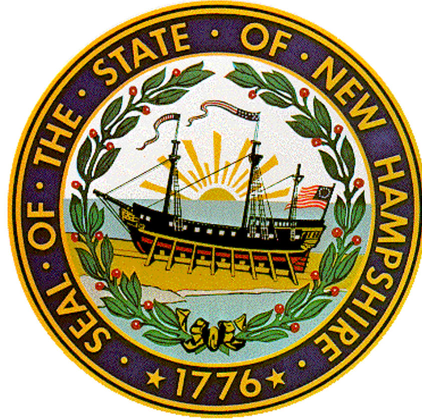

New Hampshire
Department of Health and Human Services

Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver

Amendment #2 Request

Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness

August 2, 2021

DRAFT

Demonstration Project No. 11-W-00321/1

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I. Executive Summary

The New Hampshire Department of Health and Human Services (DHHS) seeks to amend its existing Section 1115(a) demonstration as part of its approach to address the ongoing challenge of psychiatric Emergency Department (ED) boarding and to support the comprehensive, integrated continuum of mental health treatments and care available in the state. Over many years, New Hampshire (the State) has made significant investments in the community-based continuum of care to support Medicaid beneficiaries experiencing mental health crises. The State intends to continue this policy of support and expansion of its community-based mental health programs as detailed in the 10-year mental health plan[1] and discussed further below. At the same time and despite these efforts, the persistence of ED boarding (and indeed, its resurgence under the COVID-19 public health emergency or "PHE") indicates that demand for acute care capacity exceeds supply and highlights an opportunity for the State to pursue a more comprehensive strategy.

Specifically, DHHS requests authority for Medicaid reimbursement for short-term medically necessary residential and inpatient treatment services within settings that qualify as institutions for mental disease (IMDs). The State's goal is to increase access to treatment options for Medicaid eligible adults ages 21-64 with Serious Mental Illness (SMI) to appropriately address acute mental health needs, improve rates of morbidity and mortality for covered populations, and decrease utilization of less appropriate services, such as EDs.

New Hampshire is dedicated and prepared to ensure access to residential and inpatient treatment settings when medically necessary and when other less restrictive settings and services are not in the best interest of the individual. The State also remains committed to maintaining a robust continuum of community-based outpatient services and supports and will continue expanding on current efforts to promote a coordinated and integrated system of care to improve outcomes and prevent readmissions. New Hampshire's current service delivery system includes a growing number of innovative service delivery models. Particularly, within the last year, the State has demonstrated its commitment to a responsive and coordinated statewide system of care by (1) beginning to implement a Critical Time Interventions program and (2) developing a statewide Rapid Response system featuring a centralized access point with regional rapid response teams (e.g., mobile crisis teams) that will position the state for readiness to implement 9-8-8 (all of which is described in more detail below). The exacerbation of mental health conditions[2] caused by the COVID-19 PHE and measures taken to mitigate the PHE only serve to reinforce the need for diligent, comprehensive action.

The State requests an effective date for this amendment of July 1, 2022.

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[1] New Hampshire 10-year Mental Health Plan, January 2019, https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf

[2] Vahratian A, Blumberg SJ, Terlizzi EP, Schiller JS. Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic — United States, August 2020–February 2021. MMWR Morb Mortal Wkly Rep 2021;70:490–494. DOI: http://dx.doi.org/10.15585/mmwr.mm7013e2

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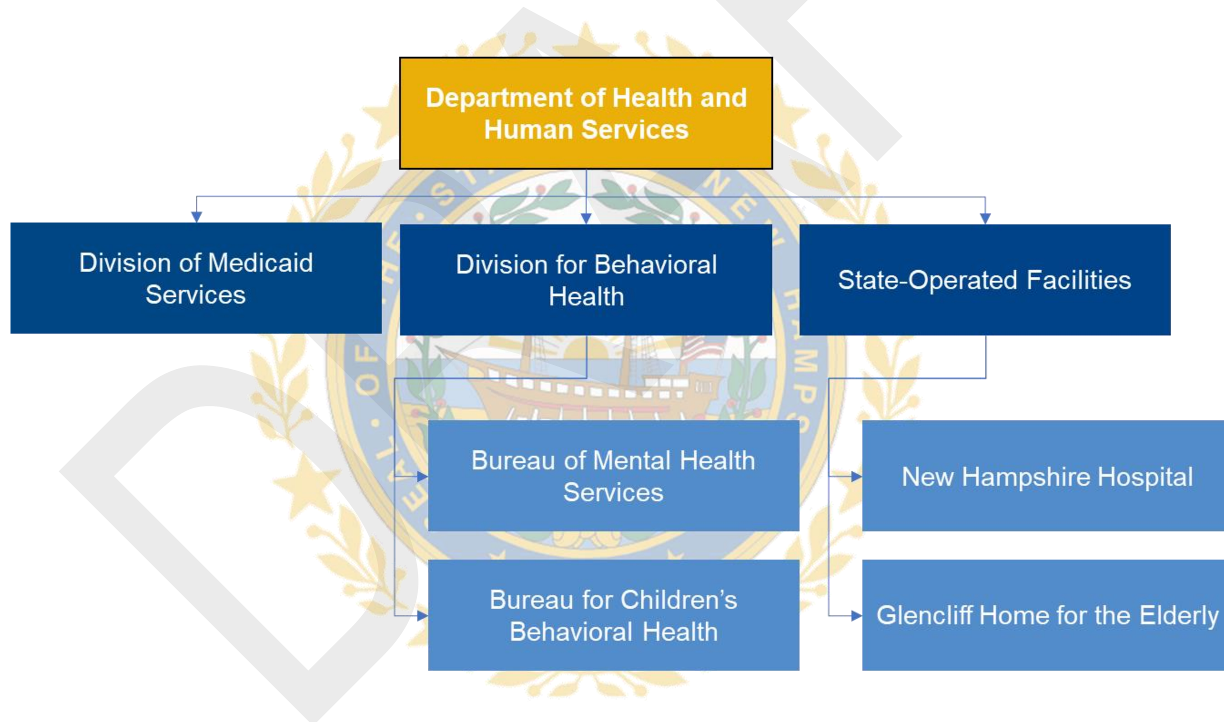
II. System of Care Background

Overview of New Hampshire Mental Health System

The New Hampshire Department of Health and Human Services (DHHS), and through its contracted provider organizations, provided mental health services to 12,420 youth and 28,196 adults in State Fiscal Year (SFY) 2020[3]. Approximately 91% of the youth served met the criteria for serious emotional disturbance (SED), and 51% of the adults served met the criteria for serious mental illness (SMI)[4]. The following facilities in New Hampshire (the State) meet the regulatory definition of an Institution for Mental Disease (IMD): the State operates (a) one psychiatric hospital serving adults, New Hampshire Hospital (NHH), with 187 beds and (b) one nursing facility primarily serving the elderly, Glencliff Home for the Elderly (Glencliff Home), with 115 beds; and the private sector operates (c) one hospital primarily serving youth, Hampstead Hospital, with 76 beds[5]. The State also contracts with a regional network of 10 Community Mental Health Centers (CMHCs) as well as various professionals licensed in mental health to ensure a complete continuum of care for its residents.

Below is a simplified chart that depicts the organizational structure of the institutions referenced in this amendment application.



Currently, the State has authority through its 1115 Substance Use Disorder Treatment and Recovery Access (SUD-TRA) demonstration to provide high-quality, clinically appropriate Substance Use Disorder (SUD) treatment services for short-term residents in residential and inpatient treatment settings that qualify as IMDs. It is seeking to expand this authority to encompass treatment services for SMI in accordance with State Medicaid Director Letter SMD

[3] Figure only includes beneficiaries enrolled in CMHCs. Other Medicaid beneficiaries who meet the diagnostic criteria may not be reflected in these figures.
[4] Figure only includes beneficiaries enrolled in CMHCs. Other Medicaid beneficiaries who meet the diagnostic criteria may not be reflected in these figures.
[5] At the time of writing this amendment application, 15 of these beds have been temporarily allocated to serve adults.

18-011 issued on November 13, 2018.

In addition to funding the operating budgets of its state-operated IMDs and expenditures under contracts with the CMHCs, the State legislature invests millions annually to support and continuously transform its mental health service delivery system. A synopsis of these efforts over the last five years is provided below.

1. During the 2017 legislative session, the State Legislature passed House Bill 400 requiring DHHS to create a 10-year mental health plan[6] (the Plan). The Plan set forth a vision for the State's mental health system prioritizing 14 recommendations for implementation within the first two years.

