



New Hampshire
Department of Health and Human Services
Building Capacity for Transformation
Section 1115 Demonstration Waiver

Draft Application

April 28, 2014

Draft for Public Comment



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Building Capacity for Transformation Section 1115 Demonstration Waiver Application - Executive Summary

The New Hampshire Department of Health and Human Services (DHHS) is applying for a Section 1115 Demonstration Waiver from the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to support the continuing reform of its Medicaid program and to address critical mental health, substance use disorder (SUD), and population health priorities.

The primary purpose of New Hampshire's *Building Capacity for Transformation* Section 1115 Demonstration Waiver is to request authority to recognize costs not otherwise matchable in order to establish Designated State Health Programs (DSHPs). The initiatives proposed within this *Building Capacity for Transformation* Section 1115 Demonstration Waiver are designed to build on ongoing New Hampshire health care reforms and to enhance health care delivery in the State. They include improvements to the delivery of mental health, physical health, SUD, oral health, and population health programs and services.

This Demonstration Waiver application presents the rationale and data supporting the urgent need for Medicaid reform in these areas and how these programs compliment New Hampshire's overall health reform strategy, including the implementation of a Medicaid Care Management (MCM) program and the expansion of health coverage under the New Hampshire Health Protection Program. The *Building Capacity for Transformation* Section 1115 Demonstration Waiver will promote the improvement of overall health, will integrate and align with New Hampshire's recently launched MCM program, and will improve the quality of care and access to care for Medicaid and CHIP beneficiaries accessing mental health, SUD, oral health, and population health related services. This application revises and builds upon the Concept Paper submitted to CMS during the week of April 14, 2014 and distributed for public comment on April 21, 2014. In this Section 1115 Demonstration Waiver, the State will work with CMS to develop and implement five DSHPs.

DHHS proposes five programs focused on improving the delivery of mental health and SUD services, dental health services to select populations, and population health programs through payment reform. Through this Demonstration Waiver, DHHS proposes to:

1. Establish a community reform pool focused on mental health and physical health delivery system issues that rewards hospitals, health systems, and/or community providers for their active participation in system reform initiatives and their overall commitment to reform.
2. Implement components of its Ten Year Mental Health Plan and its December 2013 settlement agreement with the United States Department of Justice (U.S. DOJ) for the State's non-Medicaid population.
3. Establish a grant program that would fund training education and workforce development programs focused on SUD treatments and services.
4. Extend the current InShape program by establishing a funding pool to award grant applications from hospitals, health systems, and/or community providers to implement an InShape program that (1) include as participants children with serious mental illness (SMI), (2) include as participants those enrolled in New Hampshire's 1915(c) Home and Community Based Services



Waiver for Developmentally Disabled (HCBS-DD), and (3) includes a smoking cessation component for all InShape participants who smoke.

5. Establish a pilot program to demonstrate the impact on children's oral health and improved birth outcomes by providing oral health education, tobacco cessation, and Medicaid coverage for dental services to women during pregnancy and up to the child's fifth birthday.

The design and improvements made by each DSHP program will demonstrate that by spending Medicaid dollars differently, DHHS can provide better health outcomes for its Medicaid clients, and these outcomes will be defined and measured throughout the length of this Demonstration. This action will not result in a loss of revenue or an increase in State funds associated with the Medicaid program. New Hampshire will maintain budget neutrality over the five-year lifecycle of its *Building Capacity for Transformation* Section 1115 Demonstration Waiver, with total spending under the waiver not exceeding what the federal government would have spent without the waiver.



Building Capacity for Transformation Section 1115 Demonstration Waiver Application - Introduction

This proposal describes a Demonstration Waiver under Section 1115(a) of the Social Security Act for costs not otherwise matchable that is designed to build on existing New Hampshire health care reforms to continue the reform of New Hampshire's health care delivery and payment systems in a manner that is consistent with the CMS' Triple Aim. The Demonstration Waiver will improve the health of populations and contain health care costs, as well as improve the quality of care. The State seeks to establish Designated State Health Programs (DSHPs) to support transforming the Medicaid care delivery system through this Demonstration. This *Building Capacity for Transformation* Section 1115 Demonstration Waiver will promote the improvement of overall health, will integrate and align New Hampshire's Medicaid Care Management (MCM) program, and will improve the quality of care and access to care for Medicaid and CHIP beneficiaries accessing mental health, substance use disorder (SUD), oral health, and population health programs and services.

New Hampshire requests authority to recognize and receive federal financial participation (FFP) for costs not otherwise matchable for mutually agreed upon local and state designated health program services. The additional state and local funds that result from additional federal matching funds would be used to provide financial assistance to implement the state's Ten Year Mental Health Plan and delivery system reforms that will help improve the New Hampshire mental health care system as coverage expansion begins in July 2014. Costs not otherwise matchable are incurred by the following state agencies, local governments, and health systems:

- Department of Health and Human Services (DHHS)
- Department of Corrections
- Counties
- Municipalities

To establish DSHPs, DHHS is requesting approximately \$78.6 million (all funds) each year over the five year term of the waiver, with approximately \$39 million in additional FFP annually. A list of identified non-federal funding sources is included as *Attachment A: Resources for Costs Not Otherwise Matchable / Designated State Health Programs*. The programs included within *Attachment A*, which are incurring costs but not otherwise matchable, provide vital services that today are not reimbursed by Medicaid or any other Federal source.

The DSHPs funded under this Section 1115 Demonstration Waiver are designed to promote innovation, reform delivery and payment systems, and reduce the number of uninsured patients who seek treatment from health care providers. These programs are vital to the successful transformation of the health care delivery system, spanning mental health, physical health, public health, oral health, and community-based services. Currently, state and local funds support these programs because Medicaid, as it is currently structured, does not. The populations affected by the proposed DSHPs and served using the demonstration funding receive services alongside Medicaid eligible individuals, who also are part of the 'churn' in and out of Medicaid. New Hampshire is requesting federal investment in these programs in recognition that they are vital to



improving the health of Medicaid enrollees and the communities in which they live.

Federal funding for these services is critical to stabilizing the mental and physical health delivery system, providing a foundation for expanded coverage that will begin in 2014 when many recipients of these services will gain health coverage, and for increasing capacity for the provision of important new benefits made available under the Affordable Care Act, such as the new SUD benefit, which will be implemented initially for the new adult group under the New Hampshire Health Protection Program. New Hampshire's request to CMS is patterned after approved requests in other states (e.g., New York, New Jersey, California, Texas and Massachusetts). CMS approval of this request will allow the State to move forward to meet its healthcare reform goals.

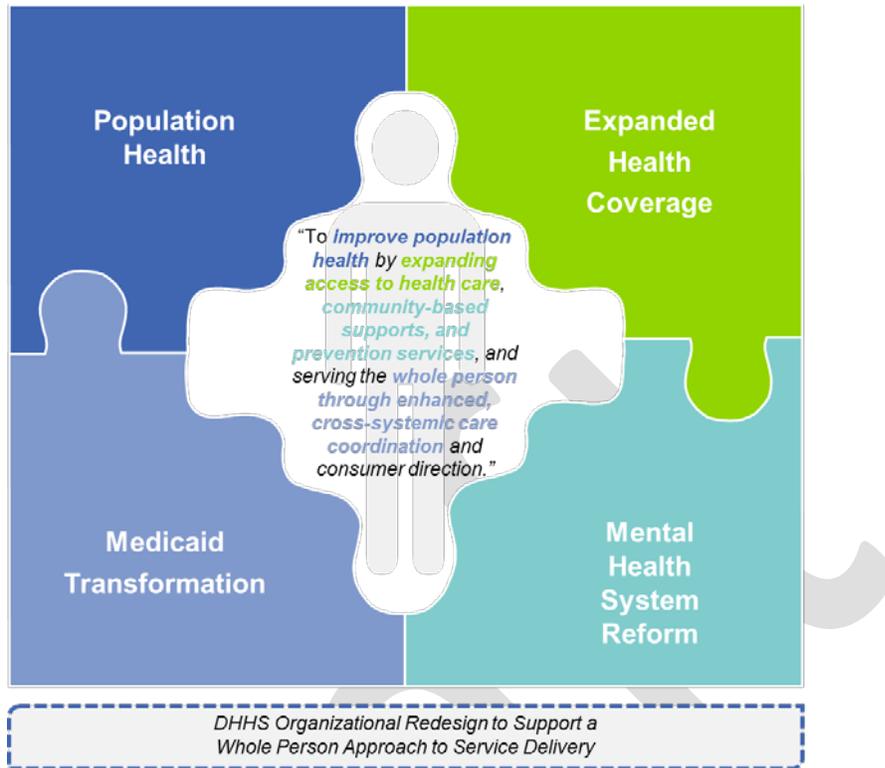
Section I - Program Description and Historical Context

Background and Current State

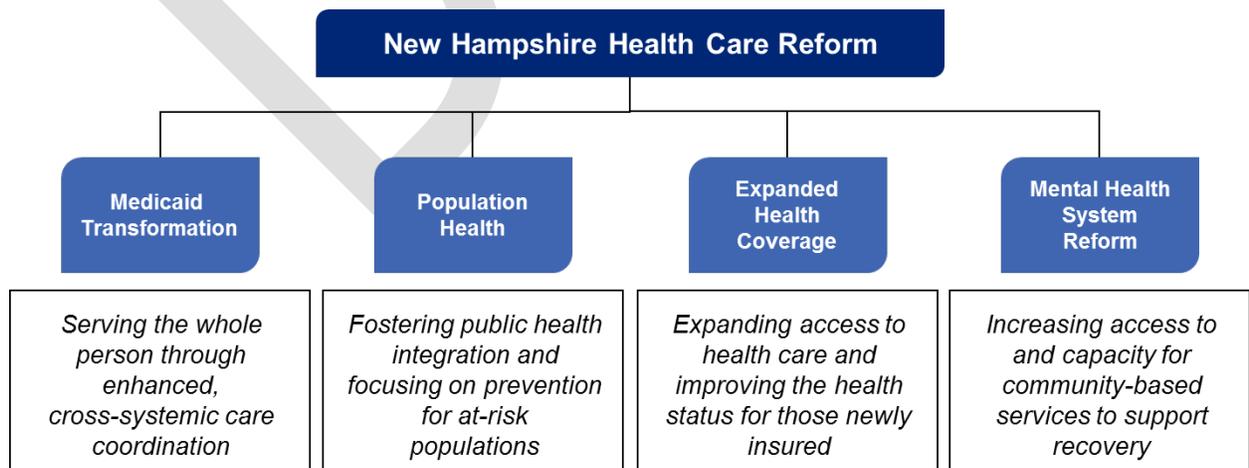
DHHS' mission is to join communities and families in providing opportunities for citizens to achieve health and independence. As such, New Hampshire is consistently ranked as one of the healthiest states in the U.S. according to United Health Foundation's America's Health Rankings, but there is still more work to do. For example, the Department's recent State Health Improvement Plan documents that tobacco use and dependence "remains the single most preventable cause of death and disability in New Hampshire. Helping those who are tobacco dependent and preventing kids from starting tobacco use can save many lives and health care dollars".¹ This finding and its implications for population health and health costs in New Hampshire is why the Department has included in its Demonstration Waiver proposals to implement a tobacco cessation component into the current InShape program for adult and adolescent participants and into the oral health pilot program for pregnant women and mothers of young children.

New Hampshire has taken significant steps toward addressing population health needs in its overall health reform efforts. Four key themes, as illustrated in the graphic below, reflect New Hampshire's approach to health care reform, which focuses on quality, outcomes, and costs, and are driving forces for the initiatives proposed by DHHS in this Demonstration Waiver. In order to support the implementation of these multiple strategic initiatives, DHHS is undergoing a department-wide organization redesign that supports a whole-person approach to service delivery.

¹ New Hampshire Department of Health and Human Services, Division of Public Health Services. "State Health Improvement Plan 2013-2020: Charting a Course to Improve the Health of New Hampshire." December 2013. <<http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf>>.



The graphic and subsequent sections below review the steps DHHS has taken toward health care reform and outline the role of each strategic initiative as the a collective catalyst for this *Building Capacity for Transformation* Section 1115 Demonstration Waiver.





Comprehensive Medicaid Reform

Medicaid Transformation

New Hampshire is currently engaged in the comprehensive reform of its Medicaid program and its health care delivery system through its Medicaid Care Management (MCM) program. New Hampshire Senate Bill (SB) 147 was signed into law by the Governor in June 2011, mandating a MCM program in the State. The MCM program is being implemented by DHHS via a three-step approach that recognizes the issues of providing specialty services for vulnerable populations. The first step of the program launched on December 1, 2013 and included the mandatory enrollment of all Medicaid populations, with the exception of those dually eligible for Medicare and Medicaid (dual-eligibles), and those requiring long term services and supports (LTSS) including nursing homes services. These groups are permitted to opt out of MCM until all populations are later mandated in. Currently, there are over 116,000 beneficiaries that are receiving health care coverage through the three managed care organizations (MCOs) in the MCM program.

