up after ED visit for AOD (30 days)	22.19%
17b	Follow-up after ED visit for mental illness (7 days)	-3.91%
	Follow-up after ED visit for mental illness (30-days)	-3.30%
25	All-cause readmissions among beneficiaries with SUD (decrease is preferred)	-5.68%

Exhibit 4-16 on the following page provides performance results for Milestone 6 metrics.

Exhibit 4-16. Milestone 6 Metrics

#	Name	Description	Goal	2018	2019	Status
15	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)	Initiation of AOD Treatment—the percentage of beneficiaries 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 (Total Score)	Increase	41.41%	48.78%	Meeting
		Alcohol Abuse or Dependence - Sub-Group Score	Increase	37.37%	47.37%	Meeting
		Opioid Abuse or Dependence - Sub-Group Score	Increase	54.94%	63.37%	Meeting
		Other Drug Abuse or Dependence- Sub-Group Score	Increase	33.82%	37.83%	Meeting
		Engagement of AOD Treatment—the percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit (Total Score)	Increase	17.86%	22.05%	Meeting
		Alcohol Abuse or Dependence- Sub-Group Score	Increase	11.74%	17.60%	Meeting
		Opioid Abuse or Dependence - Sub-Group Score	Increase	34.62%	39.12%	Meeting
		Other Drug Abuse or Dependence- Sub-Group Score	Increase	9.39%	11.55%	Meeting
17	Follow-up after discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Percentage of ED visits for beneficiary's diagnosis of AOD abuse or dependence and who had a follow-up visit for AOD within 7-days of the ED visit	Increase	20.70%	26.50%	Meeting
		Percentage of ED visits for which the beneficiary received a follow-up visit for AOD within 30 days of the ED visit		32.82%	40.10%	Meeting
		Percentage of ED visits for beneficiary's diagnosis of mental illness which the beneficiary received a follow-up visit for mental illness within 7 days of the ED visit		75.55%	72.61%	Low Risk
		Percentage of ED visits for which the beneficiary received a follow-up visit for mental illness within 30 days of the ED visit		83.97%	81.18%	Low Risk
25	Readmissions for SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD (lower is preferred)	Decrease	0.1234	0.1164	Meeting

Milestone 6. Assessment

Overall, the State is meeting expected performance for Milestone 6. Expected Implementation Plan activities have been accomplished apart from reissuing BDAS provider rule He-A 300. However, the elements necessary to align with CMS SUD requirements are contained in NH statute, related Medicaid rules, MCO and BDAS provider contracts. Contract compliance monitoring is routinely conducted by both BDAS and the MCOs. In addition, BDAS has a plan to re-issue its expired rules by the end of the Demonstration period.

Thirteen results are reported for three measures under Milestone 6. Two results (15.4 percent) show a slight decline from the baseline. Eleven (84.6 percent) are trending in the desired direction.

OTHER SUD MONITORING PROTOCOL METRICS

In addition to SUD Monitoring Protocol metrics reported for each CMS milestone, CMS included several measures in the category of 'other'. These include:

> ***#24 Inpatient Admissions***: Total number of inpatient discharges per 1,000 beneficiaries in the measurement period.
>
> ***#26 Overdose Deaths (count)***: Number of overdose deaths during the measurement period among Medicaid beneficiaries affected by the Demonstration.
>
> ***#32 Access to Preventive/ Ambulatory Health Services***: The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.

New Hampshire's annual goal was to decrease inpatient admissions and overdose deaths while increasing access to preventive/ambulatory health services.

In examining the State's progress relative to CMS metric #24 (Inpatient Admissions), the total count of beneficiaries served monthly was converted to an average monthly number for each year studied. Inpatient admissions decreased 8.14 percent from DY1 to DY2 and 16.95 percent from DY1 through the first half of DY3.

Access to preventive/ambulatory health care has increased from DY1 to DY2 by 9.34 percent. Data for DY3 has not been reported.

The year-over-year change is not available for overdose death counts. CMS and DHHS agreed on an alternative reporting schedule for overdose death counts and Medicaid overdose death rates; to date, the rates have been compiled for DY1.

