DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

October 22, 2025

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) completed its review of the Evaluation Design, which is required by the Special Terms and Conditions (STCs), specifically, STC 11.3 "Draft Evaluation Design" of New Hampshire's section 1115 demonstration, "Substance Use Disorder, Serious Mental Illness, and Serious Emotional Disturbance, Treatment Recovery and Access" (Project No: 11-W-00321/1), effective through June 30, 2029. CMS has determined that the Evaluation Design, which was submitted on December 6, 2024 and revised on September 29, 2025, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore approves the state's Evaluation Design.

CMS has added the approved Evaluation Design to the demonstration's STCs as Attachment C. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Design may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an Interim Evaluation Report, consistent with the approved Evaluation Design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a Summative Evaluation Report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with New Hampshire on the Substance Use Disorder, Serious Mental Illness, and Serious Emotional Disturbance, Treatment Recovery and Access section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

Digitally signed by DANIELLE DALY -S
Date: 2025.10.22 10:30:52 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Joyce Buttersworth, 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 approval letter 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 July 16, 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 July 16, 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 July 16, 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	Evaluation Design
Attachment D	SUD Implementation Plan
Attachment E	Reserved for SUD 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	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 15, 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. SMI/SED Health Information Technology (Health IT) Plan. 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) 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

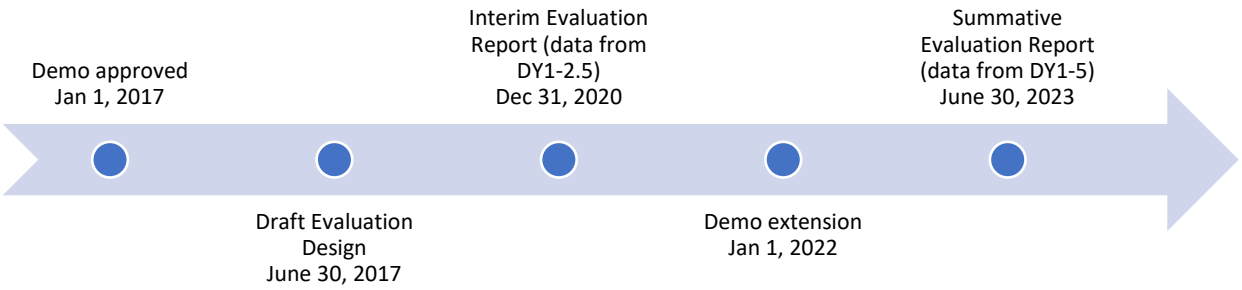
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, 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

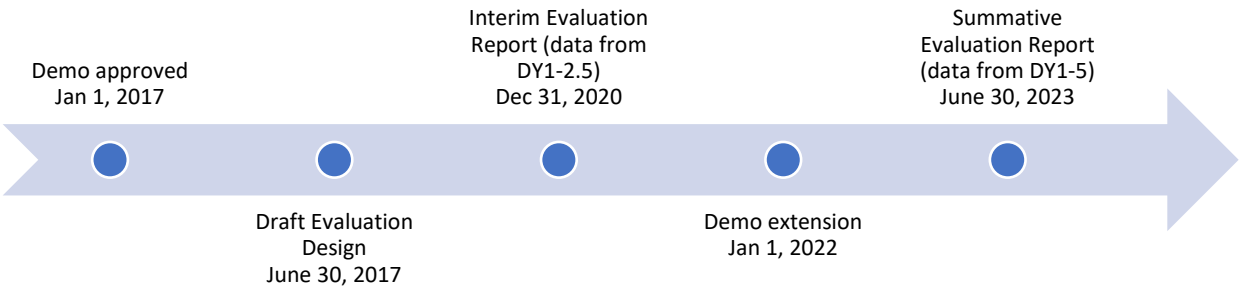
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved 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:
Evaluation Design

New Hampshire Substance Use Disorder, Serious Mental Illness and Serious Emotional Disturbance Treatment and Recovery Access
Section 1115 Medicaid Demonstration
11-W-00321/1

Final Evaluation Design

(Extension Period July 1, 2023 – July 15, 2024
Renewal Period July 16, 2024 – June 30, 2029)

Draft Submitted to CMS December 2024; Final Submitted July 2025; Revised September 2025

TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS

ANOVA	Analysis of Variance
AOD	Alcohol and Other Drug
ASAM	American Society of Addiction Medicine
BN	Budget Neutrality
CEM	Coarsened Exact Matching
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DBH	Division of Behavioral Health
DHHS	New Hampshire Department of Health and Human Services
DO	Dental Organization
DOC	Department of Corrections
DY	Demonstration Year
ED	Emergency Department
FFS	Fee-for-Service
GLM	Generalized Linear Model
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
IET	Initiation and Engagement in Treatment
IMD	Institution for Mental Diseases
IP	Inpatient
ITS	Interrupted Time Series
LTC	Long Term Care
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MOUD	Medications for Opioid Use Disorder
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NPI	National Provider Identifier
OUD	Opioid Use Disorder
PAP	Premium Assistance Program
PHE	Public Health Emergency
PHPG	Pacific Health Policy Group
PMPM	Per Member Per Month
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SMI	Serious Mental Illness
STC	Special Terms and Conditions
SUD	Substance Use Disorder

A. GENERAL BACKGROUND INFORMATION

The New Hampshire Substance Use Disorder (SUD), Serious Mental Illness (SMI), Serious Emotional Disturbance (SED) Treatment Recovery and Access (TRA) Section 1115(a) Demonstration (11-W-00321/1) was approved for renewal by the Centers for Medicare and Medicaid Services (CMS) for a second five-year period July 16, 2024 through June 30, 2029. The New Hampshire Department of Health and Human Services (DHHS) is the single state agency responsible for the oversight of the State's Medicaid program. The Demonstration will improve the health of communities and populations in New Hampshire by:

1) Continuing medical assistance for individuals with substance use disorder (SUD), serious mental illness (SMI), serious emotional disturbance (SED) who receive residential treatment from programs designated as Institutions for Mental Disease (IMDs).
2) Continuing coverage for dentures for eligible individuals ages 21 and older residing in nursing facilities.
3) Developing targeted pre-release services for Medicaid eligible individuals with an SUD or SMI who are incarcerated and preparing for community reentry.

Outlined below is an overview of the issues addressed by the Demonstration, including the history, goals, and populations impacted by the Demonstration.

1. ISSUES ADDRESSED

Through the Demonstration, the State is addressing issues related to access to specialized treatment services, including:

- SUD IMD treatment services
- Psychiatric IMD treatment services for adults and youth
- Prosthodontics for nursing facility residents
- Pre-release services for members who are incarcerated and who have a SUD or SMI

An overview of the issues addressed through each initiative is provided below.

Substance Use Disorder

At the time of the State's original application, New Hampshire was experiencing some of highest overdose death rates in the country. The New Hampshire DHHS had invested more than $30 million to build service capacity and support a full continuum of care to treat individuals with SUD. These investments included maintaining existing prevention, treatment, and recovery capacity, while also expanding access to medication assisted treatment (MAT), peer recovery support services, direct prevention services, and coordination of immediate crisis stabilization and care through a centralized statewide crisis hotline. The State established nine regional treatment hubs (Doorways) to serve as 24/7 access points to addiction treatment. The

Doorway provides screening, evaluation, care management, social service referral and addiction treatment services across the state.

These investments were made in support of a robust, resiliency- and recovery-oriented system of care for individuals with SUD. Although capacity for services increased, the limited availability of treatment in all settings, particularly residential treatment, was challenging.

The State implemented the New Hampshire Substance Use Disorder Treatment and Recovery Access Demonstration (SUD Demonstration) to address critical unmet needs for residential SUD treatment; improve quality of SUD treatment; and maintain or reduce cost of care for Medicaid enrollees with an SUD.

Psychiatric Treatment Services

Effective in the final year of the original Demonstration, CMS authorized Medicaid payments for psychiatric treatment in residential programs designated as Institutions for Mental Disease (IMDs) for adults with a serious mental illness (SMI). The approval also included coverage for children with a serious emotional disturbance (SED) who receive services in Qualified Residential Treatment Programs.

The State requested this authority to address gaps in the psychiatric treatment system for inpatient treatment services. In the period immediately prior to the Demonstration amendment request, the Department of Health and Human Services (DHHS) observed an increase in individuals utilizing Emergency Departments (EDs) for mental health and psychiatric crisis. The State's inpatient psychiatric bed capacity could not meet the increased demand. This in turn resulted in long wait times for treatment. Psychiatric boarding in the ED, previously reduced to near zero, had increased dramatically. Executive Order 2021-0915, issued on May 13, 2021, required DHHS to enact emergency rules and expand the number of available beds and other resources available to state residents in crisis.

These actions, coupled with the State's commitment to strengthening community-based mental health treatment, caused DHHS to seek the Demonstration amendment in support of a full continuum of psychiatric care options for individuals with a SMI or SED. The full continuum of care includes evidenced-based psychiatric treatment services in residential and inpatient settings, including those classified as IMDs.

Prosthodontic Coverage for Nursing Facility Residents

The Demonstration includes a removable prosthodontic benefit (i.e., dentures) for Medicaid members ages 21 and older who are residents of nursing facilities. The dentures benefit includes upper, lower and full sets of dentures whether new, replaced or repaired. In 2023, the New Hampshire legislature authorized a limited dental benefit for Medicaid members, including removable prosthodontics for members receiving home and community-based waiver services and members receiving long term services and support (LTSS). DHHS sought Demonstration

authority to ensure that members who resided in nursing facilities had access to the same benefits as their peers receiving LTSS services and support in the community.

Community Reentry Program (Pre-Release Services)

As part of the Demonstration renewal on July 16, 2024, CMS approved a new program that authorizes federal Medicaid matching funds for the provision of services to individuals who are incarcerated in NH Department of Corrections (NHDOC) custody in state prisons and in county run jails with behavioral health (BH) disorders (i.e., SUD, OUD, SMI, or SED). As part of its Demonstration request to CMS, the State noted that almost 15 percent of incarcerated men and 30 percent of incarcerated women in New Hampshire had a mental illness. The New Hampshire Department of Corrections (DOC) estimated that over 50 percent of people incarcerated in State prisons had an opioid use disorder (OUD). Between December 2019 and December 2020, over half of all parole revocation hearings listed substance abuse as a reason for revocation, and failure to comply with treatment and substance use were among the top three reasons for parole revocations in 2017.

The Community Reentry Program will support individuals who are transitioning to the community through a limited Medicaid benefit up to 45 days prior to their release date. This group of Medicaid members are also designated as a priority population for care coordination following release, through the managed care delivery system. Pre-release services include:

- Case management to assess and address physical and behavioral health needs
- MAT for all types of SUDs as clinically appropriate medications in combination with counseling/behavioral therapies
- A 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release from the correctional facility
- Pre-release community-based provider intake appointments
- Peer Support Services

The State's objective in implementing the Reentry initiative is to improve continuity of care and establish strong community connections for members to improve continuity of care and treatment outcomes for Medicaid members returning to community life. The Reentry Program is expected to start January 1, 2025.

2. DEMONSTRATION OVERVIEW

The New Hampshire SUD SMI SED TRA Section 1115 Demonstration was originally authorized by CMS on July 10, 2018 and was approved through June 30, 2023.

On June 16, 2021, CMS approved an amendment that revised the SUD per member per month (PMPM) budget neutrality limits.

On June 2, 2022, CMS approved an amendment that extended expenditure authority for Medicaid state plan services furnished to eligible individuals who are short-term residents in facilities that meet the definition of an IMD.

On March 17, 2023, CMS approved an amendment that added expenditure authority to provide removable prosthodontic coverage (dentures) once every five years (subject to medical necessity) for Medicaid eligible adults ages 21 and older who reside in nursing facilities. 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 July 16, 2024, CMS approved a five-year extension of the Demonstration through June 30, 2029. The extension continued existing authorities granted for SUD, SMI/SED, and dentures coverage. In addition, the extension included approval of the Community Reentry Program.

During the Demonstration period, the State seeks to achieve the following CMS-defined goals:

SUD Treatment

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

Psychiatric Treatment for SMI/SED

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

Removeable Prosthodontic (Dentures) Coverage

1. Improve access to removable prosthodontic services for nursing facility residents.
2. Reduce incidence of dental infections among nursing facility residents.
3. Reduce incidence of hospitalizations due to aspiration pneumonia among nursing facility residents.
4. Increase healthy weight gain in nursing facility residents.
5. Improve quality of life for nursing facility residents.

Community Reentry Initiative

1. 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
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry
3. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers
4. 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
5. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs
6. Reduce all-cause deaths in the near-term post-release
7. 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
8. 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

3. POPULATION GROUPS IMPACTED BY DEMONSTRATION

Under the Demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain set forth under the Medicaid State Plan. The Demonstration allows Medicaid recipients under age 65 with OUD/SUD and ages 21 to 64 with SMI to receive coverage for services furnished to them while they are short-term residents in SUD residential and SUD and psychiatric inpatient treatment settings that qualify as an IMD. CMS and the State are continuing discussion related to coverage for Medicaid recipients under 21 years old who receive treatment services furnished by Qualified Residential Treatment Programs for SMI/SED.

Medicaid eligible adults ages 21 and older who reside in nursing facilities are eligible for dentures apart from members who are:

- Qualified Medicare Beneficiaries (QMB)
- Special Low-Income Medicare Beneficiaries (SLMB)
- Qualified Individual Special Low-Income Medicare Beneficiaries (QI / SLMB2)
- Receiving temporary eligibility
- Non-citizens qualifying for emergency services only benefits
- Receiving family planning only services

Medicaid members who are participating in the Reentry Initiative must meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility as specified in the STCs, and have a diagnosis of SUD/SMI/SED.

B. EVALUATION QUESTIONS AND HYPOTHESES

Evaluation questions and hypotheses are presented separately for each of the programs authorized under the Demonstration. The remainder of the section will outline the Demonstration logic model and discuss how the Demonstration promotes the objectives of Title XIX.

SUD IMD Treatment

Coverage for SUD treatment services in facilities designated as an IMD is associated with six goals areas under the Demonstration. A crosswalk of Demonstration goals to SUD-related evaluation questions and hypotheses is provided below.

CMS Goal	Evaluation Question	Hypothesis
1. Increase identification, initiation, and engagement in treatment	1. Is the Demonstration associated with improved rates of SUD identification, initiation and engagement in SUD treatment?	1. The Demonstration will be associated with improved initiation and maintain access to residential SUD treatment.
2. Increase adherence to and retention in treatment	2. Is the Demonstration associated with improved adherence and retention in SUD treatment?	1. The Demonstration will be associated with improved adherence and retention in treatment.
3. Reduce overdose deaths	3. Is the Demonstration associated with a reduction in overdose deaths?	1. The Demonstration will be associated with stabilizing or lowering overdose related deaths.
4. Reduce utilization of ED and IP settings	4. Is the Demonstration associated with a reduction in utilization of the ED and inpatient services?	1. The Demonstration will be associated with reductions in hospitalizations and in ED visits.
5. Fewer readmissions to the same or higher level of care	5. Is the Demonstration associated with fewer readmissions to the same or higher levels of care?	1. The Demonstration will be associated with stabilizing or lowering readmission rates.
6. Improve access to care for physical health conditions	6. Is the Demonstration associated with improved access to ambulatory/preventive care?	1. The Demonstration will be associated with increased ambulatory/preventive visits.

Psychiatric IMD Treatment

The evaluation for coverage of psychiatric treatment services provided in inpatient IMD settings will consider five evaluation questions in alignment with the five CMS-defined goals for psychiatric IMD demonstrations.

The State received authority to reimburse services from Qualified Residential Treatment Programs for Medicaid enrollees under the age of twenty-one experiencing a serious emotional disturbance pending final approval of the State's transition plan. Discussions with CMS on possible implementation activities and timelines are still in progress. Should the QRTP authority be implemented during the Demonstration period, the evaluation will include a subsidiary analysis to assess how outcomes vary for children and adolescents.

CMS Goal	Evaluation Question	Hypothesis
1. Reduce utilization and lengths of stay in hospital emergency departments (ED)	1. Is the Demonstration associated with reduced ED utilization and length of stay in the ED for enrollees who receive psychiatric treatment services in a NH IMD?	1. The Demonstration will be associated with stabilizing or reducing ED visits for enrollees who receive NH IMD services.
		2. The Demonstration will be associated with stabilizing or lowering the length of stay in the ED for enrollees awaiting psychiatric placement in NH IMDs.
2. Reduce preventable readmissions	2. Is the Demonstration associated with fewer readmissions to NH IMDs?	1. The Demonstration will be associated with stabilizing or lowering NH IMD readmissions to NH IMDs.
3. Improve availability of crisis stabilization services	3. Is the Demonstration associated with increased use of community-based crisis stabilization services?	1. The Demonstration will be associated with increased utilization of community-based crisis stabilization services.
4. Improve access to community-based services to address chronic MH needs through increased integration of primary and BH care.	4. Is the Demonstration associated with improved access to community-based primary and BH services?	1. The Demonstration will be associated with maintaining or improving access to ambulatory/preventive care.
		2. The Demonstration will be associated with maintaining or improving access to mental health services
5. Improve care coordination following hospitalization	5. Is the Demonstration associated with improved follow-up following discharge from the IMD setting?	1. The Demonstration will be associated with maintaining or improving follow-up after discharge from an NH IMD.