2. During the 2019 legislative session, the State Legislature passed Senate Bill 292 requiring DHHS to report annually on the implementation status of the Plan. The first such report was released in September 2020 and demonstrates that the State has made significant progress towards implementation of the Plan's recommendations[7]. At the time of its publication, a summary of these accomplishments included, but was not limited to:

    a. Since June 2017, the State's Section 811 Project Rental Assistance program has filled 86 units of permanent housing for individuals with mental illness. Forty-two (42) additional units are currently open with applicants in the process to move in.
    b. NH's Housing Bridge Subsidy Program was budgeted for 398 vouchers since SFY 2018. Starting in SFY 2021, 500 vouchers are budgeted.
    c. Since 2017, the State has created 48 new transitional housing program beds, including 16 at the Philbrook Adult Transitional Housing (PATH) Center that opened in September 2020.
    d. In 2019, the State expanded Designated Receiving Facility (DRF)[8] bed capacity by adding 24 beds. Hampstead Hospital opened a 16-bed DRF to serve youth, Parkland Medical Center added four new DRF beds, and Portsmouth Regional Hospital added four additional DRF beds.
    e. In 2018, the State was awarded a five-year ProHealth NH SAMHSA grant. To date, ProHealth has created integrated primary and behavioral health care programs at CMHCs for youth and young adults in three of ten mental health regions with nearly 250 individuals ages 16 to 39 years served in the first year and a half of enrollment.
    f. The number of children served by the Care Management Entity (CME)[9] and enrolled in its Home- and Community-based care wraparound program increased from 60 to 200 in the past two years.
    g. Over 200 individuals have been trained in the past two years on a standardized Behavioral Health Assessment tool to be used across systems and services.
    h. The expansion of Assertive Community Treatment (ACT) teams from 12 to 13 teams in 2019 allowed for full ACT coverage in a rural, northern area of the state. ACT level of care is now more accessible to all New Hampshire residents.
    i. In 2020, ACT and Supported Employment "mini consults" were developed in place of fidelity reviews during COVID-19 to support the ongoing quality of

[6] New Hampshire 10-year Mental Health Plan, January 2019, https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf
[7] Report on Priorities for Implementation of New Hampshire's 10-year Mental health Plan of 2019, September 2020, https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan-progress-092020.pdf
[8] In accordance to He-M 405, DRFs are hospital based psychiatric units or a non-hospital based residential treatment program designated by the commissioner to provide care, custody, and treatment to persons involuntary admitted to the state mental health services system.
[9] CME is the entity that provides FAST forward and other community-based services for high need children, youth, and families.

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Evidence Based Practices. A process was developed to provide the CMHCs with ongoing remote support and monitoring during the public health emergency with attention paid to decreasing administrative burdens.

3. During the 2019 legislative session, in addition to passing Senate Bill 292 as referenced above, the State Legislature passed Senate Bill 14, authorizing a complex set of required system components for an enhanced children's behavioral health system. This enhanced system of care includes several major new initiatives, such as:

    a. Expanding the CME programming, developing a single statewide behavioral health assessment tool, procuring the youth residential treatment array (including Qualified Residential Treatment Programs or "QRTPs" and Psychiatric Residential Treatment Facilities or "PRTFs");
    b. Increasing the population eligible for FAST Forward[10];
    c. Establishing a children's mobile crisis program;
    d. Developing a plan to address infant mental health;
    e. Establishing a parent information clearinghouse and online treatment and support locator;
    f. Implementing Prevention / First Episode Psychosis; and
    g. Providing Evidenced Based Practice Technical Assistance and training support.

4. Since SFY 2019, the State has included in its Medicaid Managed Care Organization (MCO) contracts 5 million dollars annually in directed payments for the CMHCs. These directed payments are intended to enhance and preserve critically necessary community-based services for adults experiencing SMI[11] and build upon progress made by other programs and initiatives in this area. Pending CMS approval, for SFY 2022 the MCOs will make fee schedule enhancements for Assertive Community Treatment (ACT), same day / next day follow-up (and weekly thereafter for 90 days) upon discharge from NHH or a DRF, timely prescriber referral after intake, Illness Management and Recovery (IMR) services, and step-down community specialty residence beds for individuals who are dually diagnosed with SMI / Developmental Disabilities.
    a. The ACT portion of the directed payments is used to enhance the sustainability of the ACT teams and incentivize providers to join and remain in the CMHC workforce.
    b. The majority of the remaining directed payments are intended to prevent emergency department (ED) admissions and / or readmissions to NHH or DRF by incentivizing timely access to outpatient services.
    c. Through directed payments for specialty residence beds, the State seeks to increase the number of timely discharges to a less restrictive environment for dually diagnosed individuals, as opposed to keeping them in acute care settings for longer stays.
    d. Mobile crisis services were included in previous SFY directed payments, but were removed from the SFY 2022 program due to the State's redesign work on the mobile crisis system this year.
    e. Timely prescribing and IMR directed payments are new in SFY 2022.
    f. Separate and apart from the directed payment programs listed above, in

[10] FAST Forward is a community-based service provided by a Care Management Entity that provides Care coordination through a high fidelity wraparound model and includes services such as family and youth peer support and operates in conjunction with the community-based treatment providers. FAST forward services children, youth and their families who have need psychiatric hospitalizations/ residential treatment or who are at high risk for hospital / residential treatment.
[11] CMHC directed payments currently support services for adult Medicaid beneficiaries.

SFY 2022 the State also created a minimum fee schedule directed payment to support the community residential housing rate increase. This ensures that the MCOs reimburse the CMHCs for community residential housing services at least at the same rate as the NH Medicaid Fee for Service (FFS) rate.

5. During the February 2021 legislative hearings on the State budget for SFY 2022, the Director of the Bureau of Mental Health Services (BMHS) – responsible for overseeing services for adults who experience SMI – highlighted a list of recent accomplishments that included, but was not limited to, the following:

    a. The addition of three regional peer recovery-oriented Step-up / Step-down programs of four beds each, and contracting for two additional transitional housing beds;
    b. As part of the State's rollout of the federal 9-8-8 behavioral health crisis number, BMHS launched a Request for Information to redesign and centralize the State's crisis response system and utilized a COVID-19 grant to increase crisis response staff by 20 full time equivalents (FTEs) at the CMHCs;
    c. BMHS also renewed and intensified efforts around suicide prevention by hiring the State's first Suicide Prevention Coordinator, training 19 DHHS employees to become Question, Persuade, Refer (QPR) suicide prevention trainers, and formulated a statewide publicity campaign to address mental health awareness and suicide prevention; and
    d. BMHS decentralized the Housing Bridge Subsidy Program to collocate housing specialists in all 10 CMHC regions and continued to expand the number of Housing Bridge vouchers available statewide.

6. During the February 2021 legislative hearings on the State budget for SFY 2022, the Director of the Bureau for Children's Behavioral Health (BCBH) – responsible for overseeing services for children who experience SED – highlighted a list of recent accomplishments that included, but was not limited to, the following:

    a. Growing BCBH staffing from two FTEs initially to nine, including hiring and onboarding four staff members during the COVID-19 Public Health Emergency (PHE);
    b. Identifying and implementing the systemwide assessment tool, the Child and Adolescent Needs and Strengths (CANS) assessment, as well as training over 100 providers in use of the CANS since January 2020;
    c. Contracting with two CME providers to aid in the smooth and successful transition of children / youth back to home and community;
    d. Conducting Requests for Proposal (RFPs) related to both the QRTP and PRTF levels of care and contracting with providers selected through the RFP process (QRTP implementation is expected to begin by August 2021 and PRTF implementation by spring of 2022);
    e. Conducting an RFP for statewide mobile crisis services for children (implementation expected by August 2021); and
    f. Contracting a Comprehensive Assessment for Treatment (CAT) that will assess children to determine if he/she requires residential (including QRTP or PRTF) level treatment.

7. In March 2021, the State began implementing a Critical Time Interventions (CTI) program. CTI is "a time-limited evidence-based practice that mobilizes support for society's most

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vulnerable individuals during periods of transition."[12] CTI was originally developed to prevent recurrent homelessness in people with SMI leaving shelters, but has since been applied to meet the needs of people with mental illness leaving hospitals or incarceration with the outcome of decreasing readmissions or recidivism, respectively. The State expects CTI pilot programs to be operational in three regions by January 2022 with statewide deployment in all 10 CMHC regions anticipated for July 2022.