Exhibit 4-17 illustrates year-over-year change for other CMS metrics.

Exhibit 4-17 Year-Over-Year Change Other Metrics

#	Metric Name	Percent Change DY1-DY2	Percent Change DY1-DY3 (6-mos)
24	Inpatient Admissions (decrease is preferred)	-8.14%	-16.95%
26	Overdose deaths (count)	N/A	N/A
32	Access to preventive/ ambulatory health services	9.34%	N/A

Exhibit 4-18 provides an overview of performance for other CMS metrics.

Exhibit 4-18 Other CMS Metrics

#	Name	Description	Goal	2018	2019	Status
24	Inpatient Admissions	Total number of inpatient discharges per 1,000 beneficiaries in the measurement period (converted to average monthly for each year – lower is preferred)	Decrease	5.33	4.90	Meeting
26	Overdose deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries affected by the Demonstration	Decrease	358	N/A	Low Risk*
32	Access to preventive/ ambulatory health services	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period	Increase	45.25%	49.47%	Meeting

**Alternative reporting timeline established with CMS*

5. SUD INFORMATION TECHNOLOGY PLAN

In establishing SUD Information Technology (IT) requirements for 1115 Demonstrations, CMS seeks the following assurances from States:

- **Assurance 1**: The State has a sufficient health IT infrastructure ecosystem at every appropriate level to achieve the goals of the Demonstration.
- **Assurance 2**: The State's SUD Health IT Plan is aligned with the State's broader State Medicaid Health IT Plan and, if applicable, the State's BH IT Plan.
- **Assurance 3**: The State intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B.

New Hampshire's SUD IT plan (STC Attachment D) indicates that a more complete assessment of the PDMP and a plan for enhancement would be created within 60 days of the Demonstration application (CY2018). DHHS staff could not determine if a final SUD IT plan and timeline for PDMP enhancements was developed. Significant turnover in PDMP and Medicaid staff resulted in a lack of historical knowledge regarding IT activities that occurred during the Demonstration.

At the time of the Demonstration's application and subsequent approval, oversight of the PDMP was provided by the New Hampshire Board of Pharmacy, outside of the authority of DHHS and the Division of Medicaid. Oversight of the PDMP moved from the New Hampshire Board of Pharmacy to the Department of Public Health within DHHS, effective July 1, 2021. DHHS identified collaboration between Medicaid and the PDMP team as a high priority.

Absent a CMS-approved SUD IT plan and other PDMP documents, PHPG examined current PDMP functionality through a review of the State's PDMP Strategic Plan, PDMP annual reports, a series of staff interviews and written communications with newly assigned PDMP and Medicaid staff.

The remainder of this section provides an overview of CMS PDMP requirements and the status of PDMP functionality and strategic planning in New Hampshire. A review of SUD IT measures as defined in the SUD Monitoring Protocol is also included.

Prescription Drug Monitoring (PDMP) Functionalities

CMS requirements include: enhanced interstate data sharing to better track patient-specific prescription data; enhanced "ease of use" for prescribers and other State and federal stakeholders; enhanced connectivity between the State's PDMP and any statewide, regional, or local health information exchange (HIE); and enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns.

- *Interstate Data Sharing*: Currently New Hampshire employs interstate data sharing with 15 states and the Military Health System. The Legislature retains authority for determining interstate data sharing; no new data-sharing agreements are expected during the remainder of the Demonstration.

- *Ease of Use*: In 2019 the State identified improved access and usability as a PDMP goal. The SFY2020 PDMP Annual Report show that the number of registered users and the volume of queries from prescribers, pharmacists and delegates increased. For example:

    - The total number of accounts increased 6% from SFY2019 to SFY2020;
    - The PDMP received over 1,030,000 unique patient queries in SFY2020, a 14% increase over SFY2019; and
    - The number of overall active users increased by 3%.

    The State continues work to improve reporting with professional practice boards. All PDMP users have access to an online users' manual for real time education and support.

