ATTACHMENT B: DSHP CLAIMING PROTOCOL

New Hampshire Building Capacity for Transformation Section 1115(a) Medicaid Demonstration
Approved June 29, 2016

I. Review of DSHPs included in STCs

As described in the Special Terms and Conditions (STC) of New Hampshire's Building Capacity for Transformation section 1115 demonstration, Designated State Health Programs (DSHP) expenditures may be claimed beginning January 5, 2016 and continue through December 31, 2020. The New Hampshire programs that will serve as DSHPs are described in Table A below (see also STC 58, Charts B and C) and the limits and timelines under which New Hampshire will claim matching funds for these expenditures are described in Table B (see also STC 59, Table D). As noted, expenditures for the County Nursing Home DSHP will only be claimed from January 5 through June 30, 2017 as provided for in STC 58.

Table A
DSHP List

Designated State Health Programs (DSHP)

1. Community Mental Health Center Emergency Services
2. Adult Assertive Community Treatment (ACT) Teams
3. Children Assertive Community Treatment (ACT) Teams
4. Family Planning Program
5. Tobacco Prevention
6. Immunization Program
7. Governor's Commission on Drug & Alcohol Abuse, Prevention and Treatment and Recovery
8. County Nursing Home Medicaid Services

Table B
General DSHP Annual Limits

	General DSHP	County Nursing Home	Total
DY1	$8,995,761	$20,847,257	$29,843,018
DY2	$8,995,761	$10,423,629	$19,419,390
DY3	$8,186,143		$8,186,143
DY4	$7,376,524		$7,376,524
DY5	$6,566,906		$6,566,906
Total	$40,121,095	$31,270,886	$71,391,981

II. State Documentation of Expenditures for General DSHP Programs

Documentation provided by the State to CMS for quarterly DSHP expenditures will include the following:

- The agency;
- The program;
- Provider;
- Payment amount;
- Voucher/contract information; and
- Provider costs.

III. Off-Sets: In accordance with STC 60(c) DSHP expenditures submitted to CMS will not include payment for:

- Grant funding to test new models of care;
- Construction costs (bricks and mortar);
- Room and board expenditures;
- Animal shelters and vaccines;
- School based programs for children;
- Unspecified projects;
- Debt relief and restructuring;
- Costs to close facilities;
- HIT/HIE expenditures;
- Services provided to undocumented individuals;
- Sheltered workshops;
- Research expenditures;
- Rent and utility subsidies normally funded by the Unites States Department of Housing and Urban Development;
- Prisons, correctional facilities, and services provided to individuals who are civilly committed and unable to leave;
- Revolving capital fund;
- Expenditures made to meet a maintenance of effort requirement for any federal grant program;
- Administrative costs;
- Cost of services for which payment was made by Medicaid or CHIP (including from managed care plans);
- Cost of services for which payment was made by Medicare or Medicare Advantage;
- Funds from other federal grants; and
- Needle-exchange programs.

IV. Documentation of State Expenditures for General DSHP

In claiming general DSHP expenditures, the State will provide CMS with a summary Excel worksheet by agency, program and provider in an orderly format, or other CMS-approved alternative so that CMS may review and test underlying supporting documentation as detailed in this Section.

A. For all eligible DSHPs claimed, the State will make available for CMS the following information:
   i. Identifying contract number, provider name & budget period
   ii. Program
   iii. Voucher number
   iv. Voucher amount
   v. Total amount paid to date
   vi. State financial system voucher entry
B. Documentation of expenditures for each DSHP will be clearly outlined in the state's supporting documents and be made available to CMS in accordance with this claiming protocol.
C. The State will use its voucher and accounting system to identify the amount it expended to purchase services from each service provider under each program during the claiming period.

V. Background on New Hampshire's Financing and Accounting Systems

A. Expenditure Process and the Lawson System

DSHP expenditures are paid to providers for services rendered in accordance with contractual requirements. Applicable program managers are responsible for approving such payments and the finance staff are responsible for coding the expenses with appropriate job numbers and forwarding invoices for payment to the Centralized Bureau of Finance. The Centralized Bureau handles all keying of invoices, scanning of documents, and placing applicable Lawson NH First system approvals. Final approval for payment is performed by the Shared Service Unit under the Department of Administrative Services, after which the Treasury Department releases payment.

The Bureau of Finance is responsible for traditional accounting and financial management services that include accounts payable, accounts receivable, billing, data management and financial reporting and analysis. The Bureau ensures that the Department performs cash draw downs and reports the cash draw downs (Federal Revenues) in accordance with the Federal regulations and establishing related controls.
Additionally, financial managers of the various programs are cognizant of the need for identification of allowable federal costs, proper reporting and the request for reimbursement of those costs.

