DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

July 16, 2024

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

Dear Director Lipman:

The Centers for Medicare & Medicaid Services (CMS) is approving New Hampshire's (the "state") request for a five-year extension of the "Substance Use Disorder, Serious Mental Illness, and Serious Emotional Disturbance, Treatment Recovery and Access" section 1115 demonstration (Project Number 11-W-00321/1) (the "demonstration"), in accordance with section 1115(a) of the Social Security Act ("the Act"). Approval of this request will extend many longstanding demonstration authorities and allow the state, through various expenditure authorities, to test the effectiveness of innovative practices aimed at promoting consistently high-quality, evidence-based, coordinated, and integrated care.

With this extension, New Hampshire is also introducing a new program, the Reentry Demonstration Initiative, to provide pre-release services for eligible incarcerated individuals. The demonstration will provide waiver and expenditure authority for limited coverage for certain reentry services furnished to certain incarcerated individuals for up to 45 days immediately prior to the individual's expected date of release. Overall, the goal of the demonstration is to provide medical assistance and improve the health of communities and populations. Through the addition of community reentry supports, the extension will lead to additional justice-involved populations being served by Medicaid, as well as a targeted set of services being furnished to justice-involved Medicaid beneficiaries.

The goal of the demonstration is to continue to 1) provide medical assistance to individuals with substance use disorder (SUD), serious mental illness (SMI), serious emotional disturbance (SED); 2) provide dentures to eligible individuals age 21 and older residing in nursing facilities based on medical necessity; 3) provide targeted pre-release services to eligible individuals and improve the health of communities and populations in New Hampshire. This approval is effective through June 30, 2029, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached waiver authority, expenditure authorities, special terms and conditions (STC), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable to expenditures under the demonstration.

Exent and Scope of the Demonstration Extension

With this extension, New Hampshire will continue to operationalize and refine its SUD, SMI, SED, and dentures demonstration programs. CMS is extending the state's current authority to receive federal financial participation (FFP) for providing dentures to eligible adults age 21 and older who reside in nursing facilities once every five years subject to medical necessity, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an institution for mental diseases (IMD), as well as provide additional services to enhance the comprehensive and integrated behavioral health system for children, youth, and adults with SMI, SED, and/or SUD. This extension will allow the state to continue to improve access to comprehensive behavioral health services by building a Medicaid behavioral health delivery system that is integrated and recovery-oriented care that aligns with evidence-based best practices. The state will continue to build on the longstanding authorities granted under this demonstration to enhance the benefit package and continue coverage for a continuum of behavioral health care services that emphasize screening, community-based services, and residential treatment when appropriate. These services promote prevention, early intervention, recovery, and integrated whole person care, which are the behavioral health goals of this demonstration.

The state was previously approved for but did not implement flexibility for an exemption from the foregoing limitations on length of stays for foster care children residing in Qualified Residential Treatment Programs (QRTP) that are IMDs, not to exceed two years from the date of implementation. Participating QRTPs must meet all the requirements of the Family First Prevention Services Act (FFPSA) that was signed into law on February 9, 2018, as part of the Bipartisan Budget Act of 2018 (P.L. 115-123), as well as federal guidance and regulations and state qualifications to provide services. As a condition of approval in this extension, the state is required to submit a transition plan to CMS to transition children out of QRTPs that are IMDs, including documentation of key milestones and associated timeframes, within the QRTP Implementation Plan. The state submitted this transition plan on April 25, 2024, and it is currently under CMS review.

Pre-Release Services under Reentry Demonstration Initiative

Waiver and expenditure authority is being provided to New Hampshire to provide limited coverage for a targeted set of services furnished to certain incarcerated individuals for 45 days immediately prior to the individual's expected date of release. The state's proposed approach closely aligns with CMS's "Reentry Demonstration Opportunity" as described in the State Medicaid Director Letter (SMDL) released on April 17, 2023.[1]

Eligible Individuals

New Hampshire will cover a set of pre-release benefits for qualifying individuals age 18 and older with certain behavioral health conditions who are inmates residing in a state or local jail, or state prison (hereinafter "correctional facility") with a diagnosis of SUD, SMI, or SED. To qualify for services covered under this demonstration approval, individuals residing in a correctional facility must be eligible for Medicaid as determined pursuant to an application filed

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf

before or during incarceration, and have an expected release date no later than 45 days after initiation of demonstration-covered services.

Medicaid Eligibility and Enrollment

CMS is requiring, as a condition of approval of this demonstration extension, that New Hampshire make pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the correctional facilities where the pre-release demonstration coverage services will be available.

For a Medicaid covered individual entering a correctional facility, New Hampshire will not terminate Medicaid coverage, but will suspend the individual's coverage. For individuals not enrolled in Medicaid upon entering a correctional facility, New Hampshire will ensure the individual receives assistance with completing and submitting a Medicaid application sufficiently prior to their anticipated release date unless the individual voluntarily refuses such assistance or chooses to decline enrollment.

Scope of Pre-Release Benefit Package

The pre-release benefit package is designed to improve care transitions of such individuals back to the community, including by promoting continuity of coverage, service receipt, and quality of care, as well as the proactive identification of both physical and behavioral health needs. It is designed to address these overarching demonstration goals, while aiming to ensure that participating carceral facilities can feasibly provide all pre-release benefits to qualifying incarcerated individuals.

CMS is authorizing New Hampshire to provide coverage for the following services to be detailed in the implementation plan required by the demonstration's STCs:

- Case management to assess and address physical and behavioral health needs;
- Medication-assisted treatment (MAT) services for all types of SUD as clinically appropriate, with accompanying counseling;
- A 30-day supply of all prescription medications that have been prescribed for the individual at the time of release, provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy;
- Access to clinical consultation for physical and behavioral health needs; and
- Peer support services.

CMS recognizes that many individuals exiting correctional facilities may not have received sufficient health care to address all of their physical and/or behavioral health care needs while incarcerated. This demonstration initiative will provide individuals leaving correctional facilities the opportunity to receive short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, while providing the state the opportunity to test whether these pre-release services improve uptake and continuity of MAT and other SUD and behavioral health

treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, and overdose-related death. New Hampshire believes a 45-day period will strengthen connectivity with community-based treatment providers and other supports. Therefore, CMS is approving a demonstration benefit package in New Hampshire that is designed to improve identification of physical and behavioral health needs to facilitate connections to providers with the capacity to meet those needs in the community during the period immediately before an individual's expected release from a correctional facility. Once an individual is released, the coverage for which the individual is otherwise eligible must be provided consistent with all requirements applicable to such coverage.

Eligible Juveniles and This 1115 Reentry Demonstration Initiative

Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) amends the Act and describes a mandatory population (eligible juveniles and targeted low-income children) and set of pre-release and post-release services, while section 5122 of the CAA, 2023 amends the Act and gives a state the option to receive FFP for the full range of coverable services for eligible juveniles and targeted low-income children while pending disposition of charges. Every state is required to submit a Medicaid State Plan Amendment (SPA) attesting to meeting the requirements in Section 5121 beginning January 1, 2025. To the extent there is overlap between the services required to be covered under sections 1902(a)(84)(D) and 2102(d)(2) of the Act and coverage under this demonstration, we understand that it would be administratively burdensome for states to identify whether each individual service is furnished to a beneficiary under the state plan or demonstration authority. Accordingly, to eliminate unnecessary administrative burden and ease implementation of statutorily required coverage and this demonstration, we are approving waivers of the otherwise mandatory state plan coverage requirements to permit the state instead to cover at least the same services for the same beneficiaries under this demonstration. This approach will ease implementation, administration, and claiming, and provide a more coherent approach to monitoring, and evaluation of the state's reentry coverage under the demonstration. The state will provide coverage under the Reentry Demonstration to eligible juveniles described in section 1902(nn)(2) in alignment with sections 1902(a)(84)(D) and 2102(d)(2) of the Act, at a level equal to or greater than otherwise would be covered under the state plan. Compliance and state plan submission requirements under Section 5121 and 5122 of the CAA, 2023 will remain unchanged. Coverage of the population and benefits identified in sections 1902(a)(84)(D) and 2102(d)(2) of the Act, as applicable, would automatically revert to state plan coverage in the event that this demonstration ends or eliminates coverage of beneficiaries and/or services specified in those provisions. CMS will provide additional information in the future about these CAA, 2023 provisions.

Implementation and Reinvestment Plans

As described in the demonstration STCs, New Hampshire will be required to submit for CMS approval a Reentry Demonstration Initiative Implementation Plan (Implementation Plan) and Reinvestment Plan documenting how the state will operationalize coverage and provision of pre-release services and how existing state funding for carceral health services will continue to support access to necessary care and achievement of positive health outcomes for the justice-involved population.

The Implementation Plan, to be submitted to and reviewed by CMS consistent with the STCs, will describe the new key policies being addressed under this demonstration extension and provide operational details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan will include definitions and parameters related to the implementation of the reentry authorities and describe the state's strategic approach to implementing the policies, including goals and milestones, as well as associated timelines for meeting them, for both program policy implementation and investments in transitional nonservice elements, as applicable. The Implementation Plan will also outline any potential operational challenges that the state anticipates and the state's intended approach to resolving these and other challenges the state may encounter in implementing the Reentry Demonstration Initiative.

The Reentry Demonstration Initiative is not intended to shift current carceral health care costs to the Medicaid program. Section 5032(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (Pub. L. No. 115-271) makes clear that the purpose of the demonstration opportunity contemplated under that statute is "to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX." Furthermore, demonstration projects under section 1115 of the Act must be likely to promote the objectives of title XIX, which itself includes the inmate payment exclusion in recognition that the carceral authority generally bears the costs for health care furnished to incarcerated individuals. This demonstration does not absolve carceral authorities in New Hampshire of their constitutional obligation to ensure needed health care is furnished to inmates in their custody and is not intended as a means to transfer the financial burden of that obligation from a federal, state, or local carceral authority to the Medicaid program.

New Hampshire agrees to reinvest the total amount of new federal matching funds for the Reentry Demonstration Initiative received under this demonstration extension into activities and/or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for physical and behavioral health needs that may help prevent or reduce the likelihood of criminal justice system involvement. Consistent with this requirement, New Hampshire will develop and submit a Reinvestment Plan to CMS outlining how the federal matching funds under the demonstration will be reinvested. The Reinvestment Plan should align with the goals of the state's Reentry Demonstration Initiative. It should detail the state's plans to increase access to or improve the quality of health care services for those who have recently been released, and those who may be at higher risk of future criminal justice system involvement, particularly due to untreated behavioral health conditions. The Reinvestment Plan should describe the activities and/or initiatives selected by New Hampshire for investment and a timeline for implementation. Any investment in carceral health care must add to and/or improve the quality of health care services and resources for individuals who are incarcerated and those who are soon to be released from carceral settings, and not supplant existing state or local spending on such services and resources. The reinvestment plan may include the services provided to eligible juveniles and targeted low-income children under 1902(nn)(2) and 2102(d)(2) of the Act, respectively, which are covered under this demonstration.

Budget Neutrality

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that the demonstration is likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration, the "without waiver" (WOW) costs.

CMS and states have generally been applying an approach to calculating budget neutrality that CMS described in a 2018 State Medicaid Director Letter.[2] Under this approval, CMS is departing from the budget neutrality approach described in the 2018 SMDL in a few key ways and as memorialized in the 2024 BN Approach Slide Deck[3]. CMS is making several changes including an updated approach to calculating the WOW baseline, which refers to the projected expenditures that could have occurred absent the demonstration and which, as described above, is the basis for the budget neutrality expenditure limit for each approval period. Under this approval, CMS calculated the WOW baseline by using a weighted average of the state's historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs, rather than taking the approach described in the 2018 SMDL, which was to adjust WOW PMPM cost estimates to reflect only the recent actual PMPM costs. This updated approach is expected to result in a slightly higher WOW baseline, while still primarily reflecting the state's most recent expenditures.

As described in the 2018 SMDL, when calculating budget neutrality, CMS effectively treats a hypothetical expenditure like an expenditure that the state could have made absent the demonstration. As a result, hypothetical expenditures are included in both the WOW baseline and the estimate of the "with waiver" (WW) expenditures under the demonstration, and states do not have to find demonstration "savings" to offset hypothetical expenditures. However, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued "savings" from hypothetical expenditures. That is, "savings" are not generated from a hypothetical population or service if the state does not spend up to the hypothetical expenditure limit. To allow for hypothetical expenditures, while preventing them from resulting in "savings," CMS applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical

[2] August 22, 2018. SMD#18-009 RE: Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf

[3] The 2024 BN Approach Slide Deck is available at: https://www.medicaid.gov/resources-for-states/downloads/2022-budget-neutrality-approach-june-2024.pdf.

expenditures to predetermined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by finding "savings" elsewhere in the demonstration or to refund the federal matching funds to CMS. CMS is applying the traditional hypothetical approach to the state's Reentry Demonstration Initiative.

The Medicaid expenditures for pre-release services furnished to incarcerated beneficiaries under the Reentry Demonstration Initiative include coverage of services that states can and do cover through Medicaid state plan or other title XIX authority, for beneficiaries who are not subject to the inmate payment exclusion. CMS considers these expenditures to be "hypothetical" because the pre-release services would be coverable under the Medicaid state plan or other title XIX authority if furnished to a beneficiary outside a carceral setting, similar to how CMS treats expenditures for services furnished to certain beneficiaries who are short-term residents in an institution for mental diseases primarily to receive treatment for SUD, or SMI or SED, under the SUD and SMI/SED section 1115 demonstration opportunities.

CMS is revising the approach to adjusting the budget neutrality calculation in the middle of a demonstration approval period. Historically, CMS has limited its review of state requests for "mid-course" budget neutrality adjustments to situations that necessitate a corrective action plan, in which projected expenditure data indicated a state is likely to exceed its budget neutrality expenditure limit. CMS has updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STC what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Monitoring and Evaluation

Findings from Interim Evaluation Report from the prior demonstration period, which covers the SUD component of the demonstration, showed significant progress toward achieving the demonstration's goals, especially in the context of the COVID-19 public health emergency (PHE). The SMI/SED component of the demonstration only came into effect on June 2, 2022, via an amendment, and so was not covered by this evaluation report. Using data from July 1, 2018, through June 30, 2021, the SUD evaluation documented statistically significant increases in access to IMD services in each year of the demonstration compared to pre-demonstration baseline data. Additionally, the percentage of enrollees who initiated treatment within 14 days of diagnosis significantly increased (from 51 percent during the baseline period to 58% at year 3),

as well as the percentage of enrollees who engage in treatment within 34 days of initiation (from 29 percent during the baseline period to 38 percent at year 3). Finally, the evaluation showed a statistically significant decline in emergency department visits in the 90 days following discharge from an IMD. CMS looks forward to receiving evaluation findings regarding the SMI/SED demonstration component in the Summative Evaluation Report.

The state is required to conduct systematic monitoring and robust evaluation of the demonstration extension in accordance with the STCs. The state must update its demonstration Monitoring Protocol to incorporate how it will monitor the extension components, including relevant metrics data as well as narrative details describing progress with implementing the extension. In addition, the state is also required to conduct an independent Mid-Point Assessment of the Reentry Demonstration Initiative, as provided in the STCs, to support identifying risks and vulnerabilities and subsequent mitigation strategies.

The state is required to incorporate the extension into its evaluation activities to support a comprehensive assessment of whether the initiatives approved under the demonstration are effective in producing the desired outcomes for the individuals and the state's overall Medicaid program. Evaluation of the Reentry Demonstration Initiative must align with the requirements detailed in the STCs, including examining impacts on Medicaid coverage, continuity of care, access to and quality and efficiency of care, utilization of services, health outcomes, and carceral and community coordination in service provision, among others. The state's monitoring and evaluation efforts must facilitate understanding the extent to which the extension might support reducing existing disparities in access to and quality of care and health outcomes.

Consideration of Public Comments

The federal comment period was open from October 17, 2022, to November 16, 2022, for the demonstration application submitted on October 14, 2022. CMS received nine total comments, eight of which were relevant. Four comments were in support of the demonstration extension and four comments were in opposition to this demonstration extension. One comment was from Members of Congress, one was from an individual, five were from organizations, and one was from a provider group. The organizations' comments largely pertained to the state's request to receive expenditure authority for services provided to individuals diagnosed with a SUD, SMI, or serious emotional disturbance that are residing in an IMD or in a QRTP, which we addressed in previous approvals of the demonstration originally on July 10, 2018, and the approval of the SMI/SED amendment on June 2, 2022. Four commenters wrote to support the reentry component of the extension request. One commenter, who strongly supports the state's Reentry Demonstration Initiative, highlighted the elevated risk of recidivism upon release for those with SMI, and especially those with co-occurring SUD, which has been attributed to the lack of needed services and supports for their condition. One commenter opined that incarcerated pregnant and post-partum women should have access to reproductive health care that aligns with the same guidance and recommendations that applies to those who are not incarcerated.

After carefully reviewing the demonstration proposal and the public comments received during the federal comment period, CMS has concluded that the demonstration is likely to promote the objectives of the Medicaid program by increasing access to services for beneficiaries as well as expanding on the coverage of health care services that would otherwise not be available.

Other Information

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

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Kathleen.OMalley@cms.hhs.gov
Phone: (410) 786-8987

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

Sincerely,

[redacted]

Chiquita Brooks-LaSure

Enclosure

cc: Joyce Butterworth, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: 11-W-00321/1

TITLE: New Hampshire Substance Use Disorder (SUD), Serious Mental Illness (SMI), Serious Emotional Disturbance (SED) Treatment Recovery and Access (TRA) Section 1115(a) Demonstration

AWARDEE: New Hampshire Department of Health and Human Services

Under the authority of section 1115(a)(1) of the Social Security Act ("the Act"), the following waiver is granted to enable New Hampshire (referred to herein as the state) to operate the New Hampshire Substance Use Disorder (SUD), Serious Mental Illness (SMI), Serious Emotional Disturbance (SED) Treatment Recovery and Access (TRA) demonstration. This waiver shall be effective from *July 16, 2024,* through June 30, 2029, except as otherwise noted.

The following waiver authority shall enable New Hampshire to implement the approved special terms and conditions (STC) for the New Hampshire SUD, SMI, SED TRA Medicaid Section 1115 demonstration.

1. Coverage of Certain Screening, Diagnostic, Release and Targeted Case Management Services for Eligible Juveniles in the 45 Days Prior to Release **Section 1902(a)(84)(D)**

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 45 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00321/1

TITLE: New Hampshire Substance Use Disorder (SUD), Serious Mental Illness (SMI), Serious Emotional Disturbance (SED) Treatment Recovery and Access (TRA) Section 1115(a) Demonstration

AWARDEE: New Hampshire Department of Health and Human Services

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by New Hampshire (the "state") for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from June 28, 2024, through June 30, 2029, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

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

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

2. **Removable Prosthodontic Devices (Dentures).** Expenditures related to dentures furnished to eligible adults age 21 and older who reside in nursing facilities as described in STC 6.7.

3. **Expenditures for Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid individuals for up to 45 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative under this demonstration.

4. **Expenditures for Pre-Release Administrative Costs.** Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in STC 7.11, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903 of the Act, to the extent such activities are authorized as part of the Reentry Demonstration Initiative.