The second step of MCM implementation will be the enrollment of the New Hampshire Health Protection Program population that will begin as early as July 2014. Over 50,000 newly eligible adults will receive health benefits under the New Hampshire Health Protection Program that includes a mandatory Health Insurance Premium Program (HIPP) for those newly eligible with access to cost-effective employer sponsored insurance and enrollment in managed care coverage for those non-HIPP eligible new adults, pending transition to Qualified Health Plans on the federal marketplace in New Hampshire under a proposed Premium Assistance waiver.

The third and final implementation step will require MCM enrollment for the dual-eligibles, those receiving Medicaid community-based waiver services, and the inclusion of LTSS and nursing home services in MCM. Within MCM, the MCOs are seen as change agents encouraging innovative payment and delivery reform within the health care system. New Hampshire requires each MCM MCO to submit a payment reform plan describing how the agency will engage providers in new and innovative payment and delivery strategies. Beginning in July 2014, the MCOs will have one percent (1%) of their capitation withheld and then could earn it back when the MCO successfully implements their payment reform plan.

This *Building Capacity for Transformation* Section 1115 Demonstration Waiver is a critical element of DHHS' broader MCM strategy that is focused on addressing the needs of MCM enrollees holistically and improving the coordination of care for enrollees who are served by multiple systems of care. The first step of the MCM program began the integration of behavioral health and mental health care in the State and the MCM roll out will continue to improve the integration of and access to needed services, with an emphasis on both mental health and SUD treatment services. To begin progressing towards this goal, DHHS is proposing five related DSHPs within this Section 1115 Demonstration Waiver, which are described in more detail below.

In February 2013, CMS's Center for Medicare and Medicaid Innovation (CMMI) awarded New Hampshire a State Innovation Model (SIM) Model Design grant to develop a State Health Care Innovation Plan and associated delivery system reform and payment reform models. New Hampshire focused its SIM design on models that work to reform the provision of LTSS in the State. It is important to note New Hampshire



included Community Mental Health services in its definition of LTSS services and actively engaged mental health providers in the develop of the SIM plan. The reform goals developed through the SIM process include improving access to care, promoting consumer direction, and strengthening linkages to acute medical care services for persons receiving LTSS across the continuum of care. New Hampshire is anticipating the forthcoming Funding Opportunity Announcement (FOA) from CMMI in order to determine how its SIM design goals may be advanced either through a SIM Testing grant application or in conjunction with this *Building Capacity for Transformation* Section 1115 Demonstration Waiver.

Population Health

In addition to its Medicaid transformation initiatives described in detail above, DHHS recently released its State Health Improvement Plan (SHIP) that will act as the State’s public health road map to guide health improvement work throughout New Hampshire. The SHIP defines measurable objectives, recommended strategies for improvement, and performance measures with time-framed targets for ten population health focus areas, including tobacco use, obesity/diabetes, healthy mothers and babies, and the misuse of alcohol and drugs. The SHIP aims to assist state and community leaders in focusing their work to improve the public’s health and to promote coordination and collaboration among public health partners, which has been reflected in the development of NH’s *Building Capacity for Transformation* Section 1115 Demonstration Waiver.

Expanded Health Coverage

The New Hampshire Health Protection Program will be expanding health coverage in three different ways: (1) through a Mandatory Health Insurance Premium Program (HIPP) that will help eligible workers pay for employer-sponsored insurance through calendar year 2016; (2) through a Voluntary Bridge to Marketplace plan that will offer coverage to eligible individuals through either Managed Care Organizations (MCOs) or Qualified Health Plans (QHPs) on the exchange in calendar year 2014; and (3) through a Mandatory Premium Assistance Program that will provide coverage for eligible adults through QHPs on the exchange beginning in 2016.

In addition, New Hampshire will be introducing a SUD benefit for the newly eligible childless adult population enrolled in the New Hampshire Health Protection Program. With the addition of this benefit into the New Hampshire Health Protection Program, the newly eligible population would have access to new SUD screening and treatment services. New Hampshire has seen an alarming increase in the abuse of prescription and illegal drugs in the State such as heroin and other opioids, as has occurred across the nation. This combination of an increasing need for screening and treatment services and the implementation of a SUD benefit will have an impact on an already overburdened provider network. There is a critical need to support providers as they respond to this growing need for SUD services, both through training and additional capacity.

Mental Health System Reform

The final element of New Hampshire’s comprehensive reform of its Medicaid program focuses on mental health system reform. On September 22, 2008, DHHS released “Addressing the Critical Mental Health Needs of NH’s Citizens – A Strategy for Restoration”, the Ten Year Plan for the State’s public mental health system. In order to implement the community-based programs prescribed by this plan, the State is making new investments in its mental health system for the first time in nearly a decade. The State’s current Biennial



Budget provides over \$26 million in new funding for mental health programs and the State will be investing an additional \$65 million in new community resources over the next four fiscal years as well.

Problem Statement

New Hampshire recognizes that there is a need to restructure how the State delivers mental health and SUD services to better integrate those services with the medical and LTSS services that residents receive. A recent review commissioned by Governor Hassan of the mental health services in Manchester emphasizes that “a variety of factors – [lack of public and private resources,] the economic downturn, increased substance abuse, reductions in state hospital beds, reductions in psychiatric beds at New Hampshire hospitals, and reductions in community based services – have all contributed to New Hampshire’s strained mental health system and that changes are needed at all levels to provide more appropriate and more effective mental health care to those in need”.² New Hampshire sees a strong opportunity to link these necessary mental health system reforms with the other reform initiatives previously described, and intends to use its *Building Capacity for Transformation* Section 1115 Demonstration Waiver to request DSHP funding as a catalyst to do so.

For example, as depicted in the table below, many children and adults are waiting far too long for mental health treatment, creating an ongoing crisis for both the provider and patients. On average during State Fiscal Year 2014, there were 14 to 34 individuals awaiting admission into one of New Hampshire Hospital’s 158 beds, primarily from emergency rooms across the State.

New Hampshire Department of Health and Human Services			
Average number of individuals awaiting admission to New Hampshire Hospital (158 beds) during Fiscal Year 2014 to date³			
Month	Count of Adults	Count of Children	Total Count
July 2013	16	3	19
August 2013	31	3	34
September 2013	25	4	29
October 2013	23	5	28
November 2013	21	7	28
December 2013	22	2	24
January 2014	18	4	22
February 2014	15	8	23
March 2014	11	3	14

² Nadeau, Joseph P, Alexander P. de Nesnera and Michael K. Brown. "New Hampshire Mental Health Sentinel Event Review Report." January 2014. 2014 April 10 <<http://www.governor.nh.gov/media/news/2014/documents/pr-2014-01-28-mental-health.pdf>>.

³ Provided by New Hampshire Department of Health and Human Services, New Hampshire Hospital on April 3, 2014. New Hampshire Hospital does not track how long those individuals have waited, or those waiting for a small number of other DRF beds in the State (1 Crisis Bed setting and 2 small community hospital units).



This data suggests that there is an inherent need to increase the number of psychiatric providers in the State, and to train and educate emergency room physicians on handling complex mental health and SUD patients. Similarly, New Hampshire’s provider network’s capacity to support the SUD treatment needs of its citizens is shrinking. With the addition of an SUD benefit into the State’s Medicaid program, this lack of capacity will only intensify. There is an inherent need to shift and/or improve on how SUD treatments are delivered, and one way to do so is by increasing the delivery of these treatments through hospitals, health systems, and/or community providers, e.g. community mental health centers (CMHCs), federally qualified health centers (FQHCs), and rural health clinics (RHCs).

The data to substantiate these claims are evident. As depicted in the table below, in State Fiscal Years 2011 and 2012, 33 percent of all adult Medicaid beneficiaries had mental health and/or SUD diagnosis, increasing by almost 1,000 beneficiaries from the previous year. The linkages between these two service categories combined with the lack of capacity to provide treatment and services to this population are the delivery challenges this waiver seeks to address.

New Hampshire Department of Health and Human Services				
Beneficiaries with Mental Health and/or SUD Diagnosis⁴				
Fiscal Year	Age Category	Total Beneficiaries	MH/SUD Beneficiaries	Percent MH/SUD
FY10/11	Adult	57,093	33,435	58.6%
FY10/11	Child < 19	106,581	20,548	19.3%
FY10/11	All	163,674	53,983	33.0%
FY11/12	Adult	57,253	33,991	59.4%
FY11/12	Child < 19	107,249	20,955	19.5%
FY11/12	All	164,502	54,946	33.4%

In addition to proposing solutions for improving the mental health and SUD delivery system in the State, this Demonstration Waiver will focus on promoting the overall health of individuals with a persistent and/or severe mental illness. According to Dr. Stephen Bartels, the director of Dartmouth’s Centers for Health and Aging and professor of health policy at the Dartmouth Institute for Health Policy and Clinical Practice, a person with a serious mental illness, on average, has a life span that is 25 years shorter than a person in the general population.⁵ For persons with a persistent and/or severe mental illness staying physically healthy and fit is a special challenge; yet regular exercise and proper diet can be key elements in recovering from a major mental or emotional illness. DHHS recognizes the opportunity to use this Demonstration Waiver as means for expanding population health programs currently in place in the state to reach a broader segment of this population, to include children and developmentally disabled adults.

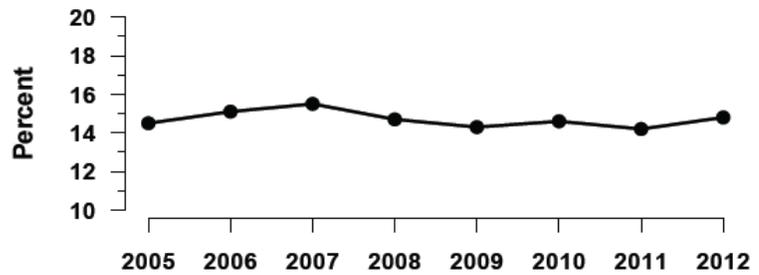
⁴ Count of every Medicaid enrollee who received a Medicaid paid service with mental health and/or SUD diagnosis code provided by Milliman on April 13, 2014. Mental health and/or SUD diagnosis codes are defined by SAMSHA, excludes tobacco use disorder.

⁵ Dartmouth College, Office of Public Affairs. Dartmouth Now: Fitness Program for Mentally Ill Expands in New Hampshire (Associated Press). 23 February 2012. 23 April 2014 <<http://now.dartmouth.edu/2012/02/fitness-program-for-mentally-ill-expands-in-new-hampshire-associated-press/>>.



The final component of this Demonstration Waiver focuses on reducing tobacco smoking and improving oral health education among pregnant women and mothers of young children. According to 2011 NH Birth Data published in the New Hampshire SHIP, 31.9 percent of pregnant women on Medicaid smoke.⁷ In comparison with the statewide population, 13.6 percent, report smoking during

Women in New Hampshire who report smoking cigarettes during pregnancy⁶



pregnancy. 26.3 percent of teenage pregnant women (up to 19 years of age) report smoking during pregnancy, compared to 13 percent of women age 20 or older. Smoking during pregnancy is associated with higher risk for poor birth outcomes often requiring hospitalization for the infant, mother or both. The estimated smoking attributable neonatal health care costs annually in New Hampshire are \$585,000.⁸

Population-based studies have demonstrated an association between periodontal diseases and adverse pregnancy outcomes, diabetes, cardiovascular disease, and stroke. There is a known correlation between maternal periodontal disease and preterm birth and/or low birth weight.⁹ Further research is needed to determine the extent to which these associations are causal or coincidental. A reduction in adverse birth outcomes and associated costs, and a decrease of perinatal morbidity and mortality would likely result from improving oral health during pregnancy.¹⁰

The March of Dimes estimated that the average costs during the first year of life for a premature and/or low birth weight baby (less than 37 weeks gestation and/or less than 2,500 grams) were more than ten times as high as medical costs for a baby born at full term (\$55,393 versus \$5,085).¹¹ In State Fiscal Year 2012, New Hampshire Medicaid covered and paid \$7.9 million for all services provided in the first month of life for

⁶ New Hampshire Department of Health and Human Services, Division of Public Health Services. "State Health Improvement Plan 2013-2020: Charting a Course to Improve the Health of New Hampshire." December 2013. <<http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf>>.