The NH Fundamental Improvements to Revitalize Systems/Services and Technology (NH FIRST or NHF), also known as the Lawson system is the State's accounting system. Lawson supports the financial management needs of the State and its functions include accounts payable, accounts receivable, general ledger, encumbrance and expenditure control, fund accounting, budgeting, budgetary and cost accounting, cash management, detail and summary reporting, and software development and maintenance of all the supporting systems. The Department uses the system for all program expenditures and revenues through the DHHS Cost Allocation Plan. Lawson updates the Department's Enterprise Data Warehouse (EDW) nightly with that day's Lawson transactions. The Department has a Financial Allocation and Reporting System (FARS), which performs the allocation of expense (from both Lawson and internal adjustments) across all programs at determined allocation rates.

The Department maintains Federal ledgers to record and track Federal expenditures and revenues. The Department reports Federal revenues in accordance with Federal regulations and requirements.

All grant transactions are tracked through the Federal ledgers maintained for each Federal program. All non-Cash Management Improvement Act (CMIA) transactions are entered first into Lawson and are posted monthly to the Federal ledgers for each program. CMIA dictates the rules and procedures for the efficient transfer of funds for federal financial assistance programs between the federal government and the states.

The integrity of these processes is audited as part of the annual audit by outside auditors.

B. Allocation of Costs to Federal Programs and Claiming

The Reporting and Analysis Services (RAS) Unit, within the Department develops and facilitates federal and management reporting processes by providing financial, programmatic and human resource information and analyses. RAS is also responsible for maintaining the Department's federally approved Public Assistance Cost Allocation Plan (PACAP), whose primary purpose is to identify all costs that are associated or allocated to programs, services, or grants to be reimbursed with Federal funds and provides the information regarding the allocation methodologies used, in order to receive federal approval. RAS reconciles the information between Lawson, the State's Accounting System, and the Cost Allocation System to ensure that the amounts used for Financial Reporting are accurate.

The Department utilizes a job cost accounting system for accumulating costs by cost objective. The Department's use of job numbers allows for the identification of costs by specific objective and provides the ability to identify allowable cost for federal reporting purposes. For each job number, a separate cost allocation methodology is assigned. Under the Demonstration unique job number(s) will be assigned and expenditures will be coded with the appropriate job number to track both DSHP and DSRIP expenses.

As DSHP expenses occur they will be coded with a unique job number and captured quarterly for reporting on the CMS64. As such, no federal cash draws will be done when the expenses are paid but rather will be reconciled quarterly after the CMS64 is filed.

The integrity of all accounting processes is audited as part of the State of NH annual audit by outside independent auditors, currently KPMG, LLP.

VI. Unreimbursed Nursing Home Expenditures as DSHPs

Until June 30, 2017, selected unreimbursed county nursing home expenditures will be treated as DSHPs in accordance with the following methodology and procedures as allowed under the STCs.

A. Unreimbursed Nursing Home Expenditures

Each of the 10 counties in New Hampshire operates at least one nursing facility, which provides services to Medicaid and non-Medicaid residents. The Demonstration allows claiming of "county funding for payment of medical services for nursing home residents" as a DSHP until June 30, 2017. The allowability of such expenses results from costs incurred by County Nursing Facilities ("Facilities"), prorated for their Medicaid residents, in excess of Medicaid revenue received by the Facilities.

(1) Incurred Facility Costs (prorated by Medicaid residents)
(2) Less - Medicaid Revenue received by the Facility (paid by DHHS)
(3) Results in Unreimbursed Medicaid Costs

B. Determination of Facility Costs

Each facility annually, submits to DHHS a Medicaid Cost Report (this report was designed after, and includes the same cost principles, as the Federal Medicare Cost Report). The report includes:

- Total annual incurred costs by cost center
- Total annual (all payor) bed days
- Medicaid annual bed days

The cost reports are reviewed and approved by DHHS and used to set the facilities base per diem reimbursement rate.

C. Medicaid Revenue received by County Nursing Facilities made by DHHS

Each County nursing facility that participates in Medicaid receives the following three (3) rates. While rates are designed to reimburse facility costs, the rates are limited to the funding

appropriated by the State Legislature. As such, facilities actual costs incurred to care for Medicaid clients exceed the revenue provided by the State.