Removeable Prosthodontics (Dentures)

The evaluation of the dentures component of the Demonstration will consider five research questions and six hypotheses outlined below.

Evaluation Question	Hypothesis
1. Is the Demonstration associated with improved access to removable prosthodontics for nursing facility residents?	1. The Demonstration will be associated with improved access to removable prosthodontic services for nursing facility residents.
2. Is the Demonstration associated with reduced dental infections for nursing facility residents?	1. The Demonstration will be associated with reduced incidence of dental infections among nursing facility residents.
	2. The Demonstration will be associated with decreased non-traumatic dental-related ED visits among nursing facility residents.
3. Is the Demonstration associated with reduced hospitalizations for nursing facility residents?	1. The Demonstration will be associated with reduced incidence of hospitalizations due to aspiration pneumonia among nursing facility residents.
4. Is the Demonstration associated with improved nutritional status of residents who received the benefit?	1. The Demonstration will be associated with improved nutritional status among residents who received denture benefit.
5. Is the Demonstration associated with improved Quality of Life of residents who receive the benefit?	1. The Demonstration will be associated with increased quality of life (e.g., participation in community meals and social events) among residents who received denture benefit.

Community Reentry Program

The evaluation of the Reentry Program will consider eight evaluation questions associated with the eight overarching goals outlined by CMS. A crosswalk of Reentry Program goals to the evaluation questions and hypotheses is provided below.

CMS Goal	Evaluation Question	Hypothesis
1. Increase coverage, continuity of care, and appropriate service uptake	1. Is the Demonstration associated with continuous Medicaid coverage following community reentry?	1. Demonstration enrollees will maintain continuous Medicaid coverage post release.
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry	2. Is the Demonstration associated with improved access to and retention in treatment post release? *Subsidiary question:* Does the length of the pre-	1. The Demonstration will be associated with improved access to and retention in treatment post release.

CMS Goal	Evaluation Question	Hypothesis
	release program support successful transitions and care in the community?	
3. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers	3. Does the Demonstration support improved communication and coordination between correctional programs, health care systems, and community providers? *Subsidiary question:* What do stakeholders report as program successes, barriers, challenges and recommendations?	Stakeholders will report improved coordination and communication between State agencies, health plans and providers.
4. 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	4. What investments were made to improve health care and related services during the Demonstration? *Subsidiary question: How do actual reentry program costs compare to the State's cost estimates as reflected in the budget neutrality limits?*	The State will increase its investments to improve health care and related services under the Demonstration
5. Improve connections between correctional facility settings and community services upon release to address physical and BH needs	5. Is the Demonstration associated with improved access to ambulatory and/or preventive care post release?	1. The Demonstration will be associated with increased visits for ambulatory/preventive care post release.
6. Reduce all-cause deaths in the near-term post-release	6. Is the Demonstration associated with lower all cause death rates in the near-term following release from incarceration?	1. The Demonstration will be associated with stabilizing or lowering deaths following release.
7. Reduce the number of ED visits and IP hospitalizations	7. Is the Demonstration associated with fewer ED visits and hospitalizations post release?	1. The Demonstration will be associated with reduced use of ED and inpatient services post release.
8. Provide interventions with the goal of reducing overdose and overdose-related death in the near-term post-release	8. Is the Demonstration associated with fewer overdose related deaths?	1. The Demonstration will be associated with stabilizing or lowering overdose related deaths.

1. QUANTIFIABLE TARGETS FOR IMPROVEMENT AND LOGIC MODEL

The New Hampshire Demonstration focuses on enhancing access to behavioral health services for all Medicaid members. This includes collaboration with DOC staff to identify members with SUD or SMI challenges and the integration of substance abuse and mental health treatment services within the Division of Behavioral Health Services at DHHS. The authority granted under the Demonstration provides Medicaid reimbursement for short-term medically necessary residential and inpatient treatment services in IMD settings for SUD and SMI. Psychiatric IMD authorities are currently implemented in inpatient settings in New Hampshire. In addition, authorities for a targeted set of pre-release services for individuals with SUD and SMI who are incarcerated will be offered for up to 45 days prior to their release from prison.

These authorities are expected to work in tandem with the State's 10-Year Mental Health Plan to ensure a full continuum of care, stronger hospital/IMD discharge planning and pre-release planning and coordination. Continuity of care is expected to improve, whether an individual is being discharged from an IMD or planning for community reentry following incarceration. Subsequently, the State is expecting to continue its successes and improve outcomes for Medicaid members.

Key actions, in addition to the Demonstration's approval, include:

- Accelerating the development of community-based services and psychiatric treatment capacity to address psychiatric boarding in the ED.
- Providing Medicaid coverage for non-residential crisis services, including a centralized call center and mobile crisis teams
- Enhancing provider requirements regarding screening for comorbid conditions and improved discharge planning
- Increasing the availability of residential SUD treatment services
- Continuing to support Critical Time Intervention program for members in transition from the ED or hospital to prevent recurrent homelessness and readmissions to IMD and other more intensive care settings
- Providing access to peer support specialists
- Continuing provider requirements, education and training around the use of ASAM criteria to support the identification, initiation and engagement in community-based treatment for members with an SUD
- Collaborating with DOC to identify and provide pre-release services to members with an SUD and SMI
- Enhancing the IT infrastructure between DOC and DHHS to support Medicaid coverage for members who are incarcerated
- Establishing a priority population in MCO care management requirements for members who reenter the community from prison (including prospective all-inclusive payment to MCOs for pre-release services)

The short-term impact of these actions is expected to:

- Maintain availability of community-based crisis stabilization services
- Increase rates of identification, initiation and engagement in treatment
- Increase continuity of Medicaid coverage and thus access to care
- Increase access to follow-up care following release from the IMD, hospital or prison settings for members with an SUD or SMI
- Improve continuity of pharmacotherapy for SUD and SMI
- Increase access to care for physical health conditions
- Increase retention in treatment

The State will continue its IT planning and infrastructure enhancements. These efforts are expected to support progress toward Demonstration goals. These moderating factors include activities such as:

- Implementation of planned event notification system (ENS) statewide in support care coordination and follow-up after ED and inpatient stays
- Availability of telehealth services to support access to care for rural and hard-to reach populations
- Continued expansion of closed loop referral system for all providers
- Development of the electronic health record exchange and enhanced interoperability
- Enhancement of the IT infrastructure in State prisons and county jails

The long-term impact of these efforts is expected to increase access to a continuum of treatment options that will in turn:

- Decrease the use of EDs for mental health and substance use treatment
- Lower the lengths of stay in the ED for members with SMI
- Decrease death rates for any cause following reentry after incarceration
- Decrease overdose-related deaths

A visual depiction of these activities and goals is presented in the Demonstration's logic model presented on the following page. Contextual variables related to the evaluation design will be discussed in Section C (Methodology) and Section D (Methodological Limitations).

Logic Model

Moderating Factors

- Implementation of planned event notification system (ENS) statewide to support care coordination
- Availability of telehealth services to improve access to care and support Reentry treatment planning
- Continued expansion of closed loop referral system for all providers and for Reentry services
- Electronic health record exchange and interoperability
- Enhance IT infrastructure in state prisons and county jails

Key Actions

- Continue Medicaid coverage of IMD treatment settings
- Continue coverage of non-residential crisis services, including a centralized call center and regional mobile outreach teams
- Obtain authorization for Medicaid coverage of pre-release services including MAT, BH and case management for members who are incarcerated
- Continue ASAM related provider requirements, education and training

- Continue Critical Time Intervention
- Increase psychiatric inpatient treatment capacity
- Increase SUD residential treatment capacity
- Develop all-inclusive payment for MCO outreach and enrollment in care management services prior to release
- Include Reentry program participants as priority population for MCO care management post release
- Provide access to peer support specialist for members in the Reentry Program
- Increase investments in health care and related services to maximize success post release from incarceration (Reentry Goal #4)
- Update rules to explicitly require psychiatric IMD settings to
  - Screen for co-morbid conditions (e.g., health, SUD and suicidal ideation) and facilitate access to treatment for those conditions
  - Perform intensive pre-discharge planning and include community-based providers in care transitions
- Enhance communication and coordination between providers and across state agencies through ongoing meetings and feedback (Reentry Goal #3)

Short-Term Outcomes

- Maintain availability of crisis stabilization services, including call centers, mobile crisis outreach, IOP, residential and inpatient care for SUD and SMI (SMI Goal #3; SUD Goal #4)
- Increase rates of identification, initiation and engagement in SUD treatment (SUD Goal #1)
- Increase coverage, continuity of care and service uptake through assessment, eligibility and availability of pre-release services (Reentry Goal #1)
- Increase access to follow-up and treatment after release from incarceration (Reentry Goal #2)
- Improve continuity of pharmacotherapy including MAT and long-acting injectable anti-psychotics (Reentry Goal #8)

- Increase access to community-based services, including through increased integration of primary and behavioral health care (SMI Goal #4)
- Increase access to care for physical health conditions (SUD Goal #6; Reentry Goal #5)
- Increase access to follow-up and treatment after discharge from IMD settings or incarceration (SMI Goal #5; Reentry Goal #2)
- Increase adherence to and retention in treatment (SUD Goal #2)

Long-Term Outcomes

Reduced ED utilization and length of stay among Medicaid members with SMI (SMI Goal #1; SUD Goal #4; Reentry #7)

Reduced preventable admissions and readmissions to acute care hospitals and residential settings (SMI Goal #2; SUD Goal #4 and 5; Reentry #7)

Reduce all cause deaths post release from incarceration (Reentry Goal #6,8)

Reduce overdose deaths, particularly those due to opioids (SUD Goal #3)

Contextual Variables

- IMD services were available and paid for by the State prior to the Demonstration approval
- Barriers to discharge from IMD settings, including housing and health related social services post discharge
- A First Episode Psychosis Program began in at least one region of the State prior to the SMI Demonstration
- DOC staff provide case management and BH services to inmates prior to release
- DOC currently provides a supply of medications upon release
- DOC release dates often change due to unplanned factors (e.g., access to housing, parole conditions, disciplinary actions)

2. PROMOTION OF THE OBJECTIVES OF TITLE XIX

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.

C. METHODOLOGY

The Demonstration provides authorities for one new program (Reentry), several long-standing initiatives (SUD- and SMI-IMD authorities) and a singular program benefit for nursing facility residents (Removable Prosthodontics). As such, the evaluation design will incorporate methods unique to each program. A description of the design, target and comparison groups, evaluation periods, measures, data sources and analytic methods are presented below.

1. EVALUATION DESIGN

The Demonstration includes both long-standing and new program initiatives with populations that vary in size. To address these challenges the State will employ different designs for each component of the evaluation.

The SUD-IMD authorities were approved in July of 2018 and followed a period of significant investment in SUD treatment services for the State of New Hampshire. SUD-IMD authorities were sought to complete the continuum of care within the Medicaid program. This evaluation focuses on members who receive IMD services under the Demonstration. In DY5 of the previous Demonstration period, 2,630 participants were identified in the study group. The initial SUD Demonstration period also included a three and one-quarter year overlap with the novel coronavirus public health emergency. The current design contemplates examining trends for IMD service recipients using an Interrupted Time Series Approach (ITS) (described in detail later in this section). The ITS design will examine current Demonstration performance as compared to the initial Demonstration period for members who receive IMD services. There are several measures associated with the general population of enrollees with an SUD, regardless of their use of IMD services; analysis for these measures will include baseline data for 2017 (i.e., prior to the original Demonstration approval).

The SMI-IMD authorities were approved and implemented in the final year of the previous Demonstration. To date, the authorities have supported the participation of two inpatient hospital facilities. The previous evaluation was designed to test and refine data in preparation for the renewal period. During the first year of operation, 320 members were identified in the study group. However, State staff noted that Medicaid claiming for IMD services in the first year was inconsistent. The current design will employ logistic and linear regression to examine change over time compared to the program's second full year of operation. A detailed discussion of data limitations and design considerations is provided later in this section.

The Nursing Facility Denture Benefit was approved and implemented in the last quarter of the previous Demonstration. The previous evaluation was designed to test and refine baseline data in preparation for the renewal period. This component of the Demonstration serves a small number of members. In the first full year of operation, 34 members received the denture benefit. The current design will employ logistic regression to examine change over time compared to the first full year of operation and qualitative data to examine potential changes in

quality of life for members receiving the benefit. A detailed discussion of data limitations and design considerations is provided later in this section.

The Community Reentry Program is new and will not be implemented until January 1, 2025. Although small (averaging fewer than 50 participants per month) this component offers the opportunity to employ a comparison strategy to examine the potential impact of the new program on outcomes. A comparison group will be identified using Coarsened Exact Matching, from members who left prison in 2023 and 2024 prior to the start of the program. The Community Reentry Program evaluation also will employ a qualitative approach to examine implementation successes and challenges.

An overview of the primary approaches proposed for each initiative is provided below. A more detailed discussion of each approach, including alternative strategies that may be used (based on population size and data availability) is provided in Section 6 (Analytic Methods).

Authority	Program Start	Primary Approach	Baseline
SUD-IMD	July 1, 2018	Interrupted Time Series; Generalized Linear Model	July 1, 2019 – June 30, 2024*
SMI-IMD	July 1, 2022	Logistic & Linear Regression	July 1, 2023 – June 30, 2024
Dentures	April 1, 2023	Logistic Regression; Qualitative	July 1, 2023 – June 30, 2024
Reentry	January 1, 2025	Comparison Strategy (Matched t-test); Qualitative	Jan 1, 2023 – Dec 31, 2024

*For measures applied to the general population of enrollees with an SUD, the evaluators will include an additional analysis using a baseline period of January 1, 2017 – June 30, 2019.

2. TARGET AND COMPARISON POPULATION

Full benefit Medicaid members at the time of participation in the Demonstration are included in the target population. It is expected that enrollees who have 12 months of continuous enrollment with no more than a 45-day gap in eligibility will be included in the evaluation. However, final criteria will be determined by the evaluator based on population size, data availability and the specifications of each outcome measure. An overview of the target group for each initiative is provided below.

Demonstration Component	Target Population
SUD-IMD	Medicaid enrollees, 21-64 years old with a primary diagnosis of SUD.
	Enrollees 21-64 years old with an SUD who have at least one IMD discharge for SUD treatment in an NH IMD during the measurement period.
SMI-IMD*	Enrollees 21-64 years old with lengths of stay less than 180 days and who have at least one IMD discharge during the measurement period for psychiatric treatment in a NH IMD.
Dentures Coverage	Enrollees 21 years old and older who reside in a NH Nursing Facility
Community Reentry Program	Medicaid members 18 years old and older who have an SUD or SMI and who are receiving pre-release services

**Should QRTP authorities be implemented during the Demonstration, measures will be stratified by age to assess outcomes for members who are under 18 years old.*

All programs authorized under the Demonstration are statewide initiatives. All Medicaid members are eligible to receive coverage under the Demonstration based on diagnosis and medical necessity. Apart from the Community Reentry Program, all other benefits are pre-existing programs. Therefore, availability of an in-state comparison groups is limited.

The evaluator will determine if a comparison group for members participating in the pre-release program can be identified. The evaluator will work with DHHS to identify members whose application for Medicaid coverage (new or continued) originated from DOC prior to release from incarceration during calendar year (CY) 2023 and 2024. As feasible, based on length of stay in DOC custody, claims will be examined prior to and after incarceration using HEDIS® value sets with alcohol, opioid and other drug dependence and the NCQA standardized definition of SMI to identify comparison group members. Claims history for CY2018-2023 will be examined.

Currently, the State is not aware of another Medicaid program with a substantially similar population, taking into account differences in program eligibility and coverage policies, demographic and geographic characteristics, behavioral health provider systems, breadth of networks, IMD availability and provider payment rates. In addition, the State does not have any data-use agreements with another State. These factors make the use of an out-of-state comparison group impractical at this time.

3. EVALUATION PERIOD

The evaluation period will include the one-year extension of the previous Demonstration July 1, 2023 – July 15, 2024 and the current Demonstration period July 16, 2024 – June 30, 2029. Baseline periods will vary based on the initiative studied and final analytic approach.

4. EVALUATION MEASURES

Measures associated with each Demonstration initiative are outlined on the following pages. Tables include evaluation questions, hypotheses, measures, target populations, data sources and primary analytic approaches. Measures will rely on diagnostic and procedural codes as specified in the CMS Technical Specifications Manual for SUD Monitoring Protocol metrics. The most recent technical manual published by CMS at the time of measure production will be used across all evaluation years. Adjustments will be made to align with the target population (e.g., age, diagnosis and service type) for each initiative and as needed to align with State-specific claiming and reporting guidelines.

Measures studied using an interrupted time series (ITS) approach will use a quarterly measurement period. Measures studied using logistic or linear regression, test of proportionality or CEM with matched t-tests will use a twelve month measurement period.