⁷ New Hampshire Department of Health and Human Services, Division of Public Health Services. "State Health Improvement Plan 2013-2020: Charting a Course to Improve the Health of New Hampshire." December 2013. <<http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf>>.

⁸ *These amounts do not include health costs caused by exposure to secondhand smoke, smoking-caused fires, smokeless tobacco use, or cigar and pipe smoking.*

⁹ American College of Obstetricians and Gynecologists. "Committee Opinion No. 569: Oral Health Care During Pregnancy and Through the Lifespan." *Obstetrics & Gynecology* 122 (2013): 417-22. <http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Oral_Health_Care_During_Pregnancy_and_Through_the_Lifespan#19>.

¹⁰ Xiong, X, et al. "Periodontal disease and pregnancy outcomes: state-of-the-science." *Obstetrical & Gynecological Survey* 62.9 (2007): 605-15.

¹¹ March of Dimes. "Premature Babies Cost Employers \$12.7 Billion Annually." 7 February 2014. March of Dimes Releases New Report about the High Cost of Preterm Birth. 12 April 2014 <<http://www.marchofdimes.com/news/premature-babies-cost-employers-127-billion-annually.aspx>>.



780 low birth weight and/or preterm babies.¹² The medical services needs and costs for low birth weight and preterm babies throughout their lifetime are much greater. Below is a chart summarizing the count of preterm births and/or low weight birth covered by New Hampshire Medicaid in the past two State Fiscal Years.

New Hampshire Department of Health and Human Services				
Count of Pre-Term and/or Low Birth Weight Newborns¹³				
State Fiscal Year	Low Birth Weight & Pre-Term	Low Birth Weight Only	Pre-Term Only	Total Newborns with Low Birth Weight and/or Pre-Term
SFY10/11	341	14	483	838
SFY11/12	327	13	440	780

In addition to reducing costs associated with poor birth outcomes, improving perinatal oral health also has potential to improve the oral health of children. According to the Children’s Dental Health Project (CD HP), evidence suggests that there is a correlation between improved oral health and reduced costs for dental treatment in children whose mothers receive routine dental care. Transmission of bacteria from mother to child is the dominant course through which children first acquire dental decay or cavities. Bacteria could be passed through saliva from a caregiver’s mouth to a child’s, such as when sharing a spoon or food. The healthier the mother’s mouth, then the longer the initial transmission of tooth decay-causing bacteria is delayed and the more likely children are to establish and maintain good oral health.¹⁴

In New Hampshire, visits related to non-traumatic dental conditions increased significantly in ambulatory care sensitive emergency departments from 2001 to 2007, from 11,067 (age-adjusted rate 89.5 per 10,000 population) in 2001 to 16,238 (age adjusted rate 129.3 per 10,000 population) in 2007.¹⁵ Improving women’s oral health during pregnancy and throughout her child’s early childhood may decrease these incidences and the costs associated with treatment for early childhood tooth decay and cavities.

Components of Section 1115 Demonstration Waiver

Based upon the delivery system challenges outlined above, DHHS developed a list of five Designated State

¹² Total cost of Medicaid services provided by DHHS to low birth weight and/or preterm babies in SFY2012 calculated and provided by Milliman on April 13, 2014.

¹³ Count of Pre-Term and/or Low Birth Weight Newborns Paid by New Hampshire Medicaid in State Fiscal Years 2011 and 2012 provided by Milliman on April 13, 2014.

¹⁴ Children’s Dental Health Project and National Institute for Health Care Management Research and Educational Foundation. "Improving Access to Perinatal Oral Health: Strategies and Considerations for Health Plans." July 2010. Issue Brief. April 2014 <<http://www.nihcm.org/pdf/NIHCM-OralHealth-Final.pdf>>. American Academy of Pediatric Dentistry. *Guideline on Perinatal Oral Health Care*. Chicago, IL: American Academy of Pediatric Dentistry, 2009.

¹⁵ New Hampshire Department of Health and Human Services, Division of Public Health Services. "State Health Improvement Plan 2013-2020: Charting a Course to Improve the Health of New Hampshire." December 2013. <<http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf>>.



Health Programs (DSHPs) that it is seeking funding for from CMS through this *Building Capacity for Transformation* Section 1115 Demonstration Waiver. These programs were also developed to address the public health needs identified in the New Hampshire State Health Improvement Plan (SHIP), as DHHS recognizes how hospitals, health systems, and/or community providers, e.g. community mental health centers (CMHCs), federally qualified health centers (FQHCs), and rural health clinics (RHCs) must be strong partners in driving the health outcomes outlined in the SHIP.

Through the development of the proposed statewide DSHPs, DHHS is seeking to improve access to quality, affordable health care by:

- Encouraging hospitals, health systems, and community providers to build an integrated system at the local level by establishing a new community reform pool that would reward providers for their active participation in system reform initiatives and their overall agreement to reform
- Expanding community-based mental health services for the State's non-Medicaid population in accordance with the Ten Year Mental Health Plan and its settlement with the U.S. DOJ
- Improving the service delivery of mental health and SUD services, especially in Emergency Departments, by offering financial resources for workforce development
- Promoting healthy behaviors and improved health outcomes by expanding the InShape program at hospitals, health systems, and community providers to additional populations – children and 1915(c) Developmentally Disabled Waiver enrollees – and to include smoking cessation classes as a component for adults
- Increasing access to dental services by establishing a pilot program that creates a dental benefit for adult pregnant women and mothers of young children

Demonstration Hypotheses and Evaluation Design

The State will submit to CMS for approval an evaluation design for the Demonstration no later than 120 days after CMS approval of the Demonstration. The overarching objective of the Demonstration is that implementation of the five DSHPs will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement. The State will test the following research hypotheses through this Demonstration:

- Maintaining and increasing access to mental health services will lead to improvement in the overall health status of the Medicaid population
- Supporting community based delivery system reforms will result in improved access to mental health, SUD, and physical health services
- Increasing SUD workforce development opportunities for health care providers will result in the increased capacity to provide needed SUD treatments and services
- Expanding successful community public health programs statewide will improve health and wellness of those who participate
- Offering dental coverage to pregnant women and mothers of young children will reduce the frequency of low birth weight babies, babies born with complications, and improve the dental health status of the new mothers' children



The design and improvements made by each DSHP program will demonstrate that by spending Medicaid dollars differently, DHHS can provide better health outcomes for its Medicaid clients, and these outcomes will be defined and measured throughout the length of this Demonstration. The State's evaluation design for the Demonstration will:

- Test the hypotheses described above;
- Describe specific outcome measures that will be used in evaluating the impact of each Demonstration-related program during the period of approval;
- Detail the data sources and sampling methodologies for assessing these outcomes;
- Describe how the effects of all Demonstration-related programs will be isolated from other initiatives occurring in the State; and
- Discuss the State's plan for reporting to CMS on the identified outcome measures and the content of those reports.

No later than 60 days after receiving comments on the draft evaluation design from CMS, the State will submit the final design to CMS. The State will submit progress reports in quarterly and annual Demonstration reports, and submit a draft final evaluation report within 120 days of the expiration of the Demonstration.

Section II – Designated State Health Programs

The next section includes detailed descriptions for each Designated State Health Program (DSHP) proposed within this *Building Capacity for Transformation* Section 1115 Demonstration:

- Establish a Community Reform Pool focused on mental health and improved care coordination of individuals with a mental health and physical health comorbidity
- Enhance Community Based Mental Health Services
- Invest in Substance Use Disorder (SUD) Workforce Development
- Expand the InShape program
- Launch Oral Health Pilot Program for Pregnant Women and Mothers of Young Children

Establish a Community Reform Pool

DHHS proposes to establish a community reform pool that would reward New Hampshire hospitals, health systems, and community providers for their active participation in system reform initiatives and their overall commitment to reform. This reform pool would encourage hospitals, health systems, and community providers to maintain and expand needed mental health/SUD services and to build an integrated physical health, mental health, and SUD system at the local level. DHHS envisions that in-state providers could receive higher rates of reimbursement and/or additional pool payments based upon their participation, which would occur through the following five components.



Five Components of Community Reform Pool	
Reform Pool	Description
1. Capacity-retention Payments	<ul style="list-style-type: none"> • A hospital would receive this payment if it pledged <u>not to</u> reduce access to mental health/SUD related services in their health system • This payment would be 10 percent of the hospital’s existing Medicaid claim payments for mental health/SUD related services in their system, based on previous years. This payment would be in place each year of the five year waiver program
2. Capacity-expansion Payments	<ul style="list-style-type: none"> • If a hospital, health system, or community provider expands its physical capacity to provide mental health/SUD related services, DHHS would pay an enhanced rate for those services provided through the new “unit” for three years, using a 25 percent payment increase
3. New Service Payments	<ul style="list-style-type: none"> • If a hospital, health system, or community provider adds inpatient or outpatient mental health/SUD related services, DHHS would pay an enhanced rate for those services for three years, using a 10 percent payment increase
4. Pilot Program Pool	<ul style="list-style-type: none"> • Establish a pool for DHHS to fund grant applications from hospitals, health systems, or community providers to form pilots related to improving the delivery and coordination of physical health, mental health, and/or SUD treatments and services • Grant applications would be evaluated by DHHS based upon a defined set of criteria
5. Provider Incentive Pool	<ul style="list-style-type: none"> • Establish a pool that would begin to provide financial incentives in Year 3 of the demonstration, based upon a hospital, health system, and/or community provider’s ability to meet defined outcome measurements • This incentive pool would be funded by a 20 percent holdback in all four components of this broader community reform pool • These hold backs would begin to accrue in Year 2 of the demonstration

The first component addresses capacity reduction and access to mental health care for Medicaid recipients. A hospital would receive this type of payment if it pledged not to reduce access to mental health/SUD related services in their health system.

These payments could reduce a trend of closing or downsizing facilities in the state. As published in the Ten Year Mental Health State Plan, inpatient and residential alternatives to New Hampshire Hospital have diminished since the 1990s. There were 236 voluntary inpatient beds in 1990 across the state, 186 beds in 2008, and 177 beds in 2014.¹⁶ A Designated Receiving Facility (DRF) is a hospital-based psychiatric inpatient unit or a non-hospital-based residential treatment program designated by the Commissioner of DHHS to provide care, custody, and treatment to persons involuntarily admitted to the state mental health services system. The number of community DRFs’ beds has decreased dramatically in the 2000s from 101 to currently 16, as have the number of Acute Psychiatric Residential Treatment Program (APRTP’s) beds (from 52 to 16).

¹⁶ New Hampshire Department of Health and Human Services. "Addressing the Critical Mental Health Needs of New Hampshire’s Citizens - A Strategy for Restoration: Ten Year Mental Health Plan." 17 September 2008. 10 April 2014 <<http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>>.

Additional information provided by New Hampshire Department of Health and Human Services, Bureau of Behavioral Health Services on April 8, 2014.



The second component of the community reform pool addresses the need to increase capacity by offering a financial incentive to hospitals, health systems or community providers that expands their capacity to provide mental health/SUD related services. DHHS would pay an enhanced rate for those services provided through the new “unit” for three years. Currently, the State is lacking regional capacity for inpatient voluntary and involuntary care. DRF or APRTP care is currently only available at four locations. DHHS has been forced to add capacity to New Hampshire Hospital, which is costly and only addresses the issue of involuntary bed capacity.

New Hampshire Department of Health and Human Services	
Designated Receiving Facilities (DRF) Beds in New Hampshire ¹⁷	
New Hampshire Hospital	158
Elliot Hospital	6
The Cypress Center (APRTP)	16
Franklin Hospital	10
Total	190

As described in the Ten Year Mental Health Plan, “Expanding capacity within local general hospitals would allow people to be treated in their own region makes more sense. Inpatient care has diminished because this care is not financially viable for providers.” This Section 1115 Demonstration Waiver presents an opportunity for health care entities to reassess the feasibility and viability of expanding capacity or offering new services for those with mental health and/or SUD needs.

The third component of the reform pool addresses mental health/SUD services by offering a financial incentive to a hospital, health system, or community provider that adds inpatient or outpatient mental health/SUD related services. DHHS would pay an enhanced rate for those new services for three years.

With few exceptions, acute care hospitals in the state have drastically reduced inpatient mental health care, many citing cost concerns. These trends have occurred in New Hampshire and nationally due to a combination of factors, including changes in Medicare and Medicaid funding, and a growing uninsured segment of the population. "The Medicaid reimbursements are so low, and the costs so high, that it just became cost-prohibitive," said John Clayton, spokesman for the New Hampshire Hospital Association.¹⁸ The proposed changes to funding for hospitals, health systems, and/or community providers under the waiver will impact more than 271 providers that received payments for mental health/SUD services under the Medicaid state plan in State Fiscal Year 2012. Implementing these three reform pools together enables them to reinforce each other and create more momentum for strengthening New Hampshire’s mental health/SUD delivery system while bending the cost curve. Enhanced payment rates introduce marketplace sustainability and incentivize adding capacity into the mental health delivery system, thereby sustaining the

¹⁷ Count of DRF Beds in New Hampshire provided by New Hampshire Department of Health and Human Services, Bureau of Behavioral Health Services on April 8, 2014.