Title XIX Requirements Not Applicable to Dentures:

Comparability **Section 1902(a)(17)**

To enable New Hampshire to provide the benefits only to adults age 21 and older who reside in nursing facilities.

Freedom of Choice **Section 1902(a)(23)(A)**

To enable New Hampshire to contract with a single managed care dental organization that will provide all Medicaid adult dental services in the state including but not limited to dentures.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services:

Statewideness **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B)**

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00321/1

TITLE: New Hampshire Substance Use Disorder (SUD), Serious Mental Illness (SMI), Serious Emotional Disturbance (SED) Treatment Recovery and Access (TRA) Section 1115(a) Demonstration

AWARDEE: New Hampshire Department of Health and Human Services

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the New Hampshire "SUD SMI SED TRA demonstration" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the New Hampshire Department of Health and Human Services (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities under section 1115(a)(2) of the Social Security Act (the "Act") authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STC set forth conditions and limitations on those expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STC neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

On July 10, 2018, CMS approved the original New Hampshire Substance Use Disorder Treatment Recovery and Access demonstration through June 30, 2023.

On June 16, 2021, CMS approved an amendment that revised the SUD TRA's per member per month (PMPM) limits—as its required Corrective Action Plan (CAP)—pursuant to STC 13.13.

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

On March 17, 2023, CMS approved an amendment that added expenditure authority with a not applicable for comparability and freedom of choice in order to provide removable prosthodontic coverage (dentures) for Medicaid eligible adults age 21 and older who reside in nursing facilities once every five years, subject to medical necessity.

On April 14, 2023, CMS approved minor, non-substantive technical corrections.

On June 16, 2023, CMS approved a one-year temporary extension period until June 30, 2024.

On June 28, 2024, CMS approved a five-year extension of the demonstration through June 30, 2029. The extension continued the existing SUD, SMI/SED, and dentures authority. In addition, the extension included approval of reentry services authority.

The STCs related to the programs for those populations affected by the demonstration are effective from June 28, 2024 through June 30, 2029, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1	Preface
2	Program Description and Objectives
3	General Program Requirements
4	Eligibility and Enrollment
5	Substance Use Disorder (SUD) Program and Benefits
6	Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) Program and Dentures Benefits
7	Reentry
8	Cost Sharing
9	Delivery System
10	Monitoring and Reporting Requirements
11	Evaluation of the Demonstration
12	General Financial Requirements
13	Monitoring Budget Neutrality for the Demonstration
14	Schedule of Deliverables for the Demonstration Period

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

Attachment A	Developing the Evaluation Design
Attachment B	Preparing the Interim and Summative Evaluation Reports
Attachment C	Reserved for Evaluation Design
Attachment D	SUD Implementation Plan
Attachment E	Reserved for Monitoring Protocol
Attachment F	SMI/SED Implementation Plan
Attachment G	Reserved for SMI/SED Monitoring Protocol
Attachment H	Reserved for Qualified Residential Treatment Program (QRTP) Implementation Plan
Attachment I	Reserved for Reentry Demonstration Initiative Implementation Plan
Attachment J	Reserved for Reentry Demonstration Initiative Reinvestment Plan

2. PROGRAM DESCRIPTION AND OBJECTIVES

In this demonstration, the state will maintain and enhance access to mental health services, opioid use disorder (OUD) and other substance use disorder (SUD) services and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment of Medicaid beneficiaries with serious mental illness (SMI) or serious emotional disturbance (SED) and/or SUD. This demonstration will provide the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SMI, SED, and/or SUD while they are short-term residents in residential and inpatient treatment settings that qualify as an IMD. It will also support state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT) and improve access to a continuum of SMI/SED and/or SUD evidence-based services at varied levels of intensity, including withdrawal management services.

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

SUD Goals:

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

SMI/SED Goals:

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

3. GENERAL PROGRAM REQUIREMENTS

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

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

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

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

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

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to

request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 3.9.

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

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

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

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

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

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

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

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

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

3.14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain

authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

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

4. ELIGIBILITY AND ENROLLMENT

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

5. SUBSTANCE USE DISORDER (SUD) PROGRAM AND BENEFITS

5.1. **SUD Program Benefits.** Effective upon CMS's approval of the SUD Implementation Plan, the demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD once CMS approves the state's Implementation Plan. CMS approved the SUD Implementation Plan on July 10, 2018. The

state will aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the Monitoring Protocol as outlined in STC 10.5, to ensure short-term residential stays.

Under this demonstration beneficiaries will have access to high quality, evidence-based OUD/SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing chronic care for these conditions in cost-effective community-based settings.

5.2. **SUD Implementation Plan and Health IT Plan.**

The state's SUD Implementation Plan, initially approved for the period from July 10, 2018, through June 30, 2023 (and temporarily extended through June 30, 2024), remains in effect for the approval period from July 16, 2024 through June 30, 2029, and is affixed to the STCs as Attachment D. Any future modifications to the approved Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral. The approved SUD Implementation Plan describes the strategic approach and a detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD demonstration project:

a. *Access to Critical Levels of Care for OUD and other SUDs.* Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication 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, within 12-24 months of demonstration approval;

b. *Use of Evidence-based SUD-specific Patient Placement Criteria.* Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of demonstration approval;

c. *Patient Placement.* Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;

d. *Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities*. Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in the New Hampshire Code of Administrative Rules at He-W 513. The state must establish residential treatment provider qualifications in

licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

e. *Standards of Care.* Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

f. *Standards of Care.* Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;

g. *Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD.* An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of demonstration approval;

h. *Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD.* Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

i. *Improved Care Coordination and Transitions between Levels of Care.* Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of demonstration approval;

j. *SUD Health IT Plan.* Implementation of a Substance Use Disorder Health Information Technology Plan which describes technology that will support the aims of the demonstration. Further information which describes milestones and metrics are detailed in STC 5.2 and Attachment D.

k. SUD Health Information Technology Plan ("Health IT Plan"). The SUD Health IT plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable Health IT Plan(s), to be included as a section(s) of the associated Implementation Plan(s) (see STC 5.2(j) and STC 5.2), to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type.

l. The Health IT Plan should describe how technology can support outcomes through care coordination; linkages to public health and prescription drug monitoring programs; establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR 433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 42 CFR part 170, subpart B.

i. The state must include in its Monitoring Protocol (see STC 10.5) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

ii. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Report (see STC 10.6).

iii. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

iv. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally recognized standards.

v. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally recognized ISA standards.

vi. Components of the Health IT Plan include:

1. The Health IT Plan must describe the state's alignment with Section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP)[1].

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

2. The Health IT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] States should favor procurement strategies that incorporate qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in RX Check for Interstate data sharing.

3. The Health IT Plan will describe how technology will support substance use disorder prevention and treatment outcomes described by the demonstration.

4. In developing the Health IT Plan, states should use the following resources:

    - States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).

    - States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

    - States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

    - States should review the Office of the National Coordinator's Interoperability Standards Advisory (https://www.healthit.giv/isa/) for information on appropriate standards which may not be required per 45 CFR part 170, subpart B for enhanced funding, but still should be considered industry standards per 42 CFR 433.112(b)(12).

5.3. **Evaluation.** The SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as described in Sections 10 (Monitoring and Reporting Requirements) and 11 (Evaluation of the Demonstration) of these STCs.

[2] *Ibid.*

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

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

6. SERIOUS MENTAL ILLNESS (SMI)/ SERIOUS EMOTIONAL DISTURBANCE (SED) PROGRAM AND DENTURES BENEFITS

6.1. **SMI/SED Program Benefits.** Under this demonstration, beneficiaries will have access to, the full range of otherwise covered Medicaid services, including SMI/SED treatment services. These SMI/SED services will range in intensity from short-term acute care in inpatient settings for SMI/SED, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days for beneficiaries receiving treatment in an IMD treatment setting through this demonstration's SMI/SED Program, to be monitored pursuant to the Monitoring Protocol as outlined in STC 10.5 below.

6.2. **SMI/SED Implementation Plan.**

a. The state's SMI/SED Implementation Plan, initially approved for the period from June 2, 2022, through June 30, 2023 (and temporarily extended through June 30, 2024), remains in effect for the approval period from [insert date of extension approval date], through June 30, 2029, and is affixed to the STC as Attachment F.

b. The approved SMI/SED Implementation Plan has been incorporated into the STCs as Attachment F, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI/SED Implementation Plan, within 90 calendar days after approval of the demonstration, would have been considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would have been grounds for termination or suspension of the SMI/SED program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 10.1.

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

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

1. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the

state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

2. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.

3. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating hospitals and residential treatment settings in which beneficiaries receiving coverage pursuant to the demonstration are residing meet applicable state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;

4. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;

5. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);

6. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

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

1. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);

2. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who have been experiencing or are likely to experience homelessness or who would be returning to unsuitable or unstable housing with community providers that coordinate housing services, where available;

3. Implementation of a requirement that psychiatric hospitals and residential treatment settings that are discharging beneficiaries who have received coverage pursuant to this demonstration have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary and the community-based provider to which the beneficiary was referred within 72 hours of discharge to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider the person was referred to;

4. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);

5. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

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

1. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability (the state must provide updates on how it has increased the availability of mental health services in every Annual Monitoring Report);

2. Commitment to implementation of the SMI/SED financing plan described in STC 6.2(e). The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI/SED program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 10.6;

3. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;

4. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association [e.g., Level of Care Utilization System (LOCUS) or the Child and Adolescent Service Intensity Instrument (CASII)] to determine appropriate level of care and length of stay.

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

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

2. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers;

3. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

d. <u>SMI/SED Health Information Technology (Health IT) Plan.</u> The Health IT plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state will provide CMS with an assurance that it has a sufficient health IT infrastructure "ecosystem" at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If the state is unable to provide such an assurance, it will submit to CMS a Health IT Plan, to be included as a section of the applicable Implementation Plan (see STC 6.2(b), to develop the infrastructure/capabilities of the state's health IT infrastructure.

i. The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them

(see Attachment F) and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

ii. The state will include in its Monitoring Plans (see STC 10.5) an approach to monitoring its SMI/SED Health IT Plan which will include performance metrics to be approved in advance by CMS.

iii. The state will monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Monitoring Report (see STC 10.6).

iv. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications'[3] (ISA) in developing and implementing the state's SMI/SED Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

v. Where there are opportunities at the state- and provider-level (up to and including usage in managed care organization (MCO) or Accountable Care Organization (ACO) participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B "Standards and Implementation Specifications for HIT". If there is no relevant standard in 45 CFR 170 Subpart B, the state should review the Office of the National Coordinator for Health Information Technology's Interoperability Standards Advisory (https://www.healthit.gov/isa/) to locate other industry standards in the interest of efficient implementation of the state plan.

vi. Components of the Health IT Plan include:

1. The SMI/SED Health IT Plan will, as applicable, describe the state's capabilities to develop and leverage an event notification system (ENS) and closed-loop referrals (CLR) in support of SMI/SED to promote high-quality care coordination and the delivery of appropriate services. The ENS should allow for identification of patients across separate clinical, financial, and administrative systems to allow for information exchange to improve care coordination. The state will also indicate how current efforts or plans to develop and/or utilize the ENS and CLR support the programmatic objectives of the demonstration.

2. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: (1) Referrals, (2) Electronic care plans and medical records, (3)

[3] Available at: https://www.healthit.gov/isa/sites/isa/files/inline-files/2022-ISA-Reference-Edition.pdf

Consent, (4) Interoperability, (5) Telehealth, (6) Alerting/analytics, and (7) Identity management.

3. In developing the Health IT Plan, states should use the following resources:

    - States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).

    - States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

    - States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

e. SMI/SED Financing Plan. As part of the SMI/SED Implementation Plan referred to in STC 6.2, the state must submit, within 90 calendar days after approval of the demonstration, a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the SMI/SED Implementation Plan in Attachment F and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI/SED Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Components of the financing plan must include:

    i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

    ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings;

6.3. **Maintenance of Effort (MOE).** The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI/SED program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 10.6.

6.4. **Availability of FFP for the SMI/SED Services Under Expenditure Authority #1.** Federal Financial Participation is only available for services provided to beneficiaries who are residing in an IMD when the beneficiary is a short-term resident in the IMD primarily to receive treatment for mental illness. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its Mid-Point Assessment that it is meeting the requirement of a 30-day average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services under the demonstration. Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the Mid-Point Assessment, the state may only claim FFP for services furnished to beneficiaries during IMD stays of up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days or 45 days, as relevant.

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

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c. Costs for services provided to beneficaries who are deemed incompetent to stand trial or found not guilty by reason of insanity or are statutorily mandated due to judicial determination to receive court-ordered treatment and who reside in psychiatric hospitals, residential treatment facilities, or transitional living programs.

d. Costs for services provided to individuals who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

e. Except as noted in STC 6.6, costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the “inpatient psychiatric services for individuals under age 21” benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

6.6. **Qualified Residential Treatment Programs.** Once the state receives approval of its QRTP Transition Plan, the state may receive FFP for treatment provided to beneficiaries residing in Qualified Residential Treatment Programs (QRTP) with over 16 beds if the QRTPs meet the following requirements:

a. The QRTP meets the definition in section 472(k)(4) of the Act, as added by section 50741 of the Bipartisan Budget Act of 2018.

b. The state performs a needs assessment for the beneficiary to assure the appropriateness of placement in the QRTP as specified in section 475A(c)(1) of the Act, as added by section 50742 of the Bipartisan Budget Act of 2018.

c. The QRTP complies with all federal requirements applicable to that setting type, including those that may be imposed by regulations that may be issued by the Administration for Children and Families.

d. The billing provider is enrolled in Medicaid.

e. The practitioner who furnishes a service meets all federal and state qualifications to provide the service.

f. The QRTP complies with CMS regulations regarding seclusion and restraint found in 42 CFR Part 483 Subpart G.

g. FFP is not available for room and board costs in QRTPs.

h. QRTPs are not subject to the 30-day average length of stay requirement as described in STC 6.1 and the 60-day maximum length of stay limit as described in STC 6.4 for the first 2 years of the demonstration.

i. The state must submit a transition plan to CMS for individuals in QRTPs that are IMDs that includes specific timeframes and key milestones for transitioning/appropriately placement of individuals in each of these facilities out of such QRTPs, such that each of these facilities will meet the 30-day average length of stay requirement described in STC 6.1 and the 60-day maximum length of stay limit as described in STC 6.4 by the end of the first two years of the demonstration. The transition plan must be approved by CMS prior to FFP being available.

6.7. **Dentures.**

a. Beneficiaries eligible for this benefit are Medicaid eligible adults age 21 and older who reside in nursing facilities.

b. Eligible beneficiaries will receive dentures once every five years, subject to medical necessity. If there is medical necessity, then an eligible beneficiary may receive dentures more frequently.

c. The following eligibility groups are not eligible for the dentures benefit:

d. i. Qualified Medicare Beneficiaries (QMB);

e. ii. Special Low-Income Medicare Beneficiaries (SLMB);

f. iii. Qualified Individual Special Low-Income Medicare Beneficiaries (QI / SLMB2);

g. iv. Temporary eligibility groups;

h. v. Non-citizens qualifying for emergency services only benefits; and

i. vi. Family planning only

7. REENTRY DEMONSTRATION INITIATIVE

7.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide coverage for pre-release services up to 45 days immediately prior to the expected date of release to qualifying Medicaid individuals who are residing in a state/local jail or state prison (hereinafter "correctional facility") as specified in STC 7.5, the implementation timeline in STC 7.8, and the implementation plan in STC 7.9.

7.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The Reentry Demonstration Initiative provides short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other Substance Use Disorder (SUD) and behavioral health treatments, as appropriate for the individual.

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

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

c. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs;

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care;

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release.

7.3. **Qualifying Criteria for Pre-Release Services.** To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 7.1 and 7.5;

b. Be enrolled in Medicaid; and

c. Meets at least one of the health-related criteria described below" Meeting such health-related criteria may be indicated by an individual, found at an initial screening conducted by the correctional facility upon intake, determined during an individual's incarceration, or found during assessment in the process of pre-release planning.

i. Diagnosis of SUD/SMI/SED.

7.4. **Scope of Pre-Release Services.** The pre-release services authorized under the Reentry Demonstration Initiative include the following services to be detailed in the implementation plan required under STC 7.10.Contingent upon CMS's approval of the state's Reentry Demonstration Initiative, the state anticipates starting to make expenditures for such services no later than January 1, 2025.

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs;

ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;

iii. A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy;

iv. Access to clinical consultation for physical and behavioral health needs; and

v. Peer support services.

b. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the Reentry Demonstration Initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule, effective January 1, 2025, remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the New Hampshire Medicaid State Plan, as relevant, that are not included in the above-described pre-release services benefit for qualifying Medicaid individuals are not available to qualifying individuals through the Reentry Demonstration Initiative.

7.5. **Participating Correctional Facilities**. The pre-release services will be provided at correctional facilities, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to New Hampshire Department of Health and Human Services' (NHDHHS) approval of a facility's readiness, according to the implementation timeline described in STC 7.8. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the Reentry Demonstration Initiative.

7.6. **Participating Providers.**

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under New Hampshire scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as a Medicaid provider.

b. Participating providers eligible to deliver services under the Reentry Demonstration Initiative may be either community-based or correctional facility-based providers.

c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the Reentry Demonstration Initiative.

d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

7.7. **Suspension of Coverage**. Upon entry of a Medicaid individual into a correctional facility, NHDHHS must not terminate and generally shall suspend their Medicaid coverage.

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid and with submitting an application, unless the individual declines such assistance or wants to decline enrollment.

7.8. **Interaction with Mandatory State Plan Benefits for Eligible Juveniles and Targeted Low-Income Children**. To the extent New Hampshire's reentry demonstration includes coverage otherwise required to be provided under section 1902(a)(84)(D) and section 2102(d)(2) of the Act, and because this coverage is included in the base expenditures used to determine the budget neutrality expenditure limit, the state will claim for these expenditures and related transitional non-service expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

7.9. **Reentry Demonstration Initiative Implementation Timeline.** Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). NHDHHS will determine that each applicable facility is ready to participate in the Reentry Demonstration Initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medicaid application and enrollment processes for individuals who are not enrolled in Medicaid prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 7.3;

c. The provision or facilitation of pre-release services for a period of up to 45 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable;

d. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers and the state Medicaid agency;

e. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the 45-day pre-release period, and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day

supply as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;

f. Operational approaches related to implementing certain Medicaid requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the Reentry Demonstration Initiative;

g. A data exchange process to support the care coordination and transition activities described in (d), (e), and (f) of this subsection subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

h. Reporting of data requested by NHDHHS to support program monitoring, evaluation, and oversight; and

i. A staffing and project management approach for supporting all aspects of the facility's participation in the Reentry Demonstration Initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

7.10. **Reentry Demonstration Initiative Implementation Plan.** The state is required to submit a Reentry Demonstration Initiative Implementation Plan in alignment with the expectations outlined in State Medicaid Director Letter (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated). As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the Reentry Demonstration Initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment I titled "Reentry Demonstration Initiative Implementation Plan," and may be revised only with CMS approval.