SUD-Related Evaluation Measures

Measure	Study Population	Numerator	Denominator	Data Source	Analytic Approach
Evaluation Question 1. Is the Demonstration associated with improved rates of SUD identification, initiation and engagement in SUD treatment?					
Hypothesis 1. The Demonstration will be associated with improved initiation and maintain access to residential SUD treatment.					
Percent of enrollees with a claim for residential SUD-IMD treatment during the measurement period	Enrollees with an SUD	The number of enrollees with a claim for treatment in an IMD during the measurement period	Total number of Medicaid enrollees, 21-64 years old with a primary diagnosis of SUD.	MMIS	ITS; GLM
Percentage of enrollees who initiated treatment within 14 days of diagnosis.	Enrollees with an SUD	The number of enrollees who initiated treatment within 14 days of the diagnosis.	Number of members 21-64 years old with at least one claim/encounter with a diagnosis of SUD with no claims or encounters with a diagnosis of SUD in the measurement period or 90 days prior	MMIS	ITS*; GLM
Percentage of enrollees who engage in treatment within 34 days of initiation	Enrollees with an SUD	The number of enrollees who had two or more additional SUD services within 34 days of the initiation visit	The number of enrollees 21-64 years old who initiated treatment within 14 days of the diagnosis	MMIS	
Evaluation Question 2. Is the Demonstration associated with improved adherence and retention in SUD treatment?					
Hypothesis 1. The Demonstration will be associated with improved adherence and retention in treatment.					
Percentage of members who engage in medication assisted treatment for OUD (MOUD), including breakouts for induction in the ED	Enrollees with an SUD	The number of members who are receiving MOUD, including stratification for those who received MOUD in the ED	Members 21-64 years old with a primary diagnosis of OUD during the measurement period	MMIS	ITS*; GLM
The percentage of members receiving OUD medication in the 90 days prior to and following an IMD discharge	IMD Service Recipients	The number of members receiving medication for OUD (a) 90 days prior to admission (b) 90 days following discharge	The number of members 21-64 years old with a primary diagnosis of OUD who have an IMD discharge during the measurement period	MMIS	ITS; GLM
The percentage of enrollees who had six or more visits in 90 days following IMD discharge	IMD Service Recipients	The number of members who had six or more SUD treatment visits in 90 days following discharge	The number of members 21-64 years old with a discharge from an IMD during the measurement period	MMIS	ITS; GLM
Evaluation Question 3. Is the Demonstration associated with a reduction in overdose deaths?					
Hypotheses 1. The Demonstration will be associated with stabilizing or lowering overdose related deaths.					
The percentage of members who had overdose-related deaths following IMD discharge	IMD Service Recipients	The number who had an overdose-related death in the 12-months post discharge	The number of enrollees 21-64 discharged from an IMD treatment service	MMIS; Vital Statistics	Logistic Regression
Evaluation Question 4. Is the Demonstration associated with a reduction in utilization of the ED and inpatient services?					
Hypotheses 1. The Demonstration will be associated with reductions in hospitalizations and in ED visits.					
The rate of ED visits for SUD per 1,000 member months	Enrollees with an SUD	Total number of ED visits for SUD	Member months for members 21-64 years old with a primary diagnosis of SUD	MMIS	ITS*; GLM
The rate of ED visits for any reason per 1,000 member months	Enrollees with an SUD	Total number of ED visits (any reason)	Member months for members 21-64 years old with a primary diagnosis of SUD	MMIS	ITS*; GLM

Measure	Study Population	Numerator	Denominator	Data Source	Analytic Approach
The rate of ED visits 90 days prior to IMD admission and 90 days post discharge	IMD Service Recipients	(a) The number of ED visits in the 90 days prior to IMD admission (b) The number of ED visits in the 90-days post IMD discharge	(a) The number of IMD admissions for members 21-64 years old (b) The number of IMD discharges for members 21-64 years old.	MMIS	Logistic Regression
Evaluation Question 5. Is the Demonstration associated with fewer readmissions to the same or higher levels of care?					
Hypothesis 1. The Demonstration will be associated with stabilizing or lowering readmission rates.					
The percentage of IMD stays followed by a readmission for inpatient or residential treatment (any facility) within 30 days	IMD Service Recipients	The number of readmissions to an IMD, hospital or residential facility within 30 days of IMD discharge	The number of IMD discharges for members who are 21-64 years old	MMIS	ITS; GLM
Evaluation Question 6. Is the Demonstration associated with improved access to ambulatory/preventive care?					
Hypothesis 1. The Demonstration will be associated with increased ambulatory/preventive visits.					
The percentage of members with an ambulatory/preventive care visit following discharge from an IMD	IMD Service Recipients	The number who had an ambulatory/preventive care visit following discharge	The total number of members who are 21-64 years old with an IMD discharge	MMIS	ITS; GLM

*For measures applied to the general population of enrollees with an SUD, the evaluators also will include analyses using a baseline period of January 1, 2017 – June 30, 2019.

Exploratory SUD Expenditure Analyses: Patterns and trends in Medicaid costs associated with SUD-IMD authority in NH will be examined. These measures capture all costs for the measurement year and are not associated with a Demonstration hypothesis or budget neutrality reporting.

Measure	Study Population	Numerator	Denominator	Data Source	Approach
How does the cost of care change over time?					
Per member per month (PMPM) Medicaid cost (Total Cost of Care) for members ages 21-64	SUD-IMD Service Recipients	Sum of all Medicaid payments made for physical health and SUD -related services	Total member months for members 21-64 years old	MMIS	ITS; GLM
PMPM cost of SUD-Related treatment for members ages 21-64		Sum of all Medicaid payments made for MH-related cost, with breakouts for SUD-IMD, SUD-other treatment			
PMPM cost of physical health care for members ages 21-64		Sum of all Medicaid payments made for physical health care			
What are the cost drivers?					
PMPM cost of outpatient (non-ED) for members ages 21-64	SUD-IMD Service Recipients	Sum of all Medicaid payments made for outpatient (non-ED) care	Total member months for members 21-64 years old	MMIS	ITS; GLM
PMPM cost of pharmacy for members ages 21-64		Sum of all Medicaid payments made for pharmacy services			
PMPM cost of outpatient ED for members ages 21-64		Sum of all Medicaid payments made for outpatient-ED services			
PMPM cost of inpatient care for members ages 21-64		Sum of all Medicaid payments made for inpatient care			
PMPM cost of Long-term care for members ages 21-64		Sum of all Medicaid payments made for Long-Term Care services			

SMI-Related Evaluation Measures

Measure	Study Population	Numerator	Denominator	Data Source	Analytic Approach*
Evaluation Question 1. Is the Demonstration associated with reduced ED utilization for enrollees who receive psychiatric treatment in a NH IMD?					
Hypothesis 1. The Demonstration will be associated with stabilizing or reducing ED utilization for enrollees who receive NH IMD services.					
The rate of ED visits 90 days prior to IMD admission and 90 days post discharge	IMD Service Recipients	(a) The number of ED visits in the 90 days prior to IMD admission (b) The number of ED visits in the 90-days post IMD discharge	(a) The number of IMD admissions for members 21-64 years old (b) The number of IMD discharges for members 21-64 years old.	MMIS; IMD dataset	Logistic Regression
Hypothesis 2. The Demonstration will be associated with stabilizing or lowering the length of stay in the ED for enrollees who are awaiting treatment services in a NH IMD.					
Average number of days in the ED for members ages 21-64 who are admitted to an IMD from the ED	IMD Service Recipients	Number of persons waiting for psychiatric treatment in an IMD	Number of days awaiting placement in the ED prior to IMD admission	MMIS; IMD dataset	Linear Regression
Evaluation Question 2. Is the Demonstration associated with fewer readmissions to NH IMDs?					
Hypothesis 1. The Demonstration will be associated with stabilizing or lowering readmissions to NH IMDs.					
Percent of members 21-64 years old with an IMD readmission within 30 days of IMD discharge	IMD Service Recipients	Number of readmissions within 30 days of discharge	Number of IMD discharges	MMIS; IMD dataset	Logistic Regression;
Percent of members 21-64 years old with IMD readmissions within 30 days who did not receive follow-up care in the community post discharge	IMD Service Recipients	Number of members with a IMD readmission who did not receive a mental health service following discharge and prior to the readmission	Number of psychiatric readmissions within 30 days of IMD discharge, excluding members on temporary leave	MMIS; IMD dataset	Logistic Regression
Evaluation Question 3. Is the Demonstration associated with increased use of community-based crisis stabilization services?					
Hypothesis 1. The Demonstration will be associated with increased utilization of community-based crisis stabilization services					
The percentage of Medicaid members 21-64 who received mobile crisis stabilization services during the measurement period	Medicaid	The number of members who received mobile crisis stabilization services	The number of members who are 21-64 years old during the measurement period.	MMIS	Logistic Regression
Evaluation Question 4. Is the Demonstration associated with improved access to community-based primary and behavioral health services?					
Hypothesis 1. The Demonstration will be associated with maintaining access to ambulatory/preventive care for members who received NH IMD services					
Percent of members ages 21-64 with a preventive or ambulatory health service post IMD discharge	IMD Service Recipients	Number of members who had a preventive or ambulatory care visit within 12 months of discharge	Number of members 21-64 years old who were discharged from an IMD	MMIS; IMD dataset	Logistic Regression
Percent of adult survey respondents who report they were able meet with a PCP to discuss physical well-being	Medicaid MCO Population	Number of respondents who agree or strongly agree that they were able to meet with a PCP	Number of respondents for survey Section D, Question 1	MCO BH Adult Survey	Logistic Regression
Hypothesis 2. The Demonstration will be associated with maintaining access to mental health services					
Percent of adult survey respondents who report staff were able to see them as often as necessary	Medicaid MCO Population	Number of respondents who agree or strongly agree that staff were	Number of respondents for survey Section A, Question 2	MCO BH Adult Survey	Logistic Regression

Measure	Study Population	Numerator	Denominator	Data Source	Analytic Approach*
		able to see them as often as necessary			
Percent of adult survey respondents who report staff return calls within 24 hours		Number of respondents who agree or strongly agree that staff returned calls within 24 hours	Number of respondents for survey Section A, Question 3		
Percent of adult survey respondents who report services were available at times that were convenient		Number of respondents who agree or strongly agree that services were available at convenient times	Number of respondents for survey Section A, Question 4		
Percent of adult survey respondents who report they were able to get all the services they needed		Number of respondents who agree or strongly agree that they were able to get all the services they needed	Number of respondents for survey Section A, Question 5		
Percent of adult survey respondents who report they were able to see a psychiatrist when they wanted		Number of respondents who agree or strongly agree that they were able to see a psychiatrist when they needed	Number of respondents for survey Section A, Question 6		
Evaluation Question 5. Is the Demonstration associated with improved follow-up after discharge from NH IMD settings?					
Hypothesis 1. The Demonstration will be associated with maintaining or improving follow-up after discharge from a NH IMD.					
Percent of members 21-64 years old who had follow-up within 7 days after hospitalization for MH	IMD Service Recipients	Number of members who had a follow-up visit with a mental health practitioner within 7 days of discharge	Number of members who are 21-64 years old discharged from an IMD	MMIS; IMD dataset	Logistic Regression
Percent of members 21-64 years old who had follow-up within 30 days after hospitalization for MH		Number of members who had a follow-up visit with a mental health practitioner within 30 days of discharge	Number of members who are 21-64 years old discharged from an IMD	MMIS; IMD dataset	Logistic Regression
Percent of members 21-64 years old who received mental health services each month in the six months following IMD discharge		Number of members who had a follow-up visit with a mental health practitioner in each of the six months following discharge	Number of members who are 21-64 years old discharged from an IMD	MMIS; IMD dataset	Logistic Regression

*The baseline period for quantitative analysis is July 1, 2023 – June 30, 2024, one year prior to the start of the current Demonstration authorities.

Exploratory SMI-IMD Expenditure Analyses. Patterns and trends in Medicaid costs associated with the SMI-IMD authority in NH will be examined. These measures capture all costs for the measurement year and are not associated with a Demonstration hypothesis or budget neutrality reporting.

Measure	Study Population	Numerator	Denominator	Data Source	Approach
How does the cost of care change over time?					
Per member per month (PMPM) Medicaid cost (Total Cost of Care) for members ages 21-64	SMI-IMD Service Recipients	Sum of all Medicaid payments made for physical health and MH-related services	Total member months for members 21-64 years old	MMIS; IMD dataset	Descriptive
PMPM cost of MH-Related treatment for members ages 21-64		Sum of all Medicaid payments made for MH-related cost, with breakouts for MH-IMD, MH-other treatment			
PMPM cost of physical health care for members ages 21-64		Sum of all Medicaid payments made for physical health care			
What are the cost drivers?					
PMPM cost of outpatient (non-ED) for members ages 21-64	SMI-IMD Service Recipients	Sum of all Medicaid payments made for outpatient (non-ED) care	Total member months for members 21-64 years old	MMIS; IMD dataset	Descriptive
PMPM cost of pharmacy for members ages 21-64		Sum of all Medicaid payments made for pharmacy services			
PMPM cost of outpatient ED for members ages 21-64		Sum of all Medicaid payments made for outpatient-ED services			
PMPM cost of inpatient care for members ages 21-64		Sum of all Medicaid payments made for inpatient care			
PMPM cost of Long-term care for members ages 21-64		Sum of all Medicaid payments made for Long-Term Care services			

Nursing Facility Dentures Evaluation Measures

Measure	Study Population	Numerator	Denominator	Data Source	Analytic Approach*
Evaluation Question 1. Is the Demonstration associated with improved access to removable prosthodontics for nursing facility residents?					
Hypothesis 1. The Demonstration will be associated with improved access to removable prosthodontic services for nursing facility residents.					
The percentage of Medicaid members ages 21 and older who reside in nursing facilities and receive dentures	NF Residents	Number of nursing facility residents who received dentures in the measurement year	Number of nursing facility residents aged 21 and older during the measurement year	Claims	Logistic Regression
Evaluation Question 2. Is the Demonstration associated with reduced dental infections for nursing facility residents?					
Hypothesis 1. The Demonstration will be associated with reduced incidence of dental infections among nursing facility residents.					
The rate of dental infections per 1,000 member months for nursing facility residents	NF Residents	Number of dental infections during the measurement year	Number of nursing facility member months for residents aged 21 and older during the measurement year	Claims	Logistic Regression
Hypothesis 2. The Demonstration will be associated with decreased non-traumatic dental related visits among nursing facility residents.					
The rate of dental-related ED visits (non-traumatic) per 1,000 member months for nursing facility residents	NF Residents	Number of dental related ED visits (non-traumatic) in the measurement year	Number of nursing facility member months for residents aged 21 and older during the measurement year	Claims	Logistic Regression
Evaluation Question 3. Is the Demonstration associated with reduced hospitalizations for nursing facility residents?					
Hypothesis 1. The Demonstration will be associated with reduced incidence of hospitalizations due to aspiration pneumonia among nursing facility residents.					
The rate of inpatient admissions for aspiration pneumonia per 1,000 member months for nursing facility residents	NF Residents	Number of hospital discharges with a diagnosis of aspiration pneumonia during the measurement year	Number of nursing facility member months for residents aged 21 during the measurement year	Claims	Logistic Regression
Evaluation Question 4. Is the Demonstration associated with improved nutritional status for residents who received the benefit?					
Hypothesis 1. The Demonstration will be associated with improved nutritional status among residents who received denture benefit.					
The number of respondents who report improved nutritional status for members who received dentures	NF Residents Receiving Dentures	N/A	N/A	NF Staff Survey	Descriptive
Evaluation Question 5. Is the Demonstration associated with improved Quality of Life for residents who receive the benefit?					
Hypothesis 1. The Demonstration will be associated with increased quality of life (e.g., participation in community meals and social events, well-being) among residents who received denture benefit.					
The number of respondents who report improved quality of life for members who received dentures	NF Residents Receiving Dentures	N/A	N/A	NF Staff and Member Survey	Descriptive

*The baseline period for quantitative analysis is July 1, 2023 – June 30, 2024, one year prior to the start of the current Demonstration authorities and the first full year of program operation.