¹⁸ Solomon, Dave. "NH mental health report: More beds needed." New Hampshire Union Leader 26 February 2014: <<http://www.unionleader.com/article/20130227/NEWS12/130229277/0/SEARCH>>.



expanding individual insurance market as a result of the ACA and New Hampshire's partnership with the Federal Market Place.

The fourth component of the reform pool establishes a pilot program pool to fund grant applications submitted by hospitals, health systems, and/or community providers to form pilots related to improving health care delivery in their communities through improved care coordination, especially for individuals with physical and mental health co-morbidities. It presents an opportunity for health systems and providers to address pressing issues and propose their own tailored solutions. By using an application approach with providers, this program would incentivize hospitals, health systems, and/or community providers to create and customize pilot programs tailored to their community's needs. DHHS would solicit and approve a wide variety of pilot program proposals across the state. Suggested pilot program may focus on, but not limited to, delivery of physical health, mental health, and/or SUD treatments and services at the local level. For each grant application put forth for the pilot program pool, providers would be required to describe its pilot program, discuss intended outcomes and populations served, and present outcome measures. This component is also directly linked to New Hampshire's overarching interest in encouraging payment and delivery reform within the health care system. Within the design of its MCM program, New Hampshire has created an innovate payment reform incentive pool where each of the MCM MCO's is required to submit a payment reform plan detailing how it will engage providers in new and innovative payment and delivery strategies to improve the delivery and coordination of care. Beginning in July, 2014 the MCOs will have one percent (1%) of their capitation withheld and then paid back if the MCO successfully implements their plan. It is anticipated that a number of hospitals, health systems and other providers will use this pilot pool to support the implementation of payment and delivery reform strategies developed in conjunction with the MCOs.

The fifth and last component is a provider incentive pool that would begin to provide rewards in demonstration year (DY) 3, based upon a hospital, health system, or community provider's ability to meet defined outcome measurements. These are rewards paid to providers for achieving outcome measures proposed in pilot program's grant application. This pool would be funded by withholding 20 percent of mental health reform pool payments in the previous demonstration year. Payment rewards would be at-risk if providers do not achieve outcomes. Improvements will drive whether or not hospitals, health systems, and/or community providers benefit from the incentive pool. New Hampshire recognizes that hospitals, health systems, and community providers will need to prepare and adapt to new outcome-based payment structures proposed under the Demonstration. In DY 1, providers would receive all payment amounts from the abovementioned components of the reform pool. In DY 2, 20 percent of payments from the mental health reform pool will be withheld, and providers will have the opportunity to earn back their 20 percent in DY 3 if outcome measures are achieved.

The community reform pool components will help fund delivery system and payment reforms that will lead to increased accountability and lasting improvements in health care delivery across New Hampshire. Payments from this pool will help providers prepare to meet new coverage demands beginning in July 2014. Hospitals, health systems, and/or community providers eligible to receive funding from the payment pool must have contracts with at least one Medicaid MCO and beginning in 2016 have contracts with at least one Qualified Health Plan offered on the New Hampshire Marketplace that is enrolling Medicaid eligible



members who are receiving premium assistance from DHHS, as well as meet any related objectives, reporting and metrics identified for the provider.

All of the abovementioned payments will be in the form of supplemental payments. The expenditure plan showing the allocation between reform pool components over the five-year waiver period will be included at a later date in the Appendices.

Enhance Community Based Mental Health Services

On September 22, 2008, the Department of Health and Human Services (DHHS) released “Addressing the Critical Mental Health Needs of NH’s Citizens – A Strategy for Restoration”, the Ten Year Plan for the State’s public mental health system. It was the result of a DHHS Commissioner-appointed task force, charged with identifying the critical mental health needs of New Hampshire’s citizens. Among the areas identified in this report as needing attention are housing and residential supports; more community supports to prevent hospitalization; mental health workforce retention and development; capacity for community-based inpatient psychiatric care; services for special populations; and an increase in Assertive Community Treatment (ACT) teams.¹⁹ The report is available at <http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>.

The taskforce made recommendations in the following areas:

- Increase the Availability of Community Residential Supports
- Increase Capacity for Community-Based Inpatient Psychiatric Care
- Develop Assertive Community Treatment Teams
- Community Mental Health Workforce Retention and Development
- Department of Corrections Study Committee Planning Considerations

The taskforce recommended that group homes, which provide consumers with a safe, supportive living environment, be developed and used as an alternative to state mental health facilities, including New Hampshire Hospital (“NHH”) (the State’s only psychiatric hospital) and the Glenclyff Home (a State-owned and -operated nursing facility for people with mental illness).” However, since the report publication, the number of group home beds has diminished. In 2008, the New Hampshire Bureau of Behavioral Health identified 203 residential group home beds available to serve the approximately 7,000 adults with serious and persistent mental illness in New Hampshire.²⁰ In 2014, the number of residential group home beds available dropped to 177. As part of this Section 1115 Demonstration waiver, the State seeks FFP to add community based residential capacity.

¹⁹ New Hampshire Department of Health and Human Services, Bureau of Behavioral Health Services. "Community Mental Health Services Block Grant Monitoring Report." 4 August 2009. 10 April 2014
<<http://www.dhhs.state.nh.us/dcbcs/bbh/documents/monitoring09.pdf>>.

²⁰ New Hampshire Department of Health and Human Services. "Addressing the Critical Mental Health Needs of New Hampshire’s Citizens - A Strategy for Restoration: Ten Year Mental Health Plan." 17 September 2008. 10 April 2014
<<http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>>.



In December 2013, the New Hampshire Department of Justice entered into a comprehensive settlement agreement, subject to legislative appropriations, of the class action lawsuit, *Amanda D, et al. v. Margaret W. Hassan*²¹. Plaintiffs were represented by counsel including the Disability Rights Center and the U.S. DOJ against the State of New Hampshire on behalf of a class of New Hampshire residents with serious mental illness who are unnecessarily institutionalized in New Hampshire Hospital or Glenclyff Nursing Home, or who are at serious risk of unnecessary institutionalization in hospitals, emergency rooms, or prisons. The intention of the comprehensive settlement agreement is to expand and enhance mental health service capacity in integrated community settings within New Hampshire's mental health system. According to the U.S. DOJ Civil Rights Division, "The Agreement will enable a class of adults with serious mental illness to receive needed services in the community, which will foster their independence and enable them to participate more fully in community life. The expanded and enhanced community services will significantly reduce visits to hospital emergency rooms and will avoid unnecessary institutionalization at State mental health facilities, including New Hampshire Hospital ("NHH") (the State's only psychiatric hospital) and the Glenclyff Home (a State-owned and -operated nursing facility for people with mental illness)."²²

New Hampshire seeks FFP for costs not otherwise matchable under Medicaid to enable New Hampshire to implement components of its Ten Year Mental Health Plan and its December 2013 settlement agreement with the U.S. DOJ. The following are central components of the settlement summarized by the Disabilities Rights Center and the U.S. DOJ Civil Rights Division for which the State is seeking FFP.^{23, 24}

- *Assertive Community Treatment* - a multi-disciplinary team of professionals that are available around the clock and provide a wide range of flexible services, including case management, medication management, psychiatric services, assistance with employment and housing, substance abuse services, crisis services and other services and supports to allow individuals to live independently in the community. ACT teams are mobile, providing services in individuals' homes and in other community settings²⁵. Over the next four years, New Hampshire will expand Assertive Community Treatment teams to ensure they are on call 24 hours a day in all parts of the state. The current State budget appropriates funds to provide 7 day per week coverage.²⁶

²¹ *Amanda D, et al. v. Margaret W. Hassan*; United States v. New Hampshire. Civ. No. 1:12-cv-53-SM. United States District Court for the District of New Hampshire. Class Action Settlement Agreement filed 12 February 2014. <<http://www.dhhs.state.nh.us/dcbcs/bbh/documents/approved-agreement.pdf>>.

²² U.S. Department of Justice, Civil Rights Division. "New Hampshire ADA Mental Health Settlement Fact Sheet." 8 January 2014. *Amanda D, et al. v. Margaret W. Hassan*; United States v. New Hampshire. Civ. No. 1:12-cv-53-SM. 10 April 2014 <<http://www.ada.gov/olmstead/documents/nh-fact-sheet.pdf>>.

²³ Disabilities Rights Center, Inc. "Press Release: Federal Judge Approves Class Action Settlement Expanding Mental Health Services." 12 February 2014. 10 April 2014 <<http://www.drcnh.org/pressrelease21214judgeissuesfinalorder.pdf>>.

²⁴ U.S. Department of Justice, Civil Rights Division. "New Hampshire ADA Mental Health Settlement Fact Sheet." 8 January 2014. *Amanda D., et al. v. Hassan, et al.; United States v. New Hampshire, No. 1:12-CV-53 (SM)*. 10 April 2014 <<http://www.ada.gov/olmstead/documents/nh-fact-sheet.pdf>>.

²⁵ Disabilities Rights Center, Inc. "Press Release: Federal Judge Approves Class Action Settlement Expanding Mental Health Services." 12 February 2014. 10 April 2014 <<http://www.drcnh.org/pressrelease21214judgeissuesfinalorder.pdf>>.

²⁶ New Hampshire Department of Justice, Office of the Attorney General. "News Release: Settlement Agreement in Mental Health Services Lawsuit." 19 December 2013. 10 April 2014 <<http://doj.nh.gov/media-center/press-releases/2013/20131219-mental-health-settlement.htm>>.



- *Mobile Crisis Teams* – are able to respond to individuals in their homes and communities 24/7 and include access to new crisis apartments, where individuals experiencing a mental health crisis can stay for up to seven days, as an alternative to hospitalization. Under the settlement, New Hampshire will create three mobile crisis teams, with accompanying crisis apartments, to help divert people experiencing mental health crises from emergency rooms and New Hampshire Hospital.
- *Supported Housing* - integrated, scattered-site, permanent housing, coupled with on-going mental health and tenancy support services provided by ACT, case management, and/or a housing specialist. Under the settlement, New Hampshire will expand supported housing opportunities for people with mental illnesses.
- *Quality Assurance and Performance Improvement* - develop and implement a quality assurance and performance improvement system, emphasizing the use of client-level outcome tools and measures to ensure that individuals are provided with sufficient services and supports of good quality to best ensure their health, safety, and welfare. The goal is to help individuals achieve increased independence and greater integration in the community, obtain and maintain stable housing, avoid harms, and decrease the incidence of hospital contacts and institutionalization.
- *Independent Monitor* - an independent monitoring official, called the “Expert Reviewer,” who will assess the State’s implementation of and compliance with the terms of the Agreement, provide technical assistance when asked, and mediate disputes between and among the parties.

Specifically, DHHS is proposing to use DSHP funding to help implement the activities and services for the State’s non-Medicaid population that are not currently matched for FFP. Below is a table of the activities in State Fiscal Year (SFY) 2015 that are not currently matched for FFP. A table with the unmatched funding amount in SFY 2016 to 2018 will be included at a later date in the Appendices.



Expand and Enhance Mental Health Services: Unmatched Funding Amount in State Fiscal Year (SFY) 2015		
Mental Health Program Name	Program Source*	Unmatched Funding Amount in SFY 2015
ACT - 4 adult teams	10 Year MH Plan	\$228,000
ACT - 1 child team	10 Year MH Plan	\$70,000
ACT - 5 child teams	10 Year MH Plan	\$350,000
ACT - Bring 11 current Adult ACT teams to fidelity	DOJ Settlement	\$640,000
ACT - Add 12th & 13th Adult ACT teams	DOJ Settlement	\$57,000
Mobile Crisis Teams	DOJ Settlement	\$45,000
Community Crisis Apartments	DOJ Settlement	\$128,000
Housing Bridge Subsidy Program	10 Year MH Plan	\$545,000
Housing Bridge Subsidy Program	DOJ Settlement	\$409,000
DRF - Hospital	10 Year MH Plan	\$338,000
Residential - 12 beds	10 Year MH Plan	\$155,000
Residential - 62 beds	10 Year MH Plan	\$50,000
Expand REAP Program	10 Year MH Plan	\$75,000
Quality Assurance	DOJ Settlement	\$52,000
Expert Reviewer	DOJ Settlement	\$88,000
Total		\$3,227,000

The settlement agreement will provide people with serious mental illness in New Hampshire, both Medicaid and non-Medicaid, with robust community alternatives that will reduce or eliminate the need for hospitalization. The agreement requires the State to create and expand services over the next six years.²⁷ An independent expert reviewer will evaluate the state’s compliance with the agreement and will issue public reports on the state’s ongoing implementation efforts. The services included in the settlement agreement are proven, cost-effective measures that lead to recovery and the ability of people with serious mental illness to live successful and fulfilling lives in the community.