1. Nursing Facility Acuity Base Rate: Nursing Facilities receive a single facility per diem rate unique to the facility based upon direct care costs and administrative costs and the acuity of residents, as determined by federal medical reporting data (referred to as the Minimum Data Set or MDS). Acuity Rates are set twice each year in July and January. These rates are for direct service to Medicaid-eligible individuals who meet the clinical and financial eligibility standards defined in law for nursing facility long-term care. All county facilities bill DHHS monthly. (reference Rate Methodology in State Plan 4.19D and DHHS rule He-E806)

2. The Medicaid Quality Incentive Program (MQIP) provides quarterly Medicaid supplemental rates to nursing facilities for each paid Medicaid bed day at their facility in the prior quarter. This is done through a three-step process as follows:
   a. Every licensed nursing home pays a Nursing Facility Quality Assessment (NFQA) of 5.5% of net patient services revenue to the New Hampshire Department of Revenue, each quarter.
   b. The aggregate funds are then transferred to DHHS, which is then matched with Federal Medicaid funds.
   c. Nursing facilities, that accept Medicaid reimbursement, are then paid an MQIP payment. These supplemental Medicaid payments are based on the paid Medicaid bed days at each facility.

3. Proportional Share Medicaid payment (ProShare): ProShare are annual Medicaid supplemental payments made to each county in June. ProShare payments represent the difference between Medicaid payments for nursing home care, provided by county facilities, and what the payment would have been if the care for those residents had been from Medicare. ProShare is funded 50% by the Counties and 50% as Federal FFP. Each county documents the non-federal share, which is derived from county-government raised taxes.

In total, however, these payments do not fully cover the cost of nursing home services for Medicaid beneficiaries. Counties provide additional payments, which will be claimed as DSHPs in accordance with the procedures in section D.

D. Process for Claiming FFP for Nursing Home DSHPs

Until June 30, 2017, nursing home payments made by counties for Medicaid beneficiaries that are not being matched will be claimed as DSHPs, as illustrated below. This illustration is based off of preliminary SFY14 County Nursing Home Cost Reports.

1. DHHS receives annual Medicaid cost reports from each county facility (Administrative Rule He-E 806.02) and conducts field audits or desk reviews and makes appropriate adjustments as noted in the rule to adjust costs to Medicaid allowable costs.
2. From the Cost Reports Medicaid bed days will be divided by total bed days to arrive at the share of costs that are Medicaid eligible.
3. The Medicaid percentage will be applied to the Total Audited Cost to determine Total Cost of caring for Medicaid residents in county operating nursing facilities.
4. Total payments by the State to the county nursing facilities will be subtracted from the Total Cost of caring for Medicaid residents in county operating nursing facilities to determine the Medicaid Costs Not Otherwise Matched (CNOM).
5. On a quarterly basis, the state will draw down 25% of the aggregate unreimbursed county costs from the most recently audited Medicaid cost reports for claiming of FFP.
6. These will be reported to the Office of Finance for claiming federal participation on the CMS 64.
7. The aggregate unreimbursed county costs will also be reported to the Cost Allocation Unit for making adjustments pursuant to the Public Assistance Cost Allocation Plan.
8. When Medicaid Cost Reports are received and audited/reviewed for the period, adjustments will be made to the claimed amounts resulting in reimbursement of FFP or an additional claim for FFP.

Table D
EXAMPLE – FOR ILLUSTRATIVE PURPOSES ONLY
Unreimbursed Costs Incurred By County Nursing Homes for Medicaid Residents
DHHS will use the most recently audited Medicaid cost reports from each county facility for calculations

Medicaid Costs		
1.	Total Bed Days	534,006
2.	Total Medicaid Bed Days	437,153
3.	Medicaid Percentage of Bed Days	81%
4.	Total costs – County Operated Nursing Facilities	$165,915,732
5.	**Cost Allocable To Medicaid**	**$135,643,898**
State Reimbursements		
1.	Acuity per Diem Medicaid Payments	$53,420,288
2.	Medicaid Quality Incentive Payments (MQIP)	$19,876,020
3.	ProShare	$41,500,333
4.	**Total Payments to County Facilities**	**$114,796,641**
Costs Allocable to Medicaid less Total Payments To County Facilities		**$20,847,257**
Federal Participation (50%)		$10,423,629
Amount per Quarter		
County Costs		$5,211,814
Federal Participation (50%)		$2,605,907

(Note: The state will report the total computable (federal plus non-federal share) amounts when reporting payment.)

VII. General (Non-Nursing Home) DSHP Program Details

General DSHP expenditures will be claimed for the following programs, as listed in Table A.

1. Community Mental Health Center Emergency Services
2. Adult Assertive Community Treatment (ACT) Teams
3. Children Assertive Community Treatment (ACT) Teams
4. Family Planning Program
5. Tobacco Prevention
6. Immunization Program
7. Governor's Commission on Drug & Alcohol Abuse, Prevention and Treatment and Recovery

A description of each of these programs and the procedures used to document expenditures for these programs are included below.