Reentry Program Evaluation Measures

Measure	Study Population	Numerator	Denominator	Data Source	Analytic Approach*
Evaluation Question 1. Is the Demonstration associated with continuous Medicaid coverage following community reentry?					
Hypothesis 1. Demonstration enrollees will maintain continuous Medicaid coverage post release.					
The number of members who are assigned limited benefits for pre-release services in each year	DOC Medicaid Applicants	N/A	N/A	DHHS Eligibility System	Descriptive
The percentage of members with the Reentry benefits who maintained full Medicaid coverage for 12 months post release		The total number who retained coverage for 12 months, excluding those who became ineligible due to income or employer sponsored coverage	(a) Total number of members who left incarceration (b) Total number of members who received Reentry benefits		Matched t-test with CEM
Evaluation Question 2. Is the Demonstration associated with improved access to and retention in treatment post release? a. Does the length of the pre-release program support successful transitions and care in the community?					
Hypothesis 1. The Demonstration will be associated with improved access to and retention in treatment post release.					
The percentage of participants with MH or SUD follow-up within 30 days of release	Reentry Program Enrollees	The number who received follow-up care with a MH or SUD treatment provider within 30 days of release	(a) Total number of members who left incarceration (b) Total number of members who received Reentry benefits	DHHS Eligibility System; MMIS	Matched t-test with CEM
			(c) Members receiving pre-release services less than 30 days compared to those with 30 days or more of pre-release services	DHHS Reentry Tracking; DHHS Eligibility System; MMIS	Student's t-test
The percentage of members with prescribed antipsychotics at release who have follow-up care with a prescribing provider within 30 days of release	Reentry Program Enrollees	The number who had follow-up with a prescribing provider within 30 days of release	Total number of members who received antipsychotic medications at release	DOC Pharmacy data; MMIS	Logistic Regression
The percentage of participants with pharmacotherapy for OUD at release who have at least 180 days of continuous treatment post release	Reentry Program Enrollees	The number who had 180 days of continuous treatment post release	Total number of members who received MOUD medications at release		Logistic Regression
The percentage of participants who had six or more visits in 90 days post release	Reentry Program Enrollees	The number of members who had six or more SUD or MH treatment visits in 90 days following discharge	(a) Total number of members who left incarceration (b) Total number of members who received Reentry benefits	DHHS Eligibility System; MMIS	Matched t-test with CEM
			(c) Members receiving pre-release services less than 30 days compared to	DHHS Reentry Tracking; DHHS	Student's t-test

Measure	Study Population	Numerator	Denominator	Data Source	Analytic Approach*
			those with 30 days or more of pre-release services	Eligibility System; MMIS	
Stakeholder feedback regarding length of program services	Reentry Stakeholders	N/A	N/A	Interview or Survey	Descriptive
Evaluation Question 3. Does the Demonstration support improved communication and coordination between correctional programs, health care systems, and community providers? a. What do stakeholders report as program successes, barriers, challenges and recommendations?					
Hypothesis 1. Stakeholders will report improved coordination and communication between State agencies, health plans and providers					
Stakeholder satisfaction with communication, implementation activities and planning efforts, including success, challenges and recommendations	MCO, DOC, Medicaid, Community Stakeholders	N/A	N/A	Interview or Survey	Descriptive
Provider satisfaction with referral system and discharge planning	Providers	N/A	N/A	Interview or Survey	Descriptive
Evaluation Question 4. What investments were made to improve health care and related services during the Demonstration? a. How do actual reentry program costs compare to the State's cost estimates as reflected in the budget neutrality limits?					
Hypothesis 1. The State will increase its investments to improve health care and related services under the Demonstration					
Descriptive information on the type and scope of investments made under the Demonstration	N/A	N/A	N/A	DHHS; CMS Reporting	Descriptive
Descriptive information on actual expenditures compared to BN limits	N/A	N/A	N/A	DHHS; CMS Reporting	Descriptive
Percent of participants receiving pre-release care management from an MCO during the calendar year	Reentry Program Enrollees	Number of participants who received MCO care management services	Total number of members participating in the reentry program	DHHS; MCO Supplemental Reports	Logistic Regression
Percent of participants who receive services from a community based provider prior to release during the calendar year		Number of participants with provider encounters pre-release		DHHS Eligibility System; MMIS	Logistic Regression
Percent of participants who receive peer support services prior to release during the calendar year		Number of participants with peer support encounters pre-release		DHHS Eligibility System; MMIS	Logistic Regression
Evaluation Question 5. Is the Demonstration associated with improved access to ambulatory and/or preventive care post release?					
Hypothesis 1. The Demonstration will be associated with increased visits for ambulatory/preventive care post release.					
Percent of participants who have an ambulatory or preventive care visit in the year following release	Reentry Program Enrollees	Number of participants who had a preventive or ambulatory care visit within 12 months post release	(a) Total number of members who left incarceration (b) Total number of members who received Reentry benefits	DHHS Eligibility System; MMIS	Matched t-test with CEM

Measure	Study Population	Numerator	Denominator	Data Source	Analytic Approach*
Stakeholder and member survey re: discharge planning and appointments made for physical and BH	Reentry Staff & Enrollees	N/A	N/A	Interview or Survey	Descriptive
Evaluation Question 6. Is the Demonstration associated with lower all cause death rates in the near term following release from incarceration?					
Hypothesis 1. The Demonstration will be associated with stabilizing or lowering the death rate following release.					
The all-cause death rate in the year following release for Medicaid Reentry Program participants	Reentry Program Enrollees	The number of deaths from any cause in the 12 months post release	Total number of members who received Reentry coverage	MMIS; Vital Statistics	Logistic Regression
Evaluation Question 7. Is the Demonstration associated with fewer ED visits and hospitalizations post release?					
Hypothesis 1. The Demonstration will be associated with reduced use of ED and inpatient services post release.					
Rate of ED visits per 1,000 member months for participants 12 months post release	Reentry Program Enrollees	The total number of ED visits (any cause)	Total number of member months in the measurement period for: (a) Members who left incarceration (b) Members who received Reentry benefits	DHHS Eligibility System; MMIS	Matched t-test with CEM
Rate of ED visits for SUD per 1,000 member months for participants 12 months post release		Total number of ED visits with SUD diagnosis			Matched t-test with CEM
Rate of ED visits for MH per 1,000 member months for participants 12 months post release		Total number of ED visits with MH diagnosis			Matched t-test with CEM
Rate of potentially avoidable ED visits per 1,000 member months for participants 12 months post release		Total number of ED visits with diagnosis identified as potentially avoidable			Matched t-test with CEM
Rate of inpatient hospitalization (all cause) per 1,000 member months for participants 12 months post release		Total number of inpatient discharges (all cause)			Matched t-test with CEM
Evaluation Question 8. Is the Demonstration associated with fewer overdose related deaths?					
Hypothesis 1. The Demonstration will be associated with stabilizing or lowering overdose related deaths post release.					
The number and percentage of overdose deaths in the Medicaid Reentry Program population 12 months post release	Reentry Program Enrollees	The number of overdose related deaths post release in the 12 months post release	Total number of members who received Reentry coverage	MMIS; Vital Statistics	Logistic Regression

*The baseline period for quantitative analysis is January 1, 2023 – December 31, 2024, one year prior to the start of the Community Reentry Program

5. DATA SOURCES

The quantitative measures identified for evaluation rely on the New Hampshire Medicaid Management Information System (MMIS) and New Heights Medicaid Eligibility and Enrollment System. This includes Medicaid claims and Medicaid eligibility information. Managed care encounter, claims and cost data is available through the MMIS (eligibility and claims) and will be made available to evaluators through a standardized quarterly extract to support the evaluation. Use of fee-for-service and managed care encounters will be limited to final adjudicated claims and encounters using a six-month runout period.

Existing agreements with Managed Care Organizations require that all MCOs make data available to support evaluations and performance monitoring efforts. DHHS does not anticipate problems with data collection and reporting; however, DHHS monitors data closely for completeness and will take corrective action if required. A summary of each data source and its use under the evaluation is provided below.

Data System	Evaluation Data/Target Group
Medicaid Management Information System (MMIS)	Medicaid claims and MCO encounter data submitted to the State by providers used to support performance, utilization, and cost metrics
New Heights Medicaid Eligibility and Enrollment System (EES)	Eligibility and enrollment detail for Medicaid beneficiaries is used to determine enrollee aid category, residence, race/ethnicity and to stratify data into sub-groups, when applicable
New Hampshire Psychiatric Hospital (IMD) Dataset	The SMI target population is identified using admission and discharge data for Medicaid members who use New Hampshire IMD programs. This dataset also includes information on ED length of stay prior to IMD admission
MCO Behavioral Health Survey Data	DHHS developed a standardized methodology and required survey tool for all MCOs. Survey results are due to DHHS on February 1 of each year. As described in the evaluation measures table, aggregated responses to specific questions will be used as part of the SMI-IMD evaluation component
Vital Statistics	Public health birth, death, and other vital records used to track death and overdose-related deaths attributed to New Hampshire residents. DHHS receives death data and matches it to Medicaid enrollment files. DHHS will provide cause of death information to the evaluator for use in the SUD and Reentry evaluation components
DOC Pharmacy Management System	The department maintains a separate pharmacy management system to track services to members while incarcerated. Medication records and dispensing history will be used to identify members who receive medications on the day of release

Quantitative Data

The evaluator will schedule ad hoc meetings with State subject matter experts if anomalies are found in the data. For example, results or sample size that represent a significant departure from the prior year without clear explanation will prompt individual meetings with data and program experts. In addition, the evaluator will record changes in measure specifications and changes in program operations or policy that may impact data or outcomes. An overview of data collection and validation processes related to the evaluation datasets is provided below.

Medicaid Management Information System and New Heights Medicaid Eligibility and Enrollment Data: The measures identified for the evaluation rely predominately on the MMIS and New Heights data. This includes Medicaid claims (paid, suspended, and denied) and Medicaid eligibility information. The evaluator will receive raw claims extracts quarterly. The evaluator then will perform a data audit process to identify problems and inconsistencies with the data received. This includes direct comparisons to previous raw claims extracts to evaluate trends and validate consistency. The evaluator will work with the State to answer questions and provide feedback to resolve discrepancies in output.

New Hampshire Psychiatric Hospital (IMD) Data: Admission and discharge data will include Medicaid ID, admission and discharge date, primary diagnosis, length of stay and discharge status (i.e., leave of absence, against medical advice, conditional discharge). Data will be submitted to the evaluation team quarterly. The evaluator will perform a data review to identify problems and inconsistencies with the data received (e.g., duplicate files, admit/discharge on same day). This includes direct comparisons to previous extracts to evaluate trends and validate consistency. The evaluation team will cross-check the IMD dataset using the MMIS claims for the New Hampshire Hospital (NPI 1861491334) and Hampstead Hospital (NPI 1952450082).

The evaluator will schedule ad hoc meetings with the DHHS IMD data team to answer questions and provide feedback to resolve discrepancies.

MCO Behavioral Health Survey Data: DHHS requires each MCO to conduct a Behavioral Health Satisfaction Survey. DHHS issued standardized survey tools, instructions, and sample size requirements. MCOs are required to conduct the survey annually between September 1 and November 30. Results will be reviewed for adherence to DHHS sampling and reporting requirements. PHPG will work with the State and MCOs to answer questions and provide feedback to resolve discrepancies in results received annually.

Vital Statistics Data: This Public Health Department data base serves as the authority for birth, death, and other vital records in New Hampshire. Death records are recorded with the cause of death and are used to track overdose deaths attributed to New Hampshire residents. The DHHS links with the Vital Statistics database as part of its program integrity process to ensure Medicaid members who have died are removed from the eligibility system. Deaths attributed to opioid and other drug overdose are matched to Medicaid members to calculate the number and rate of overdose deaths among Medicaid beneficiaries. Cause of death data may lag up to one year.

DOC Pharmacy Data: The DOC pharmacy management system tracks medication services for members while incarcerated. Medication records and dispensing history will be used to identify members who receive psychiatric medications and/or medications for OUD on the day of release. The evaluator will allow for at least three months run out to assure that pharmacy information has been reconciled for members whose release date changed or who refused medications at release.

Qualitative Data

The evaluation contemplates the use of qualitative data collection for three Demonstration initiatives: Reentry, Dentures and SMI authorities. Each activity is summarized below

Dentures Beneficiary Survey: During the last evaluation period the evaluator collaborated with DHHS and the Dental Organization to develop a survey, methodology and distribution process for members who received the dentures benefit (Attachment 4). Six months after receiving their dentures, surveys are distributed to members. This allows time for members to acclimate to the prosthodontics and for any pre-existing condition related to not having prosthodontics to subside.

A single survey was designed that includes questions that can be completed by the member or through staff observation. Staff observation is used when the member cannot remember or respond independently due to a cognitive decline or medical condition.

The survey addresses the following three topic areas:

- Nutritional Status (e.g., ability to eat a variety of foods from all food groups, improving and/or maintaining a healthy weight)

- Social Interactions (e.g., participation in congregate meals and other social events, frequency of verbal interactions with staff and peers)

- General Well-Being (e.g., overall satisfaction, level of oral pain, ability to effectively communicate wants and needs)

Psychiatric/Behavioral Health Member Survey: DHHS requires each MCO to conduct a Behavioral Health Satisfaction Survey. DHHS issued standardized survey tools, instructions, and sample size requirements. MCOs are required to conduct the survey annually between September 1 and November 30. The minimum survey sample size is 1,350 for adults. MCOs are expected to oversample as needed to ensure a minimum of 411 completed surveys each year. MCOs submit a sampling plan to DHHS prior to conducting the survey. Data is collected using a mixed methodology process (e.g., electronic, telephonic, etc.). The survey was initially conducted on a smaller sample and reported to DHHS June 30, 2020. Results for the full sample are submitted to DHHS by February 1 of each year.

Beginning with the February 2021 survey results, evaluators will aggregate the data collected by the MCOs to create a statewide total for specific questions related to evaluation hypotheses as delineated in measures table in the section above. All survey questions examined for the evaluation utilize a five-point Likert-scale response methodology.

Reentry Program Stakeholder Survey/Interviews: The evaluation team will collaborate with DHHS and DOC to develop qualitive data collection tools and methodologies for the Reentry

Program. The table below provides an overview of topic areas and target group for soliciting feedback. In all areas surveys and interviews will solicit feedback from stakeholders on success, challenges and recommendations for improvement.

Survey/Interview Topic Area*	MCO Staff	DOC, DHHS Staff (State and Loca)	Providers	Members
Satisfaction with agency (DHHS and DOC) communication, implementation activities and Reentry planning efforts	✓	✓	✓	
Satisfaction with referral system and discharge planning processes			✓	✓
Ease of planning and availability of appointments post release for physical and BH	✓	✓	✓	✓
Satisfaction with the length of pre-release program services	✓	✓	✓	

* All topic areas will include a discussion of success, challenges and recommendations for improvement

6. ANALYTIC METHODS

Data analysis will consist of both exploratory and descriptive strategies and incorporate univariate, bi-variate, and multi-variate techniques. The analysis will be performed to systematically apply statistical and/or logical techniques to describe, summarize, and compare data within the State and across time. The evaluation questions and hypotheses will use member-level data to draw program level conclusions.

Descriptive statistics will be used to describe the basic features of the data and what they depict, and to provide simple summaries about the sample and the measures. They also will be used to provide summaries about the participants and their outcomes. Data will be analyzed as rates, proportions, frequencies, and measures of central tendency (e.g., mean, median, mode), and/or qualitatively analyzed for themes. Given the specific focus of the target group and uniqueness of the State initiatives, comparisons to national benchmarks are not available.

Where feasible, based on population size and availability of data, the analysis will be stratified by racial and ethnic sub-populations. Race and ethnicity data is collected as part of the Medicaid eligibility and enrollment system; however, responses to these demographic questions are voluntary.

As appropriate, analytic methods will include Logistic and Linear Regression, t-test, and ANOVA. These tests are useful for comparing population means and standard deviations over time and the objective is to determine whether the mean of a certain outcome variable of interest is significantly different between two time periods.

The traditionally accepted significance level ($p \leq 0.05$) will be used for all comparisons. Where multiple comparisons are being made with the same data and outcome, a Bonferroni Correction will be used to control for potentially spurious correlations.

The SUD-related authorities have been in place since 2018. The evaluator will assess SUD-related data for the feasibility of using an interrupted time series approach. The evaluator will determine whether the data includes enough observations (pre and post) and reflects a stationary time series (i.e., the statistical properties of the time series did not change over time – in this case in the pre-Demonstration data subset and the post Demonstration data subset). In addition, the data should preserve enough non-zero values and variation to allow for time series analysis.

If time series is feasible, the pre-Demonstration period will be defined as July 1, 2019 – July 15, 2024. The post period will include the current authorities (July 16, 2024 – June 30, 2029). The Demonstration's one-year extension period (July 1, 2023 – July 15, 2024) coincided with the end of the PHE and will serve as the base year. For a limited number of SUD-related measures that examine trends for enrollees with an SUD, a second analysis will be completed with a pre-Demonstration period of January 1, 2017 – June 30, 2019.

The ITS approach was ruled out for the SMI-IMD, Dentures and Reentry programs due to the small population size and sparse data issues. During prior examination of the SMI-related and nursing facility data, the evaluator concluded that the number of observations of various outcomes (discharges, readmissions, ED visits, inpatient stays, etc.) was too few in any given month or quarter to provide meaningful analysis. The Reentry program is expected to serve fewer than 50 individuals per month, also contributing to sparse data challenges. However, prior to interim and summative report analysis, the evaluator will retest the data to determine whether it includes enough observations (pre and post) and reflects a stationary time series such that an ITS approach may be applicable for these programs.

As part of the Community Reentry Program evaluation, subsidiary question (a) under evaluation question two (Does the length of the pre-release program support successful transitions and care in the community?) will be examined using a Student's t-test. Carceral factors such as credits for time served and good behavior, conditions of release (e.g., approved housing) and unplanned disciplinary actions can result in changes in the expected release date at any point in the reentry process. If the population size is sufficient, the evaluators will examine the difference in post release engagement for reentry program participants whose length of participants in the pre-release programs are less than 30 days compared to those who were engaged for 30 or more days. In anticipation of a small sample size, matching is likely to result in discarding observations. Therefore, the evaluators will perform a Student's t-test with no matching.

An overview of the primary and alternative approaches considered is provided below. Final decision will be made by the evaluator based on data availability and population size.