Despite New Hampshire's commitment to strengthening community supports for those with mental illness, the State has observed an increasing number of individuals who present in hospital EDs in mental health crisis causing the demand for inpatient psychiatric bed capacity to exceed the supply. This has resulted in psychiatric boarding in EDs, long wait times for treatment, and a substantial wait list for admission to NHH. While the ED wait list had been reduced to virtually zero as of April 2020, it unfortunately returned to previous heights as a result of the exacerbation of mental health symptoms during the PHE[13]. The psychiatric boarding crisis came to a head in the case of *Jane Doe v. The Commissioner of the New Hampshire Department of Health and Human Services*. A State Supreme Court opinion in that case issued on May 11, 2021[14] requires that the State hold probable cause hearings for mental health patients within three days of completion of an Involuntary Emergency Admission (IEA) certificate regardless of any wait list or ED boarding status. In response, Governor Sununu signed Executive Order 2021-09[15] on May 13, 2021, requiring DHHS to enact emergency rules and expand the number of available beds and other resources available to State residents in crisis. DHHS continues to adopt emergency rules and seek enactment of legislation to comply with the court order. These actions only serve to reinforce the need for this amendment.

Under the auspices of Executive Order 2021-09, on May 17, 2021 DHHS requested and received authority to utilize funding allocated to the State under the American Rescue Plan Recovery Act (ARPA) to make rapid, marked improvement relative to access to mental health services. Specifically, DHHS has allocated ARPA funding to enhance capacity in the following ways:

1. Increase the number of private sector psychiatric long-term care and assisted living behavioral health beds in order to facilitate discharges of patients in stable condition from NHH and Glencliff Home, ensuring that patients are cared for in the least restrictive and lowest cost environment to meet their clinical needs. This program currently includes up to 37 beds to be reserved for one year with a fixed payment of $45,000 per bed and reimbursed at a special case per diem rate.
2. Expand the scope of services at the PATH Center—a transitional housing facility adjacent to NHH—including facility modifications and staffing increases that will allow it to serve additional populations ready for discharge from NHH in a less restrictive and more clinically appropriate environment.
3. Augment psychiatric care for children by contracting with out-of-state providers for 10-15 inpatient psychiatric beds for children, including payment of otherwise uncompensated care that may be incurred by such providers (consistent with arrangements in place at Hampstead Hospital).
4. Reinforce psychiatric care for adults by adding 20 or more DRF beds at a fixed payment

[12] Center for the Advancement of Critical Time Intervention, https://www.criticaltime.org/cti-model/
[13] Vahratian A, Blumberg SJ, Terlizzi EP, Schiller JS. Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic — United States, August 2020–February 2021. MMWR Morb Mortal Wkly Rep 2021;70:490–494. DOI: http://dx.doi.org/10.15585/mmwr.mm7013e2
[14] Jane Doe v. The Commissioner of the New Hampshire Department of Health and Human Services, May 11, 2021, https://www.courts.state.nh.us/supreme/opinions/2021/2021022JaneDoe.pdf
[15] Executive Order 2021-09, May 13, 2021, https://www.governor.nh.gov/sites/g/files/ehbemt336/files/documents/2021-09.pdf

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of $200,000 per additional bed in return for the stipulation that such beds will remain available for IEAs for a minimum of 18 months.

New Hampshire's future vision for the State's mental health system is that it: be robust and cohesive; respect the dignity and centrality of the whole person; empower individuals, families, and communities; and reduce stigma while facilitating rapid access to a coordinated, high quality array of localized services and supports for all through a centralized portal. Increasing inpatient and residential psychiatric bed capacity for short-term treatment is one part of the infrastructure required to support this vision. This is the State's primary motivation for requesting this amendment to its authority granted under the SUD-TRA demonstration waiver. Community-based alternatives to inpatient care and post-discharge step-down options such as transitional housing are another element critical to success (the actions the State has taken to date to expand such capacity were described above). Lastly, managing readmission risk for patients discharged from inpatient care is the final component supporting this strategy, which is why the State is implementing the CTI program also described above.

III. Program Description and Objectives

New Hampshire seeks to amend its 1115 Substance Use Disorder Treatment and Recovery Access demonstration and is requesting authority to claim federal financial participation (FFP) for payment of services to Medicaid beneficiaries ages 21-64 receiving short-term inpatient psychiatric treatment or residential mental health treatment in IMDs. New Hampshire is requesting that the authorities described in this amendment apply to Medicaid beneficiaries in both the State's managed care and FFS service delivery systems.

Goals and Objectives

The overall goal of this amendment request is to enhance the flexibility and availability of mental health treatment supports and to supplement the comprehensive and integrated continuum of mental health treatments and care provided in New Hampshire. Through this amendment, the State aims to achieve the following objectives:

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

Operation and Proposed Timeline

The demonstration will operate statewide. The state intends to implement the demonstration beginning July 1, 2022 through the end of the current demonstration approval period, which is June 30, 2023.

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IV. Milestones

New Hampshire has met many of the milestones identified in the Department's implementation plan under the State's Medicaid State Plan and the Substance Use Disorder Treatment and Recovery Access Section 1115(a) demonstration. This amendment will be implemented through a series of milestones outlined below and in greater detail in the State's forthcoming Implementation Plan.

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

1. Participating hospitals and residential settings are licensed by the State and are accredited by a nationally recognized accreditation entity prior to participating in Medicaid.
2. Establishment of an oversight and auditing process that includes unannounced visits for participating psychiatric hospitals and requires that residential settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements.
3. All services undergo a medical necessity review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay.

Milestone 2: Improving Care Coordination and Transitions to Community-Based Care

1. Implementation of a process to ensure psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help transition beneficiaries out of these settings and into appropriate community-based outpatient services – as well as requirements that community-based providers participate in transition efforts.
2. Implementation of a process to assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings and connect those who are homeless or have unsuitable or unstable housing with community providers and coordinate housing services where available.
3. Implementation of a requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based provider through the most effective means possible (e.g. email, text or phone call within 72 hours post discharge).
4. Implementation of strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI prior to admission.

Milestone 3: Increasing Access to Continuum of Care Including Crisis Stabilization Services

1. Annual assessment of the availability of mental health providers across the state.
2. Commitment to a financing plan approved by CMS to:
    a. Increase the availability of non-residential crisis stabilization services including services made available through crisis call centers, mobile crisis units, observations / assessment centers with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders; and
    b. Increase availability of on-going community-based services (e.g. outpatient community mental health centers, partial hospitalization / day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model).
3. Implementation of strategies to improve state tracking of availability of inpatient and crisis stabilization beds.

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4. Requirement that providers use a widely recognized publicly available patient assessment tool to determine appropriate level of care and length of stay.
5. Implementation of requirements / policies to improve access to a full continuum of care including crisis stabilization.

Milestone 4: Earlier Identification and Engagement in Treatment through Increased Integration

1. Implementation of strategies for identifying and engaging beneficiaries with or at risk of SMI in treatment sooner (e.g. with supported education and employment).
2. Implementation of a plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SMI and linkages to treatment.
3. Establishment of specialized settings and services including crisis stabilization for young people experiencing SMI.

V. Demonstration Description

Demonstration Eligibility

This demonstration amendment will not affect any of the eligibility categories or criteria set forth in the New Hampshire Medicaid State Plan (the State Plan). Medicaid enrollees ages 21-64 with SMI[16] who are approved for full Medicaid benefits under the State Plan will be eligible under this demonstration amendment. The following eligibility groups with limited benefits will be excluded:

- Qualified Medicare Beneficiaries (QMB);
- Special Low-Income Medicare Beneficiaries (SLMB);
- Qualified Individual Special Low-Income Medicare Beneficiaries (QI / SLMB2);
- Non-citizens qualifying for emergency services only benefits;
- Family planning only; and
- COVID-19 Testing Group (eligibility group sunsets on the day the PHE ends).

Delivery System

No modifications to the current New Hampshire Medicaid FFS or managed care arrangements are proposed through this amendment; all enrollees will continue to receive services through their current delivery system. Should this application be approved, the benefits this SMI amendment seeks to authorize (as described below) will apply to both the FFS and managed care delivery systems and be available to all eligible beneficiaries.

Demonstration Benefits

As described above, New Hampshire offers a wide range of Medicaid-covered and State-funded mental health benefits. Through this amendment, the State will expand the settings that are eligible for reimbursement for clinically appropriate short-term stays for acute or residential psychiatric care. All services will be subject to medical necessity as further described in the forthcoming Implementation Plan. In accordance with CMS requirements, the State will not seek FFP for stays of more than 60 consecutive days.