- *HIE Connectivity*: New Hampshire does not maintain a local or statewide HIE network. The Legislature retains authority for determining data sharing and does not support development in this area. No local or statewide HIE networks are planned for development nor is regional connectivity with other states.

- *Clinician Prescribing and Long Term Opioid Use*: Since 2017, PDMP capabilities have included "Prescriber Reports" (launched in November 2017) to deliver data to physicians in a report format allowing them to see their prescription patterns compared to trend data. In November of 2018, a Clinical Alert function was added that displays alerts on patient reports where patients have met or exceeded State-defined thresholds of specified prescription drugs. The Clinical Alert function is currently being evaluated to address "alert fatigue" (i.e., providers being overwhelmed with too many types of alerts) and determine the most effective alert processes.

    In May 2019, a Prescriber Practice Report Card function was added to the system. Quarterly reports are now available for all prescribers. In support of clinical reviews, the system tracks whether providers review their information each quarter. In September 2019, a staff position was added to the PDMP team to audit prescribers identified as outliers. The PDMP vendor is developing a dashboard, using business intelligence software (e.g., Tableau) to provide real time information to providers and enhance interactive capabilities.

    The PDMP Annual Report for SFY2020 shows that the percentage of prescriptions with an MME greater than 100 fell from 10.8% during the first quarter of 2019 to 9.8% in the last quarter of SFY2020.

Current and Future PDMP Query Capabilities

This CMS requirement includes facilitating the State's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e., the State's master patient index strategy with regard to PDMP query).

The State's PDMP is supported through a contract with Appriss Health. The PDMP platform, 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. The vendor provides a master patient index to properly match patients and prescriptions within the PDMP. The State does not have plans to integrate master person index capabilities across State systems or between the PDMP and state systems.

Use of PDMP – Supporting Clinicians with Changing Office Workflows/Business

CMS requirements include: developing 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; developing 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.

In April of 2019, the PDMP launched an enhanced reporting function called "Mandatory Use Compliance." Reporting through AWARxE indicates whether a provider performed a PDMP search prior to prescribing specific drugs (e.g., opioids) based on the State-specific requirements. In addition, a provider survey is scheduled for the fourth quarter of CY2021 to obtain provider input on the PDMP system and how to best support clinical workflows.

Master Patient Index/Identity Management

This CMS requirement focuses on enhancing the master patient index (or master data management service, etc.) in support of SUD care delivery.

New Hampshire's PDMP is supported through a contract with Appriss Health, as described above, no plans to enhance the master patient index are planned during the Demonstration.

Overall Objectives for Enhancing PDMP Functionality and Interoperability

This requirement includes leveraging 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 ensure Medicaid does not inappropriately pay for opioids.

The SFY2020 PDMP Annual Report indicates that Medicaid is the primary payer for 5.4 percent of opioid prescriptions in SFY2019 and 5.8 percent in SFY2020, annually. The year-over-year change was reported as not substantial.

SUD IT Performance Measures

CMS approved three State-specific performance metrics for monitoring progress with the SUD IT Plan. These included:

- Q1 Provider Utilization of the NH PDMP (quarterly beginning July 2018)
- Q2 Provider Utilization of "Prescriber Report Cards (semi-annually beginning July 2019)
- Q3 Production of SUD-based "Clinical Alerts" (quarterly beginning July 2019)

To examine year-over-year change, PHPG converted quarterly and semi-annual data to an average for each DY. PDMP utilization increased 11.23 percent from DY1 to DY2 and 17.04 percent from DY1 through the first half of DY3. Provider utilization of "Prescriber Report Cards" was first reported in DY2; results show a 2.97 percent increase from DY2 through the first half of DY3. CMS and DHHS agreed on an alternative timeline for the reporting of SUD-based clinical alerts. Reporting is expected in DY4. Exhibit 5-1 provides an overview of the State-specific SUD IT Monitoring Protocol metrics.

