Care at the Crossroads:

A Financial Stress Test of the New Hampshire Substance Use Disorder Delivery System

THIRD HORIZON
STRATEGIES

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EXECUTIVE SUMMARY

In Fall 2022, Third Horizon Strategies (THS) was engaged by the NH Charitable Foundation (NHCF) to conduct an analysis of the financial health of the substance use disorder (SUD) delivery system in New Hampshire. The Charitable Foundation commissioned this report to inform shared learning and elevate guidance that can inform private, philanthropic, and public investments to continue to grow, stabilize and sustain accessible behavioral health services for all.

To conduct its analysis, THS conducted a review of publicly available information on the availability of state and federal funding, commercial and Medicaid payer information, and key informant interviews and focus groups to develop a 360 degree-view of the financial health of prevention, harm reduction, treatment and recovery services throughout the state.

In State Fiscal Year 2023 (SFY23), the State of New Hampshire has approximately $171m at its disposal for investment in SUD-related services. These funds are a mix of state and federal funding and estimated expenditures within the Medicaid Program. Though a sizeable portion of these resources are ongoing and can be viewed as "permanent" sources, some are expected to decrease in the coming 1-2 years. While commercial insurance provides revenue to support covered services, gaps in comprehensive commercial claims data, potential network adequacy, and other attendant issues have led to fewer SUD-related claims in the commercial market than expected, given New Hampshire's rates of SUD.

Providers of services in New Hampshire express concern about their financial health and sustainability, noting burdensome procurement and reporting requirements, delays in reimbursement, and an overall lack of acumen around maximizing Alternative Payment Models (APM) and similar payment innovations. These challenges, compounded by the economic downturn and ongoing workforce challenges, have led to significant concerns around both the short and long-term financial sustainability of services. This concern is most acute relative to certain elements of the SUD system, where current budgets over-rely upon time-limited funding and/or short-term contracts.

Despite these challenges, THS concludes that structural, regulatory, and strategic fiscal policy changes can be made to enhance care delivery, stabilize providers and allow New Hampshire to continue its long history of multi-stakeholder engagement and innovation to improve the delivery of behavioral health services for those who need them.

INTRODUCTION

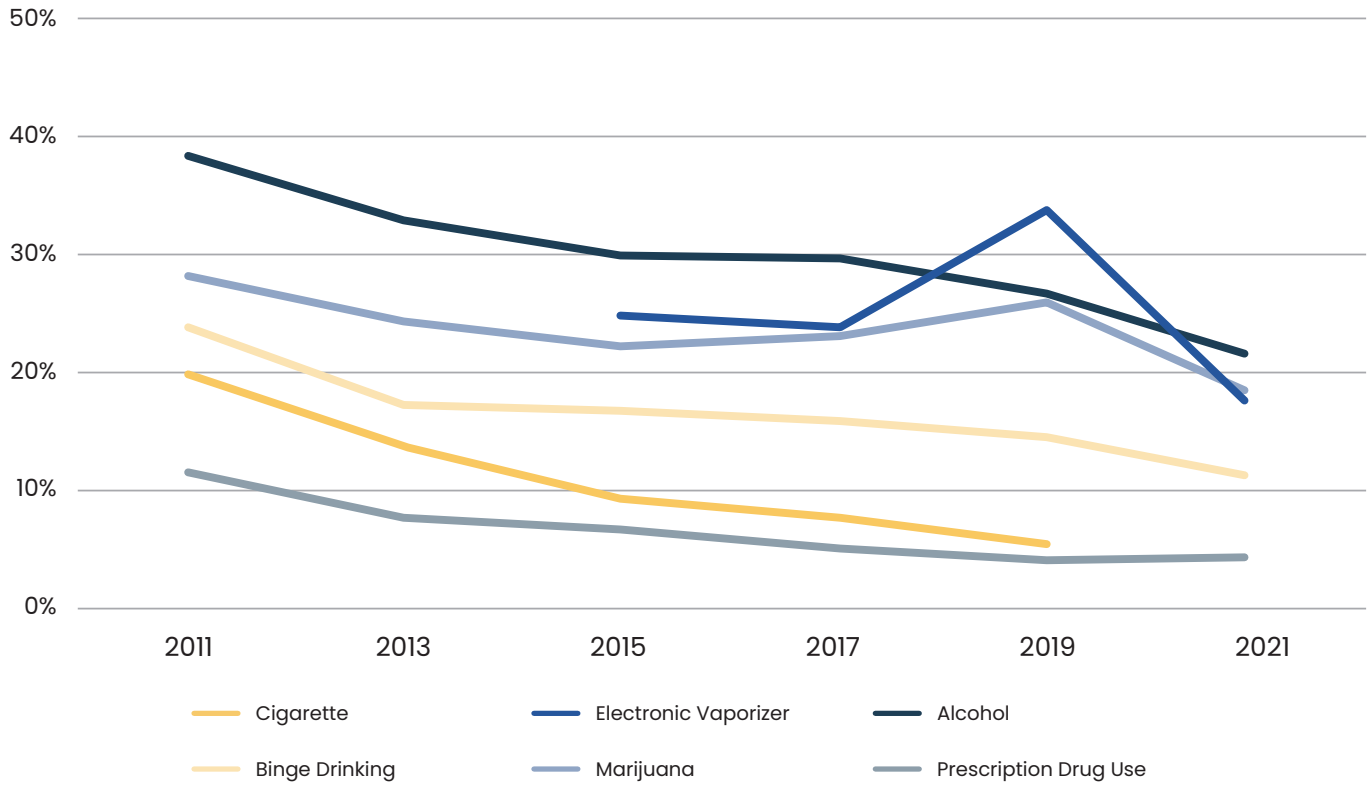
New Hampshire had a disproportionately higher rate of substance use disorders (SUD) than other states for many years. Plagued by limitations in funding, inadequate coverage by public or private insurance, high rates of use among the population, and persistent social and structural stigma surrounding SUD, the state endured unchecked disease, poor outcomes, and high costs associated with the consequences of alcohol and other drug misuse among youth and adults.

The emergence of the opioid epidemic in the early 2000s ushered in a period of even more significant challenge, with New Hampshire facing some of the highest per capita overdose death rates in the United States. However, the epidemic served as a tipping point for collective action, strategic investments, and accelerated policy work to advance the delivery of prevention, treatment, and recovery support services in New Hampshire.

Strong, cross-sector leadership, coupled with increased funding, such as the State Opioid Response (SOR) Grant and expanded insurance coverage for SUD treatment and recovery services, expanded care access. These efforts, led by advocates, policymakers, state agencies, and community leaders, increased treatment access and decreased overdose deaths. As the State Action Plan of the Governor's Commission on Alcohol and Other Drugs notes, *"Bucking the national trend, New Hampshire reduced the number of lives lost to drug overdose by more than 11% from 2018 – 2021 (CDC)."*

Additionally, the state's Public Health Network (PHN) system weathered the pandemic and continued to bring positive results as a focal point in the delivery of SUD prevention in the state. As Figure 1 indicates, results from the Youth Risk Behavior Survey (YRBS) demonstrate declines in regular substance use by youth (see Figure 1).

Figure 1: 30-Day Use 10-Year Trend



In 2023, New Hampshire now finds itself at a crossroads in its efforts to combat challenges associated with SUD. While more financial resources are available to deliver SUD services than ever, some of the resources supporting core parts of the ecosystem infrastructure will likely be reduced or are scheduled to end altogether in the next 1-2 years. Despite the emergence of new resources from litigation against opioid manufacturers, pharmacies, and distributors, as well as expanded coverage for behavioral health services in public and private insurance, nonprofit and other safety net providers of prevention, harm reduction, treatment, and recovery services still report fragile financial stability and existential risk to their ability to continue serving their community.

This disconnect between the existence of significant resources to combat addiction, and ongoing concerns around the solvency of the SUD system, prompted the New Hampshire Charitable Foundation (NHCF) to engage Third Horizon Strategies (THS) to conduct a financial resiliency scan of the state's SUD delivery system. The Foundation hopes that findings from this report will inform shared learning and elevate guidance to inform private, philanthropic, and public investments to continue to grow, stabilize and sustain accessible behavioral health services for all NH residents.

GUIDING VALUES AND APPROACH

THS is a boutique, strategic health care advisory firm focused on shaping a future system that actualizes a sustainable culture of health nationwide. The firm's mission and core values are highlighted below.

- Mission: We push against the status quo by designing integrated health and social systems so all communities, families, and individuals can thrive.
- Core Values: .
    - Impact Driven: We relentlessly pursue transformation and reflect that commitment in our daily work and interactions with clients and communities.
    - Mission Obsessed: We strategically align ourselves with public and private entities to advance our mission to create a sustainable culture of health and well-being.
    - Equity-Centered: We strive for equity in all we do and advance equitable care delivery systems so all individuals, families, and communities can thrive.
    - Knowledge Powered: We bring subject matter expertise to strategically address market and community needs while embracing and learning from different perspectives.

THS' work in behavioral health is deeply personal, as several team members have direct or familial experience engaging with mental health and SUD delivery systems. The firm's team has decades of experience working in community behavioral health and in-depth knowledge of federal and state policy, enabling it to bridge policy and strategy with on-the-ground realities to support program implementation.

THS analyzed the underlying economics of the New Hampshire SUD system with five underpinnings in mind:

- Though this project looks specifically at the financial stability of SUD services, such services are a part of "behavioral health," which THS defines as both SUD and mental health.
- SUD services should be available on par with other health care services and across the continuum of primary prevention, harm reduction, treatment, and long-term recovery supports.
- Investments in SUD services should incentivize, allow for, and enhance patients' ability to access all levels of care seamlessly and be active participants in establishing their treatment plan goals.

- Public and private investment should be strategic, aligned, and designed for the long-term sustainability of services across the continuum. Investment strategies should be transparent and easily understandable by all investors, providers, policymakers, and individuals interacting with the service array.
- Investment methodology should prioritize long-term stability in service delivery to support longitudinal reductions in disease burden at the individual and community levels and address the broad spectrum of substances while also tending to the unique service implications relative to certain drugs

The firm made a concerted effort to hear from providers across New Hampshire's continuum of care and to engage state agencies, community, and organizational leaders in the analysis. THS endeavored to understand how investment strategy, procurement, and funding management across the life cycle of a funding engagement is enhancing – or interfering with – service delivery in New Hampshire.

METHODOLOGY

THS used a mixed methods approach to conduct the financial analysis and formulate recommendations. The team reviewed and analyzed available quantitative data sets on local, state, and federal budgets for SUD services, public and commercial insurance rates, and specific commercial insurance claims available from New Hampshire's All Payer Claims Database. THS augmented this financial data with extensive qualitative research and stakeholder engagement, including reviewing national literature, conducting key informant interviews, and drawing on its team's subject matter expertise in behavioral health.

Specific activities included:

- A provider survey to ascertain the financial health and outlook of SUD service providers
- Key informant interviews with leaders from NHCF, the New Hampshire Department of Health and Human Services (NH DHHS), the New Hampshire Department of Education (NH DOE), other state agency leadership, advocacy organizations, researchers on behavioral health and payment, payers, and other key state leaders
- Focus groups with community-based service providers by the level of care (prevention, harm reduction, treatment, and recovery)
- A review of publicly available financial data from the Substance Use and Mental Health Service Administration (SAMHSA), state agencies, the New Hampshire Governor's Commission on Alcohol and Other Drugs, and the New Hampshire Opioid Abatement Commission
- Regulatory review of procurement and contracting procedures between community organizations and New Hampshire state agencies
- Analysis of data from the New Hampshire Comprehensive Health Care Information System (NHCHIS), the state's commercial all-payer claims database, from 2017-2022
- Publicly available Medicaid data aggregated and distributed from the University of New Hampshire Institute of Health Policy and Practice and from managed care Medicaid provider manuals
- Regular communication with NHCF and state officials on any substantive changes to the fiscal landscape during the project's scope
- A review of state plans to address substance use, mental illness, homelessness, and other related planning documents
- Literature review of complementary social and economic analysis of New Hampshire and its attendant health and social services systems in both the COVID-19 pandemic and post-pandemic period

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Limitations of the Analysis

Though THS sought to conduct the most robust analysis possible, some limitations should be noted. Most notable is the exclusion of Medicaid claims analysis due to regulations that limit accessibility to Medicaid claims to research projects that an Institutional Review Board has approved. As an alternative to direct access to this data, THS reviewed publicly available information on rates and reports published by the Institute of Health Policy and Practice at the University of New Hampshire. While these resources were illuminating, they did not permit the level of direct claims analysis necessary to fully comment on the implications of Medicaid utilization on the fiscal health of the SUD system.