A. Program Title: Community Mental Health Center Emergency Services

Funding Sources: General Fund $1,507,000

Accounting Unit: 05-092-9200-5945

Brief Description: These are 100% general funds used to support services that are part of NH's community mental health system for Emergency Services to individuals without insurance. These funds support the provision of services pursuant to RSA 135-C that have been cited as desirable and needed in the "Ten-Year Plan" and the Community Mental Health Agreement. The services are provided through contracts with the ten Community Mental Health Centers.

Emergency services are covered through Community Mental Health Program (CMHP) interventions for the purposes of reducing a person's acute psychiatric symptoms, the likelihood of harm to self or others, or assisting the person's return to his or her pre-crisis level of functioning. Emergency services include an emergency assessment that is used to evaluate whether the individual needs hospital placement, crisis respite care, revocation of conditional discharge or other out-of-home placement. As follow-up to the initial emergency response, individuals can receive a maximum of 5 emergency service stabilization sessions consisting of not more than 6 15-minute units per session prior to intake or referral to another service or agency. The services are provided by specialized staff who are part of discrete emergency services programs or other staff serving as part of a formalized emergency services rotation. Expected Outcomes: The use of these funds is tied to the Outcomes Measures for the Federal Block Grant: National Outcomes Measures.

The outcomes for people receiving emergency services will be referral to, or placement in, the optimal and least restrictive level of care necessary to initiate treatment and stabilize the acute psychiatric condition and resolve the psychiatric emergency or ameliorate the risk of harm to self, others, community or property.

Eligible Population: The eligible populations associated with the program are individuals with a Severe Mental Illness or Severe and Persistent Mental Illness, as well as children with a serious emotional disturbance who are receiving community mental health services in the community, but have associated program expenses not reimbursable by the Medicaid program. Emergency services are available 24 hours a day, 7 days per week to individuals served by the state's mental health services system who have a psychiatric emergency anywhere in the region served by the CMHP.

Non-Match Able Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of non-match able program expenditures included in the Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in A through L. All expenditures on these contracts are related to grants to organization to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that such services are not provided to undocumented individuals. Financial Participation (FFP) is not being claimed for the following:

A. Grant funding to test new models of care
B. Construction costs (bricks and mortar)
C. Room and board expenditures
D. Animal shelters and vaccines
E. School based programs for children
F. Unspecified projects
G. Debt relief and restructuring
H. Costs to close facilities
I. HIT/HIE expenditures
J. Services provided to undocumented individuals
K. Sheltered workshops
L. Research expenditures

B. Program Title: Adult Assertive Community Treatment (ACT) Teams

Funding Sources: General Fund $2,475,000

Accounting Unit: 05-092-9200-5945

Brief Description: These are 100% general funds used to support services that are part of NH's community mental health system Assertive Community Treatment (ACT) teams for Adults. These funds support the provision of services pursuant to RSA 135-C that have been cited as desirable and needed in the "Ten-Year Plan" and the Community Mental Health Agreement. The services are provided through contracts with the ten Community Mental Health Centers.

ACT is a multidisciplinary psychiatric specialty team approach to delivering comprehensive treatment and an integrated array of services to people who have complex needs, about 20% to 40% of people with serious mental illness. Criteria for selection include psychiatric disorders such as schizophrenia and bipolar illness, and resultant severe impaired functioning in multiple areas like basic functioning in the community; employment or homemaker roles, or maintaining a safe living situation. People receiving ACT services are also likely to have a history of high-service needs, for instance, repeated hospitalizations, a history of being involved with substance abuse or the criminal justice system, substandard housing, or homelessness. People are not excluded from ACT because of severity of illness, disruptiveness in the community or in the hospital, or failure to participate in or respond to traditional mental health services.

ACT services are delivered in the places and contexts where they are needed. A team of 10 to 12 staff serves approximately 100 people, resulting in a staff-to-consumer ratio of approximately 1 to 10. Services are provided as long as needed, not according to pre-set timelines. ACT team members do not have individual caseloads, rather the team as a whole is responsible for ensuring that consumers receive the services they need to live in the community and reach their personal goals. The team meets daily to discuss how consumers are doing. The team can quickly adjust the services they are providing to respond to changes in consumers' needs. People receive 24/7 crisis services.

Expected Outcomes: The use of these funds is tied to the Outcomes Measures for the Federal Block Grant: National Outcomes Measures.

Outcomes for people receiving ACT services include reduction in incidences of homelessness, incarceration, voluntary and involuntary hospitalizations, emergency room visits and substance use problems. People receiving ACT services are expected to experience increased amounts of competitive employment, and improvement in treatment compliance, psychiatric symptoms and overall health measures.