Invest in Substance Use Disorder (SUD) Workforce Development

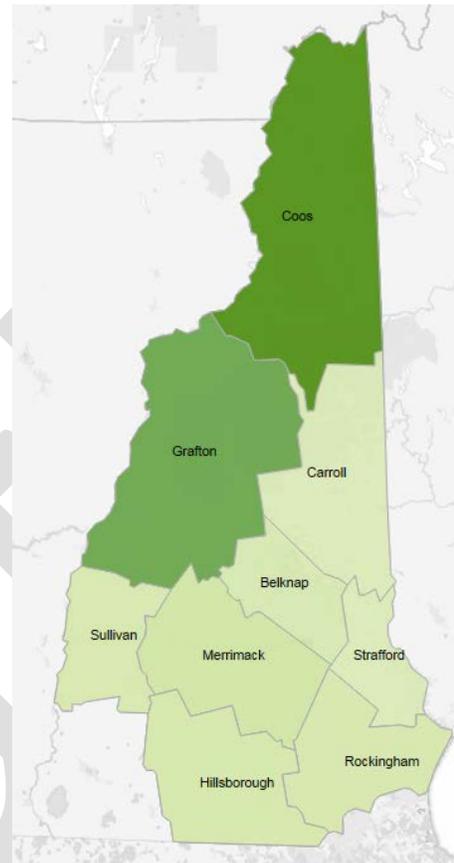
One of the State’s population health focus areas, as outlined in the SHIP, is to address substance misuse by reducing the non-medical use of pain relievers and drug-related overdose deaths in the State. Meeting these goals will require a stronger workforce capable of providing enhanced SUD treatments and services and addressing mental health and SUD comorbidities. To address this need, DHHS proposes a grant program that would fund training education and workforce development programs focused on SUD treatments and services in which hospitals, health systems and/or community providers would apply and DHHS would administer. New Hampshire is experiencing shortages of psychiatrists and other treatment staff. Over one-

²⁷ U.S. Department of Justice, Office of Public Affairs. News Release: Justice Department Reaches Settlement with State of New Hampshire to Expand Community Mental Health Services and Prevent Unnecessary Institutionalization. 19 December 2013. 12 April 2014 <<http://www.justice.gov/opa/pr/2013/December/13-crt-1347.html>>.



third of New Hampshire is designated a “mental health professional shortage area” by the Health Resources Services Administration.²⁹ The map to the right shows the degree of mental health professional shortage area across New Hampshire. According to the Ten Year Mental Health Plan, the availability of adequately trained staff is a significant challenge that directly affects service quality in both inpatient and outpatient settings, in addition to staff wages and staff turnover. This challenge will increase with the advent of a SUD treatment benefit in July 2014 for enrollees in New Hampshire’s Health Protection Plan. To access this funding pool, hospitals, health systems and/or community providers will submit proposals for workforce training programs and funding request to DHHS for review and approval.

Degree of Mental Health Professional Shortage by County in New Hampshire²⁸



Curriculum components could include, but are not limited to:

- Crisis intervention
- Crisis stabilization
- Emergency Room and related continuum of care
- Related mental health comorbidities
- Neonatal abstinence syndrome (NAS)

The proposed initiative would promote improved access and quality of care for Medicaid beneficiaries in the State by supporting the development of the health care workforce. By using an application approach with providers, this program would incentivize hospitals, health systems, and/or community providers to create and customize SUD health workforce training programs to attract and stabilize their workforce.

This training grant would be administered by DHHS, and payments would be specific to each award. FFP for workforce training programs may be limited to direct and indirect costs. Funding for activities related to this SUD workforce development initiative will be distributed outside of managed care.

Expand the InShape program

For persons with a persistent and/or severe mental illness staying physically healthy and fit is a special challenge; yet regular exercise and proper diet can be key elements in recovering from a major mental or emotional illness. To address this challenge, New Hampshire has piloted an InShape program that brings the

²⁸ Health Resources and Services Administration. Health Professional Shortage Area Data Download. 12 April 2014. <<http://datawarehouse.hrsa.gov/data/datadownload/hpsaDownload.aspx>>.

²⁹ New Hampshire Department of Health and Human Services. "Addressing the Critical Mental Health Needs of New Hampshire’s Citizens - A Strategy for Restoration: Ten Year Mental Health Plan." 17 September 2008. 10 April 2014 <<http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>>.



benefits of exercise and a healthful way of living to individuals facing these concerns.³⁰ In order to scale this program further, DHHS proposes expanding components of the InShape program to additional populations. Another population health challenge that this population faces is tobacco use. Specifically, the rate of tobacco use among people with SUD or mental illness is 94 percent higher than among adults without these disorders. Approximately 50 percent of people with mental illnesses and addictions use tobacco, compared to 23 percent of the general population.³¹ Therefore, in addition to maintaining the health and wellness component of the InShape program that is focused on improving cardiovascular health by reducing obesity, DHHS proposes adding a third element to the program, which would require the addition of smoking cessation classes as a component for smokers. Specifically, this program would establish a funding pool to award grant applications from hospitals, health systems, and/or community providers to implement an InShape program that (1) includes children with serious mental illness (SMI) as participants, (2) includes individuals enrolled in New Hampshire's 1915(c) HCBS-DD waiver as participants, and (3) offers tobacco cessation as a program component to all InShape participants who smoke.

In September 2011, the New Hampshire Department of Health and Human Services, Bureau of Behavioral Health received a \$9.9 million grant from the Centers for Medicare & Medicaid Services to implement a Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) program into its Medicaid program. This five year grant is scheduled to end in September 2016. While being overseen by DHHS, this program runs in close partnership with the State of New Hampshire's ten regional Mental Health Centers and evaluation researchers at The Dartmouth CDC Prevention Research Center and Dartmouth Institute for Health Policy and Clinical Practice. The catalyst for implementing the MIPCD program focuses on health disparities for individuals with SMI. Specifically, individuals receiving public mental health services have a 25 to 30 year reduced life expectancy, representing the greatest health disparity among Medicaid beneficiaries while also accounting for the highest costs. The New Hampshire Medicaid Wellness Incentive Program (WIP) included within MIPCD works to address both the health disparity and increased costs by providing incentivized health promotion programs to overweight or obese and/or tobacco-smoking Medicaid beneficiaries receiving services at New Hampshire's ten regional Community Mental Health Centers (CMHCs).³² One of these incentivized health programs is InShape, a motivational health-promotion program for persons with mental illness that includes (a) individualized fitness and healthy lifestyle assessment, (b) a fitness plan including eating, exercise, and health-promotion goals, (c) weekly individual meetings with a Health Mentor, (d) access to fitness resources (e.g., YMCA), (e) opportunities for group exercise and healthy eating education, and (f) group motivational "celebrations." The InShape program was initially piloted in New Hampshire in 2004 and has since expanded to most CMHCs in the State as a covered CMH Medicaid benefit. The operation of the program and its recognition by Medicaid was in effect prior to the implementation of the MIPCD. The MIPCD program, however, has since taken this existing program and incentivized its participation via randomized assignments and randomized cash rewards to pay for membership.

³⁰ Monadnock Family Services. *InShape*. n.d. 2 April 2014 <<http://www.mfs.org/services/inshape/inshape>>.

³¹ National Council for Behavioral Health. *National Behavioral Health Network for Tobacco & Cancer Control*. n.d. 1 April 2014 <<http://www.thenationalcouncil.org/consulting-best-practices/national-behavioral-health-network-tobacco-cancer-control/>>.

³² New Hampshire Medicaid Wellness Incentive Program Application and Project Narrative



Under this 1115 Demonstration Waiver, DHHS will expand on the MIPCD program by extending the funding for incentives associated with the InShape program after MIPCD grant funding concludes in September 2016. In addition to extending these incentives, DHHS will expand the populations who can participate in the InShape program, as well as expand the program's scope. Specifically, using DSHP funding, DHHS will expand participation in the InShape program to include children with SMI and to include the 1915(c) HCBS-DD waiver enrollees in the State. There are 9,763 children with serious mental illness (SMI) in the State served by the CMHCs in State Fiscal Year 2013 according to Phoenix Management Information System who could be eligible for an expanded InShape program.

In addition to expanding the InShape program to include these two new populations, DHHS will add smoking cessation classes as a component for participants who smoke. DHHS recognizes the opportunity to address this population health challenge in conjunction with the broader prevention and wellness goals of the InShape program.

Launch Oral Health Pilot Program for Pregnant Women and Mothers of Young Children

DHHS would pilot an expanded Medicaid oral health program for pregnant women and mothers of young children that would accomplish the following:

- Establish an education program for all mothers to increase the understanding and value of oral health
- Encourage participation by all mothers who smoke in an approved smoking cessation program
- Establishes a benefit that provides coverage for dental services to all mothers during pregnancy *until their child's fifth birthday*
 - This will include mothers over 21 years of age who are not currently eligible for any Medicaid dental services
 - This will include mothers under 21 years of age who are currently eligible for Medicaid dental services until they turn 21 or otherwise 60 days postpartum

Scope of dental benefits will include comprehensive and periodic dental examinations, periodontal services as indicated, restorative and limited prosthetic dental treatment, and extractions if medically necessary for women who participate by meeting certain compliance goals that include but are not limited to:

- Scheduling and completing a dentist's annual examination and cleaning (including scaling/root planning if needed);
- Participating in smoking cessation;
- Taking child to annual dental checkup beginning before age one;
- Returning annual surveys to report success with smoking cessation;
- Compliance with recommended dental treatment;
- Changes in understanding of oral health, attitude shifts, etc.

Program rewards and incentives would be provided to women and children who meet certain performance criteria developed by DHHS. Women would have an opportunity to participate in the pilot program and its



evaluation study, or elect not to participate. Non-participants would be eligible for the same dental services provided through the benefit mentioned above, and would receive the same education information provided to all mothers.

Dental services provided through the benefit to clients before they transition to MCM will be paid on a Fee-For-Service basis. When dental services are provided through the benefit to clients enrolled with one of New Hampshire's MCOs, the MCO will be required by contract to reimburse for dental services for these eligibility groups. An actuarially sound rate will be developed and amended contract language will require payments for dental services.

Section III – Impact of Demonstration on State's current Medicaid and CHIP programs

Impact of Demonstration on Eligibility

New Hampshire is not requesting any changes in Medicaid program eligibility through this Section 1115 Demonstration Waiver. Coverage for groups of individuals currently covered under the state's Medicaid and CHIP State plans, previous waiver programs, and previously state-funded programs will continue. Therefore, there is no anticipated impact on total Medicaid enrollment as a result of these proposed DSHPs. Nonetheless, DHHS anticipates that current and newly expanded Medicaid beneficiaries in general will experience:

- Increased access to certain services, such as mental health and SUD, oral health, and health and wellness services
- Improvements in the way their services are delivered at hospitals, health systems and community providers

Impact of Demonstration on Benefits and Cost Sharing Requirements

Through its *Building Capacity for Transformation* Section 1115 Demonstration Waiver, New Hampshire proposes to offer Medicaid dental benefits to women who are pregnant until their child's fifth birthday. Pregnant women under 21 years of age will continue to be eligible for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) dental services. Dental services for pregnant women and mothers of young children through the benefit will differ from those provided under the Medicaid and/or CHIP State plan. Scope of dental services within the benefit will include comprehensive and periodic dental examinations, periodontal services as indicated, restorative and limited prosthetic dental treatment, and extractions if medically necessary.

The cost sharing requirements under the Demonstration will not differ from those provided under the Medicaid and/or CHIP State plan. Copayments, coinsurance and/or deductibles will not differ from the Medicaid State plan.

Since the dental health benefit package will apply to different eligibility groups affected by the Demonstration, the chart below specifying the benefit package that each eligibility group will receive under



the Demonstration.

New Hampshire Department of Health and Human Services	
Benefit Package Chart	
Eligibility Group*	Benefit Package*
Pregnant women and mothers of young children <i>who are currently not eligible for EPSDT dental benefits</i>	Demonstration-only Dental Benefit

*Description of Eligibility Group and/or Benefit Package is subject to change

The Benefit Specifications and Qualifications form and related Benefit Charts will be included at a later date in the Appendices for benefits that differ from the Medicaid or CHIP State plan.