CMS will provide the state with a template to support developing and obtaining approval of the Implementation Plan. Contingent upon CMS's approval of the state's Implementation Plan, the state may begin claiming FFP for services provided through the Reentry Demonstration Initiative starting from the date of inclusion of the Implementation Plan as an attachment to these STCs.

7.11. **Reentry Demonstration Initiative Reinvestment Plan**. To the extent that the Reentry Demonstration Initiative covers services that are the responsibility of and were

previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan (Attachment J). The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the Reentry Demonstration Initiative, defined as services not previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals prior to the facility's implementation of the Reentry Demonstration Initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the Reentry Demonstration Initiative, with respect to the relevant increase in expenditures, as described in Attachment J the Reentry Demonstration Initiative Reinvestment Plan), is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:

    i. The state share of funding associated with new services covered under the Reentry Demonstration Initiative, as specified in this STC;

    ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

    iii. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the Reentry Demonstration Initiative opportunity;

    iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

    v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

    vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. The reinvestment plan will describe whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c. Within six months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan (Attachment J) as part of the implementation plan referred to in STC 7.10 for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment J titled "Reentry Demonstration Initiative Reinvestment Plan."

7.12. **Reentry Demonstration Initiative Planning and Implementation.**

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid pre-release application and suspension/unsuspension planning and purchase of certified electronic health record (EHR) technology to support Medicaid pre-release applications In addition, Reentry Demonstration Initiative planning and implementation funds will provide funding over the course of the demonstration to support planning and IT investments that will enable implementation of the Reentry Demonstration Initiative services covered in a period for up to 45 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among NHDHHS and Qualified Applicants listed in STC 7.12(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid. These allowable expenditures may include the following:

i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the Reentry Demonstration Initiative population with Medicaid application and enrollment for demonstration coverage. This includes the development of electronic interfaces for Qualified Applicants listed in STC 7.12(d). to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance

existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 7.12(d), in order to support the provision of pre-release services delivered in the period up to 45 days immediately prior to the expected date of release and reentry planning.

ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants listed in STC 7.12(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 45 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

iii. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

iv. **Purchase of Billing Systems.** Expenditures for the purchase of billing systems for Qualified Applicants.

v. **Development of Protocols and Procedures.** Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid enrollment process, suspension/unsuspension process for eligible individuals, and provision of care coordination and reentry planning for a period for up to 45 days immediately prior to the expected date of release for individuals qualifying for Reentry Demonstration Initiative services.

vi. **Additional Activities to Promote Collaboration.** Expenditures for additional activities that will advance collaboration among New Hampshire's Qualified Applicants in STC 7.12(d). This may include conferences and meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

vii. **Planning.** Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identify individuals who are potentially eligible for Medicaid; (2) assist with the completion of a Medicaid application; (3) submit the Medicaid application to the county social services department or coordinate suspension/unsuspension; (4) screen for eligibility for pre-release services and reentry planning in a period for up to 45 days immediately prior to the expected date of release; (5) deliver necessary services to eligible individuals in a period for up to 45 days

immediately prior to the expected date of release and care coordination to support reentry; and (6) establish on-going oversight and monitoring process upon implementation.

viii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 45 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 45 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction, or refurbishment of correctional facilities.

b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 1. In the event that the state does not claim the full amount of FFP for a given demonstration year as defined in STC 12.12, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 1. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

	DY 7
Total Computable Expenditures	$12,580,690

c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.

d. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include the state Medicaid Agency, correctional facilities, other state agencies supporting carceral health, Probation Offices, and other entities as relevant to the needs of justice-involved individuals, including health care providers, as approved by the state Medicaid agency.

8. COST SHARING

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

9. DELIVERY SYSTEM

9.1. **Delivery System.** The state's SMI/SED and SUD/OUD Medicaid delivery system is based on an integrated managed care model for physical and behavioral health. It utilizes MCOs to deliver integrated physical and behavioral health services, including SUD with a small number of members receiving services through FFS. Under the demonstration, Substance Use Disorder Serious Mental Illness and Serious Emotional Disturbance Treatment Recovery and Access, the delivery system will continue to operate as approved in Section 1932(a) state plan authority for managed care and concurrent 1915(b) and 1115 demonstration.

10. MONITORING AND REPORTING REQUIREMENTS

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

a. The following process will be used: 1) thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection 10.1(c) below; or 2) thirty (30) days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements.

b. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s).

c. For each deliverable, the state may submit to CMS a written request for any extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process will be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

d. If CMS agrees to an interim corrective plan in accordance with subsection (c) above, and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

e. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

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

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

10.3. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

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

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new system;

b. Ensure all section 1115 demonstration, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

10.5. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment E. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to the same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, as applicable and

relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., those described under the performance metrics section in STC 10.6), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS, as applicable. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) and demonstration component.

The Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Disparities Sensitive Measure Set from CMS. This set of measures consists of metrics known to be important for addressing disparities in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones including relevant transitional, non-service expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

In addition, the state must describe in the Monitoring Protocol methods and the timeline to collect and analyze relevant non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include but are not limited to data related to carceral status, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts to consult with relevant non-Medicaid agencies to collect and use data in ways that support analyses of data on demonstration beneficiaries and subgroups of beneficiaries, in accordance with all applicable requirements concerning privacy and the protection of personal information.

For the qualitative elements (e.g., operational updates as described in STC 10.6), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

Additionally, the Monitoring Protocol must include an assurance of the state's commitment and ability to report information relevant to each of the program implementation areas

listed in STC 5.1 and 6.1 and reporting relevant information to the state's SUD and SMI/SED Health IT plans described in STC 5.2(k) and 6.2(d), respectively.

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

a. Operational Updates**:** Per 42 CFR § 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The demonstration's monitoring activities through quantitative data and narrative information must support tracking the state's progress toward meeting the applicable program-specific goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments and transitional non-service expenditures, as applicable.

   Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on individuals' outcomes as well as outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.

   Specifically, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary participation in demonstration components, primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives populations. Such reporting must also be stratified by key demographic subpopulations of interest

(e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

i. The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 7.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the Form CMS-64.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of

evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. SUD Health IT and/or SMI/SED Health IT. The state will include a summary of progress made in regards to SUD and SMI/SED Health IT requirements outlined in STCs 5.2(k) and 6.2(d).

10.7. **SUD Mid-Point Assessment.** The state must contract with an independent entity to conduct a Mid-Point Assessment by June 30, 2027, and the state must provide a copy of the report to CMS no later than 60 calendar days after June 30, 2027. This timeline will allow for the Mid-Point Assessment to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In the design, planning and conduction of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, health care providers (including SUD treatment providers), beneficiaries, community groups, and other key partners.

The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment with 60 calendar days after receipt of CMS's comments, if any.

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

Elements of the Mid-Point Assessment must include:

a. An examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan and toward meeting the targets for performance measures as approved in the Monitoring Protocol.

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date.

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets.

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SUD Implementation Plans or to other pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the budget neutrality requirements.

10.8. **SMI/SED Mid-Point Assessment.** The state must contract with an independent entity to conduct an independent Mid-Point Assessment by May 30, 2025. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and conduct of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, health care providers (including SMI/SED treatment providers), and beneficiaries, community groups, and other key partners.

The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 calendar days after May 30, 2025. If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

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

Elements of the Mid-Point Assessment must include:

a. An examination of progress toward meeting each milestone and timeframe approved in the SMI/SED Implementation Plan, the SMI/SED Financing Plan, if applicable, and toward meeting the targets for performance measures as approved in the SMI/SED Monitoring Plan;

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets identified by the independent assessor as at medium to high risk of not being met, recommendations for adjustments in the state's SMI/SED Implementation Plans and/or SMI/SED Financing Plan or to other pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the SMI/SED budget neutrality requirements in these STCs.

10.9. **Reentry Demonstration Initiative Mid-Point Assessment.** The state must contract with an independent entity to conduct a mid-point assessment of the Reentry Demonstration Initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment by June 30, 2027, and the state must provide a copy of the report to CMS no later than 60 calendar days after June 30, 2027.

The Mid-Point Assessment must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the Reentry Demonstration Initiative. The report must be submitted to CMS by the end of the third year of the demonstration. In the event that the Reentry Demonstration Initiative is implemented at a timeline within the demonstration approval period, the state and CMS will agree to an alternative timeline for submission of the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any. If requested, the state must brief CMS on the report.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: provider participation in the state's Reentry Demonstration Initiative, eligible individuals, and other key partners in correctional facility and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state and CMS will collaborate to determine whether modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol are necessary for ameliorating these risks, with any modifications subject to CMS approval.

Elements of the Mid-Point Assessment must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment.

10.10. **Corrective Action Plan Related to Demonstration Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

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

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 11.7 and 11.8, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out Report.

d. The state must take into consideration CMS's comments for incorporation in the Final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 10.1.

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

a. The purpose of these calls is to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

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

11. EVALUATION OF THE DEMONSTRATION

11.1. **Cooperation with Federal Evaluators.** As required under 42 CFR § 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but it not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they will make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 10.1.

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

11.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 days after the approval of the demonstration. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs, CMS's evaluation design guidance for SUD and SMI/SED demonstrations, including guidance for approaches to analyzing associated costs, and any other applicable CMS evaluation guidance and technical assistance for the demonstration's other policy components. The Evaluation Design must

be also developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic), as these implementation strategies help create strong comparison groups and facilitate robust evaluation. The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STC 11.7 and 11.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design or submit a new Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amended Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

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

11.5. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within 60 days after receipt of CMS's comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within 30 days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.

11.6. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline

and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

Hypotheses for the SUD component of the demonstration must support an assessment of the demonstration's success in achieving the core goals of the program through addressing, among other outcomes, initiation and compliance with treatment, utilization of health services in appropriate care settings, and reductions in key outcomes such as deaths due to overdose. Hypotheses for the SMI/SED program must include an assessment of the objectives of the SMI/SED component of this 1115 demonstration, including (but are not limited to) utilization and length of stay in emergency departments, reductions in preventable readmissions to acute care hospitals and residential settings, availability of crisis stabilization services, and care coordination. Likewise, the state must test appropriate hypotheses focused on utilization and health outcomes for the other demonstration components. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by National Quality Forum (NQF).

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 45-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

Furthermore, the evaluation must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, and/or geography)—to the extent feasible—to inform a fuller understanding of existing disparities in access and health outcomes, and how the demonstration's various policies might support bridging any such inequities.

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

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses and a description of how the design was adapted should be included. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the

expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

f. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs.

11.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STC, and in alignment with the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

b. Once approved by CMS, the state must post the final Summative evaluation Report to the state's Medicaid website within 30 calendar days.

11.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

11.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and the Summative Evaluation Report.

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

11.12. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports on their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

12. GENERAL FINANCIAL REQUIREMENTS

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

12.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

12.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

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

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in

which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

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

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

12.6. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

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

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

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

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

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

12.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 10.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

12.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 13:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

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

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

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

Table 2: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Medicaid Adults (Non-Group VIII Adults)	Hypo 1	X		X	SUD Non-Group VIII Adults; see Table 3.
Expansion Adults (Group VIII Adults)	Hypo 1	X		X	SUD Group VIII Adults; see Table 3.
Adolescents	Hypo 1	X		X	SUD Adolescents; see Table 3.
SUD 1115 Waiver - SMI Medicaid Adults	Hypo 2	X		X	SMI Non-Group VIII Adults; see Table 3.
SUD 1115 Waiver - SMI Expansion Adults	Hypo 2	X		X	SMI Group VIII Adults; see Table 3.
SUD 1115 Waiver - Dentures	Hypo 3	X		X	Beneficiaries described in STC 6.7; see Table 3.
Reentry Services	Hypo 4	X		X	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 45 days immediately prior to the expected date of release from participating state prisons.
Reentry Non-Service	Hypo 4		X	X	Expenditures for planning and supporting the reentry demonstration initiative.
QRTP	Hypo 5	X		X	Expenditures for treatment provided to beneficiaries residing in QRTPs that are IMDs.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are

Table 2: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					not subject to budget neutrality.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

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

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

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

c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 13, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section 10, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

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

Table 3: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Medicaid Adults (Non-Group VIII Adults)	All medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	Y	7/10/18	6/30/29
Expansion Adults (Group VIII Adults)	All medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	Y	7/10/18	6/30/29
Adolescents	All medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	Y	7/10/18	6/30/29
SUD 1115 Waiver - SMI Medicaid Adults	All medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SMI treatment.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	Y	6/02/22	6/30/29
SUD 1115 Waiver - SMI Expansion Adults	All medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SMI treatment.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	Y	6/02/22	6/30/29

Dentures	All expenditures for costs of related to furnishing dentures	See STC 6.7 for exclusions	Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	Y	3/17/23	6/30/29
Reentry Services	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 45 days immediately prior to the expected date of release from participating state prisons, county jails, or youth correctional facilities.		Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	7/15/24	6/30/29
Reentry Non-Services	Expenditures for planning and supporting the reentry demonstration initiative.		Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	N	7/15/24	6/30/29
QRTP	All medical assistance expenditures for services provided to an individual while they are in a QRTP IMD.		Follow standard CMS 64.9 Category of Service Definitions	Date of service/Date of payment	MAP	Y	7/15/24	6/30/29
ADM	Report all additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	7/10/18	6/30/29

	not subject to budget neutrality							

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group;

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

Table 4: Demonstration Years		
Demonstration Year 1	July 10, 2018 to June 30, 2019	12 months
Demonstration Year 2	July 1, 2019 to June 30, 2020	12 months
Demonstration Year 3	July 1, 2020 to June 30, 2021	12 months
Demonstration Year 4	July 1, 2021 to June 30, 2022	12 months
Demonstration Year 5	July 1, 2022 to June 30, 2023	12 months
Demonstration Year 6 (Temporary Extension Year)	July 1, 2023 to June 30, 2024	12 months
Demonstration Year 7	July 1, 2024 to June 30, 2025	12 months
Demonstration Year 8	July 1, 2025 to June 30, 2026	12 months
Demonstration Year 9	July 1, 2026 to June 30, 2027	12 months
Demonstration Year 10	July 1, 2027 to June 30, 2028	12 months
Demonstration Year 11	July 1, 2028 to June 30, 2029	12 months

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

12.14. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service

during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

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

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

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

12.16. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 12.16(c). If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the

request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

13. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

13.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1, Master MEG Chart and Table 2, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

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

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

13.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which

effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

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

Table 5: Hypothetical Budget Neutrality Test 1 - SUD

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 7	DY 8	DY 9	DY10	DY 11
Medicaid Adults (Non-Group VIII Adults)	PC	Both	4.9%	$2,183.37	$2,290.36	$2,402.59	$2,520.32	$2,643.82
Expansion Adults (Group VIII Adults)	PC	Both	5.2%	$1,205.70	$1,268.40	$1,334.36	$1,403.75	$1,476.75
Adolescents	PC	Both	4.9%	$987.69	$1,036.09	$1,086.86	$1,140.12	$1,195.99

13.7. **Hypothetical Budget Neutrality Test 2: SMI.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Budget Neutrality Test.

Table 6: Hypothetical Budget Neutrality Test 2 - SMI								
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 7**	**DY 8**	**DY 9**	**DY10**	**DY 11**
SUD 1115 Waiver - SMI Expansion Adults	PC	Both	5.2%	$3,423.60	$3,601.63	$3,788.91	$3,985.93	$4,193.20
SUD 1115 Waiver - SMI Medicaid Adults	PC	Both	4.9%	$4,582.16	$4,806.69	$5,042.22	$5,289.29	$5,548.47

13.8. **Hypothetical Budget Neutrality Test 3: Dentures**. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Budget Neutrality Test.

Table 7: Hypothetical Budget Neutrality Test 3 - Dentures								
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 7**	**DY 8**	**DY 9**	**DY10**	**DY 11**
SUD 1115 Waiver - Dentures	PC	Both	4.0%	$1.51	$1.57	$1.63	$1.70	$1.77

13.9. **Hypothetical Budget Neutrality Test 4: Reentry.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Budget Neutrality Test.

Table 8: Hypothetical Budget Neutrality Test 4 – Reentry								
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 7**	**DY 8**	**DY 9**	**DY 10**	**DY 11**
Reentry Services	PC	Both	4.6%	$838.91	$877.50	$917.86	$960.09	$1,004.25
Reentry Non-Services	Agg	Both	N/A	$12,580,690	$0 or rollover amount	$0 or rollover amount	$0 or rollover amount	$0 or rollover amount

13.10. **Hypothetical Budget Neutrality Test 5: QRTP.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 5 are counted as WW expenditures under the Budget Neutrality Test.

Table 9: Hypothetical Budget Neutrality Test 5 – QRTP

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 7	DY 8	DY 9	DY 10	DY 11
QRTP	PC	Both	4.9%	$28,071.00	$29,446.48	$30,889.36	$32,402.93	$33,990.68

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

13.12. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from July 1, 2020 to June 30, 2029. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s) (July 10, 2018 to June 30, 2024). If at the end of the demonstration approval period the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If

the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

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

Table 10: Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 7	Cumulative budget neutrality limit plus:	2.0 percent
DY 7 through DY 8	Cumulative budget neutrality limit plus:	1.5 percent
DY 7 through DY 9	Cumulative budget neutrality limit plus:	1.0 percent
DY 7 through DY 10	Cumulative budget neutrality limit plus:	0.5 percent
DY 7 through DY 11	Cumulative budget neutrality limit plus:	0.0 percent

14. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Table 11: Schedule of Deliverables for the Demonstration Period

Date	Deliverable	STC
30 calendar days after demonstration approval	State acceptance of demonstration Expenditure Authorities and STC	Approval letter
150 calendar days after demonstration approval	Monitoring Protocol	STC 10.5
60 calendar days after receipt of CMS comments	Revised Monitoring Protocol	STC 10.5
180 calendar days after demonstration approval	Draft SUD Evaluation Design	STC 11.3
60 days after receipt of CMS comments	Revised SUD Evaluation Design	STC 11.3
180 calendar days after demonstration approval	Draft SMI/SED Evaluation Design	STC 11.3
60 days after receipt of CMS comments	Revised SMI/SED Evaluation Design	STC 11.3
No later than 60 calendar days after June 30, 2027	SUD Mid-Point Assessment	STC 10.7
60 calendar days after receipt of CMS comments	Revised SUD Mid-Point Assessment	STC 10.7
No later than 60 calendar days after May 30, 2025	SMI/SED Mid-Point Assessment	STC 10.8
60 calendar days after receipt of CMS comments	Revised SMI/SED Mid-Point Assessment	STC 10.8
No later than 60 calendar days after June 30, 2027	Reentry Demonstration Initiative Mid-Point Assessment	STC 10.9
60 calendar days after receipt of CMS comments	Revised Reentry Demonstration Initiative Mid-Point Assessment	STC 10.9
One year prior to the expiration of the demonstration on June 30, 2028, or with extension application	Draft Interim Evaluation Report	STC 11.7(c)
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	STC 11.7(d)
Within 18 months after approval period ends	Draft Summative Evaluation Report	STC 11.8
60 calendar days after receipt of CMS comments	Revised Summative Evaluation Report	STC 11.8(a)

Date	Deliverable	STC
Monthly Deliverables	Monitoring Calls	STC 10.12
Quarterly monitoring reports due 60 calendar days after end of each quarter, except 4th quarter.	Quarterly Monitoring Reports, including implementation updates	STC 10.6
	Quarterly Expenditure Reports	STC 12.11
Annual Deliverables - Due 90 calendar days after end of each 4th quarter	Annual Monitoring Reports	STC 10.6

ATTACHMENT A

Developing the Evaluation Design

Introduction

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

Expectations for Evaluation Designs

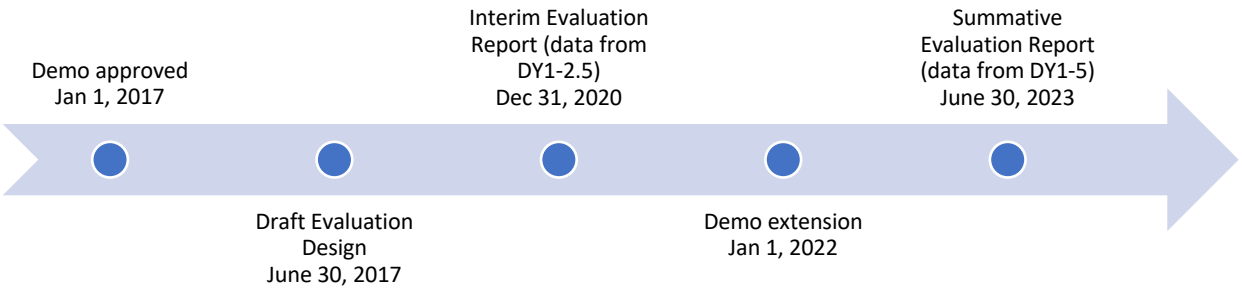
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses,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

The format for the Evaluation Design is as follows:

- General Background Information
- Evaluation Questions and Hypotheses
- Methodology
- Methodological Limitations
- Attachments

Submission Timelines

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



Required Core Components of All Evaluation Designs

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

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

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

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

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

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

5. Describe the population groups impacted by the demonstration.

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

1. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

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

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

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

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

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

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

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

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

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

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

4. Evaluation Measures. List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing;

and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.

b. Qualitative analysis methods may be used and must be described in detail.

c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).

f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

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

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

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

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

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

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).