While THS did have access to five years of claims data from the Commercial NHCHIS, there are limitations to the robustness of the data set. The federal Employee Retirement and Income Security Act (ERISA) prevents states from directly regulating employee welfare benefits, including employer-sponsored health plans. In 2016, the US Supreme Court ruled in Gobielle v Liberty Mutual Insurance Company that states may not require plans governed by ERISA to submit claims into an all-payer claims database. As NHCIS does not include all private commercial claims, THS cannot guarantee that findings from NHCIS claims analysis are indicative across all commercial claims.

THS conducted most of its focus groups and financial review in late 2022 and the first quarter of 2023. Though the project team stayed in constant contact with state and federal officials during the analysis period, some elements of the analysis involve "moment in time" observations and reflections that may not fully capture the underlying economic dynamics of the system at the time this report is published.

Finally, THS was not contracted to conduct a quality review of the funded services and therefore did not analyze the effectiveness of any specific programmatic investment.

OVERVIEW OF FINANCING OF SUD IN NEW HAMPSHIRE

Financing: State and Federal Funding Review

THS compiled an inventory of state and federal funding sources supporting SUD services and assessed each revenue stream regarding unique characteristics and degree of sustainability.

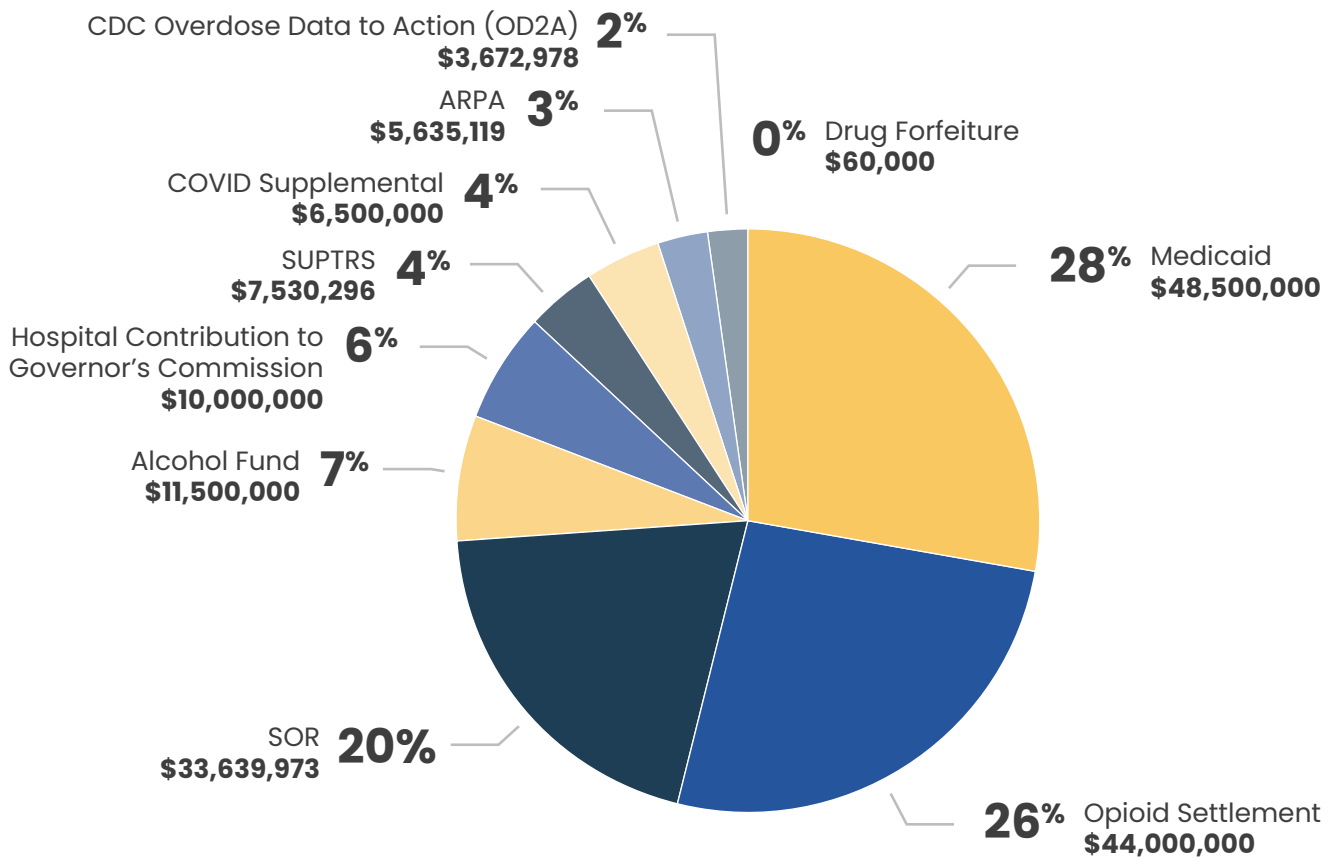
Investments in SUD services aren't tied to a unified event horizon. The State of New Hampshire most often procures services matched to the State Fiscal Year (SFY) of July 1-June 30. Federal grants, with some exceptions, flow to the state and communities based on the Federal Fiscal Year (FFY) of October 1 – September 30. Further, service providers (particularly nonprofits) may have fiscal years for financial reporting that align with only one of these time frames or follow the calendar year. In sharing its findings, THS references the total funds available based

on the state fiscal year while appreciating that some funds at the state's disposal may have expenditure horizons that follow into the next State Fiscal Year (SFY).

While THS analysis focused on the economics of the delivery of SUD care, some funding sources available to New Hampshire included mental health and SUD as mutually allowable expenses. For this report, THS includes the total resources available, even if the resource could also be supporting mental health-specific investments.

During the SFY 2023 (which runs July 1, 2022-June 20, 2023), New Hampshire has approximately $171,038,000 for SUD services at its disposal (see Figure 2). This figure does not include expenditures through commercial insurance, nor does it include federal grants that can be applied for and received directly by local communities. It also does not include state general fund appropriations that may cover SUD-related services delivered directly by state agencies. Ultimately, the total financial resources available to the state for SUD-related investment is likely higher. Relative to Medicaid, the figure represents the state's reported expenditures as a proxy for available resources in the current fiscal year. Aside from Medicaid, the other funds are most often awarded in grants to community-based organizations and local governments/schools to support services.

Figure 2: Public Funds Available for SUD Investment SFY23



Total: $171,038,366

The NH DHHS administers these resources, although some resources are transferred to other state agencies to support their efforts. Each funding source has unique characteristics that impact how the state, and its contracted organizations, can utilize these funds.

Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant

The SUPTRS has served as the backbone of stable SUD-related financing since the 1980s. SAMHSA annually provides each state a formula-based allocation of resources to deliver SUD services. SAMHSA also allocates funding to states under the companion Community Mental Health Services Block Grant.

The SUPTRS block grant supports prevention, treatment, and recovery support services. The block grant requires that a minimum of 20 percent of the total allocation to a state must be used for substance misuse prevention efforts (referred to as the "prevention set-aside"). Though efforts have been made to add a similar set-aside requirement for recovery support services, current regulations permit the remaining 80 percent of block grant resources to support treatment and recovery services at the discretion of the Single State Agencies (SSA) – which in New Hampshire, is the NH DHHS, through its Bureau of Drug and Alcohol Services (BDAS).

While that broad discretion allows the state to utilize the block grant in numerous ways, some restrictions exist. As with most federal funds, these resources can't be used for food purchases or lobbying work by organizations. The funds also currently cannot be used for rental payments for housing. Additionally, states must prioritize pregnant women, women with dependent children, and intravenous drug users in access to treatment. Block grant plans must also reflect priorities around tuberculosis services, HIV early intervention services, and prevention services.

The Consolidated Appropriations Act of 2023 increased the block grant amount and called for states to analyze current recovery support needs, with encouragement around increasing investment in recovery services. Specifically, New Hampshire's block grant increased from $7.1m to $7.5m. President Biden's proposed Federal Fiscal Year (FFY) 2024 budget calls for further increasing the federal block grant allocation to states and reintroduces the concept of a recovery set aside. Under this proposal, New Hampshire's block grant allocation could further increase to $10.2m.

State Opioid Response (SOR)

In December 2016, President Obama signed the 21st Century CURES Act, which created the State Opioid Response (SOR) program. In addition to providing all states funding to combat the opioid epidemic, the program was designed to allow additional funding to go to states with the highest per capita overdose death rates in the US. Since, at the time, New Hampshire had the 4th highest overdose rate, New Hampshire has thus far received a higher share of the resources than most other states.

Figure 3 below shows the current utilization of SOR resources in New Hampshire. This includes the third year of SOR funding and the utilization of carry-forward funds from previous SOR Grants.

Figure 3: State Opioid Response 3 and No Cost Extension Funding

State Opioid Response 3 Funding	
Doorways	$10,572,000
2-1-1 & After-Hours Call Coverage	$1,385,999
Crisis Respite Housing	$3,000,000
Medications for Substance Disorder Treatment	$1,520,000
Department of Corrections Collaboration (MOUD/Care Coordination)	$965,000
Peer Recovery Support Services	$2,000,000
Workforce Readiness and Vocational Training	$316,540
Recovery Housing	$170,000
Room & Board for Medicaid Clients in SUD Residential Treatment (3.1-3.7)	$6,024,000
SOR Technical Assistance & Drug Overdose Fatality Review Commission TA	$361,434
ACES Mitigation	$350,000
GPRA Data Collection	$225,000
Total	**$26,889,973**

State Opioid Response 2 No Cost Extension Funding	
Access and Prevention	**$3,446,266**
Treatment and Recovery	**$2,604,002**
Data and Evaluation	**$250,000**
Technical Assistance	**$202,982**
Other	**$21,750**
DHHS Cost Allocation	**$225,000**
Total	**$6,750,000**

Source: NH Department of Health and Human Services

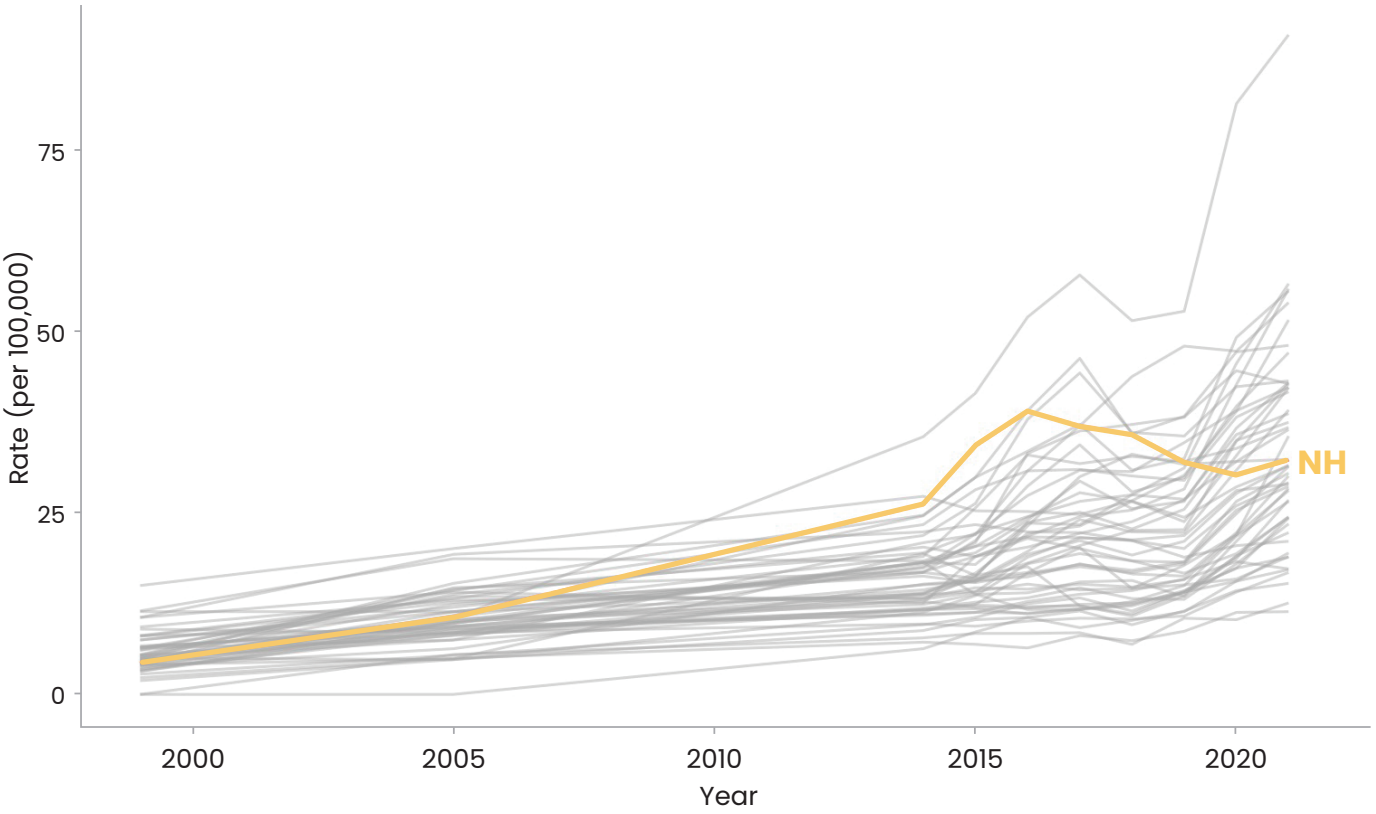
New Hampshire uses SOR dollars to primarily fund the Doorways – a system of regionally-based centers offering assessment, referral, and care coordination to support those seeking treatment and recovery support services. Though hospitals operate the Doorways, they rely on grant funding from SOR to cover staffing and operating expenses, with only limited billing for services by Medicaid or other payers.