Eligible Population: The eligible populations associated with the program are individuals with a Severe Mental Illness or Severe and Persistent Mental Illness who are receiving community mental health services in the community, but have associated program expenses not reimbursable by the Medicaid program.

Non-Match Able Expenditure List for the demonstration

Pertinent staff reviewed the attached list of non-match able program expenditures included in the Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in A through L. All expenditures on these contracts are related to grants to organization to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that such services are not provided to undocumented individuals. Financial Participation (FFP) is not being claimed for the following:

A. Grant funding to test new models of care
B. Construction costs (bricks and mortar)
C. Room and board expenditures
D. Animal shelters and vaccines
E. School based programs for children
F. Unspecified projects
G. Debt relief and restructuring
H. Costs to close facilities
I. HIT/HIE expenditures
J. Services provided to undocumented individuals
K. Sheltered workshops
L. Research expenditures

C. Program Title: Children Assertive Community Treatment (ACT) Teams

Funding Sources: General Fund $280,000

Accounting Unit: 05-092-9200-5945

Brief Description: These are 100% general funds used to support services that are part of NH's community mental health system Assertive Community Treatment (ACT) teams for Children. These funds support the provision of services pursuant to RSA 135-C that have been cited as desirable and needed in the "Ten-Year Plan" and the Community Mental Health Agreement. The services are provided through contracts the 10 Community Mental Health Centers.

Children's ACT is a multidisciplinary psychiatric specialty team approach to delivering comprehensive treatment and an integrated array of services to children and families who have complex needs. Children may have severe impaired disruption functioning in multiple areas like basic functioning in the community, schools; interpersonal and family roles or maintaining a safe living situation. Children receiving ACT services are also likely to have a history of high-service needs, for instance, repeated hospitalizations, a history of being involved with substance abuse or the juvenile justice system. Children are not excluded from ACT because of severity of illness, disruptiveness in the community or in the home, or failure to participate in or respond to traditional mental health services.

Children's ACT services are delivered in the places and contexts where they are needed. A team of 10 to 12 staff serves approximately 100 people, resulting in a staff-to-consumer ratio of approximately 1 to 10. Services are provided as long as needed, not according to pre-set timelines. Child ACT team members do not have individual caseloads, rather the team as a whole is responsible for ensuring that consumers receive the services they need to live in the community and reach their personal goals. The team meets daily to discuss how cases are doing. The team can quickly adjust the services they are providing to respond to changes in child's needs. Children receive 24/7 crisis services.

Expected Outcomes: The use of these funds is tied to the Outcomes Measures for the Federal Block Grant: National Outcomes Measures.

Outcomes for children receiving ACT services include reduction in incidences of voluntary and involuntary hospitalizations, emergency room visits, juvenile justice involvement and substance use problems. Children receiving ACT services have increased amounts of success in school and home environments, and improvement in treatment compliance, psychiatric symptoms and overall health measures.

Eligible Population: The eligible populations associated with the program are children with a serious emotional disturbance who are receiving community mental health services in the community, but have associated program expenses not reimbursable by the Medicaid program.

Non-Match Able Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of non-match able program expenditures included in the Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in A through L. All expenditures on these contracts are related to grants to organization to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that such services are not provided to undocumented individuals. Financial Participation (FFP) is not being claimed for the following:

A. Grant funding to test new models of care
B. Construction costs (bricks and mortar)
C. Room and board expenditures
D. Animal shelters and vaccines
E. School based programs for children
F. Unspecified projects
G. Debt relief and restructuring
H. Costs to close facilities
I. HIT/HIE expenditures
J. Services provided to undocumented individuals
K. Sheltered workshops
L. Research expenditures

D. Program Title: Family Planning Program

Funding Sources: $795,000 State General Funds in the Division of Public Health Services and Federal funds supported by the Office of Population Affairs, Title X Program. There are ten Title X community-based agencies, which are supported by the Federal Title X grant and three additional community-based agencies, which only receive State General Funds. Title X requires a minimum 10% State cost sharing requirement.

Accounting Unit: 05-090-9020-5530

Brief Description: These funds provide family planning and related preventive health care services. Over the past 40 years, the Family Planning Program has played a critical role in ensuring access to a broad range of family planning and related preventive health services for low-income and under insured individuals. In addition to contraceptive services and related counseling, a number of related preventive health services are provided such as:

- Breast and cervical cancer screening according to nationally recognized standards of care;
- Sexually Transmitted Disease (STD) and Human Immunodeficiency Virus (HIV) prevention education, counseling, testing and referral; and Pregnancy diagnosis and counseling.
- Family planning services are often a woman's entry point into the health care system.
- Use of long acting reversible contraceptives, such as the intrauterine device and the implant are increasingly becoming utilized.