Medicaid beneficiaries currently have access to comprehensive substance use disorder (SUD) benefits through the State's Substance Use Disorder Treatment and Recovery Access Section 1115(a) demonstration, which as noted previously, this application seeks to amend.

[16] Eligibility criteria will be determined by diagnosis of SMI regardless of whether or not an individual is enrolled in a CMHC.

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Cost Sharing

New Hampshire is not proposing any change to the cost sharing requirements under this amendment. Cost sharing will not differ from those provided under the State Plan. New Hampshire does not have cost sharing for services covered by the demonstration.

VI. Demonstration Financing

Projected Enrollment and Expenditures

Currently, New Hampshire provides inpatient and residential mental health treatment under the Medicaid State Plan. This demonstration amendment will expand the availability and access to needed treatment. The State anticipates the demonstration amendment will have no impact on annual Medicaid enrollment.

Below is the projected enrollment and expenditures for each demonstration year.

	SFY22	SFY23
Member Months	0	981
Expenditures	$0	$10,259,104

Budget Neutrality

Refer to Attachment 1 Compliance with Budget Neutrality for the State's historical and projected expenditures for the requested period of the demonstration.

Maintenance of Effort

New Hampshire's rationale for requesting this authorization is not limited to increasing inpatient bed capacity. The State will request that any parties seeking to add to IMD capacity also consider enhancing community-based care, whether through formal partnerships with existing providers or by adding supplemental capacity where warranted. At the same time as the State is pursuing this authorization, it is committing to maintain or increase funding for community-based services, most notably with the launch of the CTI program.

VII. Demonstration Evaluation

Based on the goals identified through CMS guidance, New Hampshire proposes the following evaluation plan. This approach has been developed in alignment with CMS design guidance for SMI demonstrations. The State will engage an independent evaluator to create a more definitive Evaluation Plan and conduct this review.

Tentative Hypothesis and Research Questions

Goals	Hypothesis	Data Source	Analytic Approach
Evaluation Question(s): How do SMI demonstration activities contribute to reductions in utilization and length of stay in EDs among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings?			

<table>
<tr><td>Goal 1: Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings</td><td>Hypothesis 1: The SMI demonstrations will result in reductions in utilization and length of stay in EDs among Medicaid beneficiaries with SMI while awaiting mental health treatment.

Example Monitoring Metric:
• All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit from Integrated Physical and Behavioral Health Care</td><td>• Interviews or focus groups with ED and state demonstration staff
• Interviews or focus groups with affected beneficiaries and / or their family members / caregivers</td><td>• Qualitative analysis to identify themes associated with the effectiveness of demonstration activities for reducing utilization and lengths of stays in EDs among Medicaid beneficiaries with SMI</td></tr>
<tr><td colspan="4">Evaluation Question(s): Does the SMI demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings (including, short-term inpatient and residential admissions to both IMDs and non-IMD acute care hospitals, critical access hospitals, and residential settings)? How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings? Does the SMI demonstration result in increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric hospital and residential setting stays and increased treatment for such conditions after discharge?</td></tr>
<tr><td>Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings</td><td>Hypothesis 2: The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.

Example Monitoring Metric:
• 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility</td><td>• Claims
• Interviews or focus groups with hospital / residential staff and community-based service providers
• Interviews or focus groups with affected beneficiaries and / or their family members / caregivers
• Electronic / paper medical records
• State-specific beneficiary survey</td><td>• Difference-in-difference models
• Qualitative analysis to identify themes associated with the effectiveness of demonstration activities for reducing preventable readmissions to acute care hospitals and residential settings
• Descriptive quantitative analysis comparing baseline and demonstration midpoint and end date</td></tr>
<tr><td colspan="4">Evaluation Question(s): To what extent does the demonstration result in improved availability of crisis outreach and response services throughout the state? To what extent does the demonstration result in improved availability of intensive outpatient services and partial hospitalization? To what extent does the demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community-based settings?</td></tr>
<tr><td>Goal 3: Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services</td><td>Hypothesis 3: The demonstration will result in improved availability of crisis stabilization services throughout the state.

Example Monitoring Metrics:
• Mental Health Services Utilization – Inpatient, Intensive Outpatient and Partial</td><td>• Annual assessments of availability of mental health services
• State administrative data or state-specific provider survey
• AHRF data on psychiatric care beds set up in short-term general hospitals</td><td>• Descriptive quantitative analysis of trends over time during the demonstration
• State maps that show the ratio of Medicaid beneficiaries with SMI to crisis stabilization services across the state at baseline and for each year of the demonstration</td></tr>
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provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state	*Hospitalization, Outpatient, ED, Telehealth* • *Average Length of Stay in IMDs* • *Beneficiaries With SMI Treated in an IMD for Mental Health*		• State maps that show the ratio of Medicaid beneficiaries with SMI to intensive outpatient and partial hospitalization providers across the state at baseline and for each year of the demonstration
Evaluation Question(s): Does the demonstration result in improved access of beneficiaries with SMI to community-based services to address their chronic mental health needs? To what extent does the demonstration result in improved availability of community-based services needed to comprehensively address the chronic mental health needs of beneficiaries with SMI? To what extent does the demonstration result in improved access of SMI beneficiaries to specific types of community-based services? How do the demonstration effects on access to community-based services vary by geographic area or beneficiary characteristics? Does the integration of primary and behavioral health care to address the chronic mental health care needs of beneficiaries with SMI improve under the demonstration?			
Goal 4: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI, including through increased integration of primary and behavioral health care	**Hypothesis 4:** Access of beneficiaries with SMI to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care. *Example Monitoring Metrics:* • *Access to Preventative / Ambulatory Health Services for Medicaid Beneficiaries with SMI* • *Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication*	• Claims • Annual assessments of availability of mental health services • State administrative data • Adult Core Set • AHRF county data Hybrid claims and medical records or electronic medical records	• Difference-in-differences regression model • Descriptive quantitative analysis of trends over time during the demonstration • Descriptive quantitative analysis comparing baseline and demonstration midpoint and end date • State maps that show the ratio of Medicaid beneficiaries with SMI to mental health providers across the state at baseline and for each year of the demonstration • State maps that show the ratios of Medicaid beneficiaries with SMI to FQHCs that offer behavioral health services across the state at baseline and for each year of the demonstration
Evaluation Question(s): Does the demonstration result in improved care coordination for beneficiaries with SMI? Does the demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities? Does the demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries transitioning out of acute psychiatric care in hospitals and residential treatment facilities? How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?			
Goal 5: Improved care coordination, especially continuity of care in the community following episodes	**Hypothesis 5:** The demonstration will result in improved care coordination, especially continuity of care in the	• Claims • Adult Core Set • Interviews with state demonstration and / or inpatient / residential and outpatient provider staff	• Difference-in-differences • Qualitative analysis to identify themes associated with the effectiveness of

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of acute care in hospitals and residential treatment facilities	community following episodes of acute care in hospitals and residential treatment facilities. *Example Monitoring Metrics:* • *Follow-up After Hospitalization for Mental Illness* • *Medication Continuation Following Inpatient Psychiatric Discharge* • *Follow-up After Emergency Department Visit for Mental Illness*	• Facility records • Interviews or focus groups with state demonstration and / or inpatient / residential and outpatient provider staff • Interviews or focus groups with affected beneficiaries or their families / caregivers	demonstration activities to improve data sharing systems, processes, and policies to support care coordination • Descriptive quantitative analysis comparing baseline and demonstration midpoint and end date • Qualitative analysis to identify themes associated with the effectiveness of demonstration activities for improving continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities

VIII. Waiver and Expenditure Authorities

The State requests expenditure authority for Medicaid State Plan services furnished to otherwise eligible individuals who are primarily receiving treatment for SMI who are short-term residents in hospitals or residential facilities that meet the definition of an IMD. No additional waivers of Title XIX are requested through this amendment. All other initiatives and proposed program enhancements will be implemented through other authorities outside of this amendment.

IX. Public Notice and Tribal Consultation

This section will include written documentation of the state's compliance with public notice requirements including 1) an overview of the public notice process, 2) a report of the issues raised by the public during the comment period and 3) how the state considered those comments when developing the final amendment application submitted to CMS.

New Hampshire does not have any federally recognized tribes.