Other SOR resources support critical components of the ongoing SUD infrastructure, including Recovery Community Organizations (RCOs), 211, and crisis housing. It is also notable that SOR funds are being utilized to fill gaps in financing for room and board costs associated with certain levels of residential treatment, as Medicaid can't reimburse those costs.

Two elements of SOR are particularly noteworthy in considering their role in financing SUD services in New Hampshire. **First, SOR was explicitly designed to combat the opioid epidemic.** Almost immediately, state officials and providers expressed concerns that the regulatory focus on opioids would prevent the use of funds to support those who may be misusing other substances, such as alcohol. Leveraging funds from other sources has ameliorated some of this concern – and federal guidance has allowed some flexibility in this area. As of 2022, the program was amended to provide an allowance to address stimulant use disorder as well – but the resources remain narrowly focused on specific substances at a time when polysubstance use disorder, including alcohol use disorder, is growing in prevalence.

Secondly, SOR Funding is not permanent and will decline in New Hampshire in SFY25. While Congress has taken additional action to extend and expand the scope of the SOR Grant program since its inception, it remains structured as a time-limited grant program. Additionally, though New Hampshire's overdose rates have begun rising after a period of decline before the COVID-19 pandemic, rates of overdose deaths in other states are growing faster. Given that New Hampshire no longer ranks among the states with the highest per capita overdose death rate, the state will no longer qualify for supplemental SOR funding. Figure 3 shows the state's drug

Figure 4: Drug Overdose Mortality Rate by State



overdose mortality rates over time through 2021, highlighting New Hampshire's relative place among the 50 states. As of this writing, New Hampshire ranks 23rd.

Estimates shared by state officials with THS are that, per the regulations, New Hampshire could see a decline from just over $28m to approximately $6m annually.

The Consolidated Appropriations Act of 2023 directed the SOR program to contemplate flexibility in determining the structure and approach to any declines in funding for states that drop out of the high-need list. However, as of this report, the SOR Program at SAMHSA has yet to release any guidance to affected states on the status, level, or processes for anticipated declines in funding that would commence on September 29, 2024.

CDC Overdose Data to Action Funding (OD2A)

The Division of Public Health Services administers this grant. Though it was initially for three years, a fourth year allowed the state to spend approximately $5m in unspent funding. This grant will end on August 31, 2023. Though the state has applied for another round of funding, a reduction in overall funding amount is anticipated, along with alterations in allowable use that may impact future investment strategy. Table 5 below summarizes the grant's final-year funding strategy. Of note is the ability to utilize these funds for harm reduction strategies.

Figure 5: OD2A Funding Overview

Surveillance Strategies:	
Strategy 1: Morbidity Data Surveillance - Division of Public Health Services (DPHS), Bureau of Infectious Disease Control (BIDC), Automated Hospital Emergency Department Data Program (AHEDD)	**$411,214.50**
Strategy 2: Mortality Data Surveillance (SUODRS Data Collection and Abstraction) - Department of Justice (DOJ)-Office of the Chief Medical Examiner (OCME)	**$425,406.50**
Strategy 3: Innovative Surveillance Data (Clinical Urine Sample Data and Syringe Testing) - Public Health Laboratory, (PHLab)	**$399,233.00**
Prevention Strategies:	
Strategy 4: Enhancement of the PDMP System - DPHS, Prescription Drug Monitoring Program (PDMP)	**$883,938.00**
Strategy 5: Kinship Care Navigation (guiding families caring for children separated from their parents who have substance use disorder)- DHHS, Bureau of Drug and Alcohol Services (BDAS)	**$704,099.00**
Strategy 6: Education and Linkages to Care - DPHS-Bureau of Infectious Disease Control (BIDC) (funding cannot be used to purchase syringes or Naloxone)	**$575,229.00**
Strategy 7: Academic Detailing – Harm Reduction (Training Health Care Providers in best practices for opioid prescribing) - DPHS-BIDC	**$177,240.00**

Source: NH Department of Health and Human Services

Coronavirus Relief Funds

The federal government allocated resources to address the impacts of the COVID-19 to a myriad of emergency and related efforts to stabilize the state's economy and protect social service infrastructure, including for SUD and mental health issues. States must allocate American Rescue Plan Act (ARPA) funds by December 31, 2024, and spent down by December 31, 2026. Coronavirus Relief Funds, which were part of a supplement to the SUPTRS Block Grant, must be spent down by 2024. Given the confirmed ending of the COVID-19 Public Health Emergency on May 11, further relief funds are not anticipated.

The Alcohol Fund

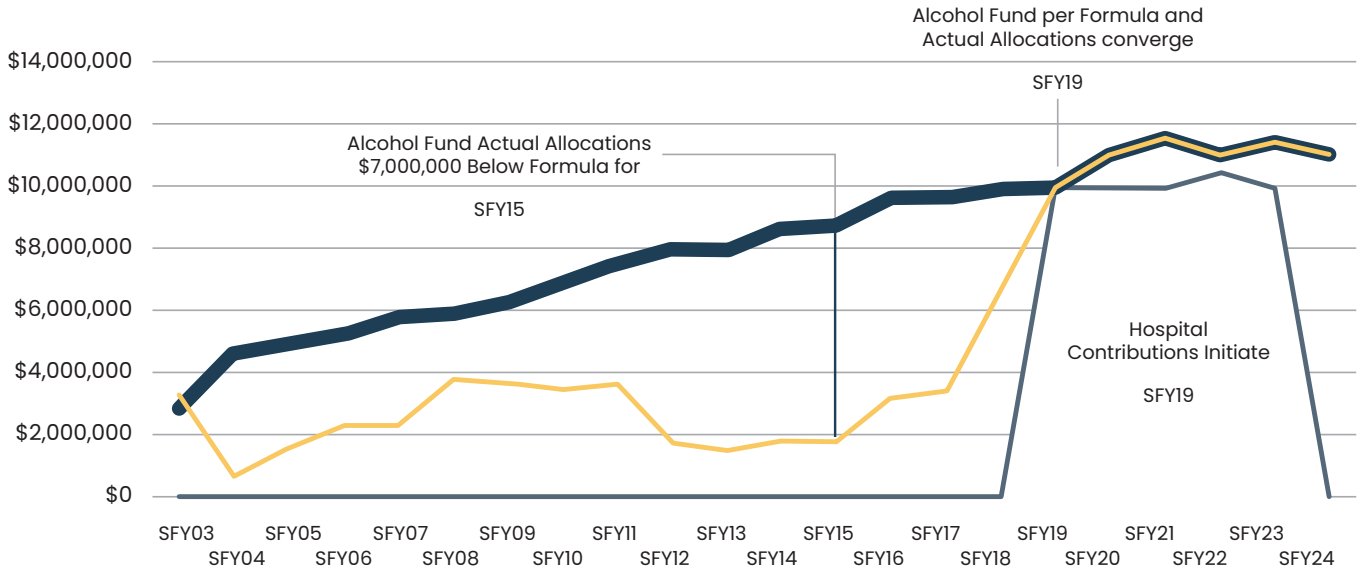
The New Hampshire Legislature established the Alcohol Abuse Prevention and Treatment Fund (The Alcohol Fund) in 2001 to support SUD-related services. The fund is derived as a percentage of gross profits from the sale of alcohol in New Hampshire Liquor Outlets. Administrative authority over the utilization of the fund rests with the Governor's Commission on Alcohol and Other Drugs, which was established simultaneously to oversee the fund's deployment. However, despite its purpose and financing scheme being codified in law, its regulatory framework has been routinely suspended during the state budget process.

From 2001-2018, the Alcohol Fund was never funded according to its funding formula. Instead, the legislature would suspend the formula in the trailer bill created during each biannual budget process, known as HB2. This effectively reduced the fund's balance to $0. The state budget would then replenish the fund with an appropriation from the state's General Fund that was never equal to the funding level per the statutory formula.

In 2018, the legislature took a different tac. In tandem with efforts to reauthorize the state's Medicaid Expansion Program, seen as a critical tool in increasing access to SUD treatment, the legislature retained the Alcohol Fund allocation per its statutory formula, but diverted the Liquor Commission proceeds to the NH DHHS to serve as a portion of the state's required Medicaid Match.

As part of repurposing the Alcohol Fund to support Medicaid expansion, the state's hospitals committed to contributing resources equivalent to the value of the Liquor Commission share – $10m – for five years. Earlier this year, the state's hospitals confirmed they would not extend their contributions beyond five years, given the financial pressures on hospitals resulting from the COVID-19 pandemic.

Figure 6: Governor's Commission on Alcohol and Other Drugs Allocation History



Source: New Futures

While the hospital contribution allowed the state to continue its commitment to Medicaid expansion while protecting investments in the SUD delivery system supported by the Alcohol Fund, the value of the hospital's commitment only matched the value of the Liquor Commission's share of the Alcohol Fund in the first year. As Figure 6 notes above, subsequent years did not consider the ongoing growth in profits from liquor sales, amounting to level funding of the Governor's Commission on Alcohol and Other Drugs – while the Alcohol Fund's contribution to Medicaid expansion increased annually based on liquor profits.

In early 2023, the New Hampshire Senate unanimously passed SB263, which would re-authorize Medicaid Expansion permanently. In its current form, the bill also untethers the use of the Alcohol Fund as a portion of the Medicaid Match. As of this publication, the Senate approved the bill, which is now under consideration in the House of Representatives.

Currently, HB2 does not reference the Alcohol Fund formula. Should the entire legislature pass and the governor sign SB263, and without further action in HB2, the Alcohol Fund would be fully funded and directed back to the Governor's Commission on Alcohol and Other Drugs for the upcoming biennium.

The Alcohol Fund is perhaps the most flexible resource at the state's disposal, as it does not carry the common restrictions tethered to federal funding. While it remains unusable by contractors for lobbying efforts, it can be used to cover capital and other expenses that typically aren't allowed by federal funds. Additionally, since the Alcohol Fund resources come directly from the Liquor Commission and not the General Fund, the resources can also be used to support harm reduction activities, such as purchasing clean supplies. This allows the Governor's Commission on Alcohol and Other Drugs broad discretion around the utilization of the funding based on current needs and available data.

Opioid Abatement Funds

New Hampshire has been involved in numerous legal actions against the producers, manufacturers, and distributors of opioid medications. This has led to several settlements, all orchestrated to provide funding to ameliorate the harms caused by the opioid epidemic.

Receipt of these resources was preempted by the creation of the Opioid Abatement Fund in New Hampshire and the establishment of an Opioid Abatement Commission to manage any funds received through such legal action.

To date, the Opioid Abatement Fund has received $44m. Though the fund's establishment contemplated settlement agreements where funds would be deposited annually, most of the current balance is from a settlement agreement with Johnson & Johnson, where the entire settlement amount was transferred to the state in one lump sum. Over the next 18 years, the state anticipates receiving over $320m, with several litigation efforts not yet concluded that could increase the total funds available and further adjust the event horizon of available abatement funds.

Per the Opioid Abatement Fund statute, 15 percent of all funds received go directly to "counties and political subdivisions," which had their direct litigation tied to the Multi-District Litigation (MDL) against opioid manufacturers. The remaining 85 percent is then deposited into the Opioid Abatement Trust Fund. All funds must be utilized for purposes outlined in the statute and the related settlement agreements. As of this writing, the legislature is considering SB32, which would make further adjustments to the use and purposes of the Opioid Abatement Fund, to place it in direct alignment with the state SUD strategy, and to clarify the ability for the Fund to be used towards prevention and harm reduction services.

In August 2022, The Opioid Abatement Commission released a Request for Grant Applications (RGA). The RGA served as an open call for nonprofits, governmental entities, state agencies, boards, and commissions to apply for funds. Proposals were due in September 2022.In May of 2023, the first round of contracts from the RGA were approved by Governor and Executive Council, using approximately $6.7m in available funds. As of this writing, a second Opioid Abatement RGA, focused on allowing municipalities and governmental entities to seek reimbursement for costs associated with the opioid epidemic, has been released.

Payer Findings

Recognizing the increasingly significant revenue generated through insurance reimbursement, THS reviewed commercial claims and data relative to Medicaid utilization in New Hampshire.