Funds within Family Planning support 14 contracts, including those with a Medical Consultant and entities such as community health centers and agencies for the provision of direct reproductive health care services.

Expected Outcomes: The Family Planning Program has the following priority indicator within the DPHS State Health Improvement Plan (SHIP):

- Reduce the unintended birth rate for adolescents from 15.7 (2010) to 15.0 by 2015 and to 14.0 by 2020.
- Family Planning contracts in Maternal and Child Health have specific performance measures to demonstrate impact, outcomes and quality assurance activities. For example:
- Percent of female family planning clients under age 25 screened for Chlamydia (CT) infection.
- The percent of women with a positive CT test that are treated within 14-30 days of the specimen collection.
- The percent of all patients diagnosed with Chlamydia who were re-screened 3-4 months after completion of treatment.
- The proportion of women <25 screened for Chlamydia and tested positive.
- The percentage of women that were provided with preconception counseling on their latest wellness exam.

- The percent of family planning clients less than 18 years of age who received education that abstinence is a viable method/form of birth control.
- The percentage of family planning clients who received STD/HIV reduction education.

The following measures ensure that Family Planning programs are providing outreach and targeting vulnerable populations:

- Percent of clients under 25 years of age in the family planning caseload.
- Percent of clients under 250% of the Federal Poverty Level.

Eligible Population: The eligible populations associated with the program includes residents seeking to access reproductive health services. Sliding fee scale available based on income.

Non-Match Able Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of non-match able program expenditures included in the Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in A through L. All expenditures on these contracts are related to grants to organization to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that such services are not provided to undocumented individuals. Financial Participation (FFP) is not being claimed for the following:

A. Grant funding to test new models of care
B. Construction costs (bricks and mortar)
C. Room and board expenditures
D. Animal shelters and vaccines
E. School based programs for children
F. Unspecified projects
G. Debt relief and restructuring
H. Costs to close facilities
I. HIT/HIE expenditures
J. Services provided to undocumented individuals
K. Sheltered workshops
L. Research expenditures

E. Program Title: Tobacco Prevention-Hotline

Funding Sources: $125,000 State General Funds and Tobacco Control Prevention and Control Grant funded by the Centers for Disease Control. 25% match requirement currently provided by local agency partners.

Accounting Unit: 05-090-9020-5608

Brief Description: The general funds are used to fund the NH Tobacco Helpline is a contracted service providing telephonic evidence-based behavior change counseling predicated on the Social Learning Theory. Calling 1-800-QUIT-NOW connects individual to the NH Tobacco Helpline directly so the client receives immediate services. Among adults who become daily smokers, nearly all first use of cigarettes occurs by age 18 years of age (88%), with (99%) of first use occurring by the age of 26. Between July 2013 and June 2014 the helpline provided services to 2049 people and completed 15,058 tasks related to callers/those referred. Overall demographics of the population receiving services from the NH Tobacco Helpline are as follows: Medicare = 18%, Medicaid = 28%, Uninsured = 24%. The NH Tobacco Helpline also aligns services to assist health systems comply with Meaningful Use by accepting patient referrals from providers and sending feedback post-treatment. Referred client abstinence point prevalence is 18.4% at 30 days. Clients calling 1-800-QUIT-NOW abstinence point prevalence is 19.5% at 30 days.

Expected Outcomes: To decrease the health and economic cost of tobacco use and addiction in NH.
The New Hampshire Tobacco Helpline-The intent of the NH Tobacco Helpline is to provide accessible and affordable (no-cost) cessation counseling to anyone in NH that is ready to quit in the next 30 days regardless of insurance status and to provide NH clinicians with a viable resource to refer patients that have expressed interest in quitting. Statewide performance measures include:

- 95% live answer for callers to the Helpline
- 100% call backs to voicemail within 48 hours
- 100% Intake Screener calls made to referred clients within 48 hours
- Abstinence Rate calculated twice annually
- Client Satisfaction calculated twice annually
- No cost nicotine replacement therapy (NRT) is available while supplies last. NRT is provided to people who are ready and willing to make a quit attempt in the upcoming 30 days, and who have limited or no access to NRT.

The following are state-wide, tobacco-related priority indicators within the DPHS State Health Improvement Program (SHIP):

- Reduce cigarette smoking by adults from 19.4% (2011) to 16.0% by 2015 and 12.0% by 2020.
- Reduce tobacco product use by adolescents (past 30 days) from 27.9% (2011) to 27.0% by 2015 and 21.0% by 2020.