X. Attachments

1. Compliance with Budget Neutrality Requirements

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July 20, 2021

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

[Sent via email: henry.lipman@dhhs.nh.gov]

Re: SMI/SED Waiver Amendment Budget Neutrality Limits - DRAFT

Dear Henry:

At your request, we are providing the New Hampshire Department of Health and Human Services (DHHS) with budget neutrality limits for the SMI/SED 1115 waiver amendment to the Substance Use Disorder Treatment and Recovery Access (SUD-TRA) 1115 Demonstration. We prepared these budget neutrality limit estimates for inclusion in the public comment period for the waiver amendment. The waiver amendment will allow DHHS to provide Medicaid payments for individuals ages 21 to 64 receiving mental health services in an Institution for Mental Disease (IMD) under the standard fee-for-service Medicaid or Medicaid managed care programs and will allow New Hampshire to claim FFP for Medicaid enrollees residing in an IMD for mental health treatment.

As part of the waiver submission, CMS requires DHHS to submit the completed CMS budget neutrality template for review. This letter includes documentation of the budget neutrality methodology and provides CMS template forms and related worksheets. The populated CMS budget neutrality template is provided in Excel format.

Please note, the information presented herein is draft and is subject to change. Milliman will continue to refine its calculations based on input from DHHS and continued review of the technical components underlying the results presented in this letter. At this time, the impact of enhanced federal medical assistance percentage (FMAP) on home and community based services (HCBS) is still under consideration for the development of the SMI/SED budget neutrality limits.

RESULTS

Table 1 shows the projected budget neutrality limits by Medicaid Eligibility Group (MEG) for SFY 2023, which is Demonstration Year 5 of the SUD-TRA IMD 1115 Waiver.

Table 1
New Hampshire Department of Health and Human Services
1115 IMD Waiver Amendment
Preliminary SFY 2023 Budget Neutrality Limits by MEG

MEG	Preliminary Budget Neutrality Limit
Medicaid Adults (Non-Group VIII Adults)	$12,281
Expansion Adults (Group VIII Adults)	$7,285

Our projections of historical data to SFY 2023 (DY5) use the President's Budget trend rates included in the recently approved waiver amendment dated June 16, 2021. The approved trend rates are as follows:

- 8.3% for Medicaid Adults
- 6.4% for Expansion Adults

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Note, the MEG structure is consistent with the SUD-TRA 1115 IMD Waiver and will be reported separately for the amendment portion of the waiver, with the exception of the adolescent MEG that is not eligible for SMI/SED stays under this waiver.

METHODOLOGY

We developed historical base year costs in the budget neutrality template separately for two specific MEGs currently included in the SUD-TRA 1115 Waiver: Medicaid adult population and expansion adult population.

The 'IMD Historical' tab in the CMS budget neutrality template contains two options for calculating the base year costs for the starting point of the budget neutrality calculations.

- Historical PMPM Cost by MEG: The top section contains actual historical expenditures, member months, and PMPM costs by MEG for individuals age 21 to 64 who had an IMD stay in CY 2019.
- Alternate Development: The bottom section requires the input of the total estimated expenditures for mental health medical assistance services provided while an individual age 21 to 64 is in an IMD. The total historical base year cost is developed from the following three components:
  - Capitated expenditures under the Medicaid Care Management (MCM) program
  - Carved out non-IMD expenditures paid by DHHS on a fee-for-service (FFS) basis
  - IMD expenditures

Per CMS direction, we populated both sections and the PMPMs resulting from the alternate development section are used as the base year costs in the budget neutrality. The main driver of the difference in cost between the historical PMPM and alternate development approach is the inclusion of the IMD expenditures in the MCM capitation rate.

Identification of Individuals Eligible Under the Waiver

We counted member months consistent with CMS instructions for budget neutrality calculation and CMS 64 reporting. We included one whole month during which a Medicaid eligible age 21 to 64 is inpatient in an IMD at least one day. All IMD stays longer than 60 days are excluded from our calculations, as these stays do not qualify for the waiver.

Historical PMPM Cost by MEG

We summarized actual CY 2019 costs and member months for individuals age 21 to 64 receiving mental health services in an IMD under the standard FFS Medicaid or MCM programs. The historical costs consist of MCM capitation payments, FFS claim payments, and IMD expenditures.

Alternate Development

We developed an estimated cost by MEG in the Alternate Development section of the "IMD Historical" tab using the member months distribution by rate cell for each MEG. Each component of this development represents SFY 2022 costs and is discussed in more detail below.

The attached Exhibit 1 contains the calculations underlying the blended PMPM calculations by rate cell and MEG. Under the waiver, there still will be some eligible individuals who will be enrolled in FFS; therefore, we then blended the FFS and MCM data to calculate a blended PMPM using the historical proportion of MCM and FFS member months eligible for this waiver.

The waiver template automatically trends this SFY 2022 to SFY 2023 using the trend rates, noted above.

Estimated Eligible Member Months for All Medical Assistance Provided in an IMD

We include all CY 2019 member months for Medicaid enrollees age 21 to 64 who could be eligible for medical assistance provided in an IMD. This approach is consistent with the development of the SUD-TRA budget neutrality limits.

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Managed Care PMPM

We calculated the expenditures for individuals enrolled in standard FFS Medicaid and MCM separately.

For individuals enrolled in the MCM program, we include capitation expenditures that represent the SFY 2022 MCM capitation rates by rate cell as documented in our actuarial certification dated May 24, 2021. The capitation expenditures include base rates including directed payments and an estimate for hospital inpatient psychiatric admission kick payments.

For individuals covered under standard FFS Medicaid (e.g., retroactive eligibility), we include CY 2019 medical expenditures trended to SFY 2022 using the currently approved President's budget trends by MEG listed above in order to put them on the same basis as the capitated expenditures.

Additionally, we added expenditures for known expansions to Medicaid covered services including:

- Maternal, Infant, and Early Childhood Home Visiting Program: We added $1,500,000 in funds to the Medicaid program for the expansion of this program.
- Expansion of Designated Receiving Facility (DRF) bed capacity by 17 beds effective July 1, 2022 and an additional 38 beds effective January 1, 2023.
- Expansion of Community Residential bed capacity from 226 beds to 286 beds.

Currently State Plan FFS (e.g., Carved Out) or Not Currently State Plan but Otherwise Approvable (Including Pending SPAs)

We add carved-out non-IMD expenditures currently covered by FFS outside the MCM program that reflect the average cost by MEG for these services. We used the average cost due to the low volume of IMD residents. The carved-out expenditures include the following service categories:

- Long Term Services and Support (LTSS)
- Mobile Crisis Response Team (MCRT) and emergency psychiatric services
- Prescription drug carve outs
- Other services excluded from MCM capitation rates (e.g., dental services)

We adjusted the base period expenditures for these services for known fee schedule changes, such as the provider rate increase legislated by House Bill 4 and the rate increase for Choices for Independence services legislated by House Bill 2.

We trended the carved out services from their CY 2019 base period to SFY 2022 using the currently approved President's budget trends by MEG listed above in order to put them on the same basis as the capitated expenditures.

Absent 1115 Authority, Not Otherwise Eligible for FFP Under Title XIX, or "Costs Not Otherwise Matchable" ("Non-IMD" or "Non-Hypo" CNOMs)

For the MCM population, we added IMD expenditures not included in the SFY 2022 capitation rates separately for New Hampshire Hospital (NHH) and other IMDs. In both cases, we spread the estimated expenses over the entire MCM population since DHHS indicated these services will be included in the SFY 2023 MCM capitation rates, subject to the waiver amendment approval. This approach is consistent with the SUD-TRA 1115 SUD waiver. We also adjust the cost for those services to reflect the administrative allowance, risk margin allowance, and premium tax that will be applied to those services when included in the capitation rates.

For admissions at NHH, we include stays less than 60 days for ages 21 to 64, since these services are currently excluded from the SFY 2022 MCM capitation rates. We identified the historical days at NHH and multiplied by the current per diem rate to develop an aggregate cost to spread across all MCM enrollment.

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For stays in other IMDs, we only include the expenditures for stays longer than 15 days in a particular month, since the SFY 2022 MCM capitation rates already include costs and enrollment for months with less than 15 days. We exclude any stays over 60 days, as these stays do not qualify for the waiver.

For the FFS population, we added all IMD expenditures for admissions for the individuals age 21 to 64 receiving mental health services at NHH. We exclude any stays over 60 days, as these stays do not qualify for the waiver.

CAVEATS AND LIMITATIONS ON USE

This letter is designed to assist DHHS with developing budget neutrality limits for the SMI/SED 1115 waiver amendment. This information may not be appropriate, and should not be used, for other purposes.