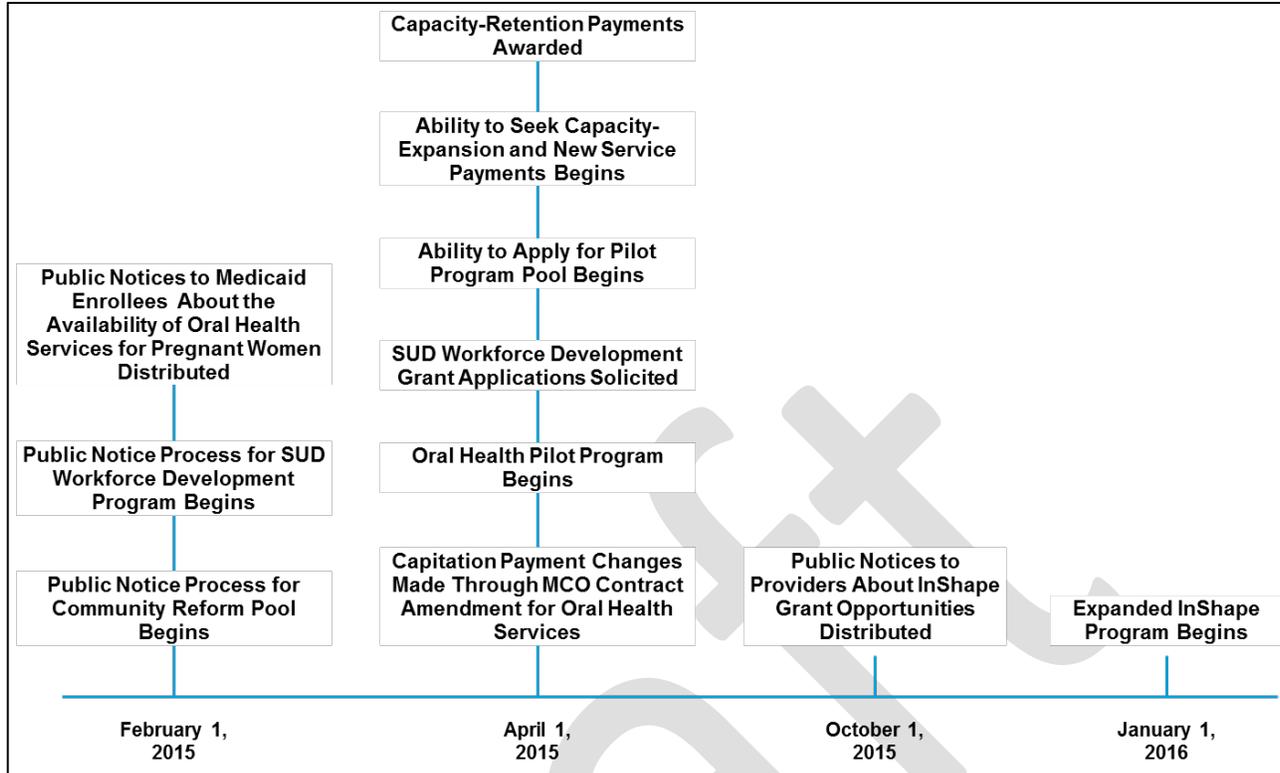
Please note that long term services and supports (LTSS) will not be provided and premium assistance for employer sponsored coverage will not be available through this *Building Capacity for Transformation* Section 1115 Demonstration Waiver.

Section IV – Delivery System of Demonstration

The delivery system used to provide benefits to Demonstration participants will not differ from the Medicaid and/or CHIP State plan. The State of New Hampshire enrolls the majority of its Medicaid beneficiaries on a mandatory basis into MCOs under its Section 1932 State Plan Amendment (12-006) effective September 2012 and will eventually include all Medicaid beneficiaries. A table depicting the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration will be included at a later date in the Appendices. This also includes the appropriate authority that is currently authorized under the State plan and/or section 1932 option.

Section V – Implementation of Demonstration

Below is the draft implementation schedule for the Demonstration Waiver, including dates by major component. Dates are subject to change and are contingent on approval from CMS.



MCOs will provide oral health benefits and InShape services as described in this Demonstration Waiver. Capitation payment changes will be made on April 1, 2015 through a contract amendment. All other payments will be made outside of MCM.

During and after initial waiver approval from CMS, New Hampshire will collaborate with providers and CMS to finalize the community reform pool, SUD workforce development and provider pilot grant pools, and select projects and associated milestones within a mutually acceptable timeline.

Section VI – Demonstration Financing and Budget Neutrality

New Hampshire will maintain budget neutrality over the five-year lifecycle of this Section 1115 Demonstration Waiver, with total spending under the waiver not exceeding what the federal government would have spent without the waiver. The budget neutrality approach is still under development, but is likely to follow the basic approach described below:

- The baseline historical data will include five full years of New Hampshire Medicaid expenditures derived from CMS-64 reports and related enrollment data from calendar year (CY) 2008 to CY 2012
- The projected “without waiver” expenditures will reflect the following changes between the baseline and waiver periods:
 - Enrollment trends, reflecting any anticipated trend differences by eligibility category (e.g., low income children and families, Medicaid-only disabled, and dual eligibles)



- Medical service trends
- Impact of known program changes (e.g., the impact of the Department of Justice settlement on behavioral health services)
- Excludes the impact of New Hampshire’s Medicaid Care Management program that was implemented on December 1, 2013
- The projected expenditures under the proposed 1115 waiver will reflect the following changes to the “without waiver” projections:
 - Managed care savings resulting from the December 1, 2013 implementation of the Medicaid Care Management program for acute care services (i.e., “Step 1” services) and future implementation of care management for long term services and supports (LTSS)
 - Trend differences due to Medicaid Care Management program implementation
 - The estimated net financial impact of the proposed Designated State Health Program (DSHP) services included in the 1115 waiver, considering both the increased costs related to the new services, payment enhancements, and incentives, as well as offsetting savings to the system such as:
 - Expanding New Hampshire’s mental health infrastructure is expected to reduce preventable inpatient mental health admissions and readmissions and reduce other acute care costs because mental health and substance use disorder conditions will be better managed
 - The DSHP oral health program for pregnant women and mothers is expected to reduce occurrences of young children and their mothers hospitalized for emergency dental treatment as well as reduce incidences of low birth weight babies and babies born with complications.

Note: With the exception of matching the state funds associated with services included in the State’s Ten Year Mental Health Plan provided to non-Medicaid enrollees, the programs described in this application could be approved by amending New Hampshire’s State Plan.

A description of the Budget Neutrality methodology and the Budget Neutrality Spreadsheet will be included at a later date in the Appendices.

Section VII – List of Proposed Waivers and Expenditure Authorities

Federal Waivers, Expenditure and Cost Not Otherwise Matchable Authorities Requested

New Hampshire seeks federal financial participation for costs not otherwise matchable under Medicaid to enable New Hampshire to implement the Designated State Health Programs (DSHPs) under this 1115 Demonstration. Under the authority of Section 1115(a)(2) of the Social Security Act, expenditures made by the State for the items identified below, which are not otherwise included as expenditures under Section 3, 455, 1003, 1403, 1603, or 1903, shall, for the period of this demonstration, be regarded as expenditures under the Medicaid.



- Costs incurred by DHHS for Glencliff Home, New Hampshire Hospital, and Sununu Youth Services Center
- Costs incurred by DHHS for activities stemming from the Ten Year Mental Health Plan and Settlement
- Costs incurred by the Department of Corrections for health care
- Correctional medical/health costs incurred by counties
- Health care expenditures incurred by municipalities

The potential sources for match are included in *Attachment A. Summary of Potential DSHP Resources*. Please note it is a preliminary list of DSHP funding sources. DHHS is in the process of identifying a complete list of sources that would be eligible for federal matching funds and inclusion in the DSHP proposals described above.

CMS and the State will identify any other waivers and expenditure authorities needed to implement this waiver.

Legislative Authority

As the single state agency responsible for the administration of Medicaid in New Hampshire, the Department of Health and Human Services is given broad authority by the New Hampshire Legislature to seek waivers in the Medicaid program. Additionally, the New Hampshire Legislature passed specific legislation in 2014 requiring DHHS to implement an 1115 Demonstration Waiver as described in this proposal. SB 413-FN-A, an act relative to access to health insurance coverage, was signed into law by Governor Maggie Hassan on March 27, 2014.

Section VIII – Stakeholder Engagement and Public Notice

As part of the stakeholder engagement process required within the development of this Section 1115 Demonstration Waiver, the State is seeking consultation with stakeholders including state, county, and local officials and health care providers.

DHHS will gather stakeholder input through a required public notice process that includes two required public hearings and a dedicate website. The website for public information on this Section 1115 Demonstration Waiver is <http://www.dhhs.nh.gov/section-1115-waiver/index.htm>. The web page will include a copy of the waiver concept paper, waiver draft, materials from stakeholder meetings (once available), and instructions (with links) on how to submit comments on waiver application draft.

The public comment period for New Hampshire’s proposed Section 1115 Demonstration Waiver is from Monday, April 21, 2014 until Tuesday, May 20, 2014 at 5 p.m. (Eastern). Comments received within 30 days of the posting of this notice will be reviewed and considered for revisions to the Section 1115 Demonstration Waiver application. Two public hearings on the proposed Section 1115 Demonstration Waiver are scheduled to solicit input on the proposed enhancements to the Medicaid program. The State will



accept verbal and/or written comments at the public hearings. The dates for the public hearings are May 8, 2014 and May 12, 2014.

As part of the state's oversight of its Medicaid Care Management (MCM) program, Governor Hassan established a commission that brings together members of the public representing a broad range of experience in health care issues to review and advise on the implementation of an efficient, fair and high-quality Medicaid care management system.³³ The Governor's Commission on Medicaid Care Management is being actively engaged in the development of this Section 1115 Demonstration Waiver application. Specifically, the second public hearing will be held in conjunction with a meeting of the Governor's Commission on Medicaid Care Management.

The state legislature is significantly involved in the development of this waiver. This process formally began on March 27, 2014 when SB413 was signed into law requiring DHHS to submit a statewide Section 1115 Demonstration Waiver by June 1, 2014. DHHS meets regularly with legislative leadership in both informal and formal venues, including the legislature's Fiscal Committee. This waiver application will be presented to, reviewed by, and approved by the legislature's Fiscal Committee before its submission to CMS.

During and after approval from CMS, the State will continue to seek stakeholder input in standing up each DSHP program and conduct a robust engagement process to spread awareness about these system improvements.

Section IX – Demonstration Administration

The contact information for the state's point of contact for the Demonstration application is below.

Name and Title: Jeffrey A. Meyers, Director, Intergovernmental Affairs
New Hampshire Department of Health and Human Services

Please email 1115waiver@dhhs.state.nh.us to submit comments regarding the New Hampshire Department of Health and Human Services *Building Capacity for Transformation* Section 1115 Demonstration Waiver.

³³ State of New Hampshire. "Press Release: Governor Hassan Issues Executive Order Creating Commission on Medicaid Care Management." 10 April 2013. 2 April 2014 <<http://www.governor.nh.gov/media/news/2013/pr-2013-04-10-medicaid-care.htm>>.



Section X – Appendices



Attachment A: Resources for Costs Not Otherwise Matchable / Designated State Health Programs

The State of New Hampshire identified the following State and locally funded health programs that may qualify for federal financial participation (FFP).