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

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

Table 1: Example Design Table for the Evaluation of the Demonstration

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

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

1. When the state demonstration is:

    a. Long-standing, non-complex, unchanged, or

    b. Has previously been rigorously evaluated and found to be successful, or

    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

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

    a. Operating smoothly without administrative changes; and

    b. No or minimal appeals and grievances; and

    c. No state issues with CMS-64 reporting or budget neutrality; and

    d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments.

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

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

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

ATTACHMENT B

Preparing the Interim and Summative Evaluation Reports

Introduction

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

Expectations for Evaluation Reports

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

Intent of this Guidance

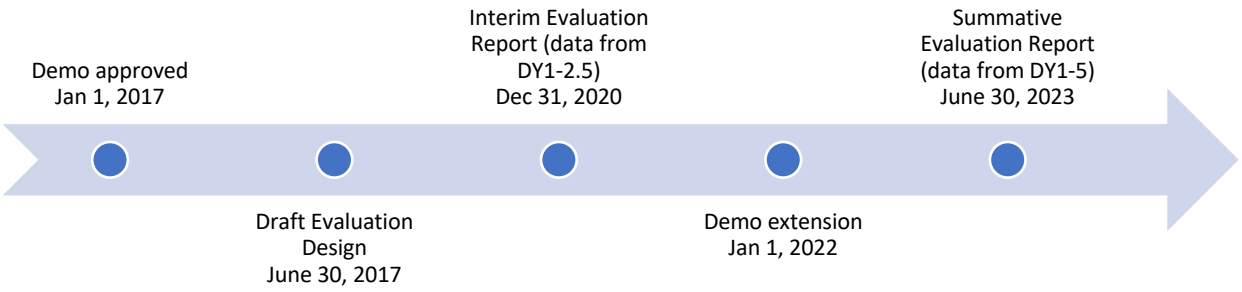
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved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

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

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

Submission Timelines

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



Required Core Components of Interim and Summative Evaluation Reports

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

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

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

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

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

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

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

5. Describe the population groups impacted by the demonstration.

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

1. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

2. Identify the state's hypotheses about the outcomes of the demonstration;

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

    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and

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

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

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

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

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

1. Evaluation Design. Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?

2. Target and Comparison Populations. Describe the target and comparison populations; include inclusion and exclusion criteria.

3. Evaluation Period. Describe the time periods for which data will be collected

4. Evaluation Measures. What measures are used to evaluate the demonstration, and who are the measure stewards?

5. Data Sources. Explain where the data will be obtained, and efforts to validate and clean the data.

6. Analytic Methods. Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

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

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

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

G. **Conclusions.** In this section, the state will present the conclusions about the evaluation results.

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

2. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

    a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

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

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

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

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

F. **Attachment: Evaluation Design.** Provide the CMS-approved Evaluation Design.

ATTACHMENT C:
Reserved for Evaluation Design

ATTACHMENT D
SUD Implementation Plan

Section I – Milestone Completion

Milestones

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

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

   Current state:

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

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

Table 1. NH Medicaid Substance Use Disorder Benefit

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

Future state:

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

Support Systems

In Level 2.1 programs, necessary support systems include:

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

Therapies

Therapies offered by Level 2.1 programs include:

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

Milestone Criteria	Current State	Future State	Summary of Actions
State Medicaid programs must provide coverage of the following services: • Outpatient Services; • Intensive Outpatient Services; • Medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); • Intensive levels of care in residential and inpatient settings; and • Medically supervised withdrawal management levels of care with codes covering	New Hampshire provides coverage for a robust array of substance use disorder services, including all of those outlined in the milestone requirement	NH will update the He- W 513 rule to align with the recently updated state plan. This update will include a list of therapies and supports that are offered under each ASAM level of care covered by NH. This will allow for Medicaid providers to understand what types of services are covered under each ASAM level of care, including understanding requirements around therapeutic milieu, hours of services, and types of staff required to deliver each.	Medicaid authority will update the He-w 513 rule in collaboration with Bureau of Drug and Alcohol Services by November 30, 2018.

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

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

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

Current state:
Patient Placement Criteria

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

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

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

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

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

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

Future State

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

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

Current state:

Utilization management

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

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

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

(b) Supporting documentation shall include:

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

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

a. The treatment modality and duration;

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

c. The primary therapist's professional discipline; and

d. The date of each treatment session; and

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

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

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

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

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

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

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

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

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

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

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

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

Residential treatment provider qualifications

Current state:

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

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

The selected vendor must meet minimum staffing requirements that include:

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

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

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

Future state:

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

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

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

Reviewing compliance to standards

Current state:

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

Future state:

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

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

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

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

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

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

Current state:

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

Future state:

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

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

4. **Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD**
   To meet this milestone, states must complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care listed in Milestone 1. This assessment must determine availability of treatment for Medicaid beneficiaries in each of these levels of care, as well as availability of MAT and medically supervised withdrawal management, throughout the state. This assessment should help to identify gaps in availability of services for beneficiaries in the critical levels of care.

Current state:

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

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

Future state:

NH will establish an assessment process to meet this milestone.

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

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

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

Current state:

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

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

Measure ID	Measure Name	Data Collection Status	Results
CMS_A_OHD	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage (CMS Adult Core Set)	Started with FFY 2016 Reporting (for measurement year 2015)	https://medicaidquality.nh.gov/reports/use-of-opioids-at-high- dosage-ohd-
CMS_A_CUOB	Concurrent Use of Opioids and Benzodiazepines	Will start with FFY 2018 Reporting (for measurement year	N/A
PHARMQI.09	Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	Started with CY 2016 Quarter 2	https://medicaidquality.nh.gov/reports/safety-monitoring---opioid-prescriptions-meeting-nh-dhhs-morphine-equivalent-
SUD_11	Continuity of Pharmacotherapy for Opioid Use Disorder	Will start with SFY 2019 Reporting	N/A

Table 1. Managed care opioid prescribing metrics

Future state:

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

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

Milestone Criteria	Current State	Future State	Summary of Actions
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	The Office of Professional Licensure and Certification (OPLC) developed prescribing guidelines that were placed in administrative rules for their licensees which include physicians, APRNs, Pas, dentists and veterinarians. The Opioid Prescribing Guidelines from the NH Board of Medicine went into effect on January 1, 2017 (https://www.oplc.nh.gov/medicine/documents/med 502- adopted.pdf) Please see attached prior authorization criteria for Methadone, Long Acting Narcotics, Short Acting Fentanyl and Morphine Milligram Equivalence (MME). The pharmacy point of sale (POS) system has a cumulative morphine milligram equivalence (MME) calculator. NH DHHS has a system edit in place that will not allow claims to process once the cumulative MME is equal or greater than 100mg. Beneficiaries that require doses that are equal to or greater than 100mg MME are required to get prior authorization. Prior Authorization ensures that the high dose is medically necessary. Doses that exceed 100mg MME will not be authorized with concurrent use of benzodiazepines. The MCOs are also required to have a MME calculator in built into the pharmacy POS system and to require prior authorization for all prescriptions where the dose is equal to or greater than 100mg MME The MCOs are required to submit a quarterly report	NH will explore additional opportunities for enhancing opioid prescribing guidelines through Managed Care re-procurement efforts NH will further enhance implementation of existing laws related to opioid prescribing in collaboration with the OPLC and Board of Medicine.	Meet with PDMP by August 2018 Meet with Governor's Commission Opioid and Healthcare taskforces to discuss guidelines by August 2018 Consult with vendor assisting with managed care re-procurement to develop

Expanded coverage of and access to naloxone for overdose reversal

Current state:

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

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

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

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

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

3. The organization must have written policies for their dispensing protocol.

Organizations including social service agencies, treatment providers, and recovery organizations are screened by the DHHS Emergency Services Unit (ESU) before they receive a kit.

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

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

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

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

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

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

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

Current state:

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

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

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

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

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

Future state:

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

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

6. **Improved Care Coordination and Transitions between Levels of Care**
   To meet this milestone, states must implement policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities.

Improved Care Coordination and Transition between Levels of Care

Current state:

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

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

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

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

Future state:

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

1) Continuing Care and Discharge

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

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

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

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

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

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

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

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

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

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

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

Section II – Implementation Administration

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

Name and Title: Deborah Scheetz, New Hampshire Medicaid Deputy Director
Telephone Number: 603-271-9459
Email Address: Deborah.Scheetz@dhhs.nh.gov

Section III – Relevant Documents

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

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

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

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

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

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

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

Section I.

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

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

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

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

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

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

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

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

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

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

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

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

Table 1. State Health IT / PDMP Assessment & Plan

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

Enhanced “ease of use” for prescribers and other state and federal stakeholders	The NH PDMP is web-based and has been assessed for ease of use, requiring approx. 3 clicks for providers to navigate through the program when conducting a query	NH DHHS will develop a plan to identify the future state within 60 days of waiver submission on April 9, 2018	The plan submitted within 60 days of waiver submission will identify activities, action steps and timelines associated this milestone. The plan will also include 60-90 day check-in meetings with CMS to discuss progress

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

[6] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1.

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

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

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

Attachment A, Section II – Implementation Administration

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

Name and Title: Deborah Scheetz, New Hampshire Medicaid
Deputy Director Telephone Number: 603-271-9459
Email Address: Deborah.Scheetz@dhhs.nh.gov

Attachment A, Section III – Relevant Documents

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

ATTACHMENT E
Reserved for SUD Monitoring Protocol

ATTACHMENT F:

SMI/SED Implementation Plan

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

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

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

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

State may submit additional supporting documents in Section 3.

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

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

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

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

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

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

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

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

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

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

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

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note anyactions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt doesnot pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions.

Answers should be concise, but provide enough information to fully answer the question.This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	*Current Status:* The two hospitals that will participate in the demonstration—New Hampshire Hospital and Hampstead Hospital—are authorized by the state to treat mental illness, enrolled in Medicaid / Medicare and are in compliance with the Conditions of Participation. Both hospitals are also Joint Commission accredited. NH Administrative Code details licensure requirements for acute settings: • NH Administrative Code **He-P 802 Rules for Hospitals** and **RSA 151:2 Residential Care and Health Facility Licensing: License or Registration Required** requires licensure for hospitals. • NH Administrative Code **He-M 405.04 Application Procedure and Designation/Redesignation Criteria** states that hospital-based Designated Receiving Facilities (DRFs) which submit an application for (re-designation shall include a certificate of compliance with the Conditions of Participation (CoPs) for hospital-based psychiatric services set by CMS, obtained from either DHHS

	on behalf of CMS or by a national accrediting organization deemed by CMS as having standards and a survey process that meets the Medicare CoPs and federal survey requirements. • New Hampshire Hospital is state-owned and authorized to provide care and treatment to persons who have mental illness by RSA 135-C:4 rather than facility licensure. 14.1. In accordance with NH administrative code, upon the initial enrollment in NH Medicaid, the licensure requirement is a mandatory field and verified with the appropriate licensing entity for the Provider. This information displays the end date of the license and the MMIS staff have an overdue license report that is worked weekly to update and record license dates to maintain current information. This function is done upon expiration of the license and at the time of revalidation every 5 years.
	Future Status: In addition to continuing operation of current requirements, New Hampshire (the State) plans to require all IMDs to verify that they are accredited by a nationally recognized accreditation entity as part of the Medicaid enrollment process.
	Summary of Actions Needed: DHHS will draft new administrative rule language to specify that all hospitals participating in the demonstration must be accredited by a nationally recognized accreditation entity. Once the new administrative rule language is drafted, DHHS will coordinate with the Administrative Rules Unit to finalize rule language and submit the rule for publication. Following a public comment period, the Rules Unit will bring the proposed rule change(s) in front of Joint Legislative Committee Rules for approval. After the administrative rule is formally filed with the Office of Legislative Services, DHHS will conduct outreach to providers and MCOs. DHHS updates the provider and other stakeholder communities, and the public on the progress of the IMD Demonstration, inclusive of public comment periods at key moments through its website. The promulgation of administrative rules includes public notice and hearings to allow agency adoption through Joint Legislative Committee on Administrative Rules (JLCAR). DHHS will specifically issue guidance to the MCOs regarding these administrative rule changes, along with any billing and coding instructions. These efforts will be joined with aligned approaches for DHHS' provider relations team's work at the individual provider level. This entire process will take approximately 12-18 months. DHHS has set an internal goal to complete draft language by October 2022 and to begin public review and comment of the proposed rules by Jan 1, 2023. These specific dates

	are subject to change based on internal staff capacity and timing with other ongoing internal processes.

Prompts	Summary
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	*Current Status:* The Program Integrity Unit performs on-site visits of every **moderate and high-risk provider** during the initial enrollment process and revalidation every 5 years to assess the meeting of the requirements for each provider type. Additionally, Program Integrity may increase a limited risk provider to moderate or high based on the risk to the Medicaid program. The State also completes a full designation review of DRFs once every five years. Bureau of Licensing and Certification (BLC) reviews are conducted pursuant to federal regulations requiring the periodic inspection of all CMS certified hospitals by the NH DHHS Licensing and Certification Unit, specifically the CMS contracted certification unit or the accrediting organization. Pursuant to **RSA 151:5-b Deemed Licensed**, all CMS certified hospitals are deemed licensed and are exempt from inspections required by **RSA 151:6 Investigations and Consultations** and NH Administrative Rule **He-P 802 Rules for Hospitals**. NH Administrative Code **He-P 405.04 Application Procedure and Designation/Redesignation Criteria** requires that DHHS assign staff to review the application materials and conduct a site visit of any DRF applying for designation or redesignation. The BLC conducts the onsite visits for licensed facilities, pursuant to NH RSA 151. BLC's federal CMS team conducts onsite surveys for licensed facilities that are CMS certified. These surveys are conducted as defined in CMS SOM, depending on the provider type. The State BLC exempts hospitals which are accredited and CMS certified from its site visits. These facilities are instead subject to unannounced visits from their accrediting entity, including at minimum an unannounced audit visit every three years. NH Hospital and Hampstead Hospital are both Joint Commission accredited and subject to unannounced visits from this accreditation entity.
	Future Status: Continued operation of current requirements.

	Summary of Actions Needed: N/A – Milestone met.
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	*Current Status:* NH Administrative Code **He-W 543.11 Utilization Review** requires evaluations of the quality, medical necessity, appropriateness of care, and length of stay determinations for all inpatient hospital services at in-state and border hospitals in accordance with **42 CFR 456.100**. Operationally, the program area or their designated contractor reviews whether individual beneficiaries are receiving appropriate services. NH DHHS contracts with MCOs who employ or contract with licensed health care personnel to perform utilization review activities. These activities are outlined in the written Utilization Management policies included in each MCO contract. At a minimum, MCOs must outline policies which address Second Opinion programs, pre-hospitalization admission certification, pre-inpatient service eligibility certification, concurrent hospital review to determine appropriate lengths of stay, and the process for preserving confidentiality of patient information. Each MCO also maintains a collaborative agreement specific to New Hampshire Hospital (NHH) that includes mutually-developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to NHH. This requirement is further outlined by MCM Section 41.11.5.18.1.3, "The collaborative agreement shall also include mutually developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to New Hampshire Hospital." New Hampshire Hospital employs Utilization Review as a key function in determining clinical necessity for levels of psychiatric care that patients receive. This process closely follows CMS guidelines outlined in Chapter 2, section 30.2.1 of the **Medicare Benefit Policy Manual** and **Pub 100-01- Medicare General Information, Eligibility, and Entitlement**, from the CMS Manual System. Throughout a patient's stay, utilization review is employed to determine a patient's continued medical necessity for inpatient psychiatric care, and when medical necessity is no longer met, Utilization Review staff members partner with Social Workers, Clinicians, and a variety of community-based and step-down facility providers in finalizing a safe and effective discharge plan for patients. New Hampshire's focus on ensuring patients are served in the most appropriate and least restrictive environment possible is a key reason the state invested in and opened the Philbrook Adult Transitional Housing (PATH) program, a 16-bed transitional housing facility, owned and operated by the State of New

	Hampshire, that ensures a timely transition to a more appropriate level of care for patients who no longer require acute psychiatric hospitalization. In its oversight capacity, NH DHHS's External Quality Review Organization conducts annual MCO contract compliance reviews. NH DHHS also conducts annual contract compliance audits for all state funded treatment facilities to ensure adherence to clinical standards when determining level of care placement. NH Administrative Code **He-W 520.04 Surveillance and Utilization Review and Control** requires DHHS to perform utilization reviews directly or through contracted organizations for the purposes of assessing quality of care, including through random reviews of claims. In the last two years, the Program Integrity Unit (PIU) has internalized its Quality Improvement Organization (QIO) function to perform utilization reviews for inpatient fee-for-service hospital claims only.
	Future Status: DHHS is in the process of amending the existing utilization management language in the MCM contract that requires MCOs to have an agreement with NHH which, "…shall also include mutually developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to New Hampshire Hospital". The amended MCM contract will strengthen and expand this existing requirement for NHH to explicitly state that MCOs must include admission and utilization review criteria in all IMD contracts, not just NHH.
	Summary of Actions Needed: The State will amend MCO contracts to explicitly require MCOs to include admission and utilization review criteria in all IMD contracts. This process will be completed by June 30, 2022.
1.d Compliance with program integrity requirements and state compliance assurance process	*Current Status:* In order to receive reimbursement under Medicaid, participating psychiatric hospitals must be enrolled to participate in New Hampshire Medicaid. Provider enrollment processes fully comply with **42 CFR Part 455 Subparts B&E**. PIU performs audits and investigations when an allegation of fraud, waste, or abuse is reported. PIU also uses data analytic reports to determine whether there are anomalies in billing and/or reimbursement. Further, Program Integrity will investigate an allegation that the program area reports to Program Integrity that includes questions about the accuracy of claim information or questions surrounding utilization. DHHS has also recently hired a waiver manager to oversee compliance and requirements of all NH waivers.