Milliman has developed certain models to estimate the values included in this letter. The intent of the models was to estimate budget neutrality limits for the SMI/SED waiver amendment. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

The information contained in this letter has been prepared for DHHS. To the extent that the information contained in this letter is provided to third parties, this letter should be distributed in its entirety. Any user of this information must possess a certain level of expertise in actuarial science and healthcare modeling, so as not to misinterpret the information presented.

We constructed several projection models to develop the capitation rates shown in this letter. Actual results will vary from estimates and actual results will depend on the extent to which future experience conforms to the assumptions made in these calculations. It is certain that actual experience will not conform exactly to the assumptions used herein. DHHS should monitor emerging results and take corrective action when necessary.

In preparing this information, we relied on information from DHHS regarding historical expenditures, historical enrollment, projected costs under the demonstration, and the expected return on investment for certain initiatives. We accepted this information without audit, but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this letter.

The terms of Milliman's contract with the New Hampshire Department of Health and Human Services effective July 1, 2017, apply to this letter and its use.

Please call us at 262 784 2250, if you have any questions.

Sincerely,

- DRAFT -

Mathieu Doucet, FSA, MAAA
Senior Consulting Actuary

MD/bl

Attachment

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EXHIBIT 1

Exhibit 1
New Hampshire Department of Health and Human Services
1115 IMD Waiver Amendment
SFY 2023 Budget Neutrality Limits
Blended PMPM

Eligibility Category	IMD Member Months	Medical Expenditures / Capitation Rates	Hospital Inpatient Psychiatric Admissions	LTSS Services	MCRT / ES Services Carve Out	Prescription Drug Carve Out	Other Carve Outs	New Hampshire Hospital	Hampstead & All Other	Home Visiting Program	Designated Receiving Facility Beds	Community Residental Beds	Total
Time Period of PMPM Costs		SFY 2022	SFY 2022	CY 2019	SFY 2022	CY 2019	CY 2019	CY 2019	CY 2019	SFY 2022	CY 2019	SFY 2022	
Low Income Children - Age 0 to 11 Months	0	$318.25	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$1.25	$0.00	$0.00	$0.00
Low Income Children - Age 1 to 18 Years	0	171.99	2.98	0.00	1.14	0.00	0.00	0.00	0.00	1.25	0.03	0.00	0.00
Low Income Adults	20	472.42	3.02	0.34	2.22	0.00	2.51	0.70	0.00	0.29	0.55	0.01	482.07
CHIP	0	164.32	2.65	0.00	0.89	0.00	0.00	0.00	0.00	1.06	0.04	0.00	0.00
Foster Care / Adoption	0	321.83	21.10	0.00	3.06	0.00	0.00	0.00	0.00	1.23	0.00	0.00	0.00
Severely Disabled Children	0	1,651.99	3.39	0.00	1.17	0.00	0.00	0.00	0.00	1.30	0.00	0.00	0.00
Elderly and Disabled Adults - Age 19 to 64	27	1,212.98	6.81	1,271.46	3.66	34.52	17.85	2,748.02	0.00	0.00	0.87	0.37	5,296.53
Elderly and Disabled Adults - Age 65+	0	1,045.58	2.13	0.00	0.30	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dual Eligibles	111	319.33	0.00	1,941.67	2.54	0.00	33.71	10,410.94	0.00	0.00	0.27	0.07	12,708.53
Newborn Kick Payment	0	4,369.58	0.97	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Neonatal Abstinence Syndrome Kick Payment	0	9,536.34	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Maternity Kick Payment	0	2,889.19	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Severe / Persistent Mental Illness - Non-Dual	99	$2,284.33	$52.75	$379.65	$20.67	$0.00	$74.01	$602.60	$0.00	$0.00	$5.86	$12.69	$3,432.55
Severe / Persistent Mental Illness - Dual	269	1,475.74	0.00	553.45	39.64	0.00	416.50	9,443.19	0.04	0.00	7.51	47.37	11,983.44
Severe Mental Illness - Non-Dual	16	1,527.74	43.04	253.17	10.20	0.00	3.49	1,947.11	0.00	0.00	13.11	0.22	3,798.08
Severe Mental Illness - Dual	28	911.15	0.00	605.95	37.38	0.00	43.32	8,807.17	0.00	0.00	9.68	1.81	10,416.45
Low Utilizer - Non-Dual	2	1,496.34	16.48	1,072.87	5.07	0.00	4.56	27.00	0.00	0.00	3.98	1.53	2,627.83
Low Utilizer - Dual	4	668.57	0.00	1,750.27	6.70	0.00	2.08	32.92	0.00	0.00	2.52	0.02	2,463.07
Serious Emotionally Disturbed Child	0	1,075.96	56.55	3,333.53	13.67	0.00	10.76	0.00	0.00	1.27	0.42	0.02	0.00
Granite Advantage - Medically Frail	51	$1,097.49	$11.77	$67.45	$6.94	$2.64	$23.23	$2,245.92	$0.00	$0.00	$1.55	$0.14	$3,457.13
Granite Advantage - Non-Medically Frail	74	497.21	2.43	0.01	3.09	0.23	1.40	5,406.47	0.04	0.02	0.55	0.01	5,911.44
Granite Advantage - Severe / Persistent Mental Illness	111	2,111.91	41.68	23.44	24.73	0.00	18.62	5,141.86	4.58	0.00	18.95	12.69	7,398.44
Granite Advantage - Severe Mental Illness	91	1,510.52	43.01	8.15	10.21	0.20	6.37	4,410.80	0.50	0.00	23.15	0.22	6,013.13
Granite Advantage - Low Utilizer	3	1,592.44	8.24	0.84	7.76	0.00	2.76	5,773.00	0.00	0.00	26.42	1.53	7,412.98
Granite Advantage - Serious Emotionally Disturbed Child	0	1,075.96	56.55	0.00	13.67	0.00	0.00	0.00	0.00	1.27	0.00	0.02	0.00
Summary by MEG													
Medicaid Adults	576	$1,313.18	$10.74	$809.88	$24.97	$1.62	$216.89	$7,131.32	$0.02	$0.01	$5.49	$24.43	$9,538.54
Expansion Adults	330	1,422.49	28.32	20.56	12.97	0.51	11.95	4,557.78	1.69	0.00	13.36	4.36	6,074.00
Summary by MEG Trended to SFY 2022													
Medicaid Adults	576	$1,313.18	$10.74	$988.53	$24.97	$1.97	$264.73	$8,704.44	$0.02	$0.01	$6.70	$24.43	$11,339.74
Expansion Adults	330	1,422.49	28.32	24.01	12.97	0.60	13.95	5,322.40	1.97	0.00	15.60	4.36	6,846.69

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2. Public Notice

This section will be developed in follow-up to public notice period and will document artifacts related to the public notice process such as certification that public notice was given, press release, public forum slides, etc.

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3. Provider Availability Assessment

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Medicaid Section 1115 SMI/SED Demonstrations Initial Availability Assessment (Version 2.0)

State Name	**New Hampshire**
Date of Assessment	**7/26/2021**
Time Period Reflected in Assessment (month/day/year)	**5/31/2021**

	Geographic Designation			**Beneficiaries**										
				Adult					**Children**			**Total**		
	Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Number of adult Medicaid beneficiaries (18 - 20)	Number of adult Medicaid beneficiaries with SMI (18 - 20)	Number of adult Medicaid beneficiaries (21+)	Number of adult Medicaid beneficiaries with SMI (21+)	Percent with SMI (Adult)	Number of Medicaid beneficiaries (0 - 17)	Number of Medicaid beneficiaries with SED (0 - 17)	Percent with SED (0-17)	Number of Medicaid beneficiaries (Total)	Number of Medicaid beneficiaries with SMI or SED (Total)	Percent with SMI or SED (Total)
1.	Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	8,950	616	86,108	5,790	7%	69,462	4,398	6%	164,520	10,804	7%
2.	North Country	Rural	Carroll, Coos, and Grafton Counties	1,721	76	16,657	886	5%	13,640	702	5%	32,018	1,664	5%
3.	Southwest NH	Rural	Cheshire and Sullivan Counties	1,281	56	12,364	587	5%	10,374	620	6%	24,019	1,263	5%
	Total			**11952**	**748**	**115129**	**7263**	**6%**	**93476**	**5720**	**6%**	**220557**	**13731**	**6%**

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As

State Name	New Hampshire
Date of Assessment	7/26/2021
Time Period Reflected in Assessment (month/day/year)	5/31/2021