Authority	Program Start	Primary Approach	Alternative Approach
SUD-IMD	July 1, 2018	Interrupted Time Series; Generalized Linear Model	Logistic Regression
SMI-IMD	July 1, 2022	Logistic & Linear Regression; Qualitative	Test for proportionality of change
Dentures	April 1, 2023	Logistic Regression; Qualitative	Test for proportionality of change
Reentry	Jan 1, 2025	Comparison Strategy; Qualitative	Logistic & Linear Regression

Interrupted Time Series

Evaluation measures studied using an interrupted time series (ITS) design will be examined quarterly. The ITS assumes stationarity in the data and includes the assumption that absent the Demonstration, results would have continued on the same trajectory as the pre-Demonstration quarters. If the evaluator determines that data is appropriate for ITS, the evaluation will examine whether there is: (1) no effect; (2) only an immediate effect; (3) only a sustained long-term effect; or (4) both an immediate and a sustained long-term effect. To model the time series, the following equation will be used:

$$Y = \beta_0 + \beta_1 Time + \beta_2 D + \beta_3 P + \varepsilon$$

where Y is the outcome variable or metric of interest, *Time* indicates the quarter since the beginning of the observational period (i.e., 1, 2, …), D is an indicator variable (takes on either value 0 or 1) that indicates whether this period is before or after the Demonstration, and P denotes the period or quarter since the Demonstration started (i.e., 0's until the Demonstration effective date then 1, 2, …).

Generalized Linear Model

As part of the ITS analysis, and based on the viability of the sample size, the evaluator will control for the following demographic characteristics: age, gender, geography, and aid category code using the following equation:

$$Y_t = \beta_0 + \beta_1 T_t + \beta_2 D_t + \beta_3 P_t + \beta_4 D_{AGE} + \beta_5 D_{GENDER} + \beta_6 D_{AidExpansion} + \beta_7 D_{AidNonABD} + \beta_8 D_{URBANRURAL} + \varepsilon$$

These variables are defined as:

- T_t (time since beginning of data collection)
- D_t (a dummy variable indicating if the current period is pre-intervention (D_t =0) or post-intervention (D_t =1))
- P_t (time since Demonstration start date, takes on 0 for periods before Demonstration start date)
- D_{AGE}, D_{GENDER}, $D_{URBANRURAL}$, (demographic and geography variables)
- $D_{AidExpansion}$, $D_{AidNonABD}$ (dummy variables for the member's aid category code where Aged Blind Disabled (ABD) is represented by 0 on both Expansion and non-ABD)

Generalized linear models with both demographic and time series variables (time, time since Demonstration, dummy variable for pre/post Demonstration) will be used to help isolate impact of Demonstration. The covariates explain some of the variation in the metrics of interests and thus reflect a more accurate importance of the temporal variables relating to the Demonstration date. As with all regressions, there is always the risk of confounding factors that we cannot measure or enter into the regression model having explanatory power over the variation in the outcome variable.

Linear Regression

Linear regression will be used to measure the contribution for explaining variation in the outcome of interest by variable (e.g., year), and whether the observation is from before or after a new program was put in place. The outcome of interest in these measures are non-negative numbers and often continuous. The dependent variables can be continuous or binary. For

example, x_year is a continuous variable and x_SMI is a binary indicator variable (i.e., takes on value 0 for false and 1 for true). The evaluator will estimate the following:

$$y = \beta_0 + \beta_1 x_{year} + \beta_2 x_{SMI} + \cdots + \varepsilon$$

Logistic Regression

Logistic regression will be used to measure change over the baseline year. The outcome of interest in most measures is binary, in that the member either received/engaged in the outcome of interest or did not (yes or 1 /no or 0) as denoted. The probability of 'yes' is 'p' and the probability of 'no' is thus '1-p'. 'l = log(p/1-p)' is the log odds (or logit) which we estimate with the year where the base year is typically SFY2024 (the effect is captured in the intercept) and the years following are interpreted as incremental effects compared to the base year. The design examines whether the incremental years are statistically significant on the log-odds of saying yes vs no to the measures of interest.

If they are statistically significant, the interpretation is that the year in question (e.g., the intervention and post intervention year) shows a marked difference compared to the base year. This combined with a comparison of the rates (p = # saying yes/total # of that year) shows that there was a statistically significant increase (or decrease) in the rate of yes to a measure from the base year to a future year. Outcomes (which are always binary in these cases) will be calculated annually for each of the three evaluation years (baseline, intervention and one year post).

$$l = ln\frac{p}{1-p} = \beta_0 + \beta_1(year) + \varepsilon$$

which is solved algebraically for p:

$$p = \frac{1}{1 + e^{-(\beta_0 + \beta_1(year) + \varepsilon)}}$$

Autocorrelation in Time Series

Autocorrelation is likely to be observed. IMD and other continuum of care services were available to enrollees in the previous Demonstration period. Quality improvement efforts in the behavioral health system also have been ongoing. It is likely that the distribution is stable and highly correlated to the previous year(s)'data. Identifying autocorrelation is important relative to violating assumptions of time series modeling and inference. However, autocorrelation is mostly a concern when using time series modeling for forecasting where accuracy may be impacted. Forecasting is not being used as part of the evaluation design.

As relevant, the ITS findings will include a plot of the actual time series and a plot of the partial autocorrelation function (pACF) for each outcome that results in lags that are significant at a 5 percent level.

Coarsened Exact Matching

Coarsened Exact Matching (CEM) will be used for evaluating the Reentry Program. CEM is intended to reduce confounding variables associated with the observational data by "coarsening" data (e.g., using age ranges rather than specific ages) to find exact matches more quickly between comparison and treatment groups. This allows the evaluator to create balanced subsets of comparison and treatment data in order to attribute more of the differences in the metrics of interest across these two groups to their treatment (or lack thereof in the case of the comparison group) and not to one of the demographic factors which could also explain some or all of the differences between the groups' outcomes.
Covariates will include gender, age, diagnosis, geography and aid category code (enumerated below). The evaluator will perform a separate analysis for each year of the Demonstration; thus, the year will also be entered as a covariate.

Geographic Category	County (Recipient Place of Residence)
Urban	Hillsborough, Merrimack, Rockingham, Strafford
Rural	Belknap, Carroll, Cheshire, Coos, Grafton, Sullivan

The aid category which determines how a member qualified for Medicaid will be one-hot encoded to become the following binary variables: Expansion; Aged, Blind and Disabled (ABD); Non-ABD.

Qualitative Analysis

Structured interviews, focus groups or surveys with representatives from DOC, Medicaid, MCOs and community providers will be conducted related to the Reentry Program. Structured interviews will be conducted by phone or via Zoom/Microsoft Teams and are expected to last approximately 30 minutes to one hour. Interview questions will be finalized by the independent evaluator and approved by the State.

A Thematic Analysis will be used to assess interview responses. These analyses examine structured interview data for patterns across interviews. Themes will be defined based on their appearance in the data and not on a pre-defined content structure. Thematic analysis will be conducted separately on each structured interview transcript, for each group of interviewees using an inductive approach. Patterns in the transcripts will be identified and grouped into themes. Themes will be checked against the original transcripts for validity. To ensure the reliability of the analyses, at least two evaluators will be present for interviews and conduct the analysis. The analysis is descriptive in nature; it is not intended to support comparison between groups of interviewees or follow principles of statistical significance.

Sensitivity Analysis

Apart from the MCO Behavioral Health Satisfaction Survey overseen by the State, the Evaluation Design does not rely on sampling methods. Measures are constructed using CMS recognized, reliable, and valid measure sets, and include all members who meet the criteria for the outcome being studied (e.g., diagnostic, age, gender). All eligible members are included in the design. Thus, there are limited evaluation design elements that may skew findings.

However, to evaluate the robustness of results over time, the evaluator will test the robustness of findings by removing outliers, when appropriate (e.g., +/- 2 standard deviations from the mean) and re-running the original analysis to determine if trends and results are significantly different. Findings will report any occurrence where the results of statistical probability at the 0.05 level conflict between methods.

Isolation From Other Initiatives

The State receives funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) as part of its State Opioid Response Grant (SOR). The State implemented a State Opioid Response Program, known as the Doorway, funded through SAMHSA, on January 1, 2019. Nine Doorways began offering the following core services in each region of the State:

- SUD screening and evaluation.
- SUD treatment services, including MOUD.
- Prevention and harm reduction services (e.g., naloxone distribution).
- Recovery services and supports.
- Peer recovery services.

The evaluator will control for the SOR Program by identifying Medicaid members with a claim from one of the nine Doorway providers. Where feasible, a linear regression or generalized linear model will be performed to control for members who received Medicaid reimbursable Doorway services. The evaluator will encode Doorway as a binary variable and estimate the coefficient of receiving Doorway services (i.e., Doorway-yes) versus not receiving Doorway services to control for the impact of a member being in the Doorway program. (Note, however, that members may receive Doorway services that are not Medicaid reimbursable, or providers may choose not to claim for State Plan services, limiting the extent to which the impact of these programs can be isolated from the SUD Demonstration results.)

Apart from the State Opioid Response Grant (SOR), all current Medicaid initiatives are outlined in the Demonstration's STCs and/or the Implementation Plans approved or under development for the various programs. Community, provider, and member educational efforts not targeted exclusively for Medicaid enrollees may be occurring at the same time as the Demonstration. These initiatives will be documented and provide context for findings but cannot be isolated or controlled in the analysis.

Should other program innovations outside of the Demonstration become available during the Demonstration, the evaluator will attempt to isolate Medicaid members who may be receiving services outside of the Demonstration. To account for the effects of concurrent enrollment, the evaluator will perform the analysis as stated in the design with and without those participants. If there are no statistically significant differences between the findings, the evaluator will show the results of the analysis including all participants. Otherwise, the evaluator will present the results of the analysis on the population, not including members receiving services outside of the Demonstration.

D. METHODOLOGICAL LIMITATIONS

Due to the quasi-experimental nature of the design and the limitations identified below, the evaluation results cannot be attributed to causal inference. The findings may suggest an association or correlation with various aspects of the Demonstration. However, language suggesting causation or analyses of counterfactuals may not be appropriate when describing results.

The evaluation has been designed to yield accurate and actionable findings but does have methodological limitations, most of which are inherent to Section 1115 demonstrations. Data and design limitations are outlined below.

Continuity of Services*:* New Hampshire psychiatric and residential SUD IMD treatment facilities are statewide providers who have been delivering care to Medicaid enrollees prior to the implementation of the original Demonstration. In addition, DOC staff have been providing medications for SUD and psychiatric treatment, care coordination and assistance with Medicaid applications for inmates prior to and upon their release.

Lack of True Experimental Control Groups: IMD facilities serve residents from across the State. Thus, regional control or comparison groups for IMD service recipients are not available.

Medicaid Enrollment/Disenrollment: Medicaid enrollment changes on an annual basis related to eligibility. For example, someone may be attributed to a study cohort in year one, disenroll in year two and re-enroll in year three.

The design will employ analytic techniques to mitigate the impact of these limitations including interrupted time series (SUD-related data) as well as logistic and linear regression (SMI, Dentures-related data) to examine trends over time and coarsened exact matching (Reentry data) to evaluate outcomes when feasible.

E. ATTACHMENTS

1. INDEPENDENT EVALUATOR

Procurement for an evaluation contractor to assist the State in executing its Demonstration evaluation was conducted during State Fiscal Year (SFY) 2021 pursuant to the State of New Hampshire procurement guidelines. All resulting agreements and amendments are contingent upon approval from New Hampshire's Governor and Executive Council. To mitigate any potential conflict of interest, the evaluation contractor is responsible for:

- Primary data analysis;
- Benchmarking performance to national standards when appropriate;
- Evaluating changes over time;
- Isolating key variables;
- Interpreting results; and
- Producing evaluation reports.

As part of the IMD evaluation, the evaluator is responsible for final measure selection, identifying, if viable, other State systems that may serve as comparisons, conducting all data analysis, measuring change over time, and developing sensitivity models as necessary to address study questions. The State selected the successful bidder based on demonstration, at a minimum, of the following qualifications:

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

The Pacific Health Policy Group (PHPG), was engaged to perform the independent evaluation of various programs operated by New Hampshire, including the Section 1115 IMD Demonstration and Mid-Point Assessments. The State selected PHPG because the firm has performed multiple independent evaluations of Section 1115 Demonstrations, including IMD components over the past decade. In addition to its evaluation and Mid-Point Assessment work in New Hampshire, PHPG serves as the Independent Evaluator and Mid-Point Assessor for Section 1115a evaluations in Oklahoma and Maine and previously served in this role in New Mexico (under subcontract to Deloitte Consulting) and in Vermont.

The evaluators held several design sessions with key stakeholders from each topic area to solicit information on program operations, policy priorities, data availability and data limitations. The evaluation team reviewed existing data to determine the best fit between data type and the

proposed analytic methods. The evaluation team prepared the design document based on the CMS guidance documents and STC requirements.

The State schedules regular meetings with PHPG's Project Manager/Principal Investigator to receive updates on the evaluation and address any issues that arise with respect to data collection and clarity/accuracy of findings.

2. TIMELINE AND MAJOR MILESTONES

Outlined below are major milestones and timelines.

Demo Year 7: (7/1/2024-06/30/2025)

	2024						2025					
Activity/Milestone	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Identify State Subject Matter Experts for Design Sessions	X	X										
Develop Evaluation Design		X	X	X								
Draft and Finalize Evaluation Design				X	X	X						
Reentry Program Start							X					
Submit Draft Evaluation Design for CMS Review							X					
Data Collection and Validation	X	X	X	X	X	X	X	X	X	X	X	X
Define Reentry Data Extracts							X	X	X			
Develop Reentry Member Survey/Exit Interview Questions							X	X				
Begin Reentry Data Collection										X	X	X
Project Management and Reporting	X	X	X	X	X	X	X	X	X	X	X	X

Demo Year 8: (7/1/2025-06/30/2026)

	2025						2026					
Activity/Milestone	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Review and Incorporate CMS Feedback in Evaluation Design				X	X							
Submit Final Evaluation Design for CMS Approval					X	X						
Publish Final Evaluation Design (within 30-days after approval)							X					
Quantitative Data Collection				X	X	X						
Develop Reentry Stakeholder Survey/Interview Protocols	X											
Conduct Reentry Stakeholder Survey/Interviews				X	X	X						
Data Collection and Validation	X	X	X	X	X	X	X	X	X	X	X	X
Project Management and Reporting	X	X	X	X	X	X	X	X	X	X	X	X

Demo Year 9: (7/1/2026-6/30/2027)

	2026						2027					
Activity/Milestone	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Data Collection and Validation	X	X	X	X	X	X	X	X	X	X	X	X
Project Management and Reporting	X	X	X	X	X	X	X	X	X	X	X	X

Demo Year 10: (7/1/2027-6/30/2028)

	2027						2028					
Activity/Milestone	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Data Collection, Validation and Analyses	X	X	X	X	X	X	X	X	X	X	X	X
Create Draft Interim Evaluation Report							X	X	X			
Disseminate Draft Interim Evaluation Report to DHHS for Feedback										X	X	
Submit Draft Interim Evaluation Report to CMS												X
Project Management and Reporting	X	X	X	X	X	X	X	X	X	X	X	X

Demo Year 11: (7/1/2028-6/30/2029)

	2028						2029					
Activity/Milestone	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Data Collection, Validation and Analysis	X	X	X	X	X	X	X	X	X	X	X	X
Project Management and Reporting	X	X	X	X	X	X	X	X	X	X	X	X
Incorporate CMS Comment on Interim Evaluation Report (60 days after CMS comments)												X

Post Demo: (7/1/2029-6/30/2030)

	2029						2030					
Activity/ Milestone	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Submit Final Interim Evaluation Report to CMS		X										
Publish Final Interim Evaluation Report (within 30 days after approval)						X						
Data Collection, Validation and Analyses	X	X	X	X	X	X	X	X	X	X	X	X

Post Demo: (7/1/2030-12/31/2031)

	2030						2031											
Activity/ Milestone	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
Develop Draft Summative Evaluation Report	X	X	X															
Disseminate Draft Summative Evaluation Report to DHHS for Feedback				X	X													
Submit Draft Summative Evaluation Report to CMS						X												
Incorporate CMS Comment (60 days after CMS comments)															X	X		
Submit Final Summative Evaluation Report to CMS																	X	
Publish Final Summative Evaluation Report (within 30 days after approval)																		X

3. EVALUATION BUDGET

Evaluation Activity	SFY25 (July 1, 2024 - June 30, 2025)	SFY26 (July 1, 2025 - June 30, 2026)	SFY27 (July 1, 2026 - June 30, 2027)	SFY28 (July 1, 2027 - June 30, 2028)	SFY29 (July 1, 2028 - June 30, 2029)	SFY30 (July 1, 2029 - June 30, 2030)	SFY31 (July 1, 2030 - June 30, 2031)	SFY32 (July 1, 2031 - June 30, 2032)	Total
Evaluation Design Plan	$ 77,182	$ 9,229							$ 86,411
Community Reentry Implementation	$ 47,779	$ 20,304							$ 68,084
Data Collection, Cleaning and Analysis	$ 95,559	$ 66,451	$ 26,923	$ 46,674	$ 101,181	$ 18,949	$ 18,282		$ 374,018
Draft Interim Evaluation Report			$ 78,527	$ 228,994					$ 307,521
Final Interim Evaluation Report					$ 9,871	$ 8,121			$ 17,992
Draft Summative Evaluation Report						$ 101,510	$ 87,752		$ 189,262
Final Summative Evaluation Report							$ 4,875	$ 17,708	$ 22,583
Project Management and Reporting	$ 14,701	$ 14,767	$ 15,705	$ 16,044	$ 12,339	$ 6,767	$ 10,969	$ 1,333	$ 92,626
Total	**$ 235,222**	**$ 110,751**	**$ 121,155**	**$ 291,712**	**$ 123,391**	**$ 135,347**	**$ 121,878**	**$ 19,041**	**$ 1,158,497**

4. DENTURES BENEFICIARY SURVEY

New Hampshire Medicaid Nursing Facility Dentures Beneficiary Survey							
If you received new, replacement or repaired dentures (full or partial), please complete this survey. You may complete this survey on your own or you may ask someone for help. If you are not feeling well or can't remember how you felt before getting your dentures or repairs, you can ask the nursing staff for help or to complete the survey for you.							
Section 1. General Information							
Please tell us who is completing the survey and about the type of dentures you received:							
Date Survey Completed		Person Completing Survey (check one)			Member Member w/ Assistance Nursing Facility Staff		
Survey ID		Member Age		Gender			
Nursing Facility Name							
Type of Full or Partial Dentures Received		New		Replacement		Repairs	
Section 2: Nutrition and Communication							
For each question below, please choose the box that indicates how strongly you agree with the statement. If you have no opinion, please choose "Neither Agree nor Disagree."							
Questions	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know	
A. My dentures make it easier for me to eat a wider variety of foods. For example, foods that are crunchy, hard, soft, and chewy.							
B. My dentures make it easier for me to eat.							
C. Since getting my dentures my weight has improved.							
D. My dentures make it easier for people to understand what I am saying.							
E. Since I received my dentures, I visit with staff and friends more often.							
F. Since I received my dentures, I participate in more activities and/or events.							
G. My dentures make it easier for me to tell staff what I need.							
H. Since I received my dentures, I have less pain in my mouth.							