State of New Hampshire Health Care Funding Summary of Potential Designated State Health Program (DSHP) Resources*	
Funding Sources	Funding Amount
State Funding Sources	
<i>Department of Health and Human Services SFY 2015 Biennial Budget:</i>	
Glenclyff Home General Funds	\$7,544,949
New Hampshire Hospital General Funds	\$24,650,441
Sununu Youth Services Center General Funds	\$14,683,277
<i>Department of Health and Human Services Ten Year Mental Health Plan/DOJ Settlement</i>	
<i>Department of Corrections SFY 2015 Biennial Budget for Medical and Dental Services</i>	
\$3,227,000	
\$10,760,687	
State Funding Sources Total	
\$60,866,354	
Municipality Funding Sources	
<i>2013 Report of Appropriations Actually Voted (M-2 Form) reported to the Department of Revenue Administration</i>	
Health Administration	\$4,320,521
Health Agencies & Hosp. & Other	\$7,367,123
Municipality Funding Sources Total	
\$11,687,644	
County Funding Sources	
Correctional Medical/Health Spending	\$6,093,757
County Funding Sources Total	
\$6,093,757	
Grand Total	
\$78,647,755	

**Please note that this list of unmatched health care funding only reflects potential sources for DSHP match and has not yet been reviewed and analyzed sufficiently to determine whether all the funds are potentially useable for DSHP matching purposes.*



Attachment B: Supporting Medicaid Claims Data Analyses for Designated State Health Programs

New Hampshire Department of Health and Human Services Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services In State Fiscal Year 2012 for children under the age of 19 years								
Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Hospital Inpatient								
Medical	561	\$3,395,992	739	5,474	38.5	285.4	\$620.39	\$14.75
Surgical	119	1,129,372	126	905	6.6	47.2	1,247.92	4.91
Maternity Delivery	142	267,460	142	447	7.4	23.3	598.34	1.16
Maternity Non-Delivery	13	32,534	19	101	1.0	5.3	322.12	0.14
Newborn	23	10,822	23	66	1.2	3.4	163.97	0.05
Psychiatric	451	6,176,041	668	5,947	34.8	310.0	1,038.51	26.83
Alcohol and Drug Abuse	4	5,584	4	3	0.2	0.2	1,861.47	0.02
Crossover	0	0	0	0	0.0	0.0	0.00	0.00
Other	18	837,235	117	1,687	6.1	87.9	496.29	3.64
		\$11,855,039	1,838	14,630	95.8	762.7	\$810.32	\$51.50
Skilled Nursing Facility	0	\$0	0	0	0.0	0.0	\$0.00	\$0.00
Hospital Outpatient								
Emergency Room	8,164	\$2,228,663	0	21,964	0.0	1,145.1	\$101.47	\$9.68
Surgery	1,507	2,286,447	0	60,413	0.0	3,149.6	37.85	9.93
Radiology	5,911	1,981,109	0	13,050	0.0	680.3	151.81	8.61
Pathology/Lab	8,764	771,119	0	90,933	0.0	4,740.7	8.48	3.35
Pharmacy	5,100	492,450	0	71,949	0.0	3,751.0	6.84	2.14
Cardiovascular	945	200,156	0	1,675	0.0	87.3	119.50	0.87
PT/OT/ST	1,115	1,190,413	0	43,728	0.0	2,279.7	27.22	5.17
Psychiatric	0	0	0	0	0.0	0.0	0.00	0.00
Alcohol & Drug Abuse	0	0	0	0	0.0	0.0	0.00	0.00
Crossover	0	0	0	0	0.0	0.0	0.00	0.00



New Hampshire Department of Health and Human Services Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services In State Fiscal Year 2012 for children under the age of 19 years								
Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Other	4,693	1,062,007	0	37,457	0.0	1,952.8	28.35	4.61
		\$10,212,364	0	341,169	0.0	17,786.4	\$29.93	\$44.37
Professional								
Ambulatory Surgery Center	266	\$136,284	0	382	0.0	19.9	\$356.76	\$0.59
Physician	18,330	7,503,837	0	231,011	0.0	12,043.5	32.48	32.60
Advance Registered Nurse Practitioner	325	85,995	0	2,249	0.0	117.2	38.24	0.37
Certified Midwife	2	2,067	0	16	0.0	0.8	129.18	0.01
Family Planning	306	46,279	0	1,713	0.0	89.3	27.02	0.20
Audiology	115	9,385	0	1,065	0.0	55.5	8.81	0.04
Psychology	5,203	3,718,095	0	59,677	0.0	3,111.2	62.30	16.15
Physical Therapy	302	229,244	0	11,064	0.0	576.8	20.72	1.00
Speech Therapy	308	303,186	0	16,911	0.0	881.6	17.93	1.32
Occupational Therapy	334	394,717	0	19,474	0.0	1,015.3	20.27	1.71
Podiatry	145	20,751	0	534	0.0	27.8	38.86	0.09
Laboratory	1,275	218,197	0	26,884	0.0	1,401.6	8.12	0.95
X-Ray	358	47,502	0	863	0.0	45.0	55.04	0.21
Clinic Services	3,960	21,858,284	0	8,497,328	0.0	442,997.9	2.57	94.96
Methadone Treatment Clinic	11	12,192	0	1,193	0.0	62.2	10.22	0.05
Medical Services Clinic	135	25,270	0	943	0.0	49.2	26.80	0.11
Federally Qualified and Rural Health Clinics	3,852	2,145,724	0	18,066	0.0	941.8	118.77	9.32
Other	0	0	0	0	0.0	0.0	0.00	0.00
		\$36,757,011	0	8,889,373	0.0	463,436.7	\$4.13	\$159.69
Mental Health Center								
Case Management	5,958	\$13,026,486	0	36,383	0.0	1,896.8	\$358.04	\$56.59
Long Term Support Service	3,612	10,042,189	0	433,016	0.0	22,574.8	23.19	43.63



New Hampshire Department of Health and Human Services Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services In State Fiscal Year 2012 for children under the age of 19 years								
Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Partial Hospital	31	94,995	0	1,015	0.0	52.9	93.59	0.41
Psychotherapy	7,452	8,022,894	0	183,820	0.0	9,583.2	43.65	34.86
Evidence Based Practice	29	32,289	0	1,247	0.0	65.0	25.89	0.14
Medication Management	1,382	241,797	0	5,443	0.0	283.8	44.42	1.05
Emergency Service 24/7	132	32,727	0	1,395	0.0	72.7	23.46	0.14
APRTP	9	47,214	0	86	0.0	4.5	549.00	0.21
Other	2,657	1,046,026	0	10,509	0.0	547.9	99.54	4.54
		\$32,586,615	0	672,914	0.0	35,081.6	\$48.43	\$141.57
Prescription Drugs								
Generic Scripts	16,161	\$2,662,624	0	151,396	0.0	7,892.8	\$17.59	\$11.57
Single Source Brand	11,173	19,540,768	0	92,145	0.0	4,803.9	212.07	84.89
Multi-Source Brand	782	859,616	0	3,124	0.0	162.9	275.17	3.73
Other	1,494	480,384	0	3,401	0.0	177.3	141.25	2.09
		\$23,543,392	0	250,066	0.0	13,036.9	\$94.15	\$102.28
Other Services								
Home Health	520	\$3,131,764	0	503,305	0.0	26,239.2	\$6.22	\$13.61
Hospice	0	0	0	0	0.0	0.0	0.00	0.00
Durable Medical Equipment	1,708	2,296,005	0	1,788,267	0.0	93,229.1	1.28	9.97
Ambulance	1,129	351,341	0	26,332	0.0	1,372.8	13.34	1.53
Wheelchair Van	10	6,195	0	1,373	0.0	71.6	4.51	0.03
Optometry / Glasses	4,352	435,788	0	27,121	0.0	1,413.9	16.07	1.89
Private Duty Nursing	16	803,990	0	20,518	0.0	1,069.7	39.18	3.49
Personal Care	1	39,678	0	9,059	0.0	472.3	4.38	0.17
Adult Medical Day Care	1	3,398	0	69	0.0	3.6	49.24	0.01
Home and Community Based Care: DI	701	5,268,985		259,505		13,529.0	20.30	22.89
Home and Community Based	1	2,813		541		28.2	5.20	0.01



New Hampshire Department of Health and Human Services
Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services
In State Fiscal Year 2012 for children under the age of 19 years

Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Care: CI								
Other	14,947	25,235,495	0	367,302	0.0	19,148.8	68.71	109.64
		\$37,575,452	0	3,003,392	0.0	156,578.2	\$12.51	\$163.25
All Services		\$152,529,872	1,838	13,171,544	95.8	686,682.5	\$999.48	\$662.66

DRY



New Hampshire Department of Health and Human Services Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services In State Fiscal Year 2012 for Adults over the age of 20 years								
Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Hospital Inpatient								
Medical	1,736	\$9,688,910	2,993	15,475	124.8	645.1	\$626.10	\$33.66
Surgical	728	6,544,121	849	5,722	35.4	238.5	1,143.68	22.74
Maternity Delivery	1,201	2,496,209	1,202	3,387	50.1	141.2	737.00	8.67
Maternity Non-Delivery	144	335,040	191	617	8.0	25.7	543.02	1.16
Newborn	1	467	1	3	0.0	0.1	155.71	0.00
Psychiatric	526	2,295,066	712	4,799	29.7	200.1	478.24	7.97
Alcohol and Drug Abuse	165	465,140	219	947	9.1	39.5	491.17	1.62
Crossover	3,834	7,909,243	5,625	45,644	234.5	1,902.9	173.28	27.48
Other	4,704	156,650,705	73,501	1,239,767	3,064.2	51,685.3	126.35	544.22
		\$186,384,900	85,293	1,316,361	3,555.8	54,878.5	\$141.59	\$647.53
Skilled Nursing Facility	657	\$2,691,369	1,384	25,457	57.7	1,061.3	\$105.72	\$9.35
Hospital Outpatient								
Emergency Room	12,389	\$4,968,391	0	47,440	0.0	1,977.8	\$104.73	\$17.26
Surgery	3,421	5,003,763	0	133,416	0.0	5,562.1	37.50	17.38
Radiology	15,997	9,829,767	0	57,775	0.0	2,408.6	170.14	34.15
Pathology/Lab	19,630	3,551,704	0	283,852	0.0	11,833.7	12.51	12.34
Pharmacy	14,946	9,376,110	0	692,447	0.0	28,867.8	13.54	32.57
Cardiovascular	4,761	909,867	0	9,890	0.0	412.3	92.00	3.16
PT/OT/ST	3,837	1,131,848	0	38,312	0.0	1,597.2	29.54	3.93
Psychiatric	84	9,509	0	252	0.0	10.5	37.73	0.03
Alcohol & Drug Abuse	0	0	0	0	0.0	0.0	0.00	0.00
Crossover	7,790	1,510,431	0	39,339	0.0	1,640.0	38.40	5.25
Other	8,782	4,100,528	0	103,439	0.0	4,312.3	39.64	14.25
		\$40,391,918	0	1,406,162	0.0	58,622.2	\$28.72	\$140.33
Professional								



New Hampshire Department of Health and Human Services Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services In State Fiscal Year 2012 for Adults over the age of 20 years								
Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Ambulatory Surgery Center	1,394	\$803,213	0	4,243	0.0	176.9	\$189.30	\$2.79
Physician	29,825	21,798,053	0	1,043,062	0.0	43,484.8	20.90	75.73
Advance Registered Nurse Practitioner	1,118	186,143	0	7,360	0.0	306.8	25.29	0.65
Certified Midwife	10	11,058	0	90	0.0	3.8	122.87	0.04
Family Planning	721	487,232	0	5,576	0.0	232.5	87.38	1.69
Audiology	91	3,955	0	292	0.0	12.2	13.55	0.01
Psychology	2,990	1,469,708	0	27,579	0.0	1,149.8	53.29	5.11
Physical Therapy	1,079	506,447	0	28,577	0.0	1,191.4	17.72	1.76
Speech Therapy	12	9,989	0	614	0.0	25.6	16.27	0.03
Occupational Therapy	97	17,149	0	1,268	0.0	52.9	13.52	0.06
Podiatry	2,163	111,005	0	5,682	0.0	236.9	19.54	0.39
Laboratory	3,683	438,216	0	48,566	0.0	2,024.7	9.02	1.52
X-Ray	3,581	423,515	0	13,713	0.0	571.7	30.88	1.47
Clinic Services	278	1,358,225	0	478,438	0.0	19,945.9	2.84	4.72
Methadone Treatment Clinic	1,362	3,191,303	0	312,294	0.0	13,019.4	10.22	11.09
Medical Services Clinic	129	50,966	0	1,282	0.0	53.4	39.76	0.18
Federally Qualified and Rural Health Clinics	7,256	4,329,604	0	43,864	0.0	1,828.7	98.71	15.04
Other	0	0	0	0	0.0	0.0	0.00	0.00
		\$35,195,782	0	2,022,500	0.0	84,317.1	\$17.40	\$122.27
Mental Health Center								
Case Management	6,885	\$17,118,622	0	53,982	0.0	2,250.5	\$317.12	\$59.47
Long Term Support Service	5,976	27,572,908	0	936,324	0.0	39,034.9	29.45	95.79
Partial Hospital	235	2,283,957	0	23,726	0.0	989.1	96.26	7.93
Psychotherapy	8,233	4,111,131	0	121,610	0.0	5,069.9	33.81	14.28
Evidence Based Practice	2,001	2,871,585	0	122,651	0.0	5,113.3	23.41	9.98
Medication Management	6,471	1,118,090	0	37,098	0.0	1,546.6	30.14	3.88