Commercial Claims

Commercial insurance coverage for comprehensive SUD services has been a long-standing issue nationwide to which New Hampshire has not been immune. The Mental Health Parity and Addiction Equity Act (MHPAEA), signed into law in 2008, required health plans that provided coverage for behavioral health services to do so at par with physical health services for large employer plans. Two years later, the Affordable Care Act defined mental health and SUD treatment as an essential health benefit and extended parity protections to the small group market and Medicaid expansion populations. The regulations on MHPAEA were not released until 2013 and went relatively unenforced until recent actions from the Department of Labor detailed in their 2022 report.

However, the law today requires that nearly all commercial insurance products offer both in-network and out-of-network coverage for inpatient, outpatient, and pharmacy coverage for clinical SUD care. The combination of these federal laws was poised to set the stage for a tremendous growth opportunity for providers of SUD care. However, providers continue to struggle to go in-network with commercial plans either because the rates offered are deemed inadequate, or the carrier was not looking to expand their in-network providers despite the persistent SUD crisis and access challenges for beneficiaries.

Access to New Hampshire Comprehensive Health Care Information System (NHCHIS) allowed THS to analyze specific commercial claims for 2017-2022 for SUD to evaluate key rate and network utilization trends for SUD.

Using the service definition published by the Alliance for Addiction Payment Reform, data analysts identified SUD and non-SUD claims based on a set of diagnosis codes and procedure codes. Figure 7 below shows SUD-related commercial claims for 2021, comprising 1.4 percent of claims and 2.2 percent of total paid amounts.

Figure 7: Commercial Claims 2021

TOTAL CLAIMS / AMOUNTS	SUD	Non-SUD
Total Claims	298,179 (1.4%)	21,771,221
Total Cases	127,390	9,065,315
Amount Paid	**$54,624,559 (2.2%)**	**$2,447,586,600**

The low percentage of claims sharply contrasts the general prevalence of SUD in New Hampshire reported in the National Survey on Drug Use in Health, which during similar periods was 9.1% of all those 12 and older. The difference indicates a gap between the need for SUD services and actual service utilization. This finding is significant given that 57.7% of people in New Hampshire are commercially insured, although a significant amount of ERISA-covered plan data is not currently in the NHCIS. This suggests that challenges persist with local in-network access to SUD care for the commercially insured population in New Hampshire, possibly causing a significant number of covered individuals to receive care out-of-network or not receive specialty SUD care at all.

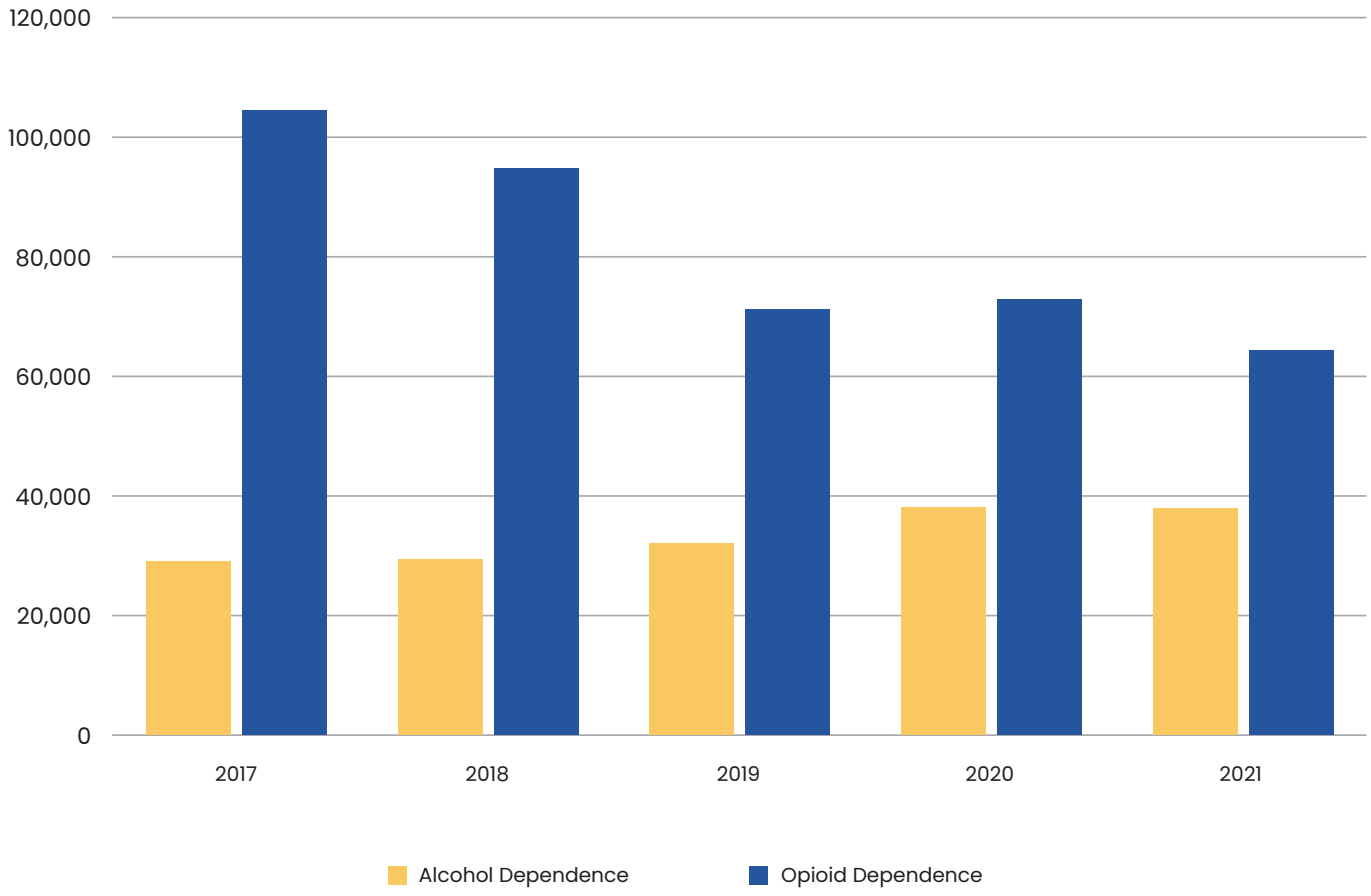
Additionally, a review of claims by providers indicates that a significant portion of claims comes from providers out of state. While some out-of-state providers are billing for services delivered in-state, New Hampshire is losing significant SUD treatment spending to out-of-state providers, despite increasing acceptance of patients with commercial insurance by many providers based in New Hampshire.

Figure 8 shows each cohort's top ten most commonly utilized services by Current Procedural

Figure 8: Top CPT Claims 2021

		SUD				Non-SUD	
1	H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	27,131		99213	Office/outpatient visit est	946,565
2	99214	Office/outpatient visit est	17,673		99214	Office/outpatient visit est	934,689
3	99213	Office/outpatient visit est	15,270		97110	Therapeutic exercises	612,081
4	90837	Psytx pt&/family 60 minutes	13,420		36415	Routine venipuncture	504,115
5	G0480	Drug test def 1-7 classes	10,583		97140	Manual therapy 1/> regions	399,312
6	908834	Psytx pt&/family 45 minutes	10,415		80053	Comprehen metabolic pane	309,229
7	80307	Drug test prsmv chem a nlyzr	9,904		90837	Psytx pt&/family 60 minutes	305,739
8	90853	Group psychotherapy	8,305		98941	Chiropract manj 3-4 regions	293,642
9	H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therap	8,250		85025	Complete cbc w/auto diff wbc	270,415
10	80305	Drug test prsmv dir opt obs	3,595		G0463	Hospital outpt clinic visit	253,573

Figure 9: Opioid Dependence vs Alcohol Dependence



Terminology (CPT) code for 2021. For the SUD cohort, the most common CPT in the claims was methadone administration (H0020).

An examination of the frequency of diagnoses in the claims showed opioid dependence (F1120) outnumbering alcohol dependence (F1020); however, as Figure 9 demonstrates, the trend over the last five years shows that the gap is narrowing (data for 2022 was incomplete).

To identify any variation in SUD and physical health rates, data analysts also examined average amounts paid from 2017 - 2021 among standard procedures and compared them to Medicaid rates, with mixed results. Data analysts chose commonly used SUD procedure codes alongside comparable intensive physical health procedures to determine if there were any visible disparities. As Figure 10 Illustrates, on average, claims range between 75 percent to 1,955 percent of the Medicaid rate.

Figure 10: SUD vs Physical Procedure Reimbursement

Category	Code	Description	Total Claims	Average Amount Paid	Averag Out of Pocket	Medicaid Fee Schedule	% of Medicaid Fee Schedule
SUD	99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	1,134	$29.92	$4.89	$39.68	75%
Physical Health	99214	Established patient office or other outpatient visit, 30-39 minutes	2,364,193	$126.14	$38.52	$69.93	180%
SUD	H0015	Alcohol and/or drug services; intensive outpatient	35,393	$294.50	$31.36	$119.36	247%
Physical Health	97110	Therapy procedure using exercise to develop strength, endurance, range of motion and flexibility, each 15 minutes	1,997,663	$27.84	$9.59	$24.22	115%
SUD	H0020	Opioid Treatment Program, Methadone	137,056	$50.20	$9.79	$10.87	462%
SUD	H0033	Opioid Treatment Program, Buprenorphine	905	$150.73	$4.74	$10.87	1387%
Physical Health	96413	Injection and Intravenous Infusion Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration	106,072	$472.01	$25.63	$107.72	438%
SUD	H2036	Partial Hospitalization Services (ASAM Level 2.5)	3,650	$495.56	$42.27	$254.86	194%
Physical Health	90945	Dialysis procedure other than hemodialysis, e.g., peritoneal dialysis, hemofiltration or other continuous renal replacement therapies	36,480	$623.44	$5.44	$31.89	1955%
SUD	H0018	Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem	4,767	$1,006.59	$88.54	$255.50	394%

Finally, the data analysts reviewed how average amounts paid for these same procedures on commercial claims varied year-over-year. CPT 99214, an outpatient primary care office visit code, was chosen to compare with CPT 99408 similar timed screening code, CPT 97110 for physical therapy was chosen to compare with the HCPCS code H0015 for intensive out-patient SUD services, and CPT 96413 for chemotherapy treatment was chosen to compare with the HCPCS code H0020 for methadone administration. These comparisons were not analyzed on a basis of average price with one another, but rather the trajectory of the rates to explore if the physical health code rate trajectory differed from the SUD rate trajectory over the same period. Overall, there were more physical health claims than SUD claims (see Figure 11) for each code, providing additional data inputs on the physical health procedure rate trends analyzed.

Figure 11: SUD vs Physical Health Utilization

SUD	Average Payment Amount (commercial paid claims)					
	2017	2018	2019	2020	2021	2022
99408						
utilization	248	134	190	277	251	34
amt paid	14.76	42.54	25.15	34.41	33.69	42.6
out of pocket	4.91	2.73	6.36	3.06	2.87	29.12
total	**19.67**	**45.27**	**31.51**	**37.47**	**36.56**	**71.72**
H0015						
utilization	6,116	5,857	7,098	7,418	8,001	903
amt paid	294.33	327.24	269.49	293.73	290.32	333.34
out of pocket	22.18	30.86	28.08	35.64	31.84	78.93
total	**316.51**	**358.1**	**297.57**	**329.37**	**322.16**	**412.27**
H0020						
utilization	31,063	27,998	21,661	26,852	26,650	2,832
amt paid	75.05	68.95	33.03	32.87	33.43	39.31
out of pocket	7.29	8.72	11.05	11.03	11.12	14.2
total	**82.34**	**77.67**	**44.08**	**43.9**	**44.55**	**53.51**

Physical Health	Average Payment Amount (commercial paid claims)					
	2017	2018	2019	2020	2021	2022
99214						
utilization	508,744	526,132	527,567	361,953	372,359	67,438
amt paid	121.76	122.28	125.35	127.57	134.35	143.65
out of pocket	34.72	37.09	39.57	41.03	39.98	49.27
total	**156.48**	**159.37**	**164.92**	**168.6**	**174.33**	**192.92**
97110 **per unit*						
utilization	403,275	401,970	390,546	338,138	407,664	56,070
amt paid	27.14	27.23	27.55	27.62	29.79	27.32
out of pocket	8.54	9.33	9.79	9.77	10.17	12.62
total	**35.68**	**36.56**	**37.34**	**37.39**	**39.96**	**39.94**
96413						
utilization	19,743	21,126	21,691	20,881	20,245	2,386
amt paid	412.18	445.41	466.02	496.55	531.9	561.15
out of pocket	15.26	19.3	21.87	29.22	32.52	109.95
total	**427.44**	**464.71**	**487.89**	**525.77**	**564.42**	**671.1**

The physical health procedures rates stayed relatively constant or trended slightly upward from year to year from 2017 to 2022. The analysis found that while SUD-related services such as screening paid amounts trended upward over the period, intensive out-patient remained nearly flat despite an increase in utilization through 2021. The most frequently found SUD procedure in the data, Methadone treatment, decreased by over half since 2017. None of the physical health codes reviewed saw nearly the volatility seen in the SUD claims. This can be partially explained by the low utilization and volume of SUD services in the NHCIS but may also portend changes in the strength and capacity of networked providers.