	Future Status: In addition to the continued operation of current requirements, PIU will enhance provider monitoring during the period of the requested demonstration amendment.
	Summary of Actions Needed: PIU will implement a formal approach to monitoring the providers that will include a six month random sampling of paid claims from the Fee-for-Service and MCO populations to determine if there are any patterns of irregularity or utilization practices including excessive high coding procedures. This process will begin in 12-18 months due to claims run out time. The State will meet internally in March of 2023 to review initial claims received and refine the sampling process. The State will target completion of this initial review within six months of the March 2023 meeting (by November 2023). As it identifies additional best-practice safeguards over the normal course of business, PIU will work with BMHS to assure integration into the rule-making process.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	*Current Status:* New Hampshire Hospital and Hampstead Hospital are both Joint Commission accredited. Joint Commission standards PC 01.02.03 EP 4 include policies that address screening requirements for co-morbid physical health conditions. The policies require that a medical health history and physical examination must be completed within 24 hours of admission. DHHS monitors MCO performance relative to the contract requirements, and if necessary, takes corrective action and/or assesses liquidated damages to enforce compliance. During a PIU review, the required documentation will be requested from the provider so that PIU may review claims for compliance with the plan of care and ensure that the provider is following proper qualifications for the staff performing the functions. If there were a screening requirement as part of a service, PIU would request the documentation specific to the screening.
	Future Status: To reinforce the impact of accreditation standards, the State plans to create new administrative rule language ensuring that all participating hospitals screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions.
	Summary of Actions Needed: DHHS will draft new administrative rule language to specify that all hospitals participating in the demonstration must screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to

	treatment for those conditions. Once the new administrative rule language is drafted, DHHS will coordinate with the Administrative Rules Unit to finalize rule language and submit the rule for publication. Following a public comment period, the Rules Unit will bring the proposed rule change(s) in front of Joint Legislative Committee Rules for approval. After the administrative rule is formally filed with the Office of Legislative Services, DHHS will conduct outreach to providers and MCOs. DHHS updates the provider and other stakeholder communities, and the public on the progress of the IMD Demonstration, inclusive of public comment periods at key moments through its website. The promulgation of administrative rules includes public notice and hearings to allow agency adoption through Joint Legislative Committee on Administrative Rules (JLCAR). DHHS will specifically issue guidance to the MCOs regarding these administrative rule changes, along with any billing and coding instructions. These efforts will be joined with aligned approaches for DHHS' provider management team's work at the individual provider level. This entire process will take approximately 12-18 months. DHHS has set an internal goal to complete draft language by October 2022 and to begin public review and comment of the proposed rules by Jan 1, 2023. These specific dates are subject to change based on internal staff capacity and timing with other ongoing internal processes.

Prompts	Summary
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	*Current Status:* The Division of Program Quality and Integrity (DPQI) requires and reviews provider submissions of sentinel event reports pertaining to individuals receiving services in residential settings operated by a provider agency receiving DHHS funding, or to individuals in residential treatment directly receiving Community Mental Health Center (CMHC) - or other DHHS-funded services. DPQI offers a website open to the public that tracks Healthcare Effectiveness Data & Information Set (HEDIS) and other commonly used healthcare quality measures. In addition, PIU provides ongoing monitoring and oversight for adherence to administrative rules in the normal course of provider audits. There are also MCO requirements to ensure quality care across the network. Under the terms of its contract with the State, the MCO shall provide for the delivery of quality care with the primary goal of improving the health status of its Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status.

	(MCO Contract Exhibit A, Section 4.12.1.1) In contracts with its providers, the MCOs are required to ensure the providers' compliance with the health plan's clinical practices guidelines. (MCO Contract Exhibit A, Section 4.13.5.2.1) In addition, under terms of their contracts with the MCO, there is a requirement of the provider to notify the MCO within one (1) business day of being cited by any State or federal regulatory authority. (MCO Contract Exhibit A, Section 4.13.5.15.1.3)
	Future Status: PIU will develop a sampling of the enrolled sites to perform program integrity reviews at certain intervals to assess programs for compliance and claim submissions for accuracy. Further, PIU will then inform the Program area of any potential issues. PIU will develop the sampling methodology and review program during the first 12 months. During year two, PIU will conduct a pilot review process with a limited sample size. From years three to five, PIU will transition monitoring review to the appropriate Program area. As part of its monitoring capacity, DHHS plans to track several of the SMI Demonstration Monitoring Metrics identified by CMS as focusing on serious mental illness, such as *30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF).*
	Summary of Actions Needed: Program Integrity will become part of the on-going monitoring plan for these providers.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	*Current Status:* Psychiatric Hospitals: NH Administrative Code **He-P 802.18 Required Services** requires hospitals to complete discharge planning on all patients admitted to a hospital. Discharge planning shall include, as applicable: • The patient's medication needs upon discharge; • The need for medical equipment, special diets, or potential food-drug interactions; • The need for further placement in another health care hospital; • The need for home health services upon discharge; and

	• Discharge instructions and education shall be provided to the patient in writing. New Hampshire Hospital (NHH) and Hampstead Hospital comply with **He-M 311.06 Rights of Persons in State Mental Health Facilities** (a.) (3-7), which states that patients have the right to quality treatment in the least restrictive setting in accordance with the timeframe set forth in their individual service plan developed under **RSA 135-C:19** and the Joint Commission Comprehensive Accreditation Manual for Hospitals (January 2015) published by Joint Commission Resources, Inc. Joint Commission PC.04.01.03 EP 1-4, 10 requires discharge planning begins early in the patient's episode of care, treatment and services. The hospital identifies any needs the patient may have for psychosocial or physical care, after discharge or transfer. NHH's Social Work Discharge Planning standard requires that NHH's communication with the outpatient CMHC begin the first business day following admission. Transition Care plans are initiated at admission and updated as required based on assessment and as treatment planning progresses. CMHCs are expected to provide an appointment within 7 days of discharge for all discharged individuals and within 48 hours to those who were receiving Assertive Community Treatment (ACT) services prior to the most recent admission. CMHCs are also engaged in a directed payment program authorized through CMS and operating through DHHS MCO agreements. The directed payment arrangement is anticipated to advance the goals of the New Hampshire Quality Strategy by improving CMHP[4] payments which will help ensure and promote continued access to care. A focused measure for these payments targets those individuals discharged from a psychiatric stay who are seen the same day of, or the next day after, discharge. If a CMHC sees an individual within these times frames, they receive a payment. Each of the 10 regionally-based CMHCs have NHH liaisons. They receive notifications of an individual being admitted to NHH and engage in discharge planning and any other communications that need to be signed off on. Hampstead Hospital currently has policies and procedures in place to assure that discharge planning begins at the time of admission and that every patient leaves with access to a safe and appropriate discharge plan.

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

	Within 24 hours of admission every patient meets with a qualified Master's level social worker. As part of that initial meeting discharge planning is discussed with a focus on accessing quality services upon discharge. The social worker then begins collaborating with the patient, family members, community mental health supports and other resources to assure that upon discharge the patient has an appropriate aftercare plan. Upon discharge every patient and/or guardian receives a copy of the aftercare plan and a copy is also retained for the medical record. This is also reviewed verbally with the patient and/or guardian. The aftercare plan contains a list of all aftercare services being provided as well as contact information for these agencies. With the patient and/or guardian's consent aftercare providers may then receive additional information including but not limited to the following: discharge summary, psychiatric history, medication lists, assessments and the aftercare plan itself. The aftercare plan also includes discharge instructions and education. Every aftercare plan contains the patient's diagnosis and a list of all scheduled appointments. It allows the patient the opportunity to access services for substance use disorders services and tobacco cessation services. It also reviews advanced directives. In addition, at the time of discharge every patient and/or guardian meets with a member of the nursing staff. Both verbal and written instructions are given for medications. The need for medical equipment, special diets or potential food-drug interactions may also be discussed as relevant. If a patient is being transferred to another facility this is also written on the aftercare plan as well as discussed verbally with the patient and/or guardian. Hampstead Hospital currently has at least one discharge liaison from each of New Hampshire's community mental health centers. The liaisons are notified of every admission within 2 business days of admission. Additionally, MCOs play an important role in care transitions. Under the MCM Agreement, the MCO is required to maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management, including appropriate discharge planning for short-term and long-term hospital and institutional stays. (MCO Contract Exhibit A, Section 4.10.9.2) The MCO works with DHHS and the applicable Community Mental Health Provider to review Member cases that New Hampshire Hospital has indicated a difficulty returning back to the community, identify barriers to discharge, and develop an appropriate transition plan back to the community. (MCO Contract Exhibit A, Section 4.11.5.18.2.17)

	Future Status: New Hampshire Hospital and Hampstead Hospital will continue operation of current practices which already meet this milestone. The State plans to create new administrative rule language ensuring that all participating facilities in the demonstration also carry out intensive pre-discharge planning, and include community-based providers in care transitions. This will ensure that any new hospitals which join the demonstration must meet this milestone.
	Summary of Actions Needed: DHHS will draft new administrative rule language to specify that all hospitals participating in the demonstration must carry out intensive pre-discharge planning, and include community-based providers in care transitions. Once the new administrative rule language is drafted, DHHS will coordinate with the Administrative Rules Unit to finalize rule language and submit the rule for publication. Following a public comment period, the Rules Unit will bring the proposed rule change(s) in front of Joint Legislative Committee Rules for approval. After the administrative rule is formally filed with the Office of Legislative Services, DHHS will conduct outreach to providers and MCOs. DHHS updates the provider and other stakeholder communities, and the public on the progress of the IMD Demonstration, inclusive of public comment periods at key moments through its website. The promulgation of administrative rules includes public notice and hearings to allow agency adoption through Joint Legislative Committee on Administrative Rules (JLCAR). DHHS will specifically issue guidance to the MCOs regarding these administrative rule changes, along with any billing and coding instructions. These efforts will be joined with aligned approaches for DHHS' provider management team's work at the individual provider level. This entire process will take approximately 12-18 months. DHHS has set an internal goal to complete draft language by October 2022 and to begin public review and comment of the proposed rules by Jan 1, 2023. These specific dates are subject to change based on internal staff capacity and timing with other ongoing internal processes.
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	*Current Status:* As part of NH Administrative Code **He-M 802.18 Required Services,** hospitals are required to complete discharge planning that includes, as applicable: • The need for further placement in another health care hospital; and • The need for home health services upon discharge. NH Administrative Code **He-M 613.09 Admission to Transitional Housing Service** provides a path from NHH to Transitional Housing Service (THS) admission as long as applicants:

	• Have been referred from NHH or have been discharged from the THS within the 30 days immediately preceding application;
	• Are 18 years of age or older and have a primary diagnosis of:
	  • Psychiatric disorder or severe personality disorder; or
	  • Intellectual disability or pervasive developmental disorder as defined in DSM-5 with a secondary diagnosis of psychiatric disorder or severe personality disorder; and
	• Have an individual service plan specifying that he or she:
	  • No longer needs the level of care provided by NHH;
	  • Requires the degree of care and supervision available from the THS; and
	  • Has an identified goal of community placement.
	
	NH Administrative Code **He-M 403.06 CMHP Services and Programs** requires CMHPs to provide outreach to persons with mental illness who are homeless for the purpose of engaging such persons in the service system, provide individuals with services at emergency shelters, provide services within an individual's home, and collaboration with state and local housing agencies and providers to promote access to existing housing and the development of housing for persons with mental illness, including home ownership and rental options.
	
	NHH employs a full time Housing Specialist to assist social work staff with locating permanent independent housing for patients who are homeless. Social Work staff collaborate with Housing Specialists at the appropriate CMHC to refer patients who are being discharged to either temporary housing or to assist with locating permanent housing. Social Work staff are also required to provide assessment of each patient's need for level of supervision post-discharge and make appropriate referrals to programs offering those supports which may include independent apartments, community residences, transitional housing or long-term care (LTC) facilities.
	
	The State provides several supported housing programs to meet the targeted population need. The primary program, Housing Bridge Subsidy Program (HBSP), has established supported, subsidized housing for over 1,000 individuals under the Community Mental Health Agreement (CMHA). The HBSP prioritizes individuals ready for discharge from NHH, Glencliff Home, and Transitional Housing Programs. Additional prioritized individuals include those being served by ACT teams in the community who are homeless or at risk of becoming homeless due to their economic circumstances, and individuals served by CMHPs currently in community residences who are ready to transition into independent living.

	HBSP provides individuals with 1:1 assistance with locating and applying for rental opportunities, landlord-tenant relationship management, financial subsidy towards rent, and ongoing supports and access to mental health services (if desired by the individual). At least 400 individuals receive a State subsidy at any one time that, combined with the individual's own contribution toward rent, fulfill monthly rent payments and maintains the individual's access to the apartment. This also allows the individual to remain on a waiting list for traditional Housing and Urban Development (HUD) funded programs, other municipally administered programs, or until the individual's own income exceeds the HBSP's financial eligibility guidelines. Additionally, the State supports individuals who need more intensive supports and services to return to the community post psychiatric hospitalization through transitional housing programs (THP). These programs combine residential, therapeutic, vocational and other services and supports to further prepare individuals for independent living. Lastly, the State provides opportunities for individuals to live as independently as possible through the coordination of voluntary services and providing a choice of subsidized, integrated housing options. The Section 811 Project Rental Assistance (PRA) program provides project-based rental assistance for extremely low income persons within the target population linked with long-term services. The grant is administered in partnership with the DHHS and the NH Housing Finance Authority.
	Future Status: The State plans to create new administrative rule language ensuring that all participating hospitals assess beneficiaries' housing situations and coordinate with housing services providers when needed and available. Further, on June 21, 2021, the State submitted a 1915(i) Supportive Housing Waiver request to provide transitional and/or sustaining supportive housing services to eligible homeless and at-risk of homelessness HCBS individuals. The State responded to CMS' Request for Additional Information (RAI) questions on November 19th and is currently waiting for CMS feedback. If approved, the 1915(i) Supportive Housing Waiver is planned to go into effect on July 1, 2022.
	Summary of Actions Needed: DHHS will draft new administrative rule language to specify that all hospitals participating in the demonstration must assess beneficiaries' housing situations and coordinate with housing services providers when needed and available. Once the new administrative rule language is drafted, DHHS will coordinate with the Administrative Rules Unit to finalize rule language and submit the rule for publication. Following a public comment period, the Rules Unit will bring the proposed rule change(s) in front of Joint Legislative Committee Rules for approval.

	After the administrative rule is formally filed with the Office of Legislative Services, DHHS will conduct outreach to providers and MCOs. DHHS updates the provider and other stakeholder communities, and the public on the progress of the IMD Demonstration, inclusive of public comment periods at key moments through its website. The promulgation of administrative rules includes public notice and hearings to allow agency adoption through Joint Legislative Committee on Administrative Rules (JLCAR) vote. DHHS will specifically issue guidance to the MCOs regarding these administrative rule changes, along with any billing and coding instructions. This entire process will take approximately 12-18 months. DHHS has set an internal goal to complete draft language by October 2022 and to begin public review and comment of the proposed rules by Jan 1, 2023. These specific dates are subject to change based on internal staff capacity and timing with other ongoing internal processes.

Prompts	Summary
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	*Current Status:* MCOs conduct follow-up calls with their members who were admitted for a psychiatric stay. NHH previously had a follow-up call process that was ineffective as the number of patients reached was very low and duplicated efforts with MCOs. As part of their scope of services, the MCOs are obligated to maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management (TCM), including appropriate discharge planning for short-term and long-term hospital and institutional stays. **[42 CFR 438.208(b)(2)(i)]** TCM is further required in the contracts to include, at minimum: • Obtaining a copy of the discharge plan/summary prior to the day of discharge, if available, otherwise, as soon as it is available, and documenting that a follow-up outpatient visit is scheduled, ideally before discharge; • Communicating with the Member's PCP about discharge plans and any changes to the care plan; • Conducting medication reconciliation within forty-eight (48) business hours of discharge; • Ensuring that a Care Manager is assigned to manage the transition; • Follow-up by the assigned Care Manager within forty-eight (48) business hours of discharge of the Member; • Determining when a follow-up visit should be conducted in a Member's home; • Supporting members to keep outpatient appointments; and • A process to assist with supporting continuity of care for the transition and enrollment of children being placed in foster care, including children who are currently enrolled in the plan and children in foster care who become enrolled in the plan, including prospective enrollment so that any care required prior to effective data of enrollment Is covered. In addition, MCOs are required under Exhibit O – Reporting Reference SUD.42 “Emergency Department Discharges for SUD: MCO Contacts and Contact Attempts” to provide a count and percent of members discharged from an Emergency Department (ED) with a substance use disorder (SUD) diagnosis during the measurement period, where the MCO either successfully contacted the member, or attempted to contact the member at least 3 times, within 3 business days of discharge by subpopulation. The MCOs produce a quarterly report that outlines all of their members who have been re-admitted during the quarter within a 30-day and 180-day window. This report is reviewed with the BMHS and cases with high re-admissions and

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

2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	*Current Status:* Division for Behavioral Health (DBH) receives a daily ED waitlist from NHH identifying all individuals – not just Medicaid beneficiaries – awaiting psychiatric beds in the State (self-pay, private insurance, etc.), which is distributed to an array of stakeholders including the MCOs. MCOs are required to review the daily ED waitlist to identify alternative bed solutions and intensive community treatment options for their members. They also have weekly meetings with DBH to report out on the status of members waiting. MCOs also engage in single-case agreements for providers out of network to support alternative bed solutions when necessary. MCOs are required to provide a monthly report on the number of its members awaiting placement in the ED or in a hospital setting for twenty-four (24) hours or more; the disposition of those awaiting placement; and the average length of stay in the ED and medical ward for both children and adult members, and the rate of recidivism for Psychiatric Boarding.
	Future Status: DBH is working to increase the number of non-hospital-based psychiatric beds such as Recovery-Oriented Step Up and Step Down beds. These beds can be used to support an individual in need of increased supports in order to avoid a psychiatric stay or to step down from a psychiatric stay. DBH is contracted with all 10 of the regionally based CMHCs to increase the number of community-based supported housing beds in each region. **Critical Time Intervention.** CTI is a time-limited, evidence- and community-based practice that mobilizes support for individuals with serious mental illness during vulnerable periods of transition (e.g., discharge from a psychiatric hospital). CTI providers will work with transitioning individuals to ensure they successfully reintegrate into their home communities. This can entail a broad range of assistance, from helping an individual secure employment, housing, or food; to identifying and accessing mental or physical health care; to reconnecting with family, friends, and peers to ensure strong, supportive relationships. **Transitional Bed Capacity.** By increasing transitional bed capacity in the State, the Hospital will be able to discharge individuals who no longer require hospital LOC and therefore accept more individuals from the ER into the Hospital. **First Episode Psychosis (FEP) Programs.** The state is targeting workforce development to support the staffing of the 3 newly established programs as well as maintaining the Nashua region based program for