- Reduce the initiation of tobacco use among children from 8.9% (2011) to 8.0% by 2015 and 5.7% by 2020.
- Reduce the number of women who report smoking cigarettes during pregnancy from 13.6% (2011) to 12% by 2015 and 10% by 2020.

Eligible Population: The eligible populations associated with the program include all residents in the State of NH.

Non-Match Able Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of non-match able program expenditures included in the Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in A through L. All expenditures on these contracts are related to grants to organization to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that such services are not provided to undocumented individuals. Financial Participation (FFP) is not being claimed for the following:

A. Grant funding to test new models of care
B. Construction costs (bricks and mortar)
C. Room and board expenditures
D. Animal shelters and vaccines
E. School based programs for children
F. Unspecified projects
G. Debt relief and restructuring
H. Costs to close facilities
I. HIT/HIE expenditures
J. Services provided to undocumented individuals
K. Sheltered workshops
L. Research expenditures

F. Program Title: Immunization Program

Funding Sources: General Fund $486,000 of State General Funds and Immunizations grant funds through the Centers for Disease Control.

Accounting Unit: 05-090-9025-5178

Brief Description: The purpose of the program is to provide access to vaccines particularly for children and to further develop and monitor a systematic approach to oversee the appropriate use, accountability and improvement in health outcomes as they relate to immunization. Distribution of vaccines for all children in NH with the intent of decreasing vaccine preventable disease. The program staff and activities invest resources toward strengthening provider partnerships and to serve as resources to ensure vaccine accountability and cost efficient use (minimal wastage) by providing and monitoring clinical best practices of vaccine distribution, handling and storage.

The service delivery system consists of

- 12 FTE in the New Hampshire Immunization Program (NHIP) who are responsible for education, vaccine accountability and quality assurance in the vaccine provider offices.
- Contracts currently exist with the Manchester and Nashua Health Departments to increase vaccination within their jurisdictions and conduct assessment visits.
- A contract exists with Community Health Institute to assist in message development and educational activities.

Expected Outcomes: The intent of the funds received through the CDC and the General Fund is to reduce vaccine preventable diseases in New Hampshire. Vaccination is the best prevention method, therefore the goal of the program is to increase and maintain a high level of immunization rates. Outcomes are achieved through education of the general public and vaccine providers, accountability for all vaccines distributed through the program and assuring the quality of clinical activity surrounding vaccines. The following tables provide the proportion of children receiving vaccines as recommended by the Centers for Disease Control and Prevention. We expect that Healthy People 2020 performance measures will be met throughout the next decade due to the efforts of the immunization program and vaccination partners in the state. The measures are:

- 85% of New Hampshire, 19 – 35 months of age will have received the following series of vaccinations: 4 DTaP; 3 Polio; 1 MMR; 3 Hib; 3 Hep B; 1 Varicella; 4 Pneumococcal.
- 85% of adolescents 13-17 years will have received each of the following vaccines: 1 Tdap; 1 meningococcal; 3 human papillomavirus.
-

Children 19-35 months

	4+DTAP	3+Polio	1+MMR	3+Hib	3+HepB	Hep B Birth dose	1+Var	3+PCV	4+PCV
2006	87.5	93.2	92.9	93.7	92.1	NA	86.3	88.9	69.0
2007	94.4	97.6	96.6	97.2	98.6	NA	95.2	96.3	87.3
2008	90.0	95.0	94.8	95.6	94.9	69.0	91.3	NA	86.6
2009	87.5	93.8	92.0	97.1	94.8	63.7	89.0	94.2	85.8
2010	92.0	97.8	95.8	99.5	97.2	62.8	92.8	99.2	93.2
2011	84.6	94.4	92.0	94.9	90.3	70.7	87.0	93.6	85.1
2012	88.7	96.2	93.7	95.2	90.3	72.2	93.3	94.5	88.9
2013	91.3	97.2	96.3	95.9	94.6	74.1	93.0	94.9	89.2

Adolescents 13-17 years

	≥ 1 Td or Tdap[¶]	≥ 1 Tdap**	≥ 1 MenACWY[††]	≥ 1 HPV[§§]	≥ 3 doses HPV	3 HPV complete
2009	88.0	72.2	67.8	60.0	39.8	NA
2010	95.9	87.9	73.8	49.6	42.2	87.1
2011	97.2	95.0	80.6	65.8	46.0	80.0
2012	97.0	96.3	83.1	52.2	34.5	69.8
2013	97.6	94.7	85.6	68.0	43.2	67.2

NA= Data not available.