1

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	Bureau of Health Facilities creates new rules specific to SUD residential treatment facilities; this includes requirements related to staffing, physical space expectations, programmatic design, and compliance requirements. The Bureau of Health Facilities will inspect facilities for compliance prior to issuing or renewing a license. Additional controls will be put in place through updates to He-W 513 and He-A 300 rules to ensure compliance checks from Medicaid Program Integrity and Bureau of Drug and Alcohol Service staff on an annual basis.	Health Facilities rule updated and effective by December 31, 2018 He-W 513 rules will be updated to include language regarding annual compliance checks by Fall 2018 He-A 300 rules will be updated to include language regarding specific standards and annual compliance by Fall 2019.

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

Current state:

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

Future state:

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

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

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

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

Current state:

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

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

Future state:

NH will establish an assessment process to meet this milestone.

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

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

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

Current state:

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

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

Measure ID	Measure Name	Data Collection Status	Results
CMS_A_OHD	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage (CMS Adult Core Set)	Started with FFY 2016 Reporting (for measurement year 2015)	https://medicaidquality.nh.gov/reports/use-of-opioids-at-high-dosage-ohd-
CMS_A_CUOB	Concurrent Use of Opioids and Benzodiazepines	Will start with FFY 2018 Reporting (for measurement year	N/A
PHARMQI.09	Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	Started with CY 2016 Quarter 2	https://medicaidquality.nh.gov/reports/safety-monitoring---opioid-prescriptions-meeting-nh-dhhs-morphine-equivalent-dosage-prior-
SUD_11 1 5.01	Continuity of Pharmacotherapy for Opioid Use Disorder	Will start with SFY 2019 Reporting	N/A

Table 1. Managed care opioid prescribing metrics

Future state:

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

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

Milestone Criteria	Current State	Future State	Summary of Actions
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	

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.	*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.
	Future Status: DHHS will monitor the provider network through the annual completion of the CMS-designated Provider Availability Assessment Template.
	Summary of Actions Needed: By completing the CMS-designated Provider Availability Assessment, the State will fulfill the requirements of this milestone.

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
Reentry Demonstration Initiative Implementation Plan

Background

The implementation plan documents the state's approach to implementing a section 1115 Reentry demonstration and helps establish what information the state will report in its monitoring reports by describing whether and how the state will phase in implementation. The state must also submit a monitoring protocol that details its plans to conduct monitoring reporting. The implementation plan does not supersede or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments. For states covering the CAA population under the 1115 demonstration, the CAA-required operational protocol is satisfied by the reentry implementation plan.

The implementation plan outlines key information on the overall demonstration design, as well as actions related to the five milestones included in the State Medicaid Director Letter (SMDL) "Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated". .

Reentry demonstration reporting topics
Implementation Settings
SMDL Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated
SMDL Milestone 2: Covering and ensuring access to the minimum set of pre-release services for individuals who are incarcerated to improve care transitions upon return to the community
SMDL Milestone 3: Promoting continuity of care
SMDL Milestone 4: Connecting to services available post-release to meet the needs of the reentering population
SMDL Milestone 5: Ensuring cross-system collaboration
Reducing Health Disparities
Reinvestment plan
Consolidated Appropriations Act Population
Appendix: Implementation Phase-In Approach (if applicable)

Implementation Settings

1. In the table below, report the total number of facilities anticipated for each facility type once the reentry demonstration is fully implemented. If the demonstration includes another facility type/s not listed in the table, add a column/s for the other facility type/s.
   - Does the state intend to phase in facilities? ☒ Yes ☐ No

[1] This SMDL (#23-003) is available in full here: https://www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf.

- If yes, provide the total estimated number of facilities for each facility type once the reentry demonstration is fully implemented, and estimate the number of facilities to be phased-in by demonstration year (DY).
- If no, only provide the total estimated number of facilities for each facility type once the reentry demonstration is fully implemented.

	State Prisons	County/Local Jails	Youth Correctional Facilities
Total	8 total	10 total	Note: Youth facilities are not part of the demonstration, but youth services will be launched on the same time frame as the waiver
DY 1	Launch in 8 (8 total)	0 (No county jails participating in DY1)	N/A
DY 2	8 total	Launch in 2 new jails (2 total)	N/A
DY 3	8 total	Launch 3 new jails (5 total)	N/A
DY 4	8 total	Launch 3 new jails (8 total)	N/A
DY 5	8 total	Launch in 2 new jails (10 total)	N/A

The landscape of New Hampshire carceral settings includes both state and county facilities, as described below.

State: NH DOC is responsible for overseeing eight state facilities. These facilities include three State Prisons: New Hampshire State Prison for Men, New Hampshire Correctional Facility for Women, and Northern New Hampshire Correctional Facility. DOC oversees five additional state facilities: the Transitional Work Center, the Secure Psychiatric Treatment Unit, and three Transitional Housing Units (THUs).

Note that the vast majority of individuals releasing from the THUs are classified as C1. Individuals classified as C1 can maintain their Medicaid coverage. Therefore, those individuals would not be part of the demonstration. As described by DOC Commissioner Hanks, NH has included THUs because there are a very small number of residents in C2 classification. These C2 residents do not have the freedom of movement to access the community that C1 residents have. Instead, these C2 residents must remain at the house, under direct supervision of officers. Because these C2s do not have free access to the community (C2-Minimum security), they remain at the house and are assigned jobs such as cooking, mowing, and laundry. These C2 individuals are not eligible for active Medicaid, and therefore their Medicaid must remain suspended while in residence at the THU. NH has included the THUs in this demonstration in order to provide services for the outlier C2s who are housed there.
Otherwise, all other C1 residents qualify for full Medicaid, as was outlined in the SHO letter

from CMS in 2016, and therefore would not participate in this demonstration.

County: County jails are overseen by each individual county. NH has ten counties, for a total of ten county jails. New Hampshire will phase in counties according to readiness.

2. Describe the state's plan for determining that participating facilities are ready to provide pre-release services to eligible beneficiaries. The description should address how the facilities will facilitate access into the correctional facilities for community health care providers (either in person or via telehealth). *(The information being requested here aligns with information required under Milestone 5.)*

   New Hampshire (NH) is readying its systems and processes to launch the reentry demonstration in state prisons on January 1, 2025. The Department of Health and Human Services (DHHS) has been actively partnering with the Department of Corrections (DOC) since 2022 to identify the scope of pre- release services for eligible beneficiaries, outline policies regarding suspension and unsuspension of Medicaid, and develop operational processes to ensure access to community-based services. Through continuous ongoing engagement with both DOC and DHHS subject matter experts (SMEs) and cross- agency leadership, DHHS has assessed that the four participating DOC state prisons are prepared to meet the core requirements of the demonstration, including:

   - Continued sharing of individual data at admissions (including Medicaid IDs) with DHHS to facilitate Medicaid suspension upon incarceration
   - Commitment to conducting broad Medicaid outreach and enrollment activities for all individuals, including initiating new Medicaid application processes 90 days prior to an individual's minimum sentence release date when desired/necessary
   - Technical infrastructure to facilitate access to community health care providers via telehealth appointments, and future plans to further increase telehealth access via procurement of new telehealth pod structures
   - Ability for DOC case managers to partner with care managers from Managed Care Organizations (MCO) during the 45-day pre-release window to ensure a warm-handoff and coordinated person-centered care planning
   - Existing processes for identification of behavioral health needs upon admission and throughout an individual's stay

As illustrated by the schedule in the above table (section 1), DHHS plans to conduct a phased approach to demonstration launch in county-based facilities, starting in demonstration year two. The order of launch in county facilities will be determined according to individual county readiness. DHHS is currently in the process of meeting with all ten counties to conduct a preliminary assessment of individual county readiness and has completed five assessments to date. NH expects to complete all ten preliminary county assessments by January of 2025.

Findings from initial county assessments: Between September and December of 2024, we met with correctional facility staff members from 8 counties, including superintendents, case workers, counselors, medical staff, and others. We introduced them to the policies and benefit packages and went through a structured interview to assess readiness. The structured interview guide contained items related to:

- Census and balance of adjudicated and non- adjudicated residents;

- Current processes and staffing surrounding reentry;
- Pathways for release into the community;
- Screening for substance use or mental illness;

- Connections to community providers;
- Processes for suspending and re-applying for Medicaid;
- Contact and support from Medicaid staff during the eligibility process;
- Challenges with Medicaid eligibility;
- Connection points with the online eligibility and enrollment system NH EASY;
- Medical and behavioral health staffing;
- Use of contractors or outside providers for medical, dental, hearing, vision and pharmacy services;
- MAT services offered and provided;
- Availability and provision of counseling;
- Record keeping in case management and medical records, a
- Ability to bill third parties for reimbursement across medical, behavioral health and pharmacy services;
- Ability to engage in telehealth; and
- Process of sharing medical records with community providers.

The assessments found wide variation in size, staffing, enthusiasm, readiness, and understanding of the benefit package. An important factor we discovered is that five counties contract with a single medical provider and we have begun to work with this medical provider with the hopes of forming a partnership for enhanced service delivery. Some facilities have strong relationships with local community providers such as federally qualified health centers and community mental health centers and others do not. Of those we have met with so far, all offer MAT (most offering multiple types of MATs). Most have a case manager who works on Medicaid eligibility – some use NH EASY directly and have close Medicaid contacts for questions and others do not.

DHHS is also creating a formal readiness assessment to codify the core elements of facility readiness described above and will utilize this formal assessment to determine the exact schedule for demonstration launch in each county. After completing the initial assessments**,** DHHS will partner with all ten counties to complete the readiness assessment jointly in preparation for launch in each jail. We anticipate beginning this process in March 2025.

SMDL Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.

3. Does the state currently suspend eligibility and benefits during incarceration? ☒ Yes ☐ No
    - If no, describe how the state will either effectuate a suspension strategy within two years from approval of the expenditure authority or implement an alternate plan that will ensure only allowable benefits are covered and paid for during incarceration, while ensuring coverage and payment of full benefits as soon as possible upon release.

4. Opportunity to enroll in Medicaid:

   ☒ The state attests that any Medicaid-eligible person who is incarcerated at a participating facility but not yet enrolled is afforded the opportunity to apply for Medicaid in the most

feasible and efficient manner and is offered assistance with the Medicaid application process in accordance with 42 CFR 435.906 and 435.908, and anticipates using the following methods described at 42 CFR 435.907 to ensure enrollment:

☒ Online application

☒ by telephone

☒ in person

☒ via mail

☐ common electronic means

☒ The state attests that all individuals who are incarcerated at a participating facility will be allowed to access and complete a Medicaid application and will be assisted in this process, including by providing information about where to complete the Medicaid application for another state (e.g., relevant state Medicaid agency website), if the person plans to live in a different state after release.

☒ The state attests that all individuals enrolled in Medicaid during their incarceration will be provided with a Medicaid and/or managed care plan card or some other Medicaid and/or managed care enrollment documentation upon release, along with information on how to use their coverage.

5. Describe any challenges not already described in the milestone 1 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

- Challenge: NH DOC currently reports that all Medicaid-related mail is sent to one central DOC location. This would pose issues ensuring that individuals receive their Medicaid card while incarcerated.
    - Mitigation Approach: New Hampshire is issuing guidance (expected to be released 12/20/2024) to DOC case managers instructing them to utilize a facility-specific address in the NH EASY application portal rather than the central DOC address. This will help ensure that Medicaid cards are delivered to the residents in a timely manner. In addition, the MCOs have provided a preview of the enrollment welcome package that will be sent via mail to ensure the package contents comply with DOC mailing requirements. Finally, DHHS has confirmed with the MCOs that individuals may access electronic enrollment cards in the case of issues with physical mail delivery. Instructions for accessing the online portal will be shared with DOC case managers in late December 2024.
- Challenge: Although NH DHHS does currently operate a Medicaid suspensions process, this process is based on a manual suspension utilizing a monthly information feed from DOC.
    - Mitigation Approach: In January in 2025, DOC will increase the frequency of this feed to a minimum of weekly transmissions. In addition, NH DHHS is establishing a new shared eligibility email address for reentry. This will serve as a point of contact where DOC case managers can communicate directly with eligibility to ensure correct enrollment / suspension / activation status of Medicaid. This new email box will be live on January 1, 2025. DOC case managers have already received information about this enhanced eligibility support in trainings conducted December 2024.

- Challenge: DOC case managers have varying level of familiarity with the DHHS online Medicaid application (NH EASY).
    - Mitigation Approach: DHHS provided eligibility training on NH EASY to DOC case managers in December 2024. This training occurred as part of a six-hour community reentry workshop that was hosted at the DOC headquarters and attended by over 30 DOC case managers and supervisors. The training was recorded and will be made available to DOC in an on-demand video format moving forward. DHHS is issuing FAQs on the NH EASY application process as well (expected 12/20/2024). Additionally, as described above, DHHS is establishing a new email inbox for DOC eligibility questions. Finally, DHHS has designated a specific SME to specialize in Medicaid eligibility cases regarding incarcerated individuals. The contact information for this new SME was shared with DOC case managers during December 2024 reentry trainings.
    - Note: Based on the initial conversations with county jails, we understand that the case managers at county facilities also have varying levels of familiarity with NH EASY. To mitigate this challenge, NH plans to hold dedicated eligibility training with county facilities in advance of launch, like the DOC training described above. Furthermore, personnel at county jails will also be encouraged to utilize the new eligibility inbox as a key point of contact for questions. Additionally, the designated DHHS SME on incarcerated eligibility described above will also be assigned to all cases originating from county facilities, and will serve as an additional point of contact for county jails.

SMDL Milestone 2: Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated, to improve care transitions upon return to the community.

6. Describe how, within two years from approval of the expenditure authority, the state will effectuate a policy to **identify Medicaid and CHIP eligible individual**s, or individuals who would be eligible for CHIP, except for their incarceration status. Include in the description how the state will implement a screening process to **identify individuals who qualify for pre-release services** in line with the qualifying criteria outlined in the state's STCs. *(The information being requested here aligns with information required under Milestone 1.)*

Screening for Medicaid Eligibility:

- **DOC:** DOC will update their case management policy (established in 2020) to screen all interested individuals for Medicaid eligibility at the 90-day mark prior to their anticipated release date. In advance of this time, DOC case managers will educate individuals on Medicaid benefits, including the community reentry program. If the DOC resident is not yet enrolled in Medicaid and is interested in applying, the DOC case manager will assist interested residents in completing the Medicaid eligibility screening process, including working with the resident to complete an online application via the NH EASY portal.
- **County Jails:** County jails will mirror the approach for DOC described above. DHHS will work with counties to establish a new case management process whereby county jails screen all interested individuals for Medicaid eligibility at least 45 days prior to their anticipated release date, for sentences at least 45 days in length. For sentences less than 45 days in length, county jails will initiate Medicaid eligibility screening at the commencement of the sentence. County jail case managers will educate individuals on Medicaid benefits, including

the community reentry program. If the county jail resident is not yet enrolled in Medicaid and is interested in applying, the county jail case manager will assist interested residents in completing the Medicaid eligibility screening process, including working with the resident to complete an online application via the NH EASY portal.

If DHHS determines that the resident is Medicaid eligible, the resident's eligibility will automatically be suspended. Once the resident is 45 days from their anticipated release date, DHHS will unsuspend the Medicaid eligibility and enroll the individual in the community reentry benefit plan to facilitate delivery of reentry demonstration services.