	FEP. By increasing the availability of FEP programs throughout the state, NH increases the likelihood of identifying an individual during their first psychotic episode and providing intense, targeted services that lead to a decrease in psychiatric hospital stays.
	Summary of Actions Needed: DBH plans to increase the number of community-based supported housing beds in each region as contracted. **Critical Time Intervention.** The State is working to implement CTI statewide, with the near-term goal of mitigating the overflowing demand on the State hospital system. Phase one CMHCs are in the process of finalizing their content, staffing, and training materials and will launch CTI services in January 2022. Strategy development for contracts with the phase two CMHCs has begun, and CTI will be launched across all 10 CMHCs by July 2022 14.2. **Transitional Bed Capacity.** Funding was provided in the SFY 20-21 State budget to construct 40 new transitional housing beds. Philbrook Adult Transitional Housing (PATH) accepted its first client on September 14, 2020 and has served 58 clients as of August 25, 2021. The State is in the process of executing a contract amendment with the ten community mental health centers to stand up a minimum of 6 new supported housing beds per region including, but not limited to, transitional or community residential beds. It is anticipated that these beds will become available between April-December 2022. 14.3. **First Episode Psychosis (FEP) Programs.** Starting in July of 2021 three additional FEP programs within the Derry, Seacoast, and Monadnock regions began standing up their services. Standing up these programs is a lengthy process due to the extensive training required to implement this evidence-based practice (EBP). These programs began accepting clients in January 2022, and are now continuing with the intensive EBP training and consultation process which typically runs for 8-12 months.
2.e Other State requirements/policies to improve care coordination and connections to community-based care	*Current Status:* Administrative Code **He-M 405.12 Services to be Provided** requires case coordination services from either the CMHC or DRF staff upon admission to a DRF and continuing through discharge. NH is undergoing the early stages of an Event Notification System (ENS) implementation, which connects a patient's entire care team — including hospitals, primary and specialty care, post-acute care, behavioral health providers,

	community service organizations, and health plans — by offering real-time patient insights that power better decision-making for improved patient outcomes. DHHS encourages education on safe practices for discharging of mental health individuals between clinical teams and mental health professionals. MCO contracts have quality and oversight reporting requirements for "member discharges from a community hospital with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a mental health practitioner within 7 calendar days of discharge".
	Future Status: The ENS implementation requires more complete engagement from all stakeholders in the state to fully utilize the benefits to coordinate care. All EDs, DRFs, CMHCs, and NHH will enter data necessary to expedite care as patients move between levels of care.
	Summary of Actions Needed: The State has drafted and is conducting final review of an advanced planning document to support the design, development, and implementation of the event notification system as a statewide initiative to support improved care coordination. As part of this implementation, DHHS plans to leverage the Contractor for provider engagement and interoperability. This will also include the implementation of a steering committee for the network of event notification and outcome-based referrals. This committee will provide governance and approvals for enhancements. A provider network user group committee will also support the continued growth and enhancement recommendations.

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	

<table>
<tr>
<td rowspan="3">3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.</td>
<td>Current Status:
Since 2013 the State has operated a Medicaid Managed Care Program for Medicaid eligible beneficiaries delivered through commercial MCOs with several minor carve-out populations. Currently, DHHS contracts with three MCOs that provide Medicaid benefits, including behavioral health services, to recipients in exchange for a monthly payment from the state. In addition to providing Medicaid benefits to eligible recipients, the MCOs are also required to ensure the availability of mental health providers.

MCOs manage and ensure all members receive primary behavioral health care through PCPs and other practitioners connected with a variety of community-based providers. MCOs are required by contract to meet network adequacy standards for all geographic regions and provider types (e.g. PCPs, specialists, family planning providers, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), hospitals, and mental health and SUD providers).
• Each MCO is required to prepare and submit a Participating Provider report during the Readiness Review period in a format prescribed by DHHS for determination of the MCO's network adequacy. The report identifies fully credentialed and contracted providers and prospective participating providers.
• MCOs are required to confirm their provider networks with DHHS and post them to their websites within 30 days of the member enrollment period.
• MCOs are subject to corrective action plans to restore network adequacy.
• MCOs are required to provide the count and percent of member requests for assistance accessing MCO Designated Primary Care Providers per average 1,000 members by county on a quarterly basis.
• Should providers give notice, have been issued notice, or left the MCO network, MCOs are required to provide the number of members impacted, impact to network adequacy, and transition plan if necessary.

The network adequacy standards in the State are outlined in the MCO contracts, including but not limited to:
• Requirements regarding having Participating Providers in sufficient numbers, and with sufficient capacity and expertise for all covered services.
• Requirements to maintain an adequate network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.</td>
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<tr>
<td>Future Status:
DHHS will monitor the provider network through the annual completion of the CMS-designated Provider Availability Assessment Template.</td>
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<tr>
<td>Summary of Actions Needed:
By completing the CMS-designated Provider Availability Assessment, the State will fulfill the requirements of this milestone.</td>
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Prompts	Summary
3.b Financing plan	*Current Status:* Please refer to Financing Plan below.
	Future Status: Please refer to Financing Plan below.
	Summary of Actions Needed: Please refer to Financing Plan below.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	*Current Status:* DHHS currently tracks psychiatric beds in a public daily, point-in-time report of DRF. Information tracked includes the following: • Facility name; • Total number of Involuntary Emergency Psychiatric Beds; • Current Unit cap; • Available Involuntary Emergency Psychiatric Beds; and • Number of Adults or Individuals Waiting for a DRF Bed. In addition to the public report, DHHS also maintains a Bed Inventory that tracks hospital-based voluntary beds. The State of NH also currently utilizes a web-based portal for bed tracking. NHH admissions staff play a key role in bed tracking and communicate with Emergency Departments (ED), Emergency Services Clinicians, and DRFs multiple times throughout the day regarding queue updates. NHH staff call every ED several times each day to confirm if patients referred to NHH are still waiting for a DRF bed. Staff also call all DRFs each day to determine unit census and bed availability, and update this data daily on the DHHS website.
	Future Status: The State of NH will continue utilizing a web-based portal for bed tracking to monitor various types of bed capacity throughout the state. In the short-term, NHH and Hampstead Hospitals will be the only IMDs participating in the demonstration and will continue to communicate daily with EDs and DRFs regarding the waitlist and bed availability.
	Summary of Actions Needed: DHHS is exploring options with one or more additional IMD provider(s) to build a facility in the State and anticipates that this additional capacity will mitigate the need for waitlisting individuals.

3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	*Current Status:* DHHS requires an Adults Needs and Strengths Assessment (ANSA), or an equivalent evidence-based tool, to be completed for every adult. These requirements are incorporated into MCO and CMHC contracts, which require initial and updated care plans to be based on a comprehensive assessment conducted using an evidenced-based assessment tool such as the NH version of the Child and Adolescent Needs and Strengths (CANS) and the ANSA. These assessments inform individualized treatment planning and level of care decision making. Individuals are reassessed on a routine basis with adjustments to level of care and or treatment plan being made accordingly. The ANSA also informs individual service needs and level of care that could include inpatient and/or residential services. As part of the State's rollout of the federal 9-8-8 behavioral health crisis number, BMHS launched an initiative (described further in 3.e) to redesign and centralize the State's crisis response system into a program called the Rapid Response Access Point. Part of this program's responsibilities is to provide an initial assessment for each individual who calls to determine the nature of crisis. The operator engages each individual in brief phone-based counseling and intervention to determine the individual's appropriate level of need, and to attempt to resolve each situation using tools such as the Patient Health Questionnaire 9 for Depression (PHQ-9), the Mood Disorder Questionnaire (MDQ), the Adverse Childhood Experiences (ACEs) questionnaire, a lethality assessment tool, the Drug Abuse Screening Test (DAST-10), an alcohol use disorder identification test, and other recognized tools for determining the nature of a behavioral health crisis. In addition to the tools above, the state has also contracted with a vendor to provide Comprehensive Assessments for Treatment (CATs) to determine whether children, youth, or young adults are in need of behavioral health residential treatment services and the least restrictive and most appropriate level of care. The vendor is required to conduct interviews using other behavioral health screening tools including, but not limited to: Columbia Suicide Severity Rating Scale (C-SSRS); Patient Health Questionnaire-9 (PHQ-9); Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT); and Juvenile Sex Offender Protocol (JSOP). *Future Status:* The State plans to complete 9-8-8 integration by the national integration date of July 16, 2022.

	Summary of Actions Needed: N/A – milestone met.

Prompts	Summary
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	*Current Status:* Currently only three regions operate mobile crisis response teams for adults with mental illness. As referenced in Topic 5. Financing Plan, DHHS has entered into a contract to establish and operate a centralized access and crisis call center via a single, statewide telephone number for individuals experiencing a mental health and/or substance use disorder crisis. The Rapid Response Access Point (RRAP) is now live. RRAP receives telephone calls, text messages, and two-way real-time chat, provides clinical crisis resolution services, and acts as a triage center for mental health and/or substance use disorders crises. The Access Point operates twenty-four hours per day, seven days per week. The contractor performs centralized triage of incoming calls, texts, and chat messages, conducts initial assessments, brief interventions, and deploys mobile response teams to the caller's location when necessary. The contractor also coordinates with regional crisis services, develops training curriculum, trains the Rapid Response workforce, and provides data collection services to promote consistency and quality. The Rapid Response Access Point serves NH residents of any age, statewide, who may be experiencing a mental health and/or substance use disorder crisis. Approximately 30,000 callers to the Access Point are expected to be served in SFY22 and SFY23.
	Future Status: DHHS has recently included a statewide integrated mobile crisis response teams in crisis services. These teams will be expanded from three (for adults) to ten for all ages. All ten CMHCs will enhance their crisis services to ensure the delivery of integrated mobile crisis response services to individuals experiencing mental health.
	Summary of Actions Needed: The State signed a contract with all ten CMHCs in June 2021 to provide statewide enhanced mobile crisis services. CMHCs have begun accepting deployments as of 1/1/2022 and are expected to fulfill the contract requirements for the mobile crisis services from this point on. Going forward, the Bureau of Mental Health Services will continue to monitor these services and issue corrective action plans if necessary.
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	

Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	

4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs	*Current Status:*
	NH DHHS has several strategies to engage beneficiaries with and at risk of SMI/SED in treatment sooner. The State, CMHCs, and private providers work together to provide a comprehensive system of care for early identification and engagement in treatment. A summary of strategies and initiatives across integrated service delivery, special education, supported employment, vocational rehabilitation, and supported housing is outlined below.
	
	System of Care Strategy / Initiatives.
	In 2016, New Hampshire passed Senate Bill 534, the System of Care (SOC) law, a major policy initiative of the Children's Behavioral Health Collaborative, which embedded the system of care approach and accompanying values in **RSA 135-F System of Care for Children's Mental Health**. The law requires the State to develop and maintain an integrated and comprehensive service delivery system for children with behavioral health needs. Ten CMHCs and other BH providers participate in the SOC initiative. Major initiatives under SoC include, but are not limited to:
	• **DHHS Initiatives**
	  • NH Families and Systems Together (FAST) Forward for Children and Youth: Awarded by SAMSHA to DHHS in 2012, this program supports the expansion and sustainability of a state-level SOC for children, youth, and their families in seven school districts. As of 2017, FAST Forward has been supported by a Care Management Entity (CME) that provides services for the FAST forward program including, but not limited to: oversight and care coordination for children and youth entering/exiting psychiatric hospitalization and/or residential treatment, wraparound coordination and coordinator training, provision of youth peer support, and provision of stipends for customizable goods and services. The CME also contracts with many qualifying provider agencies to ensure children, youth and families have what they need when they need it. In the past year, DHHS has expanded from one contracted CME to two.
	• **Department of Education (DOE) Initiatives**
	  • Adoption of NH DOE's MTSS-B model[5] through a SOC grant (awarded 2016), which includes comprehensive early access screening, an integrated delivery system, a tiered prevention network, and other non-Medicaid billable services.

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

	• **Project Aware (2014-2020)**[6] which expanded MTSS-B to an additional 12 schools and early childhood settings in NH's North Country and Lakes Region. • **School Climate Transformation Grant (2019-2024):** The NH Department of Education, through its SEA School Climate Transformation Grant, has two primary goals: 1) to develop, enhance, and expand a statewide system to support the use of NH's MTSS-B model by Local Education Agencies (LEAs) to improve school climate and 2) to support the use of best practices to promote positive school culture and climate across the state through partnerships between local communities and Office of Social & Emotional Wellness staff, especially MTSS-B consultants, and local communities. During the reporting period, considerable progress was made in advancing these goals including developing and launching the first ever train-the-trainer for NH's MTSS-B model, recruiting and hiring state-level MTSS-B consultants, and delivering evidence-based external coaching support to numerous local school districts. **Special Education.** Under the provision of the Individuals with Disabilities Education Act (IDEA) youth who are placed in a special education program because of a SED must have an Individual Education Plan (IEP). Many CMHC staff and programs affiliated with systems of care are actively involved in supporting families and children for whom an IEP is needed. In addition, DHHS supports DOE with supported employment and programs: **Supported Employment.** NH CMHCs deliver the following employment-related services: • Rehabilitation for Empowerment, Education, and Work (RENEW) intervention with fidelity to transition-aged youth who qualify for state-supported community mental health services, in accordance with the UNH Institute on Disability model. • CMHCs provide the following Evidence Based Supported Employment (EBSE) services, in accordance with the SAMHSA/Dartmouth Individual Placement and Support (IPS) model, to eligible individuals: o Job development; o Work incentive counseling;

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

	o Rapid job search; and o Follow along supports for employed clients. The NH Bureau of Vocational Rehabilitation (BVR), under NH DOE, assists eligible NH citizens with disabilities to secure suitable competitive integrated employment and financial and personal independence by providing rehabilitation services. Services are provided through seven BVR offices. Vocational rehabilitation has a long history of providing direct and indirect services to youth with disabilities as they transition from school to work. The Bureau is committed to increasing access and improving the overall quality of services offered to school age youth. Additionally, BVR has established a partnership with CMHCs and funded a full-time Work Incentive Benefits Counselor at each of the 10 CMHCs. The benefits counselors assist individuals with mental illness who are pursuing employment to complete applications for vocational rehabilitation services and engage in EBSE. The counselors conduct comprehensive incentives counseling to inform individuals of the impact different levels of income will have on existing benefits and what specific work incentives options individuals might use to increase financial independence, accept pay raises, or increase earned income. **Supported Housing.** CMHCs complete eligibility for individuals in accordance with **He-M 401 Eligibility Determination and Individual Service Planning**[7] and complete applications for Public Housing, Section 8 subsidy, and Project Rental Assistance (PRA) 811, according to their respective rules, requirements, and filing deadlines. Housing staff are located in all regions of the state to provide housing support services. This includes coordinating with and developing relationships with landlords and other vendors that provide services to individuals receiving the Housing Bridge Subsidy and coordinating housing efforts with DHHS and the New Hampshire Housing Finance Authority. CMHCs also provide supported housing services through a variety of options that range from independent apartments to community residences. DHHS has contracted with a Community Mental Health Center to expand the Housing Bridge program for individuals with mental illness who transitioned out of the criminal justice system. The contract enables these individuals to access the Housing Bridge program for a longer period than individuals would typically remain on the program based on their anticipated entrance into long term housing subsidy programs, such as HUD's Section 8. It has been in place for more than two years and approximately 20 individuals had received housing subsidies to occupy their own leased apartment.

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

	Transitional Housing / Continuum of Care Program. The NH Division of Economic and Housing Stability (DEHS), in collaboration with Housing and Urban Development (HUD), have established a Continuum of Care (COC) program designed to assist individuals (including unaccompanied youth) and families experiencing homelessness and to provide the services needed to help such individuals move into transitional and permanent housing with the goal of long-term stability. NH has three COCs: Harbor Homes (Greater Nashua), Families in Transition (FIT; Manchester) and Bureau of Housing Supports (BHS; Balance of State). **Transitional Housing / PATH.** NH DEHS also receives federal funding for SAMHSA Projects for Assistance in Transition from Homelessness (PATH) that provides homeless street outreach for individuals experiencing homelessness who have a diagnosis of SMI.
	Future Status: NH DHHS will continue operation of existing services. **System of Care Strategy.** In accordance with both **RSA 135-F**, which established the SOC, and **RSA 132:13**, which supports services for maternal and infant needs, NH DHHS and stakeholders participated in an infant and early childhood finance strategy technical assistance group through the Zero to Three national policy organization. This work included a work plan on how NH would address and finance these initiatives. The goals are to develop a comprehensive Medicaid benefit to address the needs of infants and young children who have been identified as at risk and who require treatment and support for themselves and their primary caregiver. This Medicaid Benefit will amend NH's current 1915i State Plan Amendment to include the 0-5 age group and their caregivers (known as Fast Forward in NH). There are 2 proposed amendments to the current Care Management Entity (CME) contracts, which will serve as the intermediary to deliver this new programming. The components of the Infant Mental Health Programming will include Enhanced Care Coordination (ECC), and Evidence based practices (EBP)- such as Child Parent Psychotherapy (CPP). There is a training schedule to increase the ability for the workforce to appropriately diagnose this age group and more effectively meet their targeted treatment needs with both Diagnostic Criteria (DC 0-5) and CPP. There will be an additional component within the program for an in-home/home visiting model for the highest level of need within the enrolled clients. The CME contracts amendments are targeted for approval by May 2022. This will allow for services to begin with clients by July 2022.