New Hampshire Department of Health and Human Services Cost by Category of Service for Beneficiaries Receiving Mental Health/SUD Screening and Treatment Services In State Fiscal Year 2012 for Adults over the age of 20 years								
Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Emergency Service 24/7	1,089	452,998	0	19,398	0.0	808.7	23.35	1.57
APRTP	3,177	1,778,380	0	14,346	0.0	598.1	123.96	6.18
Other	6,578	1,280,047	0	26,970	0.0	1,124.4	47.46	4.45
		\$58,587,717	0	1,356,105	0.0	56,535.4	\$43.20	\$203.54
Prescription Drugs								
Generic Scripts	23,821	\$7,067,595	0	532,652	0.0	22,206.0	\$13.27	\$24.55
Single Source Brand	10,847	31,561,567	0	110,008	0.0	4,586.2	286.90	109.65
Multi-Source Brand	1,723	4,868,404	0	10,889	0.0	454.0	447.09	16.91
Other	6,913	935,366	0	40,497	0.0	1,688.3	23.10	3.25
		\$44,432,932	0	694,046	0.0	28,934.5	\$64.02	\$154.37
Other Services								
Home Health	1,709	\$3,359,431	0	288,766	0.0	12,038.5	\$11.63	\$11.67
Hospice	0	0	0	0	0.0	0.0	0.00	0.00
Durable Medical Equipment	7,361	5,489,738	0	3,099,299	0.0	129,208.3	1.77	19.07
Ambulance	7,017	1,560,991	0	93,716	0.0	3,907.0	16.66	5.42
Wheelchair Van	2,252	1,945,420	0	335,201	0.0	13,974.4	5.80	6.76
Optometry / Glasses	6,724	625,634	0	37,874	0.0	1,578.9	16.52	2.17
Private Duty Nursing	10	585,909	0	15,906	0.0	663.1	36.84	2.04
Personal Care	87	2,720,624	0	621,147	0.0	25,895.3	4.38	9.45
Adult Medical Day Care	184	767,083	0	32,467	0.0	1,353.5	23.63	2.66
Home and Community Based Care: DI	1,940	121,692,830		6,395,970		266,645.0	19.03	422.78
Home and Community Based Care: CI	2,148	31,113,551		4,177,909		174,175.1	7.45	108.09
Other	6,075	3,720,794	0	66,790	0.0	2,784.4	55.71	12.93
		\$173,582,005	0	15,165,045	0.0	632,223.7	\$11.45	\$603.05
All Services		\$541,266,623	86,677	21,985,676	3,613.5	916,572.7	\$412.11	\$1,880.43



New Hampshire Department of Health and Human Services Cost of Hospital Outpatient Visits for Claims with Mental Health/SUD Diagnoses								
State Fiscal Year	Total Allowed	Total Paid	Total Visits	Unique Beneficiaries	Visits per Unique Beneficiary	Visits per Total Beneficiary	Allowed Cost per Visit	Paid Cost per Visit
SFY10/11	11,056,068	11,808,999	46,418	19,066	2.43	0.86	238.18	254.41
SFY11/12	12,402,076	13,207,186	47,644	19,337	2.46	0.87	260.31	277.21

The data includes a significant number of facility claims with allowed = \$0, but non-zero paid amount.

New Hampshire Department of Health and Human Services ER Visits for Claims with Mental Health/SUD Diagnoses						
State Fiscal Year	Total Allowed	Total Paid	Total Visits	Unique Beneficiaries	Allowed Cost per Visit	Paid Cost per Visit
SFY10/11	1,795,246	2,045,237	15,546	9,018	115.48	131.56
SFY11/12	2,107,373	2,318,151	15,223	8,786	138.43	152.28

Emergency Room Visits defined as claims with Revenue Code 450.

The data includes a significant number of facility claims with allowed = \$0, but non-zero paid amount.

New Hampshire Department of Health and Human Services Psychiatric Admissions for Claims with Mental Health/SUD Diagnoses						
State Fiscal Year	Total Allowed	Total Paid	Total Admissions	Unique Beneficiaries	Allowed Cost per Admit	Paid Cost per Admit
SFY10/11	2,365,557	\$2,303,181	872	632	\$2,712.80	\$2,641.26
SFY11/12	2,158,261	\$2,099,939	816	622	\$2,644.93	\$2,573.45

New Hampshire Department of Health and Human Services Inpatient and Outpatient Expenditures by Provider for Claims with Mental Health/SUD Diagnoses in State Fiscal Year 2012				
Count of Provider IDs	Allowed Amounts		Paid Amounts	
	Inpatient	Outpatient	Inpatient	Outpatient
271	\$145,791,763	\$12,199,524	\$121,305,893	\$13,002,116



New Hampshire Department of Health and Human Services Beneficiaries with Delivery Codes by Age			
State Fiscal Year	Age Category	Total Beneficiaries	Percent by Age Category
SFY10/11	< 21	919	21%
SFY10/11	>= 21	3,409	79%
SFY10/11	All	4,328	
SFY11/12	< 21	766	19%
SFY11/12	>= 21	3,306	81%
SFY11/12	All	4,072	

New Hampshire Department of Health and Human Services Cost of Dental Services for Maternity Beneficiaries Under the Age of 21 Years						
State Fiscal Year	Unique Beneficiaries	Total Allowed	Total Paid	Total Services	Allowed Cost per Service	Paid Cost per Service
FY10/11	301	150,875	151,787	2,121	71.13	71.56
FY11/12	249	119,842	122,454	1,951	61.43	62.76

Dental Services are identified as having a diagnostic code 520-526 or CPT codes starting with D.

The data includes a significant number of facility claims with allowed = \$0, but non-zero paid amount.

New Hampshire Department of Health and Human Services Cost of Emergency Dental Services for Maternity Beneficiaries Over the Age of 21 Years						
State Fiscal Year	Unique Beneficiaries	Total Allowed	Total Paid	Total Services	Allowed Cost per Service	Paid Cost per Service
SFY10/11	195	19,506	24,181	329	59.29	73.50
SFY11/12	172	19,446	23,526	278	69.95	84.63

Dental Services are identified as having a diagnostic code 520-526 and a 450 Revenue Code.

The data includes a significant number of facility claims with allowed = \$0, but non-zero paid amount.



New Hampshire Department of Health and Human Services
Cost Model for Newborns that are Pre-Term or Low Birth Weight
Services Received in the First Month After Birth
In State Fiscal Year 2012

Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Hospital Inpatient								
Medical	560	\$6,358,166	663	9,190	850.0	11,782.1	\$691.86	\$8,151.49
Surgical	11	422,401	11	667	14.1	855.1	633.29	541.54
Maternity Delivery	0	0	0	0	0.0	0.0	0.00	0.00
Maternity Non-Delivery	0	0	0	0	0.0	0.0	0.00	0.00
Newborn	157	73,670	157	391	201.3	501.3	188.41	94.45
Psychiatric	0	0	0	0	0.0	0.0	0.00	0.00
Alcohol and Drug Abuse	0	0	0	0	0.0	0.0	0.00	0.00
Crossover	1	2,906	1	7	1.3	9.0	415.07	3.73
Other	0	0	0	0	0.0	0.0	0.00	0.00
		\$6,857,142	832	10,255	1,067	13,147.4	\$668.66	\$8,791.21
Skilled Nursing Facility	0	\$0	0	0	0	0.0	\$0.00	\$0.00
Hospital Outpatient								
Emergency Room	45	\$7,221	0	72	0.0	92.3	\$100.30	\$9.26
Surgery	3	304	0	3	0.0	3.8	101.29	0.39
Radiology	37	4,341	0	42	0.0	53.8	103.35	5.56
Pathology/Lab	101	2,171	0	386	0.0	494.9	5.62	2.78
Pharmacy	14	1,263	0	61	0.0	78.2	20.71	1.62
Cardiovascular	5	2,484	0	19	0.0	24.4	130.75	3.18
PT/OT/ST	4	176	0	4	0.0	5.1	44.11	0.23
Psychiatric	0	0	0	0	0.0	0.0	0.00	0.00
Alcohol & Drug Abuse	0	0	0	0	0.0	0.0	0.00	0.00
Crossover	0	0	0	0	0.0	0.0	0.00	0.00
Other	43	6,095	0	147	0.0	188.5	41.46	7.81
		\$24,056	0	734	0.0	941.0	\$32.77	\$30.84
Professional								
Ambulatory Surgery Center	0	\$0	0	0	0.0	0.0	\$0.00	\$0.00



New Hampshire Department of Health and Human Services
Cost Model for Newborns that are Pre-Term or Low Birth Weight
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Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
Physician	749	872,032	0	12,339	0.0	15,819.2	70.67	1,117.99
Advance Registered Nurse Practitioner	0	0	0	0	0.0	0.0	0.00	0.00
Certified Midwife	2	1,032	0	14	0.0	17.9	73.70	1.32
Family Planning	1	40	0	1	0.0	1.3	40.00	0.05
Audiology	1	22	0	7	0.0	9.0	3.11	0.03
Psychology	0	0	0	0	0.0	0.0	0.00	0.00
Physical Therapy	0	0	0	0	0.0	0.0	0.00	0.00
Speech Therapy	0	0	0	0	0.0	0.0	0.00	0.00
Occupational Therapy	0	0	0	0	0.0	0.0	0.00	0.00
Podiatry	0	0	0	0	0.0	0.0	0.00	0.00
Laboratory	0	0	0	0	0.0	0.0	0.00	0.00
X-Ray	0	0	0	0	0.0	0.0	0.00	0.00
Clinic Services	6	607	0	39	0.0	50.0	15.56	0.78
Methadone Treatment Clinic	0	0	0	0	0.0	0.0	0.00	0.00
Medical Services Clinic Federally Qualified and Rural Health Clinics	3	579	0	15	0.0	19.2	38.62	0.74
Other	149	49,079	0	468	0.0	600.0	104.87	62.92
	0	0	0	0	0.0	0.0	0.00	0.00
		\$923,391	0	12,883	0.0	16,516.7	\$71.68	\$1,183.83
Mental Health Center								
Case Management	0	\$0	0	0	0.0	0.0	\$0.00	\$0.00
Long Term Support Service	0	0	0	0	0.0	0.0	0.00	0.00
Partial Hospital	0	0	0	0	0.0	0.0	0.00	0.00
Psychotherapy	0	0	0	0	0.0	0.0	0.00	0.00
Evidence Based Practice	0	0	0	0	0.0	0.0	0.00	0.00
Medication Management	0	0	0	0	0.0	0.0	0.00	0.00
Emergency Service 24/7	0	0	0	0	0.0	0.0	0.00	0.00



New Hampshire Department of Health and Human Services
Building Capacity for Transformation Section 1115 Demonstration Waiver Application

New Hampshire Department of Health and Human Services
Cost Model for Newborns that are Pre-Term or Low Birth Weight
Services Received in the First Month After Birth
In State Fiscal Year 2012

Benefits	Number of Beneficiaries	Total Paid Dollars	Total Paid Admits	Total Paid Days/Services	Admits Per 1,000	Utilization / Days Per 1,000	Average Paid Charge	Per Capita Monthly Paid Cost
APRTP	0	0	0	0	0.0	0.0	0.00	0.00
Other	0	0	0	0	0.0	0.0	0.00	0.00
		\$0	0	0	0.0	0.0	\$0.00	\$0.00
Prescription Drugs								
Generic Scripts	63	\$2,257	0	72	0.0	92.3	\$31.34	\$2.89
Single Source Brand	0	0	0	0	0.0	0.0	0.00	0.00
Multi-Source Brand	0	0	0	0	0.0	0.0	0.00	0.00
Other	1	4	0	1	0.0	1.3	4.24	0.01
		\$2,261	0	73	0.0	93.6	\$30.97	\$2.90
Other Services								
Home Health	225	\$47,512	0	753	0.0	965.4	\$63.10	\$60.91
Hospice	0	0	0	0	0.0	0.0	0.00	0.00
Durable Medical Equipment	28	4,607	0	10,102	0.0	12,951.3	0.46	5.91
Ambulance	102	75,108	0	6,743	0.0	8,644.9	11.14	96.29
Wheelchair Van	0	0	0	0	0.0	0.0	0.00	0.00
Optometry / Glasses	0	0	0	0	0.0	0.0	0.00	0.00
Private Duty Nursing	0	0	0	0	0.0	0.0	0.00	0.00
Personal Care	0	0	0	0	0.0	0.0	0.00	0.00
Adult Medical Day Care	0	0	0	0	0.0	0.0	0.00	0.00
Home and Community Based Care: DI	0	0	0	0	0.0	0.0	0.00	0.00
Home and Community Based Care: CI	0	0	0	0	0.0	0.0	0.00	0.00
Other	21	6,778	0	35	0.0	44.9	193.66	8.69
		\$134,006	0	17,633	0.0	22,606.4	\$7.60	\$171.80
All Services		\$7,940,856	832	41,578	1,066.7	53,305.1	\$811.68	\$10,180.59