Qualifying for Pre-Release Services:
Individuals will qualify for pre-release services under the demonstration if they are 1) Medicaid eligible; and 2) Determined to have either Substance Use Disorder (SUD) and/or Serious Mental Illness (SMI). DOC currently assesses for SUD and SMI upon admission and throughout a resident's stay. DOC utilizes evidence-based and nationally recognized screening tools to identify SUD/SMI, including the Ohio Risk Assessment (ORAS), Adult Needs and Strengths Assessment (ANSA), and American Society for Addiction Medicine (ASAM) Intake Assessment. NH is in the process of revising the NH EASY application to add a yes/no indicator for SUD/SMI in the DOC version of the application. This will enable NH DOC case managers to identify individuals with SUD/SMI during the Medicaid application process, and will flag the appropriate individuals as qualifying for pre- release demonstration services in NH's eligibility systems.

7. Minimum pre-release benefit package:

☒ The state attests that Medicaid-eligible individuals who are identified as demonstration participants will have access to the minimum short-term pre-release benefit package, which, at a minimum, includes the services listed below. (Provide the Medicaid benefit category or authority for each service in the space provided.)

- Case management to assess and address physical and behavioral health needs, and health-related social needs (HRSN) (if applicable): (1905(a)(19), 42 CFR 440.169 and 42 CFR 441.18)
- Medication-assisted treatment (MAT) for all types of substance use disorder (SUD) as clinically appropriate with accompanying counseling: (1905(a)(29)
- 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release: (1905(a)(12), 42 CFR 440.120(a) and 42 CFR 441.25)

8. Additional pre-release services:

- Does the state intend that Medicaid-eligible individuals who are identified as demonstration participants will have access to any pre-release services that are in addition to the minimum benefit services addressed in question 7? ☒ Yes ☐ No
  - ➢ If yes, list the additional pre-release services in the table below, along with the Medicaid

benefit category or authority for each service:

Pre-release service	Medicaid Benefit Category or Authority

Peer Support Services	SSA 1115 Demonstration
Community-Based Provider Intake	Other diagnostic, screening, preventive, and rehabilitative services (1905(a)(13), 42 CFR 440.130)

  - If no, skip down to question 9.

- If yes, does the state intend to phase-in the additional pre-release services? ☐ Yes ☒ No
  - If yes, complete the information in the Appendix A table template regarding participating facilities' Service Level selections and implementation timelines.

9. Describe any challenges not already described in the milestone 2 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

- Challenge: Medicaid eligibility processes are not immediate. Medicaid eligibility must be determined prior to 45 days before release to allow an individual to begin receiving services on day one of the demonstration period. This challenge is universal to Medicaid eligibility and would therefore apply to both DOC facilities and county jails.
  - DOC Mitigation Approach: DOC is implementing a new process to assess Medicaid enrollment status 90 days prior to expected release. This will allow DOC to submit new Medicaid applications for individuals not already in suspended status well in advance of the beginning of the demonstration period. This new 90-day eligibility scan will be implemented on January 1, 2025. DOC case managers have received training in this new process. DOC applications will also be routed specifically to specialized eligibility personnel to process said applications.
  - County Mitigation Approach: Note that due to the shorter length of stay in county jails compared to state prisons, it is likelier that individuals who are Medicaid enrolled upon incarceration will maintain eligibility throughout their sentence. To help expedite enrollment for individuals not yet enrolled in Medicaid upon incarceration, county jails will provide educational materials to proactively inform residents regarding Medicaid eligibility benefits and options. County jails will work with individuals to complete the Medicaid eligibility screening process at the earliest feasible opportunity.
- Challenge: Both DOC and county jails often receive short notice of parole dates. In order to ensure the benefit services can be delivered, identifying release dates as early as possible is critical.
  - DOC Mitigation Approach: DOC has conducted outreach to the parole boards to emphasize the benefits of advanced parole date notices. Additionally, DOC has identified events which provide reasonably likely predictability of the release date, including the scheduling of parole hearings approximately 60 days from release. DOC will continue to review key event indicators and actual release date data to fine tune the ability to identify the pre-release window.
  - County Mitigation Approach: DHHS will work with county jails in advance of launch to identify outreach opportunities to stakeholders who participate in the parole

date determination and notification process. DHHS will share learnings from DOC's work to identify events which indicate predictability of release dates and support counties as they review key event indicators and actual release date data.

- Challenge: Parole release dates may shift after the initial release date is published due to several factors, including issues with an individual's home plan or new disciplinary charges. This may potentially happen even after an individual has begun the reentry program. This poses challenges calculating the correct start / end date for the 45-day demonstration window. This challenge applies to both DOC and county jails.
    - DOC Mitigation Approach: If an individual's release date is delayed and notice of the delay occurs prior to the start of the 45-day demonstration period, DOC will update the anticipated release date in the individual's case file to ensure the demonstration does not start until the 45-day pre-release window. If the release date is delayed and notice occurs after the 45 days pre-release window has started, DOC will contact the DHHS reentry team and inform them of the delay. If the new release date is within 90 days of the original release date, DHHS will simply "pause" the clock on the 45 benefit days and resume the remaining number of days prior to the new release date. If the release date is delayed more than three months, the individual will be newly eligible for the full 45-day benefit period to ensure that release planning efforts are up to date and reflective of an individual's current needs. DHHS and DOC worked together to create this policy and have presented this approach to DOC case managers during the December 2024 training. DOC and DHHS will continue to monitor the effectiveness of this policy closely throughout demonstration year one.
    - County Mitigation Approach: County jails will mirror the approach described above. County jail case managers will receive training to support implementation prior to launch in each county. DHHS will also work closely with counties to understand the effectiveness of this approach in the immediate time period following implementation.
- Challenge: Neither DOC nor county jails have experience billing Medicaid. This is an essential function to facilitate the expanded delivery of post-release prescription medications.
    - DOC Mitigation Approach: DHHS has enrolled DOC pharmacy as a Medicaid provider. Enrollment applications for the MCO PBMs is in process at all the PBMs (this process is on track to be completed when needed). DOC has identified a billing software solution. DOC is in the process of testing Medicaid claims processing and identifying any needs for additional support.
    - County Mitigation Approach: DHHS will work with counties to enroll their pharmacy / pharmacy contractor as a Medicaid provider well in advance of implementation. DHHS will also support counties in the process of applying for the MCO PBMs and coordinate communications between counties and MCOs. Finally, DHHS will share learnings from DOC's software solutions and processes for submitting Medicaid claims to support counties as they identify a billing solution. DHHS understands that many counties utilize shared contractors and has scheduled initial meetings with the vendor to discuss enrollment and billing in Medicaid.
- Challenge: Access to providers, especially behavioral health providers, can be challenging. Such providers are essential partners in delivering pre-release services.

- Mitigation Approach: DHHS has identified a list of intended community provider partners, including peer support services. DHHS provided MCOs with this list, and

the MCOs are currently in the process of expanding their provider networks to incorporate additional community-based provider options as needed. Additionally, DHHS has conducted targeted outreach with providers including CMHCs to educate them on their role in the success of this demonstration. Moving forward, DHHS will schedule additional provider outreach sessions in December 2024 and January 2025.

SMDL Milestone 3: Promoting continuity of care.

10. Person-centered care plan:
    - Describe the state's plan to ensure that, prior to release, individuals who are incarcerated will receive a person-centered care plan that addresses any physical and behavioral health needs, as well as HRSN (if applicable) and consideration for long term services and supports (LTSS) needs that should be coordinated post release. Include any existing requirements related to care plan content for reentering individuals.

Pre-Release:
DOC case managers currently create and update comprehensive reentry plans for each resident upon admission and throughout their stay. The DOC reentry plans document information including risk assessments, housing and transportation plans, community resources, employment details, family resources, attainment of vital records and identification and follow-up appointment schedules and contacts.

As part of NH's reentry demonstration, eligible individuals will be enrolled in MCOs during the pre- release window. MCOs will be required to begin care management activities during this time period. As part of this process, MCO care managers will be responsible for creating a person-centered care plan for each member. To support this process, DOC case managers will assist in scheduling intake conversations with the resident and the MCO care manager and will participate in said intake conversations to provide a warm linkage. During this meeting, the MCO care manager will lead an intake conversation to understand the individual's needs and will utilize the information gathered to create a person-centered care plan. This person-centered care plan will document all of an individual's identified medical, pharmaceutical, dental, education, social, behavioral health or other service needs, with an emphasis on needs related to SMI/SUD. This plan outlines what is needed to manage the individual's care needs and helps organize and prioritize care and treatment, including referrals relative to health-related social needs. For individuals participating in reentry, the plan must also describe the coordination of dispensing 30 days of post-release meds prior to or at release.

MCO care managers will work with the individual throughout the pre-release period to continue developing and updating this person-centered care plan. MCOs will work in partnership with DOC case managers to ensure continued sharing of information throughout

the pre-release time period and to support updates to both the DOC reentry plan document and the person-centered care plan that will follow an individual through their journey into the post-release time period. DOC will also help facilitate information sharing releases to support these pre-release care management activities.

Note on County Implementation: DHHS is in the process of conducting readiness assessments in partnership with county facilities to better understand current case management processes, including

relevant documentation, in each county. DHHS will work with each county to identify existing documentation of physical and behavioral health needs, as well as identified HRSN (if applicable) and consideration for long term services and supports (LTSS). DHHS will support each county in creating a process to share existing documentation with MCOs to expedite the process of MCOs creating person- centered care plans. Counties will mirror the coordination approach with MCOs described above and work in partnership with MCOs to censure continued sharing of information between county case managers and MCO care managers throughout the demonstration period.

Post-Release:

Following an individual's reentry into the community, MCOs will continue to provide care management utilizing the person-centered care plan developed with the member during the pre-release period. Individuals who participate in the community reentry demonstration will be designated as an MCO priority population for one year following release. MCO contract language and written guidance will detail that post-release care management must include, at a minimum, monthly contact to review and update the person-centered care plan as necessary.

11. Case manager process and policies:

☒ The state attests to having processes and policies to ensure that case managers coordinate with providers of pre-release services and community-based providers (if they are different providers) and facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care.

☒ The state attests to having processes to facilitate coordination between case managers and community-based providers in communities where individuals will be living upon release or have the skills and resources to inform themselves about such providers for communities with which they are unfamiliar. *(This attestation additionally aligns with requirements under Milestone 2.)*

☒ The state attests to having policies to ensure that case managers have the necessary time needed to respond effectively to individuals who are incarcerated and transitioning back into the community. *(This attestation additionally aligns with requirements under Milestone 4.)*

12. Describe the state's policies to provide or to facilitate **timely access to any post-release health care** items and services, including fills or refills of prescribed medications and medical supplies, equipment, appliances or additional exams, laboratory tests, diagnostic, family planning, or other services needed to address the physical and behavioral health care needs, as identified in the person-centered care plan. The description should include how the policies will account for access across all implementation settings and for individuals with short-term sentences.

MCO Priority Population:

Under the new MCO contract amendment, individuals who participate in the community reentry demonstration will be designated as an MCO priority population for one year following reentry. Ongoing care management activities for this population will include monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively

implemented and adequately addresses the needs of the eligible individual and which may include the individual, family members, service providers, or other entities or individuals. Follow-up and monitoring activities should be conducted as frequently as necessary, including at least monthly ongoing monitoring.

Provider Prioritization:

DHHS is designating reentry participants as a priority population for both Community Mental Health Centers (CMHCs) and The Doorway. (The Doorway connects individuals to the supports and services for SUD including: screening and evaluation, treatment including Medication Assisted Treatment, prevention, including naloxone, supports and services to assist in long-term recovery and peer recovery support services)

This means that participants will be prioritized when scheduling appointments with CMHCs and Doorway. Additionally, MCOs will work with individuals to establish both pre- and post- release appointments early in the reentry time period to ensure that individuals have timely access to appointments and related services upon reentry.

13. If the state is implementing the demonstration through managed care, please attest to the item below. If not, skip down to question 14.

    ☒ The state attests that the managed care plan contracts reflect clear requirements and processes for transfer of a member's relevant health information upon release to another managed care plan or, if applicable, state Medicaid agency (e.g., if the beneficiary is moving to region of the state served by a different managed care plan or to another state after release) to ensure continuity of coverage and care.

14. Describe any challenges not already described in the milestone 3 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

    - Challenge: It can be difficult to schedule appointments with Medicaid providers in a reasonably short timeframe.
        - Mitigation Approach: To provide advanced lead for community-based appointments post-release, MCOs will work to identify service needs early in the demonstration period. This will allow MCOs to schedule post-release appointments while the individual is still incarcerated and expedite the time from release to first post-release appointments. DHHS is utilizing MCOs for care management responsibilities, which allow MCOs to schedule within their own networks in a timelier manner.
    - Challenge: MCOs will have a limited period of time to create the person-centered care plan and to identify needed appointments. It is critical to identify needs as quickly as possible in order to facilitate quick access to both pre- and post-release appointments.
        - Mitigation approach: DOC will create an information release process to utilize existing reentry planning information and share with MCOs on an expedited timeline. DOC is in the process of modifying existing information releases and expects to have

a process for sharing reentry plan documents and discharge summaries with MCOs in place by February 2024.

- Challenge: MCOs must quickly establish a relationship with individuals in order to effectively identify service needs and connect with the appropriate community resources.
    - Mitigation Approach: MCOs will coordinate with the DOC case managers to schedule an initial warm introduction with the DOC case manager, MCO care manager, and the demonstration participant. The goal of this meeting is to accelerate the process of relationship building and post-release service planning / scheduling. These meetings will be one of the first priorities upon reentry participation and will occur in the first week of individual's demonstration participation. Note that DOC case managers and MCOs have already begun coordination, as MCO care coordinators participated in an introduction session as part of the DOC case management training that occurred December 2025.

SMDL Milestone 4: Connecting to services available post-release to meet the needs of the reentering population.

15. Describe the state's plan for monitoring that contact between the reentering individuals and the case managers occurs within an appropriate timeframe. Include in the description the state's plan for ensuring ongoing case management.

    Pre-Release
    NH is adding new language to the forthcoming MCO contract amendment to require that MCOs begin care management activities during the 45-day pre-release period. MCOs will track care management activities via submission of billing codes to MCOs. DHHS will also conduct regular case management review sessions with MCOs and DOC to ensure that case management is occurring in a timely manner as individuals become eligible for pre-release services.
    Post-Release:
    Post-release, MCOs will be paid the appropriate monthly capitation payments for individuals who continue to receive Medicaid services through that MCO. Former community reentry participants will continue to be designated as a priority population for one year following reentry. Ongoing care management activities for this population should include monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may include the individual, family members, service providers, or other entities or individuals. Follow-up and monitoring activities should be conducted as frequently as necessary, including at least monthly ongoing monitoring.

    Individuals may also wish to pursue additional ongoing case management with CMHCs or Doorways. All interested participants in community reentry will have the opportunity to participate in a pre- release screening with CMHCs / Doorways (or other community-based provider) and may establish a full intake appointment to assess eligibility for services such as TCM post-release.

16. Describe any challenges not already described in the milestone 4 items above that the state anticipates

in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

- Challenge: Individuals may have limited transportation available to access post-release appointments in the community.
    - Mitigation Approach: DOC currently partners with local Archways to assist with transportation from DOC to post-release residential services. The addition of MCOs as a pre-release care delivery partner will allow MCOs to identify additional transportation options for other settings, including sober living arrangements. DHHS meets weekly with the MCOs to discuss support for demonstration activities. Future December 2024 agenda items include further documenting options for non-emergency medical transportation post-release.
- Challenge: Community-based providers may have limited knowledge of services and care delivered pre-release.
    - Mitigation Approach: NH is working to implement closed loop referral (CLR). CLR will be implemented as part of the reentry demonstration in order to facilitate information sharing and improve continuity of care between providers. NH's goal is to implement CLR as part of reentry by end of demonstration year one.

SMDL Milestone 5: Ensuring cross-system collaboration.

17. Describe the system/s the state Medicaid agency and participating facilities will employ (for example, a data exchange, with requisite data-sharing agreements) to allow the state Medicaid agency to **monitor individuals' access to and receipt of needed health care** and HRSN (if applicable), both pre- and post-release. Include in the description any anticipated data challenges and potential solutions, as well as details of the data-sharing agreements.

Data Exchange:
DHHS and DOC currently have an existing MOU to facilitate inter-departmental information exchanges. NH is in the process of updating this MOU to outline the additional information that will be shared between the departments in support of the demonstration. DHHS is also currently building out Closed Loop Referral (CLR) and anticipates using this system to support data sharing and tracking of service provision in the next phase of the community reentry demonstration.

Monitoring Protocol:
DHHS will establish a comprehensive monitoring approach for community reentry, in alignment with its approved demonstration and State monitoring priorities. The approved demonstration requires DHHS to submit a Monitoring Protocol after the approval of the demonstration and regular Quarterly and Annual Monitoring Reports throughout the duration of the demonstration.

It is expected that DHHS' Monitoring Protocol will include:

- A selection of quality-of-care and health outcomes metrics and population stratifications.
- Standardized reporting on categories of metrics, including but not limited to beneficiary participation in demonstration components, number of primary and specialist provider participation, utilization of services, quality of care, and health

outcomes.

- Metrics related to:

- Number of beneficiaries served, and types of services rendered under the demonstration.
- Administration of screenings to identify individuals who qualify for pre-release services
- Utilization of applicable pre-release and post-release services (e.g., care management, MAT, peer support services, acquisition of medications).
- Provision of health or social service referrals pre-release.
- Participants who received care management pre-release and continued to receive care management post-release.