	Summary of Actions Needed: N/A – milestone met.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	*Current Status:* Currently, the State operates the ProHealth NH grant (2019 through 2024) which aims to improve primary and behavioral health service delivery in NH with the following highlights (as of September 2020) related to integration of behavioral health care in non-specialty settings: • Integrated primary and behavioral health care is available at community mental centers for youth and young adults in three of ten regions in NH, with nearly 250 (249) individuals ages 16 to 39 years served in the first year and half of enrollment. • All individuals enrolled and receiving integrated services through ProHealth NH are receiving mental health services. • The CMHCs and FQHCs collect individual health and demographic information to improve outcomes. • The BMHS, CMHCs, and FQHCs have 20 additional full time equivalents of staff time collectively to augment Medicaid and insurance reimbursement in support of integration activities. • Staff are cross-trained in evidence-based whole-person health. Over 1,200 (1,201) staff from health settings across NH participated in 115 training opportunities, including two conferences in collaboration with the Integrated Delivery Network. • Integrated teams continuously improve services with peer experts and quality improvement staff. • State and regional plans, policies, and procedures include language to support integrated care. Efforts to sustain integration have resulted in 46 policy-related changes throughout the partnerships and at the state. • Tobacco interventions are available, including web-based motivational enhancement for tobacco and vaping prevention, Breathe Well Live Well in person or virtually, Quitline NH by phone, and Mylifemyquit via the web. • Fitness and nutrition interventions are available, including Healthy Choices Health Changes in person and virtually and the Weight Watchers and Myfitnesspal web apps. • An integrated care sustainability plan has been drafted by the ProHealth NH Administrator in collaboration with the partnerships and is being used to inform ongoing sustainability. Each partnership has completed their own individual sustainability plans, which are actively being utilized for their individual sites. • The CMHCs and FQHCs deliver high quality integrated care, including evidence-based screening,

	collocation, team meetings, health and wellness goals in treatment plans, integrated shared plans, population health initiatives, and evidence-based interventions. • The CMHCS and FQHCs provide whole health services in person and virtually using telehealth technology. • The CMHCs staff peer experts and community health workers that represent the diverse individuals served. **Behavioral Health Integration in School Settings.** Funding opportunities through DOE have worked to expand the number of mental health staff integrated in school settings. The presence of community mental health providers as a "regular" part of the school community and culture was viewed as reducing mental health stigma. Students openly talked with each other about seeing school-based mental health providers. NH AWARE was also credited, along with other MTSS-B and SOC initiatives, with contributing to a more supportive community and state policy environment. Stakeholders reported that these projects, by bringing together schools and communities via Community Management Teams and other collaborations, improved community awareness and support for social and emotional learning (SEL) and children's behavioral health. This, in turn, was viewed as supporting passage of the "System of Care" bill (**RSA 135-F**), which requires NH DOE and DHHS to work together to create a better, more cohesive system of care for NH youth with behavioral health needs. The State contracts with MCOs that are required by contract to screen for mental health conditions: • MCOs are required to make a Welcome Call to new members within 30 calendar days, which should include a screening for depression, mood, suicidality, and Substance Use Disorder (SUD). • In addition, MCOs are required to ensure that providers under contract to provide SUD services shall conduct an Initial Eligibility Screening for services as soon as possible, ideally at the time of first contact with the member / beneficiary. If screened positive, members will receive an ASAM LOC Assessment and a clinical evaluation. • MCOs are required to conduct a Health Risk Assessment (HRA) Screening of all existing and newly enrolled members within 90 calendar days to identify members with unmet health care needs and/or special health care needs. Part of this health screen must include, at minimum, questions about behavioral health needs including "depression or other Substance Use Disorders" [*sic*].[8] The State's

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

	MCO contracts include rewards (incentives) for high performance and penalties (liquidated damages) for low performance on completion of the HRA Screening. • MCOs are also required to help members arrange Wellness Visits with the members' PCPs which include a) appropriate assessments of both physical and behavioral health and b) screening for depression, mood, suicidality, and SUD.
	Future Status: In addition to the continued operation of the same programs above with participating centers, the State also plans to explore implementing the Certified Community Behavioral Health Clinic (CCBHC) model across NH as part of an approach to extend ProHealth-like capabilities across the state in a sustainable way. The State issued an RFP on March 7, 2022 seeking a vendor to study the readiness, capability, and cost-effectiveness of implementing a CCBHC model of services across the NH community mental health system. Responses are due on April 19, 2022.
	Summary of Actions Needed: N/A – milestone met.

Prompts	Summary
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	*Current Status:* **NH Crisis Response System.** As referenced in the Provider Availability Assessment Template and in F.a, the State presently has crisis stabilization services which include but is not limited to: • **33 Crisis Call Centers** – Including emergency services hotlines at the CMHCs, Mobile Crisis Response Team hotlines, Lifeline Hotlines, Doorway Numbers, and National Hotlines advertised in NH (Veterans Crisis, Trevor Project, Crisis Text Line, Translifeline, Disaster Distress Helpline, LGBT National Help Center, and 9-1-1). • **3 Mobile Crisis Units (MCU)** – There are three mobile crisis units in Nashua, Concord, and Manchester with ongoing plans to expand to all 10 CMHCs within the next year. Each unit is staffed with 24/7 available teams that may receive referrals, and respond to/with, first responders and law enforcement staff of the applicable community. This communication is bidirectional; each unit can support, or be supported by, local law enforcement. • **Drug and Mental Health Courts –** The State has specialty court programs for offenders with substance abuse or mental health diagnoses, which are available in various Superior and Circuit Court District Division locations in New Hampshire. These treatment courts combine community-based treatment programs with strict court supervision and progressive incentives and sanctions. By linking offenders to treatment services, these programs aim to address offender's substance abuse and mental health diagnoses that led to criminal behavior, thereby reducing recidivism, and protecting public safety. These treatment court programs are designed to promote

	compliance with treatment programs as an alternative to jail time. • **4 Crisis Observation/Assessment Centers** –Each MCU has four corresponding crisis apartment beds. Additionally, one standalone Behavioral Health Crisis Treatment Center (BHCTC) provides emergency services with limited walk-in capacity. • **1 Coordinated Community Crisis Response Teams** – The State maintains a Disaster Behavioral Health Response Team. The Governor or designee at the Department of Health and Human Services-Emergency Services Unit activates this team during Federal or State Emergencies. If an emergency is not declared, local municipalities or emergency response systems may request assistance in order to meet the behavioral health needs of communities in local crises. **NH Rapid Response Model.** The State is in the process of implementing a Rapid Response Model with one statewide access point & call center that provides initial assessments, de-escalation and resolution services, mobile rapid response dispatch services, referrals to location-based face-to-face rapid response services, post-crisis support, and referrals for ongoing services through the Doorways and outpatient mental health and SUD providers. In this model, staff are mobile/deployed to facilitate community-based face-to-face interventions. This would ensure availability of a location-based, drop-in behavioral health treatment location, allowing for stays of up to 23 hours for crisis intervention. The State has contracted with a vendor that was selected through a competitive Request for Proposals (RFP) process. **NH COVID-19 Rapid Crisis Response Program (NH Rapid Response).** As mentioned below in F.a, in April 2020 NH was awarded temporary funding due to COVID-19 from SAMHSA to expand crisis response services for children, youth, and adults.
	Future Status: **Statewide Mobile Crisis Services for Children.** The State has amended all ten CMHC contracts to expand mobile crisis services statewide for all ages. As of January 2022, the new CMHC contracts are in effect, including statewide mobile crisis services in all ten regions, inclusive of all age groups. This expansion is in alignment with the statewide New Hampshire Rapid Response crisis transformation plan which includes integrated crisis services for all populations across the state. **Expansion of Residential Treatment.** From June – September 2021, DHHS signed contracts with 16 vendors to provide behavioral health residential treatment services for children, youth and young adults to stabilize their behavioral health. The Residential Treatment programs are contracted and/or certified for the provision of residential treatment for children from DCYF or BCBH. Programs certified prior to the September 2021 contracts already have established licensing. Newly contracted programs, including programs which were previously licensed that have been awarded contracts and are seeking certification, as well as the newly established programs, are currently in the process of being certified as a part of the initial

	stages of implementation. There are: 83 certified programs, of those 83 programs 44 are contracted (16 vendors) and of those 44 contracted programs, 32 are in New Hampshire and 12 are in New England. There are two new programs which are seeking licensure in New Hampshire and those will encompass two 12 bed programs; the remainder of the New Hampshire and New England contracted programs have existing licenses. The procurement of the residential treatment contracts was intended to reduce the use of psychiatric, emergency room or national providers. There were 496 beds contracted for in the last procurement, with 16 beds already under contract in a separate procurement, resulting in 512 total beds under contract with DHHS. Residential treatment in New Hampshire has historically been available only through DCYF and school districts. The system itself has focused on the concept of placement and education with a lower level of care for the treatment aspect of this service. By aligning the delivery with the Families First Prevention Services Act (FFPSA) guidance, residential treatment in New Hampshire can be transitioned to a model of effective shorter-term treatment and stabilization in the system of care that is available to all children and youth who require that level of care without engaging with DCYF. This is also intended to help children and youth avoid or decrease the use of psychiatric hospitals or emergency rooms.
	Summary of Actions Needed: In general, NH DHHS will need to conduct ongoing monitoring to ensure that the contracts for the new structures and programs described above are implemented in a high-quality manner. Residential treatment services shall be licensed and certified within 6 months from contract approval, unless otherwise agreed upon by DHHS.
4.d Other state strategies toincrease earlier	*Current Status:* Aside from the programs, strategies, and initiatives already mentioned, NH DHHS has implemented the following state strategies.

identification/engagement, integration, and specializedprograms for young people	**The First Episode Psychosis (FEP)/Early Serious Mental Illness (ESMI) Initiative.** Bureau for Children's Behavioral Health (BCBH) and BMHS are in the process of planning a needs assessment and work with stakeholders to identify a model for statewide implementation of a First Episode Psychosis specialty care program. In the meantime, the State maintains the Nashua region based program for First Episode Psychosis (FEP). Starting in July of 2021 three additional programs within the Derry, Seacoast, and Monadnock regions began standing up their services. By increasing the availability of FEP programs throughout the state, the State will increase the likelihood of identifying an individual during their first psychotic episode and providing intense, targeted services that lead to a decrease in psychiatric hospital stays. **Creating Connections NH: A treatment and recovery system of care for youth and young adults with substance use disorders (SUD) or SUD with co-occurring mental health disorders.** This initiative is funded through a Cooperative Agreement between BCBH and the Adolescent and Transitional Aged Youth Treatment Implementation grant program administered by SAMHSA. Awarded in 2017, the grant supports evidence-based SUD assessment, treatment, and recovery services for youth aged 12-25. The NH Bureau for Children's Behavioral Health leads the project in collaboration with family, youth, research, and content experts. **Launch Manchester.** Coordinated by a local FQHC, Launch (Linking Actions for Unmet Needs in Children's Health) promotes the well- being of children (birth through age 8) and their families in collaboration with multiple local child and family serving agencies. The primary strategies employed by Launch are: improving access to high-quality early education and care; empowering families; identifying and mitigating the effects of Adverse Child Experiences; and improving access to health, behavioral health, and specialized medical services. In 2019, Launch Manchester developed an Early Learning Collaborative of 12 early childhood programs and the Manchester School District to support transitions into kindergarten, implement developmental screenings, and facilitate access to appropriate supports. The hope is that coordinating transitions will maximize the preservation and expansion of academic and developmental skills these children have attained in early childhood settings. Also in 2019, Launch laid the groundwork for a public awareness campaign through early childhood settings, primary care offices, hospitals and other public spaces. **Mobile App GoodLife.** DOE has partnered with a technology company to begin the planning and development of GoodLife, a mobile application designed to build and strengthen student social and emotional resilience. The GoodLife app's design will ensures that all students across New Hampshire and their families have access to evidence-based resilience cultivation tools. It aligns with the SOC values by providing a youth-driven platform where adolescents are empowered to set goals, join communities of support, and share positive messages with their peers. The app will additionally be trauma-informed in accordance with the SOC values, and builds resilience skills in youth such as empowerment, support, commitment to learning, and positive identity. The app will allow students to join communities, set physical and emotional development goals, and send and receive positive feedback. The GoodLife app is built on the Search Institute's 40 Developmental Assets for Adolescents, a list of research-based, positive experiences

	and qualities that influence young people's development, helping them become caring, responsible, and productive adults. GoodLife anonymizes the identity of users, and does not collect any personally-identifiable information. GoodLife is available free to all NH youth and their families through Google Play and the Apple App Store. **Project GROW.** Through a Learning Community effort known as Project GROW (Generating Resilience, Outcomes, and Wellness), the NH DOE's Bureau of Student Wellness – Office of Social Emotional Wellness (OSEW) has been providing expert training, consultation, and technical assistance to school districts in MTSS-B aligned, trauma-responsive practices, including district-wide systems change, school-level adoption of new practices and procedures, classroom-level instructional and student support techniques, and individual teacher and specialist professional development. These Project GROW efforts are all designed to promote student social and emotional safety, and thus contribute to the Children's SOC ecosystem.
	Future Status: N/A – milestone met.
	Summary of Actions Needed: N/A – milestone met.

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and	*Current Status:* **NH Crisis Response System.** As referenced in the Provider Availability Assessment Template and in 4.c (in greater detail), the State presently has crisis stabilization services which include but is not limited to: • 33 Crisis Call Centers • 3 Mobile Crisis Units (MCU) • Drug and Mental Health Courts • 4 Crisis Observation/Assessment Centers • 1 Coordinated Community Crisis Response Teams To build upon the existing system, the State has recently invested in the following coordinated crisis response

other first responders.	initiatives: 1. **NH COVID-19 Rapid Crisis Response Program (NH Rapid Response).** In April 2020, NH was awarded temporary funding due to COVID-19 from SAMHSA to expand crisis response services for children, youth, and adults. The $2M Rapid Response grant award addresses the needs of uninsured or underinsured individuals with SMI/SED or SUD through the State's existing community mental health system which includes the 10 CHMCs. The program also provided crisis services for other individuals in need of behavioral health supports, including health care personnel. 2. **Centralized Access and Crisis Call Center.** The State has allocated $9.2M through SFY23 in support of establishing and operating a centralized access and crisis call center via a single, statewide telephone number for individuals experiencing a mental health and/or substance use disorder crisis. 3. **Mobile Crisis Teams.** The State has allocated $13.2M annually toward the statewide expansion of mobile crisis teams from three to ten teams for SFY22 and SFY23. The expanded statewide service will serve all populations to address all behavioral health needs. The state has promoted access and coordination through the following changes in funding and reimbursement: 1. **Directed Payments.** NH DHHS received authorization from CMS to pay interim enhanced rates to eligible CMHPs for select adult services to improve access and coordination. These directed payments were effective in SFY19 and SFY 20 and subject to the following limits in each state fiscal year: a. $3M – Assertive Community Treatment (ACT) Services – payments to improve access and support ACT program fidelity. b. $1.2M – NHH Discharges – payments for a face-to-face service the same-day/next-day of discharge from NHH to enhance care coordination for transitions. c. $200K – Specialty Residential Services – to support specialized services for individuals who have co-occurring mental health and developmental disabilities. d. $600K – Mobile Crisis Teams – to support face-to-face crisis response services provided by mobile crisis teams (e.g., MCUs). 2. For SFY21, the directed payments were as follows: a. $3M– ACT – to strengthen and maintain fidelity to enhance quality of care. b. $1.2M – NHH Discharges – to reduce the 30-day and 90-day readmission rates. c. $200K – Specialty Residential Services – to improve quality of care by encouraging inpatient discharge when medically appropriate for patients with co-occurring disorders and DD who need a less acute level of care. d. $600K – Mobile Crisis Teams – crisis intervention for adults with primary mental health but also those with co-occurring mental health and substance use disorders. 3. For SFY22, the directed payments are as proposed (subject to CMS approval): e. $2.4M – ACT – to strengthen and maintain fidelity to enhance quality of care.

	f. $1.2M – NHH Discharges – reduce the 30-day and 90-day readmission rates to a DRF or NHH. g. $650K – Timely Prescriber Services Following Intake – to reduce ED visits and readmissions by emphasis on early contact upon intake. h. $600K – Illness Management and Recovery Services (IMR) – to reduce ED visits and readmissions. i. $200K – Specialty Residential Services – to improve quality of care by encouraging inpatient discharge when medically appropriate for patients with co-occurring disorders and DD who need a less acute level of care.
	Future Status: The State has implemented a system transformation for statewide integrated crisis response services (NH Rapid Response). This transformation includes two core components: a singular NH Rapid Response Access Point, which is a crisis call center with 1 statewide number (screen calls, complete initial assessments, triage, deploy mobile response, and provide information and referral services) that launched January 1, 2022; and regional Rapid Response/Mobile Crisis Response Teams (RR/MCRT; at least one team in each CMHC region in the State), which launched July 1, 2021 with teams initially responding to calls coming from within their applicable regional crisis hotlines. This legislatively-approved and -funded transformation fundamentally shifts NH's crisis response services from primarily being a hospital-based ED- delivered system to a mobile crisis team-delivered service provided directly to individuals within the community where they are at (e.g. home, work, etc.). This transformation incorporates an approach that meets the requirements necessary to draw down enhanced federal funding envisioned in the American Rescue Plan Act, as well as expanded community-based stabilization supports. These expanded stabilization supports include: capacity for walk-in stabilization and peer living room models that may also serve as a drop-off location for first responders, crisis apartment beds, follow-up phone contact for all who interact with the crisis system, in-home and out-of-home options for brief services after the crisis response, and access to 60 new community-based supported housing beds (six per region) for those who may need longer term supported housing. DHHS is working on training for first responders to better understand responses to behavioral health emergencies. First Responders are close partners on the NH 988 Planning and Implementation Coalition as well as having a specific First Responder subcommittee. First Responders are also involved in regional meetings with the Community Mental Health Centers and the Rapid Response Access Point. Additionally, DHHS is working with first responders; including 911, state and local police, fire, and EMS; in close partnership with the Department of Justice and Department of Safety, to better collaborate on when mobile crisis response teams deploy and when a first responder response is needed. With the approval of increased funding for mental health services in the state, including statewide mobile crisis services, CMHCs in New Hampshire will be better equipped to implement a vision that is: recovery-oriented, trauma-informed, integrates peer staff, aligned with suicide care best practices, committed to safety, available to children and adults, includes integrated mental health and substance use care, and has collective and cooperative coverage.

	In addition, the State has secured an additional $2.6M and an extension of the NH COVID-19 Rapid Crisis Response Program and anticipates continuing providing crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for youth and adults impacted by the COVID-19 pandemic. Finally, the crisis response system transformation includes transitioning 33 crisis call lines, which are currently maintained by various providers in regions across the state, to an integrated call model that will meet the federal mandate to shift to 9-8-8 in July 2022. This effort maximizes collaboration between the National Suicide Prevention Lifeline, with the State's provider also being empowered to directly connect callers with the Veterans Crisis Line or the Rapid Response Access Point, as applicable to the caller's needs, and ensuring real-time linkage to meet their behavioral health crisis response needs, whether child or adult.
	Summary of Actions Needed: The Rapid Response Access Point call center launched January 1, 2022, and the Rapid Response Access Point and all crisis call center lines will be integrated with 9-8-8 on July 16, 2022.
F.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	*Current Status:* **Increased CMHC and Mobile Crisis Funding.** As noted throughout this template, and as outlined in the Provider Availability Assessment, NH offers a comprehensive continuum of community-based services. For the SFY22 / SFY23 biennium, DHHS received funding to allocate $52.4M (Federal and General Funds) to the ten CMHCs. This represents a $24.5M increase over the prior contract. Part of this funding will be for statewide mobile crisis services. As part of their contract, CMHCs are required to stand up an additional six beds per region (60 statewide) for supported housing for individuals with SMI. **Assertive Community Treatment.** The State continues to support ACT services through the existing CMHC contracts. There were 1,234 unique clients receiving ACT services at CMHCs between 4/1/2020 and 3/31/2021. In addition, the CMHCs screened 8,935 unique clients not already receiving ACT services from 10/2020-12/2020 and 8,899 from 07/2020-09/2020. The CMHCs provided ACT services to 95 new clients between 10/2020-12/2020 and 132 new clients between 1/2021-3/2021. **Partial Hospitalization / Day Treatment.** The State is exploring ways to assess more precisely which providers currently offer Intensive Outpatient Programs (IOPs)/Partial Hospitalization Programs (PHPs). The State's current understanding is that five of the ten CMHCs currently maintain, or partner with hospitals to maintain, IOPs/PHPs with behavioral health services. This is an area of continued interest and potential expansion. • Intensive Outpatient Treatment – There are three intensive outpatient treatment programs in New Hampshire. • Partial Hospitalization – There are three restorative partial hospitalization programs in New Hampshire.