Geographic Designation					Psychiatrists and Other Practi					
Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations	Number of Psychiatrists and Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications	Number of Medicaid-Enrolled Psychiatrists and Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications	Number of Medicaid-Enrolled Psychiatrists and Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications Accepting New Medicaid Patients	Ratio of Medicaid beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatrists and Other Prescribers	Ratio of Total Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists and Other Prescribers	Ratio of Medicaid-Enrolled Psychiatrists and Other Prescribers to Medicaid-Enrolled Psychiatrists and Other Prescribers Accepting New Medicaid Patients
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	MMIS enrollment data and eligibility groupings based on rate cells.	SMI and SED rate cells are derived based on CMHC enrollment and may not capture 100% of the Medicaid beneficiaries who meet these diagnostic criteria. Excludes beneficiaries who reside out of state.	1,779	340	331	31.78	5.23	1.03
North Country	Rural	Carroll, Coos, and Grafton Counties			358	442	436	3.76	0.81	1.01
Southwest NH	Rural	Cheshire and Sullivan Counties			142	50	46	25.26	2.84	1.09
Total					**2279**	**832**	**813**	**16.50360577**	**2.739182692**	**1.023370234**

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As

State Name	New Hampshire
Date of Assessment	7/26/2021
Time Period Reflected in Assessment (month/day/year)	5/31/2021

Geographic Designation			Providers				
			tioners Who Are Authorized to Prescribe Psychiatric Medications				
Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Specific type(s) of practitioners used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	Provider types include: Physicians with Psychiatric Specialty, Advanced Practice Registered Nurses (APRNs) with Psychiatric, Family Psychiatric, and Adult Psychiatric Specialties.	Data sources are: NH Office of Professional Licensure and Certification (OPLC) databases, as reported by the NH DHHS Division of Public Health Services for Number Authorized (Column R); NH Medicaid MCO provider directories for Medicaid Enrolled (Column S) and Accepting New Patients (Column T).	Only professionals with independent prescribing authority were included. OPLC databases contain all active licenses in the state, whether the professional is actively practicing or retired; NH expects to have more complete data with respect to professionals' current status based on new survey requirements being implemented upon renewal of the various licensure types. For these categories of provider types the timelines for enhanced surveys are as follows: MDs/DOs/Psychiatrists: available July 2021; APRNs: available July 2022 (however, OPLC stated that at present only active nurses are licensed as APRNs). Medicaid Enrolled (Column S) and Accepting New Patients (Column T) figures may contain out-of-state providers who are contracted with Medicaid but not licensed in the State of NH (hence, they are not reflected in Column R). Of the 54 total professions categories in the database, OPLC confirmed that the four professions provided in the dataset – Medical, Nursing, Mental Health, and Psychology – are the only ones with licensees working in mental health. For professions where not all licensees work in mental health, OPLC further restricted the query to only those licensees with a designation of “psychiatry” listed in their “Specialty” panel.	2,364	928
North Country	Rural	Carroll, Coos, and Grafton Counties				450	254
Southwest NH	Rural	Cheshire and Sullivan Counties				243	132
Total						**3057**	**1314**

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As

State Name	New Hampshire
Date of Assessment	7/26/2021
Time Period Reflected in Assessment (month/day/year)	5/31/2021

Geographic Designation			Other Practitioners Certified and Licensed to Independently Treat Mental Illness					
Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Ratio of Other Practitioners Certified or Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Ratio of Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness Accepting New Patients	Specific type(s) of practitioners used to populate this sub-section	Brief description of data source(s) used to populate this sub-section
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	898	11.64	2.55	1.03	Provider types include: Psychologists, Pastoral Psychologists, Licensed Clinical Mental Health Counselors (LCMHCs), Licensed Independent Clinical Social Workers (LICSWs), and Marriage and Family Therapists (MFTs).	Data sources are: NH Office of Professional Licensure and Certification (OPLC) databases, as reported by the NH DHHS Division of Public Health Services for Number Authorized (Column AA); NH Medicaid MCO provider directories for Medicaid Enrolled (Column AB) and Accepting New Patients (Column AC).
North Country	Rural	Carroll, Coos, and Grafton Counties	238	6.55	1.77	1.07		
Southwest NH	Rural	Cheshire and Sullivan Counties	125	9.57	1.84	1.06		
Total			**1261**	**10.44977169**	**2.326484018**	**1.042030135**		

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State Name	**New Hampshire**
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Time Period Reflected in Assessment (month/day/year)	**5/31/2021**

Geographic Designation				**Community Mental Health Centers**							
Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Additional notes on this sub-section, including data limitations	Number of CMHCs	Number of Medicaid-Enrolled CMHCs	Number of Medicaid-Enrolled CMHCs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled CMHCs	Ratio of Total CMHCs to Medicaid-Enrolled CMHCs	Ratio of Medicaid-Enrolled CMHCs to Medicaid-Enrolled CMHCs Accepting New Patients	Brief description of data source(s) used to populate this section
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	OPLC databases contain all active licenses in the state, whether the professional is actively practicing or retired; NH expects to have more complete data with respect to professionals' current status based on new survey requirements being implemented upon renewal of the various licensure types. For these categories of provider types the timeline for enhanced surveys is July 2022. Practice address utilized in lieu of personal mailing address. Medicaid Enrolled (Column AB) and Accepting New Patients (Column AC) figures may contain out-of-state providers who are contracted with Medicaid but not licensed in the State of NH (hence, they are not reflected in Column AA). Of the 54 total professions categories in the database, OPLC confirmed that the four professions provided in the dataset – Medical, Nursing, Mental Health, and Psychology – are the only ones with licensees working in mental health. For professions where not all licensees work in mental health, OPLC further restricted the query to only those licensees with a designation of “psychiatry” listed in their “Specialty” panel.	8	8	8	1,350.50	1.00	1.00	NH DHHS Division for Behavioral Health.
North Country	Rural	Carroll, Coos, and Grafton Counties		3	3	3	554.67	1.00	1.00	
Southwest NH	Rural	Cheshire and Sullivan Counties		2	2	2	631.50	1.00	1.00	
Total				**13**	**13**	**13**	**1056.23077**	**1**	**1**	

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State Name	**New Hampshire**
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Geographic Designation				**Intensive Outpatient Services**							
Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Additional notes on this section, including data limitations	Number of Providers Offering Intensive Outpatient Services	Number of Medicaid-Enrolled Providers Offering Intensive Outpatient Services	Number of Medicaid-Enrolled Providers Offering Intensive Outpatient Services	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Providers Offering Intensive Outpatient Services	Ratio of Total Facilities/ Programs Offering Intensive Outpatient Services to Medicaid-Enrolled Providers Offering Intensive Outpatient Services	Ratio of Medicaid-Enrolled Providers Offering Intensive Outpatient Services to Medicaid-Enrolled Providers Offering Intensive Outpatient Services Accepting New Medicaid Patients	Specific type(s) of services used to populate this section	Brief description of data source(s) used to populate this section
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	As of 5/2021, all CMHCs are enrolled in Medicaid and all CMHCs are accepting new patients, but some may have wait lists. All CMHCs have committed to implementing same-day intakes, but not all are fully operational yet.	4	4	4	2,701.00	1.00	1.00	Services provided by Community Mental Health Centers (CMHCs) and select hospital partners.	Survey of individual CMHCs.
North Country	Rural	Carroll, Coos, and Grafton Counties		1	1	1	1,664.00	1.00	1.00		
Southwest NH	Rural	Cheshire and Sullivan Counties		2	2	2	631.50	1.00	1.00		
Total				**7**	**7**	**7**	**1961.571429**	**1**	**1**		

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State Name	**New Hampshire**
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Geographic Designation				Residential Mental Health Treatme							
Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Additional notes on this section, including data limitations	Number of Residential Mental Health Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities Accepting New Medicaid Patients (Adult)	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Ratio of Total Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) Accepting New Patients	Total Number of Residential Mental Health Treatment Facility Beds (Adult)	Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds (Adult)
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	NH DHHS utilized a self-attestation approach that involved surveying the CMHCs on the scope of programs offered to clarify the total number of providers for this type of service. These service categories are not currently tracked in licensure database and other customary data sources.	1	1	1	6,406.00	1.00	1.00	16	16
North Country	Rural	Carroll, Coos, and Grafton Counties		0	0	0	-	-	-	0	0
Southwest NH	Rural	Cheshire and Sullivan Counties		0	0	0	-	-	-	0	0
Total				**1**	**1**	**1**	**8011**	**1**	**1**	**16**	**16**