Eligible Population: The eligible populations associated with the program includes all children (birth through 18 years of age) in New Hampshire who may receive vaccines at no cost to the parents or vaccine providers.

Non-Match Able Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of non-match able program expenditures included in the Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in A through L. All expenditures on these contracts are related to grants to organization to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that such services are not provided to undocumented individuals. Financial Participation (FFP) is not being claimed for the following:

A. Grant funding to test new models of care
B. Construction costs (bricks and mortar)
C. Room and board expenditures
D. Animal shelters and vaccines
E. School based programs for children
F. Unspecified projects
G. Debt relief and restructuring

H. Costs to close facilities
I. HIT/HIE expenditures
J. Services provided to undocumented individuals
K. Sheltered workshops
L. Research expenditures

G. Program Title: Governor's Commission on Drug & Alcohol Abuse, Prevention and Treatment and Recovery

Funding Sources: Other State Funds $3,327,761

Accounting Unit: 05-049-4915-2989

Brief Description: The Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery managed State funds for substance use disorders prevention and treatment services and related provider training and technical assistance is provided by the Bureau of Drug and Alcohol Services at the Department of Health and Human Services. Funding contributes to substance use disorder prevention and treatment services administered by the Bureau of Drug and Alcohol Services (BDAS). Services include the "Life of an Athlete" Prevention program, outpatient and intensive outpatient services, short-term residential and transitional living treatment services. Funding also supports provider training and technical assistance to all Bureau of Drug & Alcohol Services treatment and prevention service providers for systems and operational modifications needed for adopting evidence-based practices, programs and policies. Multiple training events support staff meeting New Hampshire licensing, certification and administrative rule requirements outlined in provider contracts with the Department of Health and Human Services.

The service delivery system includes:

Treatment Services:

- 15 Community based treatment contractors offering a continuum of care including outpatient and intensive outpatient counseling, short term residential and transitional living services serving approximately 5,200 clients per year.
- Life of an Athlete – There are approximately 50 schools implementing Life of an Athlete (LoA) in state fiscal year 2015. The Governor's Commission will likely want to continue to support this program that works to prevent participants from misusing alcohol and drugs and requiring more costly early intervention and treatment services. LoA anticipates increasing the number of schools from 50 to 65 in SFY 16 and from 65 to 75 in SFY 17, contingent upon a no-cost extension for the Federal Partnership for Success grant.

Training & Technical Assistance: The Training Institute on Addictive Disorders supports a staff of 1.5 FTEs who plan, contract for, market and provide logistical support for training events, including trainings to meet credentialing requirements for services supported by the Bureau of Drug and Alcohol Services. Technical assistance is provided through direct contact, learning collaboratives, utilizing analysis and management techniques and the publication of data to inform programs, practices and policies (data driven decision making).

Expected Outcomes: The Bureau will continue to measure client abstinence from both alcohol and drugs and involvement with the criminal justice system at discharge from a treatment episode as required by the federal National Outcomes Measures (NOMs).

• Outcome Measure Measures at Discharge	2014
• Abstinence Alcohol	58%
• Abstinence Illicit Drugs	54%
• % Without Criminal Justice Involvement	98%

Training and Technical Assistance: The Center for Excellence will provide appropriate support to increase provider use of evidence and outcome-based policies, programs and practices and will synthesize and manage information and data to support data-driven decision-making. The statewide training contract provides work force development services for alcohol and other drug abuse prevention, intervention, treatment and related professionals, providing approximately 30 trainings per year serving an estimated 1,120 professionals.

Eligible Population: The eligible populations associated with the program includes the following:

- Treatment clients are individuals who are being assessed for or who meet the American Psychological Association (APA) criteria for substance use disorders.
- Prevention services are directed at individuals at particular risk for misusing alcohol and or illicit drugs. Services are provided by agencies under contract with the Department of Health and Human Services.

Non-Match Able Expenditure List for the demonstration:

Pertinent staff reviewed the attached list of non-match able program expenditures included in the Special Terms & Conditions of the demonstration. For this particular program, it was determined that no claimed expenditures are made for the items listed in A through L. All expenditures on these contracts are related to grants to organization to provide services to clients. Costs for administering the program, including the program reviews and audits noted above, are not included in the DSHP claims. It is noted that such services are not provided to undocumented individuals. Financial Participation (FFP) is not being claimed for the following:

A. Grant funding to test new models of care
B. Construction costs (bricks and mortar)
C. Room and board expenditures
D. Animal shelters and vaccines
E. School based programs for children
F. Unspecified projects
G. Debt relief and restructuring
H. Costs to close facilities
I. HIT/HIE expenditures
J. Services provided to undocumented individuals
K. Sheltered workshops
L. Research expenditures