	Certified Community Behavioral Health Clinics. The Mental Health Center of Greater Manchester (MHCGM) is the recipient of a $4 million grant from SAMHSA, to implement a comprehensive mental health and substance use treatment program by becoming a Certified Community Behavioral Health Clinic (CCBHC). The population of MHCGM's service area makes up about 15% of the population of NH, while 56% of clients are from medically underserved areas. The State issued an RFP on March 7, 2022 seeking a vendor to study the readiness, capability, and cost-effectiveness of implementing a CCBHC model of services across the NH community mental health system. The State received responses on April 19, 2022.
	Future Status: In addition to the continued operation and expansion of existing programs, the State is currently implementing Critical Time Intervention. CTI is a time-limited, evidence- and community-based practice that mobilizes support for individuals with serious mental illness during vulnerable periods of transition (e.g., discharge from a psychiatric hospital). CTI providers work with transitioning individuals to ensure they successfully reintegrate into their home communities. This can entail a broad range of assistance, from helping an individual secure employment, housing, or food; to identifying and accessing mental or physical health care; to reconnecting with family, friends, and peers to ensure strong, supportive relationships. CTI is backed by $4.2M in state and federal funding for SFY22 and SFY23. CMHCs are contractually required to stand up 54 of the 60 transitional beds by April 2, 2022. The final 6 beds are contractually required by 12/2022. DBH will also assess which providers offer IOP and PHP services and create an inventory.
	Summary of Actions Needed: The State plans to monitor the operations of existing programs and ensure oversight over the implementation of new programs like CTI. Phase one CMHCs are in the process of finalizing their content, staffing, and training materials and launched CTI services in January 2022. Strategy development for contracts with the phase two CMHCs has begun, and CTI will be launched across all 10 CMHCs by July 2022. DHHS will select a vendor to study the readiness, capability, and cost-effectiveness of implementing a CCBHC model

	of services across the NH community mental health system by April 26, 2022. Once a vendor has been selected, DHHS will commence negotiating definitive terms of the contract, the final version of which will require approval by the Governor & Executive Council (G&C). The vendor will approach the study in two phases, with Phase 1 being the analysis of the NH service system which is projected to last nine months from the date of contract approval by G&C. Contingent upon the outcome of Phase 1, Phase 2 will continue into year two and support the development and implementation planning of the CCBHC model. DBH will survey CMHC and hospital providers to create an inventory of IOP and PHP services by 12/30/2022.

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] *The HIT Plan should also describe, among other items, the:* • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	The State of New Hampshire has an established health IT infrastructure that supports the continuum of care and measurement of the health care system. The State's health IT infrastructure includes, but is not limited to, three managed care organizations (Well Sense, NH Health Families and AmeriHealth Caritas), an Event Notification System (ENS) for admissions, discharges and transfers (ADTs) to/from inpatient care, a statewide closed loop referral (CLR) system, an All Payer Claims Database (APCD), an aging and disability resource center (ADRC), and an integrated eligibility system (NH EASY). **Managed Care Organizations**. The State contracts with three Managed Care Organizations that file claims, perform medical necessity, and share encounter information with the State. They are responsible for managing or conducting the utilization review of health and medical records. **Event Notification System**. In partnership with seven geographically established Integrated Delivery Networks, the ENS system was implemented in New Hampshire to coordinate admission, discharge and

	transfer event notification to improve shared care planning for individuals. Currently, 19 of 26 hospitals' systems and 9 of 10 Community Mental Health Centers' (CMHC) systems have access to a platform to access and contribute to an electronic plan of care for their patients. **Closed Loop Referral System**. DHHS is planning to conduct an RFP process to secure and contract with a third-party vendor to maintain a service referral care coordination network. This network encompasses DHHS, federally qualified health centers, 10 CMHCs, nine Doorway locations, and relevant social service organizations providing single points of entry for people seeking help for substance use and/or mental health crises. **All Payer Claims Database**. The State's APCD provides access to the majority of the claims from the commercially insured adult population in New Hampshire and provides a comparative resource for monitoring change in rates of hospitalization, emergency department visits, and community services in the Medicaid population. **Aging and Disability Resource Center**. ADRCs are a collaborative effort of the Administration on Community Living and the Centers for Medicare & Medicaid Services (CMS). ADRCs serve as single points of entry into the long-term supports and services system (LTSS) for older adults and people with disabilities of all income levels. In New Hampshire, ADRCs are called ServiceLink and are state contracted, regionally based offices and partners to help individuals: a) access and make connections to long term services and supports, b) access family caregiver information and supports, c) explore options, and d) understand and access Medicare and Medicaid. Presently, the ServiceLink contractors access New HEIGHTS and NH EASY. At this time, ServiceLink does not push eligibility information to the MMIS system or to the MCOs for enrollment. **New HEIGHTS and NH EASY.** New HEIGHTS is the integrated eligibility system for NH DHHS. Eligibility programs determined within New HEIGHTS include Medicaid, TANF, SNAP, Child Care, Foster Care and more. Eligibility information such as demographics, income, resources, family composition and relationships, disability information, and much more is collected and stored in New HEIGHTS. In addition, LTSS, including eligibility for the various waiver programs, is contained within New HEIGHTS. New HEIGHTS is also the MCO enrollment broker for Medicaid. Eligibility, enrollment

	and client demographic information is sent to the MMIS via a nightly interface. The MMIS passes this information on to the MCOs. NH EASY is the online portal for clients to manage their accounts. Functionality within NH EASY includes applications for all programs in New HEIGHTS, redeterminations, change reports, etc. In addition, clients can upload documentation for their case, see what is due, read their notices, change their MCO, etc. NH EASY is tightly integrated with New HEIGHTS, so information entered in NH EASY is immediately available in New HEIGHTS. NH EASY also is used by providers and other community partners for a variety of reasons. Providers are able to (with client permission) act on behalf of their clients and assist them with upcoming events such as redeterminations, providing assistance with understanding notices, etc. Community partners who assist DHHS with determination for the Choices for Independence (CFI) waivers do so within NH EASY. The functionality allows both community partners within NH EASY as well as DHHS LTSS workers within New HEIGHTS to manage medical determinations for clients, as well as services they need when eligible. Dashboards are available in both systems so that there is transparency regarding the list of next steps and the key personnel assigned to each step. When services are approved by both entities, New HEIGHTS sends this information to the MMIS. This information is then passed to the MCOs.

Prompts	Summary
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	The SUD Health IT planning effort is aligned with DHHS IT planning efforts. DHHS leverages common platforms for reporting, data analytics, and analysis; is working on a standard case management platform; and, where necessary, is working towards interoperability between systems.

Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	New Hampshire has reviewed the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B and, as a result, the MCOs who operate in New Hampshire are required by contract to develop and implement a strategy to address how the Interoperability Standards Advisory standards, from the Office of the National Coordinator for Heath Information Technology, informs the MCO system development and interoperability.

Prompts	Summary
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group contact. [3] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."*[4]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	*Current State:* All 10 CMHCs are utilizing EHRs. Additionally, the CMHCs are utilizing an ENS implemented statewide for shared care plan coordination and secure messaging associated with EDT functions. DHHS implemented a CLR system (through a third-party vendor) and the 10 CMHCs, and an additional 40 behavioral health service providers, are engaged in utilizing the secure messaging of outcome-based referrals in conjunction with their in house EHR for

	clinical care.
	Future State: DHHS is planning to conduct an RFP process to secure and contract with a third-party vendor to maintain the CLR system that encompasses behavioral health providers; hospitals; federally qualified health centers (FQHCs); community-based organizations; local government, education, and justice systems; and MCOs.
	Summary of Actions Needed: Additional funding to maintain the CLR system is being sought. DHHS anticipates the following preliminary target milestones for delivery: 1. Allocation of funds – September 2021 2. Procurement and Contracting – October 2021 through July 2022 3. Finalization of network governance – September through October 2022 4. Finalization of Interoperability Standards – January 2023 5. Integration of targeted providers (CBOs, FQHC, Hospitals) geographically – September 2022 through June 2023 6. Integration of Local Government, Education and Justice systems – September 2022 through June 2023 7. Integration of Managed Care Organizations – July 2024

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

	Summary of Actions Needed: See section 1.1 summary of actions needed.
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	*Current State:* The CLR, described above in section 1.2, Current State, is inclusive of physician/mental health provider to community-based supports referrals.
	Future State: The CLR, described above in section 1.2, Future State, is the same for section 1.3.
	Summary of Actions Needed: See section 1.1 summary of actions needed.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	*Current State:* The current state-operated psychiatric hospital, New Hampshire Hospital (NHH), the CMHC's systems, and the New Hampshire's acute care hospitals (required to have event notification) can each create and use electronic care plans. NHH's electronic care plan is accessible by the patient's care team, including mental health providers where there is a treating relationship and the patient has consented to sharing data. NHH providers currently enter care insights to the patient care plan. These insights include level of certainty of diagnosis, treatments including medications that work well for the patient, and the insights a provider gained during the hospitalization that would have been helpful to know at admission. **Event Notification System.** In addition, the State is in the early stages of implementing ENS which is capable of supporting event notification and shared care plans. Providers can access and/or contribute to an electronic SCP and receive ADTs related to ED, urgent/immediate care, and inpatient visits through the system. Currently, 19 of 26 hospitals' systems and 9 of 10 CMHCs' systems have access to a platform to access and contribute to an electronic plan of care for their patients. In 2020, this includes NHH, which is a major contributor of information to the system and whose entry brings value to the rest of the partners. Also as of 2020, key accomplishments regarding ENS implementation include: • Addition of 2 hospitals, including NHH, added to the network, bringing the total to 19 hospitals connected and contributing ADT data. • Increase of 69 ambulatory facilities on the network, bringing the total to 115 (additional facilities may

	have been added in the past year). Ambulatory facilities, include behavioral health clinics, Skilled Nursing Facilities (SNFs), CMHCs, and primary care providers (PCPs). • 3.66% increase in patient records viewed by ambulatory providers. • More than 2,800 logins per months to the platform. • ED utilization dropped 2% and inpatient utilization dropped 10% statewide, March 2019-March 2020 (pre COVID-19). **Medicaid EHR Incentive Program.** For several years, NH DHHS has also provided incentive payments to eligible professionals and eligible hospitals as they adopted, implemented, upgraded, or demonstrated meaningful use of certified EHR technology. The program, which began in 2012 and ends in 2021, encourages Certified Electronic Health Record Technology (CEHRT) for use in a meaningful manner to improve public health. From 2012 to 2017, DHHS has disbursed 45 payments to 26 eligible hospitals, the most that were eligible to participate. In the same time period, the State disbursed 445 incentive payments to 667 eligible professionals.
	Future State: DHHS and the intended healthcare stakeholders will work to agree to promote a statewide strategy for consistent use for clinical outcome improvement and realized value. DHHS will also onboard to the platform, where there is a beneficiary HIPAA-covered treatment, payment, or operations relationship to use and contribute to electronic care plans in collaboration with providers. This strategy will include any future IMDs and psychiatric providers.
	Summary of Actions Needed: DHHS will seek to ensure continuation of the platform and implement it further statewide. DHHS also needs to plan and execute a statewide implementation to include all providers, a strategy to standardize key components of a plan of care, and workflows that leverage the information to improve patient care.

Prompts	Summary
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	*Current State:* The current state is outlined in section 2.1. The early stages of ENS implementation key in on the following relationships between systems: • **NHH EHR and ENS:** NHH staff manually enter record data into its EHR. NHH staff download extracts from the EHR and submit the extracts to the ENS, at least once a day. • **Eligibility System and ENS**: There is currently no interface between NEW HEIGHTS and ENS. NH Medicaid beneficiaries are in New Heights, and Medicaid claims are processed through MMIS.

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

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

Prompts	Summary
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	*Current State:* All CMHCs have electronic health records that serve both children and adults. As individuals transition between systems, information pertaining to the transition can be shared between providers on an individual, case-by-case basis.
	Future State: See responses for 1.1 and 1.2.
	Summary of Actions Needed: See responses for 1.1 and 1.2.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is	*Current State:* Consent is captured on providers EHR systems as well as on the CLR system.

electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	
	Future State: N/A – milestone met.
	Summary of Actions Needed: N/A – milestone met.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	*Current State:* All documentation is included in the provider's EHR and, as defined in the template (notes field) for information that is agreed to be shared, is interoperable via ENS.
	Future State: Future interoperability between providers EHR systems and the CLR system will connect the referrals with the rest of the HIT ecosystem; the goal of the State is to take the CLR system and expand it to hospitals, local government, education systems, and MCOs to complete the circle of services and opportunities to send and receive referrals, thereby eliminating arduous manual processes.
	Summary of Actions Needed: See section 1.1 summary of actions needed.

Prompts	Summary
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	*Current State:* In July 2020, the State Legislature passed **HB 1623**, which greatly expanded how care providers interact with telehealth technologies. The bill: • Ensured reimbursement parity, expands site of service, and enables all providers to provide services through telehealth for Medicaid and commercial health coverage, with limited exceptions. • Enabled access to medication assisted treatment (MAT) in specific settings by means of telehealth services. • Amended the Physicians and Surgeons Practice Act to expand the definition of telemedicine. • Amended the relevant practice acts to expand the definition of telemedicine. • Enabled the use of telehealth services to deliver Medicaid reimbursed services to schools.

	According to **RSA 167:4-d Medicaid Coverage of Telehealth Services**, Medicaid provides coverage and reimbursement for health care services provided through telemedicine on the same basis as the Medicaid program provides coverage and reimbursement for health care services provided in person, with limited exceptions. Medicaid providers are allowed to perform health care services through all modes of telehealth, including video and audio, audio-only, or other electronic media. This includes mental health practitioners governed by **RSA 330-A** and psychologists governed by **RSA 329-B** and community mental health providers employed by CMHPs pursuant to **RSA 135-C:7.** American Rescue Plan Act funds were used to pay for increased broadband connectivity for rural and HRSA-defined medically underserved areas of New Hampshire.
	Future State: Continued operation of telehealth policy, and continued promotion of telehealth technologies, in accordance with statutes. Expansion of outreach to support medication assisted treatment providers for the treatment of opioid use / mental health disorders via telehealth.
	Summary of Actions Needed: Evaluate long-term uptake of telehealth service provision, particularly in rural areas of the State. Evaluate the evidence to provide coverage for remote patient monitoring and store-and-forward billing codes, and consider the need for submitting a State Plan Amendment.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[5])	*Current State:* NH Administrative Code **He-M 405.05 Collaboration with Community Mental Health Programs** require the joint development of discharge plans and referrals for clients whom CMHPs and Designated Receiving Facilities (DRFs) both serve. The discharge plan must include information about community supports, such as peer support agencies, and the availability of family support and education, and CMHPs must offer an appointment to a discharged client to occur within 7 days of discharge.
	Future State: As part of its Critical Time Intervention (CTI) implementation, DHHS will be working with CTI providers to ensure transitioning individuals successfully reintegrate into their home communities. This can entail a broad range of assistance, from helping an individual secure employment, housing, or food; to identifying and accessing mental or physical health care; to reconnecting with family, friends, and peers to ensure strong, supportive relationships. DHHS has developed CTI metrics for CMHCs to track key information such as appointments, readmissions, and other health

	and treatment metrics. CMHCs are responsible for routinely updating their clients' EHRs and should help the State better track individuals who are discharged from NHH and DRFs to ensure proper follow-up is provided. In addition to better visibility into discharges and follow-up, the State plans to improve linkages between its eligibility system and the CLR/ENS systems mentioned above to better identify whether patients: 1) are eligible for services, 2) have a referral, 3) have been discharged from treatment, and 4) have received follow-up. Doing so will provide the State better visibility into patient care. Finally, the State has recently discussed examining data from assessment tools like CANS and ANSA, which may help identify patients who are at risk of discontinuing engagement in their treatment. The analytics described in this response will be used to notify the centralized resource coordination system and care teams (outlined in the Future State section of 2.2) for outreach. All patients have the right to consent to treatment, to their release of information, and the State will leverage the best programs and services possible in order to provide the treatment consented to by each individual. In doing so, the State will leverage the systems of care to not only analyze the information the State has, but to also provide a notification process to update the client as to their eligibility for services and how the State can help them.
	Summary of Actions Needed: The State will need to stand up a trend-based analytics environment platform to extract the data sources outlined above, and to establish a process for care team notification.

Prompts	Summary
6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis	*Current State:* The Bureau of Children's Behavioral Health and Bureau of Mental Health Services is in the process of planning a needs assessment and work with stakeholders to identify a model for statewide implementation of a First Episode Psychosis (FEP) specialty care program. In the meantime, the State maintains the Nashua region based program for FEP.
	Future State: Starting in July of 2021, three additional programs within the Derry, Seacoast, and Monadnock regions began implementing FEP programs. By increasing the availability of FEP throughout the State, NH increases the likelihood of identifying an individual during their first psychotic episode and providing intense, targeted services that lead to a decrease in psychiatric hospital stays. The coordination of care is a key requirement in this effort.

	Because Nashua is the only region that has an FEP program, they currently accept clients from other regions for this specific program. The State anticipates CMHCs will utilize their EHRs for the coordination of care with the SCPs already implemented in the ENS. The State will leverage referrals in the CLR.
	Summary of Actions Needed: The State is currently contracting with a technical assistance and consultation resource to assist the applicable CMHCs in implementing FEP. Any other IT needs would be identified as the State embarks upon those additional programs. In addition, see 1.1 for summary of actions needed.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	*Current State:* If appropriate and needed, the State is capable of linking a child's electronic medical record with that of their respective parent's or caretaker's medical record.
	Future State: The State's goal is to build interoperability standards to allow for providers to consume the standards subsequent to creation of necessary data sharing agreements to allow for the linkage of child's electronic medical records with their respective parent/caretaker medical records.
	Summary of Actions Needed: N/A – milestone met.
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	*Current State:* NHH's EHR is reliable in capturing all episodes of care. When NHH's EHR links to other data systems, it is capable of providing detail at the admissions and discharge level from NHH. Episodes of care can be aggregated and summarized by individual. NHH's EHR validates data with NHH and updates old data periodically to ensure information is up-to-date.
	Future State: N/A – milestone met.
	Summary of Actions Needed: N/A – milestone met.

Section 3: Relevant documents

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

ATTACHMENT G
Reserved for SMI/SED Monitoring Protocol

ATTACHMENT H

Reserved for Qualified Residential Treatment Program (QRTP) Implementation Plan

ATTACHMENT I

Reserved for Reentry Demonstration Initiative Qualifying Conditions and Services

ATTACHMENT J
Reserved for Reentry Demonstration Initiative Implementation Plan

ATTACHMENT K

Reserved for Reentry Demonstration Initiative Reinvestment Plan