Exhibit 5-1. SUD IT Metrics

#	Name	Description	Goal	DY1	DY2	DY3 (6-months)	Status
Q1	Provider Utilization of the NH PDMP (Quarterly)	The quarterly number of patient queries performed by provider or provider delegate using the NH PDMP *(converted to average per demo year)*	Increase	157,758	175,487	184,663	Meeting
Q2	Provider Utilization of "Prescriber Report Cards (semi-annual)	Number of Prescribers who are emailed "Prescriber Report Cards" *(converted to average per demo year)*	Increase	N/A	5,363	5,523	Meeting
Q3	Production of SUD-based "Clinical Alerts"	Number of providers issued "Clinical Alerts"	Increase	-	-	-	Low Risk*

**Alternative reporting timeline established with CMS*

6. SUD AMENDMENT BUDGET NEUTRALITY FINDINGS

The quarterly and annual monitoring process for each SUD Demonstration requires states to include the status of budget neutrality (BN) along with a discussion of any issues that may impact expenditures and BN trends. DHHS identified utilization trends and other factors that were unknown during the implementation and approval processes of the Demonstration that were adversely impacting the original BN calculation. In addition, the State identified that provider rate increases and other payment changes impacted BN. DHHS followed up with CMS by providing an impact analysis completed by the State's actuary. At that time, impacts were analyzed for: actual enrollment experience; retroactive coverage; provider rate changes; and changes in the Sununu Youth Center timelines.

STC 64 provides for mid-course corrections in BN limits. If at any time during the Demonstration approval period it is determined that the Demonstration exceeds (or is expected to exceed) its BN, the State is required to submit a corrective action plan (CAP) for CMS review and approval.

On August 21, 2020, DHHS submitted an amendment request to CMS as part of its CAP to adjust the BN limits. The request identified adjustments for the following items, not originally anticipated during Demonstration development.

Unanticipated retroactive enrollment under Fee-For-Service (FFS). Due to the small size of the FFS population, the IMD costs incurred during the retroactive eligibility period distorted the PMPMs.

Enrollment Experience. Actual experience with IMD enrollment showed that the mix of individuals in IMDs are weighted in more expensive rate cells than originally assumed.

Provider Rate Increases. The Legislature approved the following rate increases to ensure access to SUD and other treatment services:

- Effective January 1, 2019, DHHS increased reimbursement for high-intensity residential treatment services for adults (H0018) to $247.82 per day
- Effective July 1, 2019, DHHS increased reimbursement for residential sub-acute detoxification (H0010) to $340.32 per day
- Effective January 1, 2020, New Hampshire House Bill 4 required a 3.1% provider rate increase applicable to nearly all Medicaid services. This rate increase went into effect again on January 1, 2021, by another 3.1%.

Hospital-directed payments. Effective July 1, 2020, the Medicaid Managed Care capitation rates include a hospital-directed payment to promote access to high-quality acute care services provided by critical access hospitals across New Hampshire.

On June 16, 2021, CMS approved a prospective adjustment to the State's hypothetical budget neutrality limits to more accurately reflect actual expenditure data reported under the SUD Demonstration.

7. ASSESSMENT SUMMARY AND RECOMMENDATIONS

Overall, the progress to date for the State's SUD Demonstration as measured through its Implementation Plan and Monitoring Protocol is strong. The State made planned enhancements, apart from one administrative rule. The timeline for the BDAS rule revisions related to State-contracted providers was adjusted from completion in CY2019 to completion in CY2022. However, it should be noted that absent the administrative rule, all CMS and BDAS requirements are met through provider and MCO contract requirements, compliance monitoring, and State Statute.

In addition, the majority of SUD Monitoring Protocol performance goals have been met. Of the 27 SUD Monitoring Protocol measures reviewed, four could not be assessed due to lags in data. DHHS has submitted alternative timelines to CMS, thus these were deemed to be at low risk. The three measures with only one data point and one measure not yet reported include:

- #22 Continuity of Pharmacotherapy (Milestone 1)
- #27 Overdose Death Rate (Milestone 6)
- #26 Overdose Death Count (Other Metrics)
- #Q3 Production of SUD Clinical Alerts (SUD IT Plan – not yet reported)

Six metrics are trending below expected performance. Four of the measures are influenced by small sizes and the pandemic. Two of the measures are trending lower, consistent with national trends.