Medicaid

In 2014, New Hampshire expanded Medicaid to persons earning up to 133 percent of the federal poverty level. The state is an integrated managed care Medicaid state, meaning that the state contracts with private carriers to administer most of the program. Today, 91 percent of New Hampshire Medicaid enrollees are covered by one of three contracted managed care organizations (MCOs). Each entity manages care for beneficiaries' physical and behavioral health needs. Figure 12 shows a significant increase in the covered Medicaid population since 2014. However, the trend line begins to decline in 2023 as the public health emergency is set to end, given that the continuous coverage Medicaid policy expired on March 31, 2023.

Service Prevalence

The Transformed Medicaid Statistical Information System (TMSIS) submitted a SUD Data Book to Congress in 2022, as the SUPPORT Act requires. The report found that in 2020 in New Hampshire, 12.6 percent (20,144 individuals) received treatment for any SUD, 7.5 percent of treatment for OUD, and 4.3 percent for polysubstance use disorder. This is significantly different from just the 1.2 percent of commercially insured individuals who received SUD treatment described above.

As Figure 13 indicates, New Hampshire Medicaid beneficiaries receive slightly more intervention, screening/assessment, and treatment programs than the U.S. average and a considerably more significant amount of Medication Assisted Treatment and physician services.

Figure 12: Medicaid Enrollment February 2014-February 2023

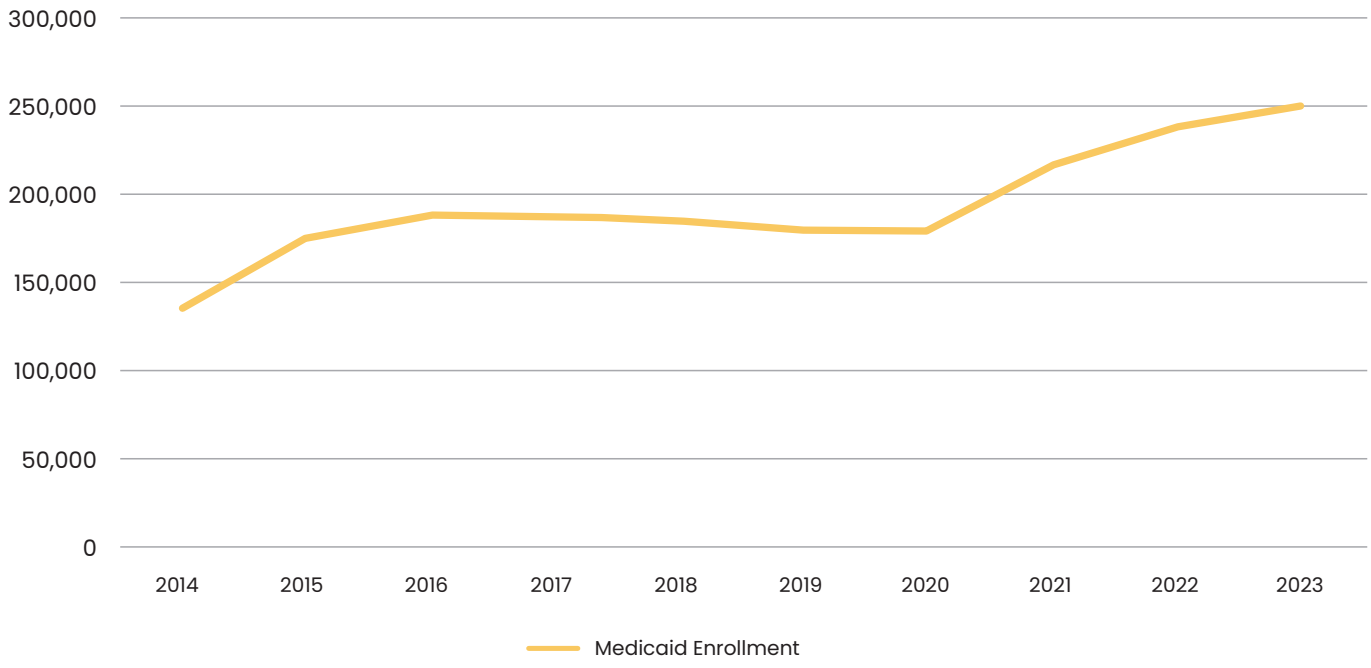


Figure 13: Medicaid Beneficiaries Receiving SUD Services, By Type

	Case Management		Consultation		Counseling		Detoxification		Emergency Services	
	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
New Hampshire	4.4%	6.0%	12.9%	**12.9%**	25.7%	**31.9%**	2.5%	4.8%	29.8%	29.7%
United States	5.8%	6.9%	7.8%	7.6%	26.1%	26.6%	3.9%	4.4%	43.4%	42.0%

	Inpatient Care		Intervention		MAT		Medication Management		Peer Support	
	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
New Hampshire	23.5%	27.3%	4.7%	**4.6%**	58.3%	**57.1%**	0.6%	0.6%	2.0%	1.9%
United States	40.4%	40.4%	4.1%	3.9%	31.6%	33.0%	1.3%	1.3%	1.4%	1.9%

	Physician Services		Screening/ Assessment		Treatment Program	
	2019	2020	2019	2020	2019	2020
New Hampshire	42.7%	**45.2%**	19.3%	**23.4%**	9.9%	**12.9%**
United States	34.1%	34.7%	19.5%	19.7%	7.6%	7.2%

The data also showed that the state provided greater care outside of the inpatient settings relative to the U.S (see Figure 14).

Figure 14: Medicaid Beneficiaries Receiving SUD Services, By Setting

	Inpatient Setting		Outpatient Setting		Residential Setting		Community-Based Setting	
	2019	2020	2019	2020	2019	2020	2019	2020
New Hampshire	24.6%	29.3%	88.5%	**87.4%**	5.6%	**9.5%**	1.5%	**5.5%**
United States	41.9%	42.4%	77.8%	77.9%	6.3%	5.5%	2.0%	2.2%

Cost

The Institute for Health Policy and Practice publishes a visual analytics tool of New Hampshire Medicaid claims supporting analysis of the costs associated with SUD in the Medicaid population. The SFY 2022 average per member per month (PMPM) Medicaid expenditure is $450 in New Hampshire, a slight decrease over the past four years from $476 in 2019 (see Figure 15). Individuals with cocaine and amphetamine dependence have 3x greater than the average Medicaid beneficiary. The significant difference in the cost of Medicaid beneficiaries with any SUD in New Hampshire as depicted in Figure 15 and 16 is not inconsistent with national trends. However, it provides clear urgency that the SUD population on Medicaid in New Hampshire warrants a continued dedicated focus and strategy surrounding care management and the navigation of the SUD continuum generally.

Over the past four years, the total PMPM cost of care for individuals with acute alcohol intoxication has decreased by 6 percent. The PMPM cost of care for cocaine or amphetamine dependence and opioid or barbiturate dependence has increased by 3 percent and 2 percent, respectively. The total PMPM cost of care for alcohol and other drug dependence has remained relatively flat. In FY 2020 and 2021, Other Drug Dependence was among the top ten most common Episode Treatment Groups (ETGs) based on member months (see Figure 16).

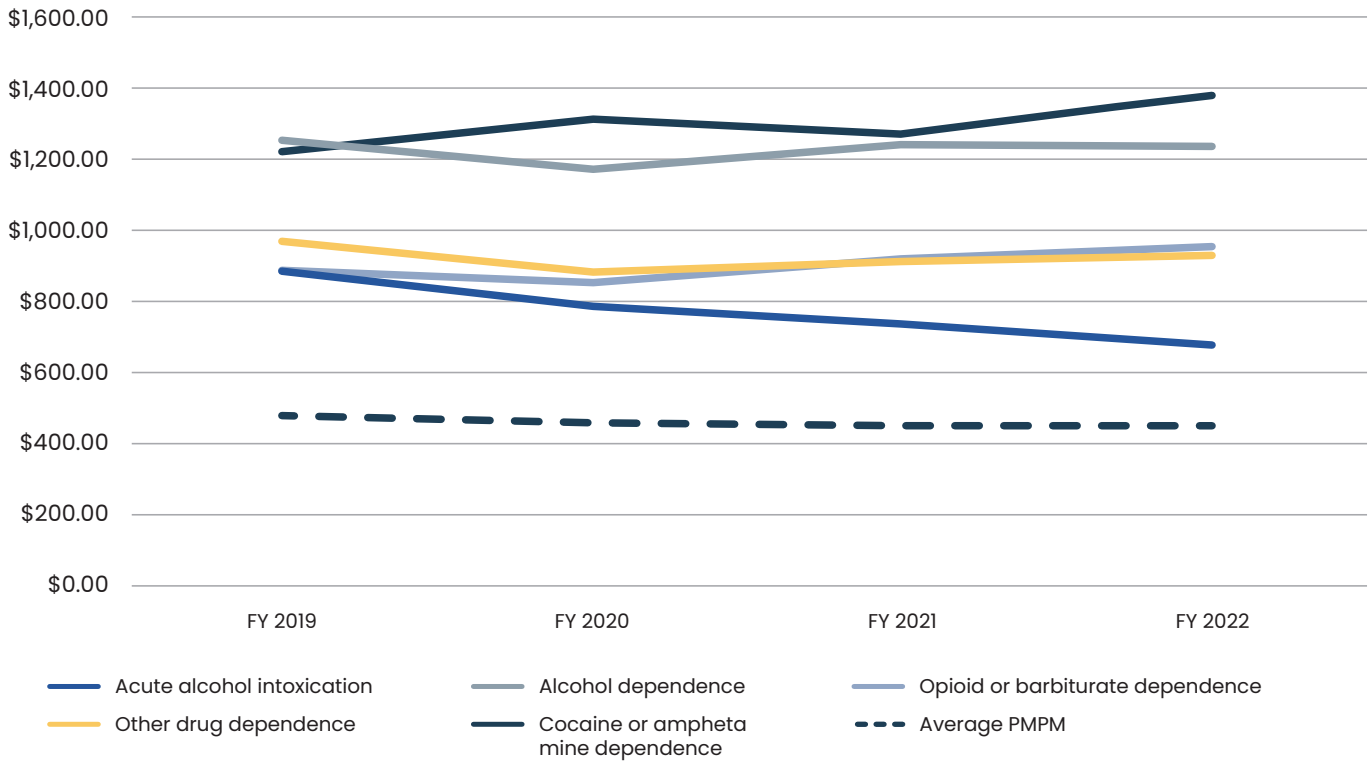
The state sets the current reimbursement rates for SUD, which are publicly available here.

Figure 15: FY 2022 PMPM

Episode Treatment Group*	Percentage of Member Months with Condition	Total Cost of Care for Members with Condition	Total Cost of Care Members with Condition (PMPM)	Total Cost of Care PMPM Relative to Medicaid Average PMPM
Acute alcohol intoxication	0.4%	$6,426,307	$682	1.5x
Alcohol dependence	2.2%	$71,583,098	$1,239	2.8x
Cocaine and amphetamine dependence	0.9%	$33,179,065	$1,308	3.1x
Opioid or barbiturate dependence	5.4%	$136,657,948	$952	2.1x
Other drug dependence	7.0%	$174,869,741	$934	2.1x

** OPTUMInsight's Symmetry Episode Treatment Groups® (ETGs®) software was used to identify Episode Treatment Groups (ETG). Optum®, Symmetry®, Episode Treatment Groups®, ETG®, service marks, and logos are registered and unregistered trademarks of Optum and its affiliates in the United States and other countries.*

Figure 16: Total Cost of Care PMPM, FY 2019 - 2022



1115 Waivers

In September 2022, New Hampshire submitted an Extension Request to the Centers for Medicare & Medicaid Services (CMS) for its "Substance Use Disorder Serious Mental Illness and Serious Emotional Disturbance Treatment and Recovery Access" 1115 waiver demonstration. CMS approved the original waiver from July 10, 2018, through June 30, 2023. The six SUD goals listed in the waiver extension request include the following:

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 another continuum of care services.
5. Reduce readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate and
6. Improve access to care for physical health conditions among beneficiaries with SUD.

As part of the extension, the state requested to use federal funds to offer a tailored Medicaid plan targeting those incarcerated with a Behavioral Health Disorder, including SUD, transitioning into the community 45 days before release. The services include care coordination such as MCO enrollment, peer recovery support, counseling, and new prescribing provider appointees with a community-based provider. The waiver remains pending from CMS as of this writing.