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State Name	New Hampshire
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Geographic Designation			Residential Mental Health Treatment Facilities									
			nt Facilities (Adult)									
Geographic designation	Is this geographic designation primarily urban or rural?	Additional notes on this sub-section, including data limitations	Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Adult Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Beds	Ratio of Total Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health Treatment Beds	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Medicaid Patients	Specific type(s) of facilities used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Psychiatric Residential Treatment Facilities (PRTF)	Number of Medicaid-Enrolled PRTFs	Number of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	16	400.38	1.00	1.00	Facilities include: Acute Psychiatric Residential Treatment Facilities.	NH DHHS Division for Behavioral Health beds report.	N/A	0	0	0
North Country	Rural	Carroll, Coos, and Grafton Counties	0	-	-	-				0	0	0
Southwest NH	Rural	Cheshire and Sullivan Counties	0	-	-	-				0	0	0
Total			**16**	**500.6875**	**1**	**1**				**0**	**0**	**0**

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State Name	New Hampshire
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Geographic Designation			Psychiatric Residential Treatment Facilities									
Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PTRFs	Ratio of Total PTRFs to Medicaid-Enrolled PRTFs	Ratio of Medicaid-Enrolled PRTFs to Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Total Number of PRTF Beds	Number of Medicaid-Enrolled PRTF Beds	Number of Medicaid-Enrolled PRTF Beds Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PRTF Beds Available to Medicaid Patients	Ratio of Total Number of PRTF Beds to Medicaid-Enrolled PRTF Beds	Ratio of Medicaid-Enrolled PRTF Beds to Medicaid-Enrolled PRTFs Available to Medicaid Patients	Specific type(s) of facilities used to populate this sub-section
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	-	-	-	0	0	0	-	-	-	N/A
North Country	Rural	Carroll, Coos, and Grafton Counties	-	-	-	0	0	0	-	-	-	
Southwest NH	Rural	Cheshire and Sullivan Counties	-	-	-	0	0	0	-	-	-	
Total			**-**	**-**	**-**	**0**	**0**	**0**	**-**	**-**	**-**	

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State Name	**New Hampshire**
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Geographic Designation					Public and Private Psychiatric Hospitals							
Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Public and Private Psychiatric Hospitals	Public and Private Psychiatric Hospitals Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Public and Private Psychiatric Hospitals Available to Medicaid Patients	Ratio of Public and Private Psychiatric Hospitals to Public and Private Psychiatric Hospitals Available to Medicaid Patients	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Psychiatric Units in Acute Care Hospitals	Number of Psychiatric Units in Critical Access Hospitals (CAHs)
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	N/A	There are no PRTFs currently operating in NH, but they may be a factor in future reporting.	2	2	5,402.00	1.00	NH DHHS Division for Behavioral Health beds report.	Facilities include: New Hampshire Hospital and Hampstead Hospital.	8	2
North Country	Rural	Carroll, Coos, and Grafton Counties			0	0	-	-			1	0
Southwest NH	Rural	Cheshire and Sullivan Counties			0	0	-	-			0	0
Total					**2**	**2**	**6865.5**	**1**			**9**	**2**

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State Name	**New Hampshire**
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Geographic Designation			**Inpatient**										
			Psychiatric Units										
Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Number of Medicaid-Enrolled Psychiatric Units in CAHs	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Number of Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in CAHs	Ratio of Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	Brief description of data source(s) used to populate this sub-section
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	8	2	7	2	1,350.50	5,402.00	1.00	1.00	1.14	1.00	NH DHHS Division for Behavioral Health beds report.
North Country	Rural	Carroll, Coos, and Grafton Counties	1	0	1	0	1,664.00	-	1.00	-	1.00	-	
Southwest NH	Rural	Cheshire and Sullivan Counties	0	0	0	0	-	-	-	-	-	-	
Total			**9**	**2**	**8**	**2**	**1525.666667**	**6865.5**	**1**	**1**	**1.125**	**1**	

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State Name	New Hampshire
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Geographic Designation			Psychiatric Beds									
Geographic designation	Is this geographic designation primarily urban or rural?	Additional notes on this sub-section, including data limitations	Additional notes on this sub-section, including data limitations	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units) Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Licensed Psychiatric Hospital Beds Available to Medicaid Patients	Ratio of Licensed Psychiatric Hospital Beds to Licensed Psychiatric Hospital Beds Available to Medicaid Patients	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	Critical Access Hospital psychiatric units are not double counted in the number of Acute Care Hospital psychiatric units. Psychiatric Hospitals are not reflected in any of these counts.	449	439	24.61	1.02	NH DHHS Division for Behavioral Health beds report.	N/A	0	0	0
North Country	Rural	Carroll, Coos, and Grafton Counties		21	21	79.24	1.00			0	0	0
Southwest NH	Rural	Cheshire and Sullivan Counties		0	0	-	-			0	0	0
Total				**470**	**460**	**29.85**	**1.02173913**			**0**	**0**	**0**

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State Name	New Hampshire
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Geographic Designation			Institutions for Mental Diseases								
			Residential Treatment Facilities That Qualify As IMDs						Psychiatric Hospitals That Qualify A		
Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities that Qualify as IMDs	Ratio of Total Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting New Medicaid Patients	Specific type(s) of facilities used to populate this sub-section	Brief description of data source(s) used to populate this sub-section	Additional notes on this sub-section, including data limitations	Number of Psychiatric Hospitals that Qualify as IMDs	Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals that Qualify as IMDs	Brief description of data source(s) used to populate this sub-section
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	-	-	-	Facilities include: Acute Psychiatric Residential Treatment Facilities.	NH DHHS Division for Behavioral Health beds report.	According to the State Medicaid Manual threshold (>16 beds), Cypress Center is not considered to be an IMD.	2	5,402.00	NH DHHS Division for Behavioral Health beds report.
North Country	Rural	Carroll, Coos, and Grafton Counties	-	-	-				0	-	
Southwest NH	Rural	Cheshire and Sullivan Counties	-	-	-				0	-	
Total			**-**	**-**	**-**				**2**	**6865.5**	

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State Name	**New Hampshire**
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Geographic Designation			s IMDs	**Crisis Stabilization Services**									
Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Additional notes on this sub-section, including data limitations	Number of Crisis Call Centers	Number of Mobile Crisis Units	Number of Crisis Observation/ Assessment Centers	Number of Crisis Stabilization Units	Number of Coordinated Community Crisis Response Teams	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Call Centers	Ratio of Medicaid Beneficiaries with SMI/SED to Mobile Crisis Units	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Observation/ Assessment Centers	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Stabilization Units	Ratio of Medicaid Beneficiaries with SMI/SED to Coordinated Community Crisis Response Teams
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	Facilities include: New Hampshire Hospital and Hampstead Hospital.	27	3	4	0	1	400.15	3,601.33	2,701.00	-	10,804.00
North Country	Rural	Carroll, Coos, and Grafton Counties		17	0	0	0	1	97.88	-	-	-	1,664.00
Southwest NH	Rural	Cheshire and Sullivan Counties		14	0	0	0	1	90.21	-	-	-	1,263.00
Total				**58**	**3**	**4**	**0**	**3**	**236.7413793**	**4577**	**3432.75**	**-**	**4577**

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State Name	New Hampshire
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Geographic Designation						Federally Qualified Health Centers			
Geographic designation	**Is this geographic designation primarily urban or rural?**	**Additional notes on this sub-section, including data limitations**	Specific type(s) of services used to populate this section	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations	Number FQHCs that Offer Behavioral Health Services	Ratio of Medicaid Beneficiaries with SMI/SED to FQHCs that Offer Behavioral Health Services	Brief description of data source(s) used to populate this section	Additional notes on this section, including data limitations
Central NH	Other-please explain	Mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties.	Services include: BH crisis lines operating in NH, Mobile Crisis Response Teams (that also operate Crisis Apartments) from select CMHCs, Behavioral Health Crisis Treatment Center, Disaster Behavioral Health Response Team (one team statewide).	NH DHHS Division for Behavioral Health Policy Team.	There are 33 unique crisis hotlines in operation as of 6/30/2021 (some serve more than one region). These are all transitioning to a centralized 9-8-8 behavioral health crisis number to streamline access for the public. The 33 unique hotlines include: 10 CMHC emergency services lines, 3 mobile crisis teams, national suicide prevention lifeline, veterans crisis line, etc.	8	1,350.50	Bi-State Primary Care Association Serving Vermont & New Hampshire.	Includes FQHC look-alikes that offer Behavioral Health services.
North Country	Rural	Carroll, Coos, and Grafton Counties				6	277.33		
Southwest NH	Rural	Cheshire and Sullivan Counties				1	1,263.00		
Total						**15**	**915.4**		

4. Implementation Plan

This section will be submitted after the amendment application and prior to drawing FFP, consistent with CMS requirements and guidance.

DRAFT