The four measures influenced by small sample sizes, leading to wide variations in results and that may be impacted by the novel coronavirus PHE, are outlined in Exhibit 7-1.

Exhibit 7-1. Metrics at Low-Risk for Poor Performance

Metric	Factors Influencing Performance	Performance Risk
#7 Utilization of Early Intervention Services	Small sample size	Low
#11 Utilization of Withdrawal Management Services	Small sample size; Novel Coronavirus PHE	Low
#5 Medicaid Beneficiaries Treated in an IMD	Novel Coronavirus PHE	Low
#36 Length of Stay in IMDs	Novel Coronavirus PHE	Low

The remaining two metrics trending below expected performance are related to follow-up after an ED visit for mental illness. Both the 7-day and 30-day follow-up rates declined by just under 4% from DY1 to DY2. However, New Hampshire rates remain well above the national benchmark for Medicaid programs at the 75th percentile, as illustrated in Exhibit 7-2 on the following page.

Exhibit 7-2. Follow-up after ED visits for mental illness compared to Nat'l rates

Metric	New Hampshire		Medicaid 75th Percentile FFY2019	Performance Risk
	2018	2019		
Follow up in ED after visits for mental illness (7-day)	75.55%	72.61%	48.9%	Low
Follow up in ED after visits for mental illness (30-day)	83.97%	81.18%	64.8%	Low

Exhibit 7-3 provides an overview of each SUD Milestone requirement and New Hampshire policy alignment.

Exhibit 7-3. New Hampshire Alignment with CMS Milestone Requirements

CMS Milestones/Requirements	MCO Contract	BDAS Contract	Administrative Rule/Statute	Other
1. Access to critical levels of care for OUD and other SUDs				
Coverage of outpatient services, intensive outpatient (IOP) services, Medication Assisted Treatment (MAT), intensive levels of care in residential and inpatient settings, medically supervised withdrawal management	✓	✓	✓	State Plan
2. Widespread use of evidence-based, SUD-specific patient placement criteria				
Implementation of requirements that 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	✓	✓	✓	Compliance Tools and Audits
Implementation of UM approaches such that: beneficiaries have access to SUD services at the appropriate level of care; interventions are appropriate for the diagnosis and level of care; there is an independent process for reviewing placement in residential treatment settings.	✓	✓	✓	
3. Use of Nationally Recognized SUD-specific Program standards to set Provider Qualifications for Residential Treatment Facilities				
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	✓	✓	✓	Compliance Tools and Audits

CMS Milestones/Requirements	MCO Contract	BDAS Contract	Administrative Rule/Statute	Other
Implementation of a State process for reviewing residential treatment providers to assure compliance with these standards	✓	✓	✓	
Implementation of a requirement that residential treatment facilities offer MAT on-site or facilitate access off-site	✓	✓	✓	
4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD				
Completion of 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 the availability of treatment for beneficiaries in each of these levels of care, as well as the availability of MAT and medically supervised withdrawal management, throughout the state	✓			MCO Network Adequacy Reports
5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD				
Implementation of opioid prescribing guidelines and interventions to prevent opioid abuse	✓		✓	Strategic Plan
Expanded coverage of and access to naloxone for overdose reversal	✓			
Implementation of strategies to increase utilization and improve the functionality of PDMPs	✓			Strategic Plan
6. Improve Care Coordination and Transitions Between Levels of Care				
Implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and support following stays	✓	✓	✓	Strategic Plan

Budget Neutrality

On June 16, 2021, CMS approved a prospective adjustment to the State's hypothetical budget neutrality limits to more accurately reflect actual expenditure data reported under the SUD Demonstration.

SUD IT Plan

In reviewing the PDMP use and functionality in New Hampshire, it appears that some CMS requirements are met. However, the approved SUD IT Plan (STC Attachment D) indicates the need for further assessment. No further assessment or SUD IT plan could be found. In the absence a CMS-approved assessment or enhancements made during the Demonstration

period, the evaluators cannot ascertain whether CMS expectations have been met. For this reason, the SUD IT plan is deemed a "High Risk" area.