Alternative Payment Models (APMs)

The current fee-for-service (FFS) payment model for commercial and Medicaid plans severely impede closing critical care gaps and organizing services to serve best those suffering from SUD. FFS drives individuals to redundant

short-term and acute stabilization services reimbursed in direct opposition to the current evidence surrounding the chronicity of the condition. To help more people sustain their addiction recovery, alternative payment models (APMs) have the potential to shift incentives from a short-term, acute treatment response to a comprehensive, sustained patient-focused solution that traverses the health care continuum and provides effective early intervention efforts, clinical treatment, and ongoing recovery support services for individuals and families.

Value-based Payment (VBP) is a type of APM that aligns financial incentives for better outcomes. VBP adoption for SUD provides future opportunities for clinical transformation and improved outcomes by connecting parts of the fragmented care continuum. VBP strategies have also allowed for smoother and more flexible payments to providers than uneven, solely current census-reliant methods. For example, generally health providers in VBP arrangements faired far better than providers in fee-for-service during the COVID-19 pandemic.

The state Medicaid contracts outline coverage and network adequacy requirements for SUD services and payment provisions. The state requires, at least 50 percent of all MCO medical expenditures are in qualifying APMs, meaning a Health Care Planning and Learning Action Network (HCP-LAN) APM Category 2-B or greater that assures a higher benchmark of linking quality and value that align with state priorities. The state includes contract language explicitly requiring MCOs to develop at least one APM designed to increase access to MAT for SUD and one for treating babies born with neonatal abstinence syndrome (NAS) (Section 4.11.6.5.7). Additionally, The New Hampshire Medicaid Care Management Strategy incentivizes MCOs to meet quality measures related to SUD care. While this is a positive step in the Medicaid program, according to interviews THS conducted with providers and MCOs, the level of adoption of the MAT APM and the APM for NAS received in the market to date is limited.

SYSTEM RESILIENCY SNAPSHOT

Survey results

THS conducted an online survey to get general feedback from the SUD field regarding their financial health and stability. The firm deployed the survey using Qualtrics and promoted it through broad communications from THS, the NHCF, and other partners.

Forty-one organizations responded to the survey from across the continuum of care. 97.5 percent of the respondents were non-profit or underneath a nonprofit fiscal sponsor. Figure 17 shows that organizations were asked to identify themselves by organization type.

Figure 17: Respondents by Organization Type

Drug-Free Community Coalition	7
Regional Public Health Network	4
Other prevention-based organization	2
Multi-service organization/other	12
Recovery Community Organization (RCO)	9
SUD Treatment Provider	7
Doorway	3
Juvenile Court Diversion	3
SSP/Harm Reduction Organization	3
Hospital	3
Family Resource Center (FRC)	2
Federally Qualified Health Center (FQHC)	2
Recovery Housing	2
Community Mental Health Center (CMHC)	1
Syringe Service Program	1
School	0

Respondents varied in size, with organizational budgets in 2022 between $50,000 and $40m, the larger being multi-service organizations or hospitals. To analyze responses, THS broke the respondents into quartiles based on the annual operating budget (Figure 18)

Figure 18: Organizational Quartiles by Operating Budget

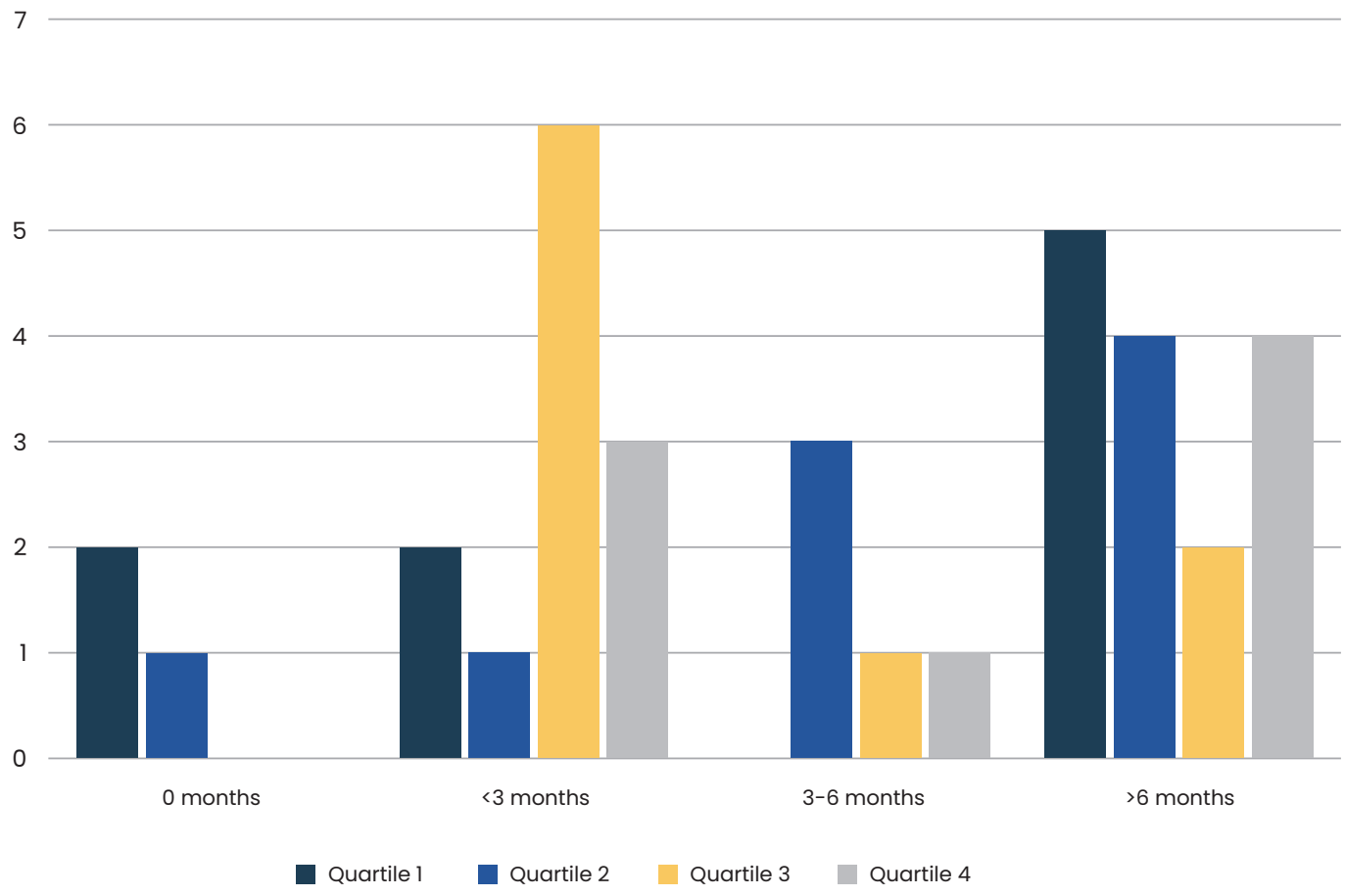
Quartile 1	**< $250K**
Quartile 2	**$250K - $600K**
Quartile 3	**$600K - $1.2M**
Quartile 4	**$1.2+**

Operating Reserves

Operating reserves are a critical marker of financial stability, allowing organizations to have enough cash to weather revenue volatility. As a general guide, the common practice for nonprofits is to have 3-6 months in reserve.

As Figure 19 indicates, 20 respondents noted having more than three months of operating reserve on hand, with fifteen organizations indicating they have more than six months in reserve. However, 15 respondents, including most in Quartile 3, had less than three months, meaning they are more at risk of financial hardship if there are changes to or delays in revenue streams.

Figure 19: Operating Reserve Levels By Quartile



Capacity to Deliver Services

Respondents were asked to identify how their budgets impacted staffing capacity to deliver services. THS analysis validates the concerns of many providers who reflected in focus groups that demand for services is rising. At the same time, staff capacity remains limited, with limitations driven by both funding and workforce shortage issues. These gaps in staffing capacity were not equally experienced among organizations, with smaller organizations demonstrating more capacity strain than larger ones.

Figure 20 provides an overview of the average case load by organization staff members, by annual budget quartile. The case load was calculated by looking at the number of individuals served, and the Full Time Equivalency (FTE) reported by the organizations.

The average budget of Quartile 4 is skewed, as the respondents on the lower end of the Quartile had budgets of less than $2 million, compared to a high of more than $40 million. This creates a very inconsistent trend in budgets between quartiles. The average budget of Quartile 2 is close to three times that of Quartile 1, and the average budget of Quartile 3 is nearly double that of Quartile 2. In other words, there is a 200 to 280 percent increase in the average budget between the first three quartiles. However, the average budget of Quartile 4 is nearly 16 times that of Quartile 3, or an increase of 1,600 percent.

Despite the inconsistency in budget trends, the average number of individuals served increased fairly consistently from Quartile 1 (927 individuals) to Quartile 4 (5,760 individuals). The average number of individuals served increased by around 1,400 to 2,000 individuals between each quartile, or an average 180 percent increase between quartiles.

As Figure 20 indicates, the most disproportionate and inconsistent trend was found in average FTE. There is little change in the number of average FTE between Quartile 1 and Quartile 2, suggesting that Quartile 2 is at a disadvantage regarding staffing. However, one respondent in Quartile 1 was an outlier with 16 FTE. Removing this outlier brings the average FTE in Quartile 1 to around three. Still, if consistent with the trends in budget and individuals served, the average FTE in Quartile 2 should have been around double that of Quartile 1. Quartile 3 is at a similar disadvantage.

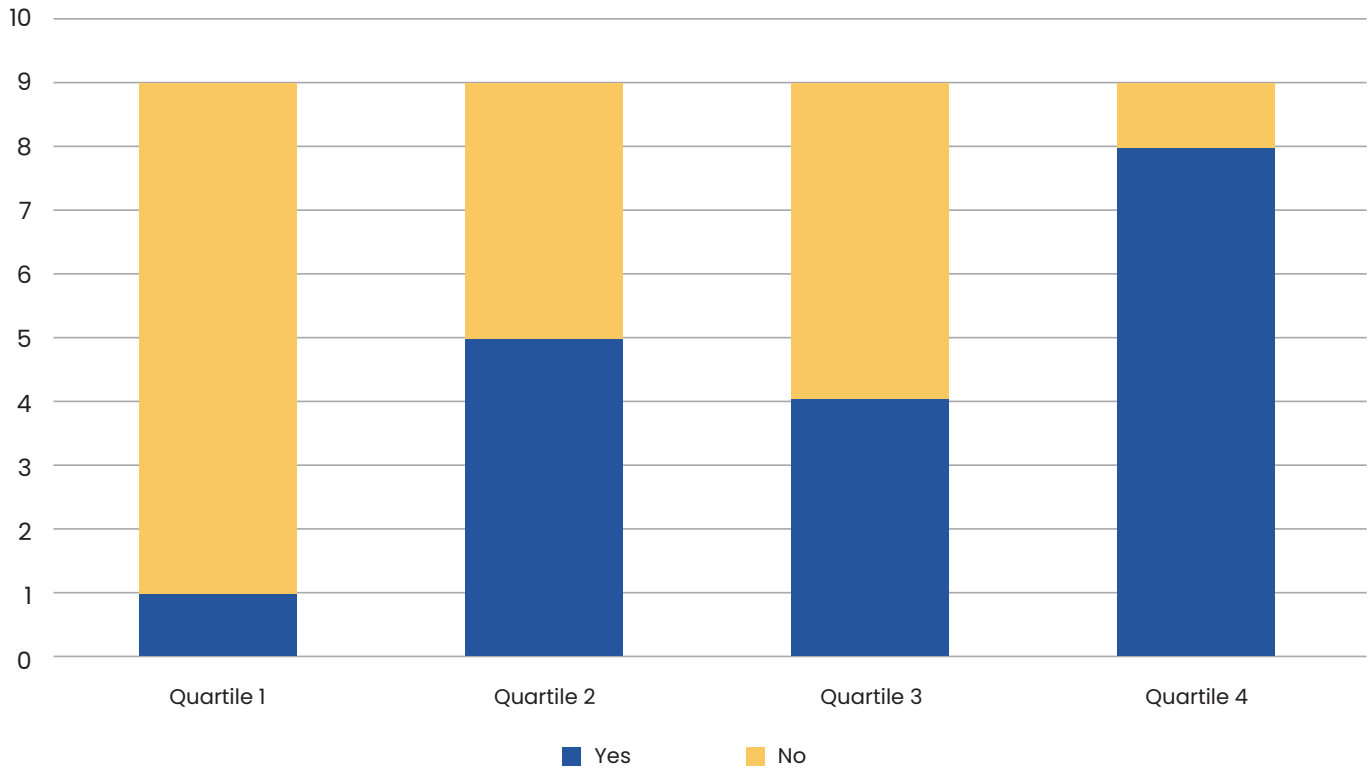
On the other hand, the average number of FTE in Quartile 4 is exponentially higher than in the other quartiles. However, as with the average budgets, the average FTE among respondents in Quartile 4 ranges widely from 18 to 410 FTE. The respondents on the lower budget end of this quartile (less than $2 million budget) staff about 20 FTE on average, whereas respondents on the higher end ($14 million and up) staff about 250 FTE on average. This suggests that even the respondents on the lower budget end of Quartile 4 are slightly disadvantaged in terms of staffing.