- Methods and timeline to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics

Independent Demonstration Evaluation:
In addition to the Reentry Demonstration Monitoring Protocol, DHHS also intends to establish an overall program monitoring and evaluation approach. Building upon the readiness assessment process described above, DHHS will establish ongoing monitoring and oversight within the correctional facilities to ensure delivery of pre-release services consistent with the approved Demonstration.

18. Engagement of key entities:

A. Specify the types of key entities (e.g., correctional systems, community supervision entities, health care providers, managed care organizations, supported employment and supported housing agencies, etc.) the state intends to include in existing and future engagement for this demonstration.

NH will include the following key entities in stakeholder engagement activities: DOC state prisons, county jails, MCOs, community-based providers including CMHCs and Doorways, peer support agencies, probation parole officers, courts, and providers of related HRSN such as, but not limited to, housing and transportation.

B. Describe the plan for the organizational level engagement, coordination, and communication between the state and the entities listed above.

NH conducts monthly cross-agency steering committee meetings with leadership from DHHS and DOC to coordinate implementation activities and align on engagement of additional stakeholder such as MCOs and community-based providers. These meetings serve as the overarching framework for coordinating engagement with key entities. For example, the steering committee guides the design of weekly summits with MCOs to discuss demonstration requirements and outline new care management processes. In the future state, NH will continue to convene these monthly steering committee meetings to coordinate engagement activities.

The below table summarizes NH's ongoing and future planned engagement with various key stakeholders. Note that this is considered a living document, as NH plans to regularly revisit and update engagement strategies as demonstration needs require. NH will provide updates on stakeholder engagement in the monitoring reports submitted to CMS.

Category	Entities	Ongoing/Prior Communications	Future Communications
Internal Personnel	DOC case managers	• Information sharing from DOC leadership on program basics	• Two-pager on demonstration • Kick-off meeting to review processes • Policy documentation
Internal Personnel	DHHS eligibility team	• Weekly eligibility summits • Change request documentation	• Policy documentation • Formal training
Delivery Partner	CMHCs and Doorways	• Townhall meetings on program basics	• Additional townhalls to communicate specifics
Delivery Partner	MCOs	• Weekly MCO Summits	• Written MCO guidance
Delivery Partner	WIOA, homeless shelters, FQHCs, other resources in housing/employment services	• N/A	• Virtual stakeholder convening
Delivery Partner	NH Parole Board	• DOC communications from leadership	• Continued DOC engagement
Other	Governor's Advisory Comm. on Mental Illness and the Corrections System, Governor's Advisory Comm. on Alcohol and Other Drugs	• Presentations from DOC and DHHS leadership	• Continued information sharing regarding status of program launch
Other	MCAC	• Presentation re: demonstration approval	• Presentation re: demonstration launch
Other	Individuals currently incarcerated	• Information sharing from DOC CMs	• One-pager on demonstration • Presentation to Resident Communications Committee
Other	General public	• Press release re: CMS approval	• Press release re: launch

19. Describe the state's strategies for **improving awareness about, and providing education on, Medicaid coverage** and health care access among various stakeholders (e.g., individuals who are incarcerated, community supervision agencies, corrections institutions, health care providers, etc.).

    DOC currently utilizes a tablet-based communication and educational tool to share resources and information with residents. NH is designing materials about the benefits of Medicaid and the community-reentry program to share via this program. Additionally, NH is developing a one-page program summary to share as a flier to publish on digital signs for staff and to publish throughout the DOC facilities. This information will also be disseminated to county jails as they implement the program. DOC case managers will receive additional information to share with residents and will be encouraged to discuss Medicaid and community reentry as part of reentry planning conversations.
    Similarly, NH will share these additional materials with county jail case managers in advance of implementation in each county to support Medicaid and community reentry planning conversations.

    Additionally, NH is planning to present information about the demonstration to DOC's Resident Communications Committee (RCC) to assist in spreading awareness about the program within facilities via peer education. DHHS will work with individual counties to identify communications venues where it would be appropriate to share information directly with residents to encourage continued awareness and peer education around the reentry program.

    Note on County Implementation: DHHS has established a connection with correctional leadership in all ten counties, including presenting at the NH Association of Counties Executive Committee meeting. DHHS will continue to communicate with counties through these monthly leadership meetings as needed. Following completion of the county readiness assessments in early 2025, and establishment of the rollout timeline shortly thereafter, DHHS

will establish more regular check-ins with individual counties who are in the first wave of implementation. DHHS plans to mirror the implementation workgroup structure, including communications processes, utilized for DOC when preparing counties to implement. This includes organizing MCO summits with each county in advance of implementation (to be scheduled once implementation schedule for counties is determined following the formal readiness assessment process).

20. Describe any challenges not already described in the milestone 5 items above that the state anticipates in meeting this milestone. For each challenge, describe the actions needed to overcome the challenge, as well as the associated timelines.

- Challenge: DOC and DHHS will need to work together in a closer and more frequent manner than is currently occurring.
    - Mitigation Strategy: DOC and DHHS will continue to conduct at minimum monthly leadership summits (described above) throughout demonstration year one. DOC and DHHS have created a revised MOU to formalize data sharing operations. This MOU is in the process of being finalized. Additionally, DOC has committed to increasing the file frequency of admissions and releases sent to DHHS. This new frequency of file transmissions will be implemented in the first quarter of calendar year 2025.
- Challenge: Initial implementation will require extraordinarily close communication between DHHS and DOC as individuals work to become more familiar with demonstration operations.
    - Mitigation: DHHS and DOC are standing up frequent operational updates to identify and escalate any demonstration questions. These new operational update meetings will occur at least twice a week throughout the first three months of demonstration implementation.
- Challenge: Post-release DOC oversight entities (ex: parole officers) have limited insight into individual's activities and success indicators, including confirmation of after care.
    - Mitigation Approach: MCOs will continue to provide enhanced care coordination for a period of one year post-release to monitor delivery of post-release services. DHHS is currently exploring opportunities for MCOs to share out monthly progress updates with the DOC parole officers (PPO). We expect this new MCO > PPO feedback process to be implemented during demonstration year one.

Reducing Health Disparities

21. Describe the state's strategies to **drive positive changes in health care quality for all beneficiaries** through the reentry demonstration, thereby reducing health disparities, and **address how the strategies will be integrated** and how the state will meaningfully **involve the population of focus** into the demonstration implementation and the approach for monitoring and evaluation.

NH has established the following goals to drive positive changes in health care qualities for demonstration participants:

- 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
- Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry
- Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers
- 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

- Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs
- Reduce all-cause deaths in the near-term post-release
- 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
- 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

NH is currently working to build out CLR, with the goal of improving provider connectivity, enhancing care coordination, and improving health outcomes. CLR will be implemented as a key component of the community reentry demonstration to help monitor and enhance beneficiary health across programs and ensure transparency of outcome tracking.

As described in the communications section above (question 18), NH has identified DOC residents as a key stakeholder group and is prioritizing engagement and communication with residents as the population of focus. To support effective ongoing engagement with residents, NH is first focusing on education and communication around the demonstration. This awareness phase will include sharing resources via the tablet-based educational program, case managers, and fliers.

NH has also identified the DOC RCC as a key opportunity to engage with the population of focus throughout the demonstration and receive ongoing input from DOC residents. NH is planning to present information about the reentry demonstration to the RCC to assist in spreading awareness about the program within facilities via peer education. Following this initial awareness-building phase, NH plans to continue engaging regularly with the RCC to support continued information sharing, as well as to provide a dedicated opportunity for residents to share experiences and insight into the demonstration operations with DOC and DHHS.

Reinvestment Plan

22. Describe the state's plan for reinvesting the total amount of federal matching funds received under the demonstration for any existing carceral health care services that are currently funded with state and/or local dollars. If the state already submitted this plan separately, please indicate this below.

NH is primarily utilizing the demonstration funding to support new services not currently offered by carceral settings, including pre-release intake appointments with community-based providers and peer support services.

However, NH will utilize federal matching funds through the demonstration to support the following two carceral health care services already in existence:

- Supply of prescription meds upon release. Note that the current policy at DOC is 14-30 days, depending on the resident, but in the future state this supply will be expanded to 30 days for all residents. County jail policies vary.

- MAT medications provided during the pre-release period (currently provided by DOC and funded through SOR)

Given the relatively small share of federal matching funds that NH will receive for existing carceral health care services, NH plans to meet the reinvestment requirement through the state's share of expenditures for new and expanded pre-release services under the demonstration, as outlined in the SMDL released on April 17, 2023.

These new and expanded pre-release services include:

- (New) Pre-release community-based provider intake appointments
- (New) Peer support services
- (Expanded) Additional supply of post-release medications

Consolidated Appropriations Act Population

23. ☐ The state attests to complying with all requirements outlined in section 5121 of the CAA by including the population in the section 1115 demonstration. ☐ The state attests to complying with all requirements outlined in section 5121 of the CAA by including the population in the section 1115 demonstration. If the state plans to partially cover the required population and services of the CAA as part of the section 1115 demonstration, please describe what populations and services will be included here:

`Note: NH is implementing the requirements of section 5121 of the CAA through a State Plan Amendment (SPA). Individuals who potentially who potentially qualify for both the 1115 and services through 5121 will receive both services through the SPA and the waiver. When services between 5121 and the 1115 demonstration overlap, such as case management, NH will default to utilizing the 1115 demonstration authority, including for such purposes as federal reporting requirements (i.e., the CMS 64 report).

- **Youth Eligibility Under 5121:**
  - Eligible population includes children and youth who are:
    • Enrolled in Medicaid or CHIP;
    • Under 21 years of age or between the ages of 18 and 26 under the mandatory former foster care eligibility group; and
    • Being held in a carceral facility post-adjudication (i.e. after conviction).
  - Carceral Settings: Correctional facilities that are subject to the requirements are defined as all types of carceral facilities where eligible children and youth are incarcerated, including: state prisons, local jails, tribal jails and prisons, and juvenile detention and youth correctional facilities.
    - Participating DOC State facilities will include: New Hampshire State Prison for Men, New Hampshire Correctional Facility for Women, Northern New Hampshire Correctional Facility, the Transitional Work Center, and the Secure Psychiatric Treatment Unit. New Hampshire also operates three Transitional Housing Units (THUs). The vast majority of individuals releasing from the NH THUs are classified as C1, which qualifies an individual for full Medicaid (if eligible). Therefore, it is

theoretically possible, but unlikely that there would be any demonstration participants at the THUs.

- Participating youth correctional facilities will include Sununu Youth Services Center (SYSC). This is the only youth correctional facility in NH.
- Federal prisons are not included.
- Jails: DHHS plans to conduct a phased approach to demonstration launch in county-based facilities, starting in CY2025. The order of launch in county facilities will be determined according to individual county readiness. DHHS is currently in the process of meeting with all ten counties to conduct a preliminary assessment of individual county readiness and has completed five assessments to date. NH expects to complete all ten preliminary county assessments by January of 2025. Please see the implementation settings section above for a description of initial findings from these pre-release readiness assessments.
- DHHS is also creating a formal readiness assessment to codify the core elements of facility readiness described above and will utilize this formal assessment to determine the exact schedule for demonstration launch in each county. After completing the initial assessments**,** DHHS will partner with all ten counties to complete the readiness assessment jointly in preparation for launch in each jail. We anticipate beginning this process in March 2025.

➢ Covered Services under youth reentry:

- Targeted Case Management (TCM): TCM will be delivered beginning the 30 days pre-release and continuing 30 days post-release. TCM will be delivered via the MCO case managers for all individuals enrolled in managed care.
    - TCM will include:
        - comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services;
        - Developing a person-centered care plan;
        - Referral and relative activities to help the individual obtain needed services to address identified needs and achieve goals specified in care plan;
        - Availability in the geographic region of the home/residence of the eligible juvenile (where feasible);
        - Covered services available under state plan or waiver; and
        - Monitoring and follow up: activities/contacts necessary to ensure that care plan is effectively implemented and adequately addresses needs of the individual.
    - TCM services may include the individual, family members, services providers, and other entities/individuals.
    - Monitoring and follow-up activities must be conducted at least once annually but should be completed as frequently as necessary.
    - If TCM is transitioned to a new case manager post-release, DHHS will ensure a warm hand-off and support continuity of care, including a meeting between member, pre-release case manager, and post-release case manager.

- TCM will primarily be delivered via telehealth, but may be delivered in person, as necessary.

- Physical exams and screening services, including:
  - An annual physical (new or established patient appointment);
  - Assessment of emotional or behavioral problems;
  - Administration of an HRA (patient-focused or caregiver-focused, as appropriate);
  - Annual alcohol screening;
  - Annual depression screening;
  - Dental screenings;
  - STD screenings, as appropriate; and
  - Diagnostic services, as appropriate.
- Delivery method: All youth community reentry services will be facilitated by the MCOs. The MCOs will receive a kick payment for coverage of youth reentry services.

➢ **<u>Youth Eligibility Under 5121 & Adult Eligibility Under 1115:</u>**

- Covered Populations: For any eligible youth who are also eligible for the Adult CRE benefit plan, the Member will receive both benefit packages. This will include any eligible youth who are over the age of 18 and have a Substance Use Disorder (SUD) or Serious Mental Illness (SMI) diagnosis as determined by the carceral facility. The existing eligibility rules for both adult CRE and youth CRE continue to apply. The MCO will be providing the services for the combination youth/adult benefit plan.
- Covered Services: All individuals eligible for youth/adult services will have coverage for the full scope of adult community reentry pre-release benefits as well as the full scope of youth community reentry pre-release and post release benefits, as defined above in this implementation plan.
- Delivery method: All youth/adult community reentry services will be facilitated by the MCOs. The MCOs will receive one kick payment for coverage of the youth/adult combined benefit of reentry services.

24. ☐ The state attests to covering all or a portion of the optional CAA population outlined in section 5122 of the CAA by including the population in the section 1115 demonstration.
    - ➢ If the state plans to partially cover the optional population and services of the CAA as part of the section 1115 demonstration, please describe what populations and services will be included here: Individuals who fall into both will receive 1115 services as well – describe
25. Describe the state's internal operational plan for CAA populations and services that do not overlap with the section 1115 demonstration. The internal operational plan should include all the requirements outlined in "Section 5121 of the CAA, 2023 Internal Operational Plan" of the State

Health Official Letter (SHO) #24-004.2 If the state has already submitted this plan indicate below.

Please note that per previous CMS guidance, NH plans to utilize the operational policies described in the above implementation plan for both the 1115 demonstration and 5121. NH can however make a formal operational plan for 5121 available upon request by the end of January 2025.

[2] SHO# 24-004, "Provision of Medicaid and CHIP Services to Incarcerated Youth," is available in full here: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf.

Appendix A: Reentry Implementation Phase-in Approach Template

If a state is intending to phase-in additional pre-release services, provide the information below regarding the services in each Service Level, the number of facilities anticipated to provide each Service Level, the associated timeline for implementation, and any challenges and/or barriers that facilities may experience in providing a service/s or Service Level/s.

Service Level Description

1. In Table 1 below, provide the services included in each Service Level. Add more rows as necessary.

Table 1: Services in each service level.

Service Level	Services included in the Service Level
1 (Minimum benefit package)	• Case management to assess and address physical and behavioral health needs, and health-related social needs (HRSN): Medicaid benefit/category • Medication-assisted treatment (MAT) for all types of substance use disorder (SUD) as clinically appropriate with accompanying counseling: Medicaid benefit/category • 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release: Medicaid benefit/category • Access to clinical consultation for behavioral health needs (including pre-release screenings with community-based providers such as CMHCs and Doorways) • Peer support services

2. Describe any anticipated challenges and/or barriers experienced by state prisons in providing a service/s or service level/s.

Service Level Information by Facility Type

3. In Table 2 below, provide the requested information regarding the number of facilities anticipated to provide each service level, by facility type and demonstration year. Indicate the demonstration year (DY) for implementation, as well as the DYs following implementation, in the table, adding service level columns and types of facility rows as needed.

4. Describe any anticipated challenges and/or barriers experienced by facilities in providing a service/s or service level/s.

Table 2: By service level, total number of facilities, number of facilities anticipated to offer service level/s at implementation, and number of facilities anticipated to implement service level/s by DY.

		Service Level 1 (Minimum Benefit Package)	Service Level 2	Service Level 3	Service Level 4
State Prisons	Planned number of facilities offering each service level	8			
	Number of facilities anticipated to offer service level at implementation (during DY1)	8			
	Number of facilities anticipated to implement service level, by DY				
	DY				
	DY				
	DY				
	DY				
County/Local Jails	Planned number of facilities offering each service level	10			
	Number of facilities anticipated to offer service level at implementation	10			
	Number of facilities anticipated to implement service level, by DY				
	DY				
	DY				

	DY				
	DY				
Youth Correctional Facilities	Planned number of facilities offering each service level				
	Number of facilities anticipated to offer service level at implementation				
	Number of facilities anticipated to implement service level, by DY				
	DY				
	DY				
	DY				
	DY				
	Planned number of facilities offering each service level				
	Number of facilities offering service level at implementation				
	Number of facilities anticipated to implement service level, by DY				
	DY				
	DY				
	DY				
	DY				

ATTACHMENT J
Reserved for Reentry Demonstration Initiative Reinvestment Plan