Exhibit 7-4 provides an overview of SUD Mid-Point Assessment findings.

Exhibit 7-4. Overview of SUD Mid-Point Assessment Findings

SUD Mid-Point Assessment Overview		
CMS Milestone	**Assessment of Progress**	**Key Findings**
Milestone #1: Access to Critical Levels of Care for OUD and Other SUDs	**Meeting**	Seven of the eight metrics reported (87%) are trending positive. • One metric (Withdrawal Management) yielded fewer than 150 observations each year; and • One metric (Early Intervention) is not routinely billed through claims resulting in fewer than 75 observations each year. One metric (Continuity of Pharmacotherapy) could not be assessed. Results were first reported in DY2 and have not yet been reported for DY3. Assessment of Need metrics show that more members with an SUD have been identified year over year.
Milestone #2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria	**Meeting**	State statutes require the use of ASAM or other nationally recognized criteria for SUD assessment. All Implementation plan activities were accomplished. Two metrics associated with IMD utilization show a slight shift away from the desired direction. However, the State's PHE response is responsible for some impact on utilization.
Milestone #3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	**Meeting**	The State successfully updated the Medicaid and Bureau of Health Care Facilities licensing rules. BDAS rule updates have been delayed and are now scheduled for 2022.
Milestone #4: Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD	**Meeting**	Two of the two metrics reviewed (100%) are trending positive. Provider rate increases were implemented. However, a change in data sources and reporting methodology may account for some of the change.
Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	**Meeting**	Three of the three reported metrics (100%) are trending positive. • The use of opioids at high doses declined by 15.22%; • The concurrent use of opioids and benzodiazepines declined by 11.69%; and • ED utilization declined by 4.84% in the year prior to the PHE; and 12.40% since the PHE. CMS has approved an alternative reporting schedule for one metric (Overdose Death Rate). Results have been reported for DY1, trends could not be assessed.

SUD Mid-Point Assessment Overview		
CMS Milestone	**Assessment of Progress**	**Key Findings**
Milestone #6: Improved Care Coordination and Transitions between Levels of Care	**Meeting**	Thirteen of the fifteen results, across three measures are trending positive. • Initiation in treatment (total score) improved by 17.80% • Engagement in treatment (total score) improved by 23.55%; • Follow up after ED visits for AOD improved by 27.99% (7-days) and 22.19% (30-days); • Follow-up after ED visits for mental illness declined by 3.91% (7-days) and 3.30% (30-days). However, both rates remain well above the Nat'l Medicaid benchmark at the 50th percentile; and • All-cause readmission rates declined by 5.68% (lower rates are preferred).
SUD IT Plan	**High Risk**	New Hampshire appears to be meeting some of the CMS requirements. However, the approved SUD IT Plan (STC Attachment D) indicates the need for the development of the IT plan. No evidence of a revised plan could be found.
Budget Neutrality	**Meeting**	The State recognized it would exceed the original PMPM limits due to a variety of factors not known during the application and approval period. In addition, provider rate increases further strained the PMPM limits. DHHS submitted a CAP in the form of a Demonstration amendment. CMS prospectively approved adjustments to BN in 2021.
Other Monitoring Protocol Metrics	**Meeting**	Two of the two reported metrics (100%) are trending positive. • Inpatient admissions are decreasing (8.14%) • Access to ambulatory/preventive care is increasing (9.34%) CMS has approved an alternative reporting schedule for one metric (Overdose Death Count). Results have been reported for DY1, trends could not be assessed.

Recommendations

There were no medium or high risk areas identified relative to the timeline and action steps for the six CMS-defined milestones contained in the SUD Implementation Plan. The majority of the performance measures are trending in the desired direction. There are currently no risks associated with budget neutrality.

As the Demonstration moves forward, we recommend that the State and CMS collaborate to review PDMP functionality and CMS expectations. This collaboration will be valuable in developing actionable steps for the State to strengthen the SUD IT capabilities, if needed to meet federal requirements.