In short, respondents with average budgets ranging between $378,000 and $2m are not as well staffed as those with average budgets

Figure 20: Staff Case Loads by Quartile

	Average Budget	Average Served	Average FTE	Staff Case Load
Quartile 1	$135,000	742	4.86	152.67
Quartile 2	$378,000	2270	5.06	448.61
Quartile 3	$738,000	3732	7.94	470.20
Quartile 4	$11,675,000	5760	108.25	53.21
All Respondents	$3,466,000	3207	28.89	111.00

Figure 21: Lines of Credit by Quartile



below and above that range. Given the lesser budget flexibility that is often inherent in smaller organizations, limitations on staffing capacity at smaller providers carry an increased risk of a negative impact on the organization's ability to deliver services and retain current staff.

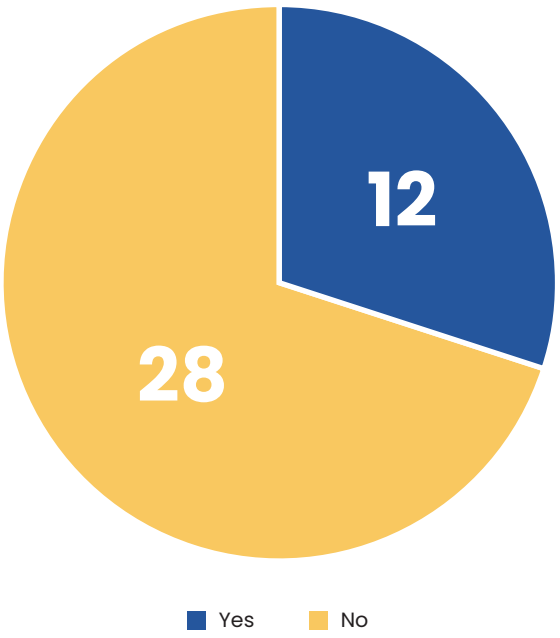
Line of Credit

A little over half of the respondents noted their agency having a line of credit. This was less true in the lower quartiles and more common among higher quartile providers (Figure 21). Though lines of credit can be a tool in managing cash flow, volatility in interest rates and repayment requirements can hide the potential risk of utilizing lines of credit as a core component of everyday financial operations.

Anticipation of Funding Reductions

As Figure 22 indicates, most respondents did not anticipate reductions in funding in the near future. While this is a positive, these organizations may be unaware of the impact of any potential funding reductions, such as the forthcoming drop in SOR resources, the end of COVID-19 relief-related investments, etc.

Figure 22: Organizations Anticipating Funding Reductions



Managing Delays in Reimbursement

Most agencies that contract with the state are awarded contracts that only pay based on reimbursement of reported allowable expenses, known as cost-based reimbursement. Reported wait times for reimbursement appear extensive. For example, one provider interviewed by THS is awaiting six different reimbursements that have been delayed, the lengthiest delay being six months as of this writing. Providers of services covered by insurance must similarly expend resources first to provide the service before being reimbursed.

Knowing this, THS surveyed providers on managing any delays in reimbursement from a contract or payer. While a significant portion tapped into their operating reserves, several other tactics were reported that warrant elevation as signs that delays in reimbursement can be problematic to the operations of SUD service providers. Each tactic is described below.

Utilizing lines of credit or credit cards. In both instances, credit utilization brings potential risk if reimbursement to pay off credit use is not timely. Given ongoing rises in interest rates, organizations utilizing credit lines with adjustable rates or credit cards are at increased risk of added financial losses due to delays in reimbursement.

Separating Medicaid Reimbursements into a special account as a "reserve" to manage future delays. While this strategy may prove helpful to manage future delays in Medicaid reimbursement specifically, the lower reimbursement rates for Medicaid services do not allow for that revenue stream to be a secure method to address cash flow gaps that may arise from higher revenue-generating delays in reimbursement.

Tap into the finances of the Fiscal Agent. Such practice brings financial risk to the fiscal agent. Further, most fiscal agency agreements typically do not include direct financial relationships beyond agreed-upon administrative costs for serving as a fiscal sponsor.

Pay bills late. Such tactics risk the organization's solvency and open them to additional financial burdens relative to late payment fees, loss of utilities, etc.

Tap into funds reimbursed from other grants to carry the organization until funds are reimbursed from the delayed payer. State contracts routinely do not permit organizations to utilize funds from one grant to cover expenses incurred for another. Such accounting practices are often a red flag of poor financial management and solvency risk, as was the case with the closure of Serenity Place in 2017.

While THS doesn't directly suggest that specific respondents to this survey are at a stage of significant financial risk, the reflection of respondents utilizing these tactics should be seen as a warning sign that there is a vulnerability in the ecosystem that is attributable to delays in reimbursement from both contracts and payers.

Provider Focus Groups and Interviews

THS conducted focus groups and key informant interviews with organizations that provide SUD services to augment

the input received through the survey. Many issues were cross-cutting across organizations, regardless of the type of SUD services they offered. Common themes include:

1. **The procurement process is cumbersome and time-consuming.**

   Across the focus groups, providers noted significant challenges in navigating the process of applying for financial resources from the state. Attendees felt that the procurement process could be more manageable in many instances, particularly for smaller organizations needing more capacity for grant-writing staff. Some described the process as inequitable – inherently favoring larger organizations that may or may not be able to do the work done by smaller partners in the community.

   Respondents also raised timing as a concern. Requests for Proposals often dropped with little advanced notice and tight turnaround times, with providers feeling pressures from the current behavioral health workforce crisis that further restrict an organization's ability to respond quickly to an RFP that "came out of nowhere." Additionally, providers noted that the high pressure and the rapid turnaround for proposals are often followed by extended periods of "radio silence." They perceived delays in funding decisions beyond what was outlined in the original RFP. In some instances, when the RFP was around the continuation of an existing service, these delays impacted the ability to continue ongoing work. Given limitations in reserves and access to other capital, for some organizations, these delays in funding determination put at risk the continuity of care and the organization's stability.

   Some providers – particularly those doing SUD prevention – felt that current procurement processes exclude their ability to access funding. Drug-Free Communities Grantees – dominantly funded by direct federal grants – reflected that there are little to no RFPs from the state directly to communities for substance misuse prevention work. Instead, prevention funding to community entities is often made available in small bursts through the Regional Public Health Network (RPHN) system. While attendees spoke highly of the RPHNs, they noted that there had been significant turnover in prevention staffing at the Networks, limiting relationships and opportunities to consider financial support to priority partners in the community. It is also unclear to some of those providers whether flexible funding is available from the PHNs to partner organizations.

2. **Providers experience excessive paperwork burdens and delays in reimbursement.**

   Providers across the service array universally reported that, once contracts were awarded, reimbursement on state contracts has become incredibly burdensome and included significant requirements around documentation that did not appear related to costs for which reimbursement was being requested. Providers noted recent NH DHHS reporting and reimbursement policy changes that impacted the reporting process. However, none of the focus group attendees could articulate the justification for the new reporting methodology.

   While delays in reimbursement pose a financial risk, providers feel that the reporting process is exacerbating their financial stress. In some instances, providers reported that the staffing cost of filing an appropriate reimbursement exceeded the value of the reimbursable expenses they requested. Further, organizations reflected that they are requesting reimbursements with documentation that justifies expense amounts higher than the final reimbursement ends up being, with, in some instances, providers reporting that they are not spending down the resources they were awarded in their contract as the state is reimbursing at a lower amount, without a clear indication as to why.

   As noted previously in this report, delays in reimbursement from state contracts are on top of reported delays in reimbursement from insurance carriers, particularly Medicaid.

Further, treatment providers reported having claims rejected on services as "not covered" that were formerly reimbursed without issue. Whether this is an administrative error, or a rule change not clarified with the providers, it creates further delays and administrative burdens for the provider.

3. **Contracting periods are too short.**

   Focus group attendees noted that long-term contracting effort around SUD services appears absent. Contracts seem typically geared to only a year or two. For providers, this keeps them in a constant churn of procurement uncertainty, unable to ascertain whether current investments with contracted funds will be able to be sustained at the end of the contract period, assuming there is either no extension, renewal, or new RFP that the organization can bid on. Many noted that this exacerbates the workforce crisis, as providers can't provide enough guarantees around position sustainability to entice candidates to apply for or accept vacant positions.

4. **There is an over-emphasis on building new systems at the expense of service delivery within current systems.**

   Providers also noted that there has been a long history of the state "building new systems on top of other systems and not investing in what we have." They highlighted Regional Public Health Networks, Integrated Delivery Networks, and Doorways as examples where the emphasis has been perceived to be placed on systemic infrastructure while continuing to underfund the delivery of services.

   While participants in the recovery focus group cite the system of Recovery Community Organizations (RCOs) as an exception, they felt strongly that the state continues to attempt to grow that system with limited funding, forcing the system to do more with less rather than considering increasing investments of available resources to adequately support the operating costs of recovery community organizations, where much of the business model and service delivery is not reimbursable by insurance. RCO funding has been under constant threat for some time in this tension, with often 11th-hour solutions to keep the ecosystem operating that are perceived as only short-term fixes for a longer-term problem.

   Prevention providers felt that the lack of direct funding support for prevention services also indicated a need for prioritizing prevention. Some reflect that the state can have a robust and successful prevention system "if it chooses to prioritize it." Of note were juvenile court diversion, student assistance programming, and Multi-Tiered System of Supports for Behavioral Health (MTSS-B), where attendees pointed out there is no state funding strategy to support the ongoing work.

5. **Communication of funding sources, strategies, and opportunities must be improved.**

   THS conducted many of these focus groups during the open call period for the Opioid Abatement Commission. When asked about

the RGA, many providers were unaware of its existence. They voiced a need for more understanding of the commission, its strategy, or if funding would be available to them. While some attendees reported applying for resources, others reviewed the RFP and decided not to apply, citing the burdensome issues with procurement in general or a lack of clarity around whether their work would be considered for funding in the RGA. Respondents also noted uncertainty around funds available from the NH DHHS and the Governor's Commission on Alcohol and Other Drugs, desiring an overall improvement in proactive communication from state funding sources around existing investments and forthcoming procurement opportunities.

6. **Funding is not keeping up with increasing operating costs.**

   Many providers noted that operating costs, such as utilities, have increased dramatically due to current inflation issues, putting significant pressure on organizational health. Several participants reported delaying or canceling plans to provide salary increases or additional benefits to recruit and retain their workforce because of these pressures. These cost pressures further exacerbate the impacts of reimbursement delays and too-low reimbursement rates from Medicaid.

7. **Providers are unfamiliar with payment reform opportunities.**

   When asked about APM or VBP models, many treatment and recovery providers seemed unfamiliar with their use in New Hampshire. Some noted they had APMs with private insurers but none with Medicaid. Some attendees seemed unfamiliar with APM/VBP models in general but noted that low rates and a lack of innovative payment arrangements served as a disincentive to take Medicaid Clients and instead prioritize commercial insurance-covered patients, where reimbursement rates were at least better. Attendees noted that this could be a concerning trend that will leave Medicaid-insured patients lacking treatment access as providers lean more on commercially covered patients to ensure operating stability.

State leader interviews

THS spoke with state officials at the NH DHHS, the NH DOE, and other system leaders to garner their perspective on the financial resiliency of the sector and how they view some of the challenges noted in focus groups. The feedback reflected important challenges these stakeholders deal with that impact some of the experiences that providers shared. Key findings include:

1. **Federal procurement and reporting requirements limit the state's ability to be nimble and easier to navigate.**

   State officials noted that federal reporting regulations often drive reporting requirements at the provider level. They expressed their concerns about how federal requirements burden state agencies to translate those reporting requirements to providers.

   Additionally, federal funding timelines often contradict the state's ability to enter long-term contracting arrangements. This has been particularly challenging with SOR funds, where federal notification of funding awards often comes within days of the new funding cycle launch. Federal delays in releasing guidance on funding also complicate the state's ability to make strategic investments in a timely fashion, as often that guidance translates into language that must be included in contracts to providers.

   Such federal pressures can dramatically impact the state's ability to move non-federal funds. Given that federal funds are a significant share of total investment in SUD, regulatory frameworks for contracting and procurement often default to mirroring federal requirements and processes – especially in instances where federal and state funds may be braided into contracts.

2. **State agencies are experiencing workforce pressures.**

   The workforce crisis is not limited to community-based organizations. State agencies such as the NH DHHS continue to struggle with vacancies and under-resourced staffing that can hinder procurement and contract management, slow strategic initiatives, and ultimately limit the state's ability to effectively and rapidly deploy resources. This can be particularly challenging as available resources increase because new funding sources often lack adequate funding for state agencies to manage the administrative costs necessary to deploy those resources.

3. **There are concerns about provider errors and contracting acumen.**

   State agency officials noted that they often observe providers needing help submitting reports and financial reimbursement requests accurately and that submission errors significantly contribute to reimbursement delays. Additionally, contract managers reported concern that provider error is often attributable to the provider needing a clearer understanding of their contractual requirements.

TOP FINDINGS

THS' analysis found that while New Hampshire's current SUD system appears stable, significant factors put it at risk. These factors are discussed below.

New Hampshire has robust strategic plans but lacks an overarching investment strategy for comprehensive SUD services.

While the state has robust strategic plans around mental health and substance misuse, they serve as programmatic guideposts without an underlying, long-term financing strategy. The most recent 10-year Mental Health Plan included a financial section focused on financing needs in the fiscal biennium that was under review when the plan was created. Though language appears in the document that indicates the budgetary/financial planning would be ongoing, publicly available updates have yet to be provided that clarify how the state intends to develop long-term investments to protect existing and new infrastructures. There remains ongoing litigation around how much financing for mental health services meets the overall need. In the case of substance use, the State Action Plan to address SUD does not include a financing section. However, the Governor's Commission on Alcohol and Other Drugs' annual reports often include summary details on the SUD-specific resources reported by state agencies. Regarding the Opioid Abatement Fund, providers reflect a limited understanding of those funds and the strategy behind their use over the next 18 years. The Opioid Abatement Commission has not released an over-arching funding strategy.

Investments in SUD services over-rely on short-term funding methodologies for more "permanent" services and utilize "temporary" funding for investments that need to be long-term.

The Alcohol Fund has existed for 22 years, contains no sunset provision, and is non-lapsing. It is within the legislative intent to consider it as a permanent, long-term funding source. However, given the history of legislative action to alter the fund's scope, purpose, and amounts, the Governor's Commission on Alcohol and Other Drugs has been unable to administer the funds that way. Yet, the state is currently using funding that is known to be time-limited – SOR Funding – to finance critical parts of the SUD infrastructure, including room and board expenses in residential treatment, the state's Recovery Community Organizations, and the Doorways. Additionally, contract periods are too short, disincentivizing provider engagement and driving instability in the sector.

Resources are siloed and walled behind unnecessary administrative rules, procurement processes, state/federal regulations, and multiple decision-making structures.

This limits transparency and accountability, slows the ability of the state to move quickly to invest in needed services, and creates unnecessary burdens on state agencies and community providers. Collectively, these administrative barriers increase the risk of service gaps, threaten the financial health of organizations, and exacerbate the workforce crisis.

The system has yet to take full advantage of opportunities to maximize public and commercial insurance to stabilize access to care.

Though treatment providers report an increase in accepting patients with private insurance, the lack of total claims in the NHCHIS indicates ongoing issues relative to network adequacy for the population. Additionally, the lack of broad adoption of Alternative Payment Models deprives providers of the opportunity to attain innovative contract structures that can stabilize revenue while improving access and coordination of care.

Three elements of the SUD service array – the Doorways, Recovery Community Organizations, and the state's harm reduction ecosystem – are particularly at risk.

Unless adequately planned for, forthcoming declines in SOR Funding will lead to the closure of Doorways and recovery centers across New Hampshire. Though other elements of the SUD system show some signs of financial risk, these two are particularly notable given the over-reliance on SOR funds to support them compared to funding from other, more stable sources. As it relates to harm reduction services, given continued regulatory exclusions for using certain funds to support harm reduction supplies and similar expenses, there is an urgent need to affirm and leverage allowable funds to sustain this critical public health strategy, such as the approval in May 2023 of a contract to the NH Harm Reduction Coalition from the Opioid Abatement Fund.

RECOMMENDATIONS

While the challenges identified in this report can be viewed as complex, THS believes there are several action steps that stakeholders and policymakers can take to address the current fiscal uncertainty that is impacting provider sustainability and care delivery. THS views these recommendations as achievable, given the strength of leadership and partnership at all levels of New Hampshire's SUD system. While some of these recommendations are interrelated and could be taken in stages, the firm does not present them here in order of any priority, viewing all of them as viable action steps required to attend to the report findings. Lastly, while some recommendations could be acted upon near-term, stakeholders should be mindful that some recommendations are longer-term and will take time to implement.

Recommendation 1: Develop a cross-sector, cross-stakeholder unified financing strategy.

New Hampshire stakeholders should most aggressively develop a transparent, coherent

financial plan for delivering SUD prevention, harm reduction, treatment, and recovery support services in New Hampshire. The plan should include the following:

- Further analysis and recommendations on maximizing coverage and reimbursement through public and commercial insurance payment reform.
- Clear regulatory crosswalk of all available funds, their event horizons, restrictions, and allowable uses against the specific investments those dollars are currently tied to.
- Clear articulation of funding strategy for 5-10 years, based on planned available funds and aligned with the State Action Plan for SUD.
- Near-term strategy to manage the transition away from funding sources anticipated to end during the event horizon.
- Where possible, ensure alignment with the financing strategy of other related health care investments, including mental health.

Such a financial strategy process should involve robust engagement by state agencies, the NH Governor's Commission on Substance Use, and the NH Opioid Abatement Commission.

Recommendation 2: Consolidate decision-making, oversight and cross-sector collaboration.

There are three origin points for authority over SUD financing in New Hampshire: the NH DHHS, The Governor's Commission on Alcohol and Drugs, and the Opioid Abatement Commission. Each of these entities controls specific funds with different requirements, decision-making processes, and levels of stakeholder engagement. While there is clear evidence that all three entities are working closely together to ensure alignment, different requirements, timelines, and processes lead to confusion among providers and slow opportunities to get money to the ground. To better align resources while ensuring New Hampshire continues its tradition of cross-sector engagement, THS recommends that the Governor's Commission on Alcohol and Other Drugs and the state's Opioid Abatement Commission be consolidated.

Further, THS recommends that the consolidated commission be granted oversight of the state's strategic and financial plans, with adequate resources and reporting infrastructure that ensures proper tracking of all sources of SUD-related funding in compliance with necessary state and/or federal regulations.

Recommendation 3: Address administrative barriers to accessing and utilizing resources.

Cost-based reimbursement methodologies inherently damage contractors' solvency and put the continuity of care at risk. The reimbursement methodology is not unique to New Hampshire – many states operate this way. However, with the majority of sources of SUD funding being deployed, including federal programs like SOR and the SUPTRS block grant, there is no explicit federal requirement that states use a cost-based reimbursement contracting strategy. THS believes that the state should reevaluate its approach to contracting to bring more security and certainty to its vendors while reducing the administrative burden.

New Hampshire has engaged in contracting innovations that have provided more accessible investment opportunities that could be brought to current SUD procurement and contracting processes. In the first year of SOR Funding, procurement timelines were shortened to ensure the deployment of funds within the time window directed by SOR. Additionally, vendors launching new services received funding up front to build capacity rather than working from reimbursement. In the child protection arena, NH DHHS partnered with the Government Performance Lab at the Harvard Kennedy School to transform its approach to managing, financing, and contracting in the Child Welfare System. The state utilized Requests for Information (RFIs), and publicly released procurement forecasting, to offer more transparency to current and potential vendors and ensure that contractor perspectives were authentically considered in the development and structure of RFPs.

While the current processes can undoubtedly reduce the risk of fund misuse or mismanagement by contractors, the current administrative approach sacrifices provider stability, funding transparency, and service continuity and thus should be adjusted.

Recommendation 4: Strengthen and expand the use of APMs in both Medicaid and commercial payers.

When deployed effectively, APMs can provide more consistent, stable funding for providers while developing a shared risk framework that incentivizes the delivery of quality care. New Hampshire has yet to maximize the potential benefit of such payment models and should strengthen its position in driving APM adoption in both public and commercial insurance. Such action would drive coordination and collaboration across a currently fragmented provider landscape, improve beneficiary outcomes and reduce redundant acute care episodes.

While the state can strengthen contract enforcement and requirements around APM implementation among payers, support should also be considered for SUD providers to strengthen their position to negotiate for and take on such alternative arrangements. For example, New York State has recently supported the development of Independent Practice Alliances (IPAs). An IPA can provide a single point of engagement for Medicaid MCOs and commercial payers to purchase a more holistic SUD continuum for individuals from various providers offering different levels of care across a focused geographic area. These entities can provide shared administrative services, offer increased numbers of beneficiaries, and provide critical quality measurement and data reporting functions foundational to any APM.

Various other policy and program opportunities to increase the use of APMs for SUD should be explored.

- New Hampshire could establish minimum thresholds for APM contracting for mental health/SUD services that must be reached by a future date within their current Medicaid program targets.
- Incentivize multi-payer APM models that allow for consistency in the model components across a fragmented payer landscape.
- Provide care management funding in any APM that supports and augments the clinical and recovery supports being provided.
- Support for electronic medical records interoperability across different providers in local markets
- Increasing the adoption of mobile technology engagement with individuals can provide opportunities for longer patient retention and augmentation of in-person clinical or recovery support services.
- Supporting training and technical assistance for APM budgeting and administration for providers
- Developing strong connections between community-based SUD providers and the emergency department, primary care, and criminal justice systems.

Appreciating some of these will require fiscal and regulatory changes to implement; such reforms should be considered for prioritizing the agenda of state agencies, the legislature, and community advocates.

Recommendation 5: Enhance support to provider organizations on contract management, payment reform, payer negotiation, and rate setting.

Provider struggles with contracting, payer relations, and rates are not singularly issues with how the state leads on rate setting or payer policies. Many provider organizations, particularly

smaller ones, need more staffing capacity and acumen demonstrated by larger organizations in rate negotiation and contract management. The state and other partners should undertake efforts to provide improved provider education and training on contract literacy and management, payment reform, and rate negotiation with payers to increase the likelihood that such relationships will yield appropriate resources and reduce the risk of provider reporting errors that can delay reimbursements.

Recommendation 6: Promote policy change that makes permanent, long-term system investment a central strategy (state/federal)

Ultimately, provider and state agency confidence that they can engage in long-term investment and service delivery will be contingent upon a regulatory and fiscal environment that supports and incentivizes long-term stability of the service array while fostering innovation and competition that promotes ongoing quality improvement based on the best practices in SUD services. Such modifications could include the following:

- Continued commitment to funding the state's Alcohol Fund per formula and the long-term end of efforts to raid or repurpose the fund for things other than initially intended by the legislature. The Alcohol Fund is too precious a commodity in financing SUD services to be continually under threat every two years. While there may or may not be a regulatory way to enshrine the Alcohol Fund methodology more permanently in the state budget, continued advocacy and education should be done to carry forward the current momentum around adherence to the formula for the foreseeable future.
- As much as state fiscal policy around substance use disorders is more siloed than it needs to be – the same is accurate at the federal level. The SOR Grant program has proven to be a valuable resource to states. Rather than retaining the SOR program as a separate funding source, Congress should be encouraged to merge the SOR Grant funds into the Substance Use Prevention, Treatment, and Recovery Services Block Grant.
- It is important to underscore that efficient and streamlined delivery of resources to community providers and successful management of resulting contracts requires staff time and resources. Efforts to stabilize,

restructure or increase state or federal resources available for SUD services should include adequate resourcing to ensure the receiving state agency has adequate resources for funding administration, contract procurement, and contract management.

- Advocates should continue to push for more vigorous enforcement of the parity provisions of the Affordable Care Act, both at the state and federal levels, as well as promoting increases in reimbursement rates and reimbursement rate parity between commercial plans and Medicaid. The Mental Health and Substance Abuse Advisory Committee of the New Hampshire Department of Insurance has not met since July, 2021, and should be reconvened.

CONCLUSION

Though the system for SUD services in New Hampshire currently struggles with financial uncertainty, workforce issues, and increasing demands for services, these challenges come at a time when a diverse pool of resources exists to tackle the problems that in the past have been insurmountable given prior financial limitations. New Hampshire's recent history of innovations and progress in improving SUD services provides a sound foundation upon which further transformation is possible to sustain and accelerate gains made in care delivery. THS' analysis indicates that the ingredients are in place for New Hampshire to continue its leadership in modeling ways to improve access, quality, and stability within the SUD system.

At the same time, THS identified substantial challenges that, if not addressed, could negatively impact SUD services across the state. New Hampshire's collective, cross-sector commitment to reducing the harms caused by substance misuse can and should be maximized now to support what potentially could be another period of significant forward momentum in the delivery of quality care.

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Lastly –THS extends gratitude to the advocates, providers, and recovery leaders who commit daily to bringing the promise of recovery to the citizens of New Hampshire.

The firm hopes this report serves as a tool for all these partners in their collective efforts.

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