



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

September 3, 2021

# Table of Contents

I.	Executive Summary .....	2
II.	System of Care Background .....	3
	Overview of New Hampshire Mental Health System .....	3
III.	Program Description and Objectives .....	8
	Goals and Objectives .....	8
	Operation and Proposed Timeline .....	8
IV.	Milestones .....	9
V.	Demonstration Description .....	10
	Demonstration Eligibility .....	10
	Delivery System .....	10
	Demonstration Benefits .....	10
	Cost Sharing .....	11
VI.	Demonstration Financing .....	11
	Projected Enrollment and Expenditures .....	11
	Budget Neutrality .....	11
	Maintenance of Effort .....	11
VII.	Demonstration Evaluation .....	11
	Tentative Hypothesis and Research Questions .....	11
VIII.	Waiver and Expenditure Authorities .....	14
IX.	Public Notice and Tribal Consultation .....	14
	Public Notice & Public Hearings .....	14
	Tribal Notice & Consultation .....	15
	Public Comment Period .....	15
X.	Attachments .....	19
	1. Compliance with Budget Neutrality Requirements .....	I
	2. Public Notice .....	II
	A – Public Comment Website & Social Media Post	
	B – Public Notice	
	C – Public Hearing Slides	
	D – MCAC Meeting Agenda	
	E – MCAC Meeting Minutes	
	F – Newspaper Tear Sheets	
	G – Letters of Comment Received	
	H – Summary of Testimony from Public Hearings	
	3. Provider Availability Assessment .....	III
	4. Implementation Plan .....	IV

## 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<sup>1</sup> 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<sup>2</sup> 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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<sup>1</sup> New Hampshire 10-year Mental Health Plan, January 2019, <https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf>

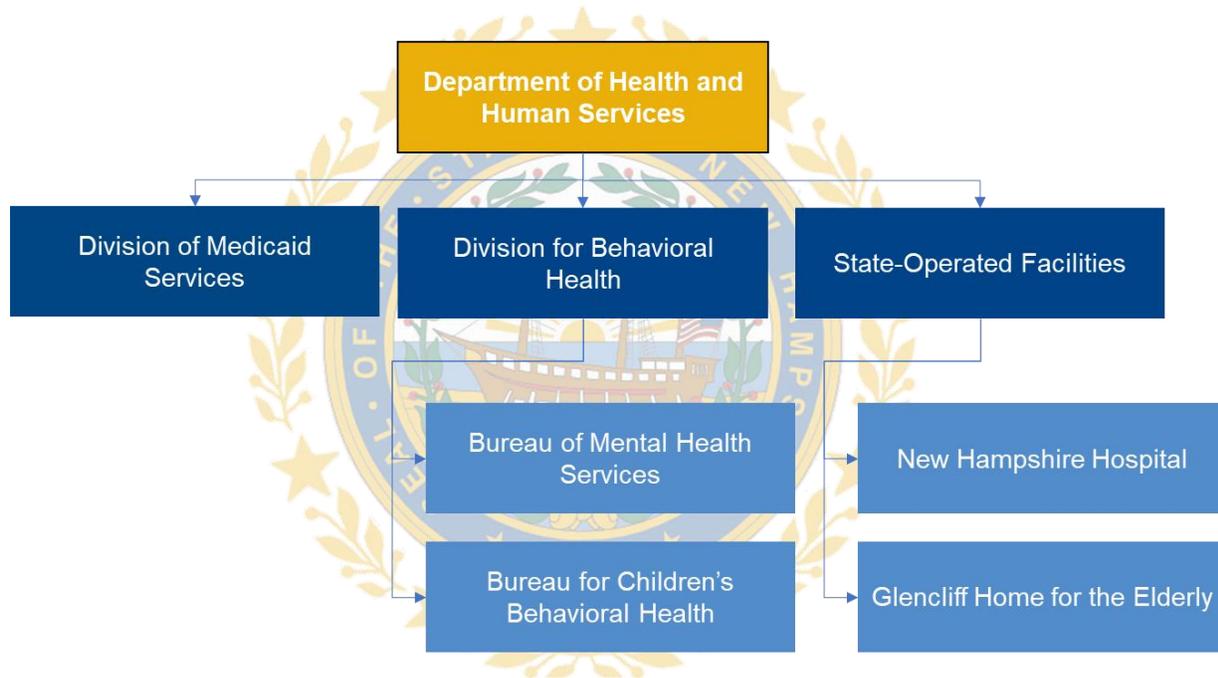
<sup>2</sup> Vahratian A, Blumberg SJ, Terlizzi EP, Schiller JS. Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic — United States, August 2020–February 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:490–494. DOI: <http://dx.doi.org/10.15585/mmwr.mm7013e2>

## 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<sup>3</sup>. 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)<sup>4</sup>. 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<sup>5</sup>. 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

<sup>3</sup> Figure only includes beneficiaries enrolled in CMHCs. Other Medicaid beneficiaries who meet the diagnostic criteria may not be reflected in these figures.

<sup>4</sup> Figure only includes beneficiaries enrolled in CMHCs. Other Medicaid beneficiaries who meet the diagnostic criteria may not be reflected in these figures.

<sup>5</sup> 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<sup>6</sup> (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<sup>7</sup>. 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)<sup>8</sup> 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)<sup>9</sup> 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

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<sup>6</sup> New Hampshire 10-year Mental Health Plan, January 2019, <https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf>

<sup>7</sup> 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>

<sup>8</sup> 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.

<sup>9</sup> CME is the entity that provides FAST forward and other community-based services for high need children, youth, and families.

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<sup>10</sup>;
  - 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<sup>11</sup> 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

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<sup>10</sup> 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.

<sup>11</sup> 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

vulnerable individuals during periods of transition.”<sup>12</sup> 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 State has made significant improvements in ED boarding, the need for mental health services was exacerbated during the PHE<sup>13</sup> (including the new onset of mental health symptoms for some individuals), and there needs to be continued focus on the issue. 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<sup>14</sup> 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<sup>15</sup> 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 Glenclyff 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).

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<sup>12</sup> Center for the Advancement of Critical Time Intervention, <https://www.criticaltime.org/cti-model/>

<sup>13</sup> 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>

<sup>14</sup> *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>

<sup>15</sup> Executive Order 2021-09, May 13, 2021, <https://www.governor.nh.gov/sites/g/files/ehbemt336/files/documents/2021-09.pdf>

4. Reinforce psychiatric care for adults by adding 20 or more DRF beds at a fixed payment 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. Prevent and 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.

## 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 Implementation Plan (see [Attachment 4](#)).

### **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.

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<sup>16</sup> 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.

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<sup>16</sup> Eligibility criteria will be determined by diagnosis of SMI regardless of whether or not an individual is enrolled in a CMHC.

## 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
<b>Evaluation Question(s):</b> 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?			

<p><b>Goal 1:</b> Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings</p>	<p><b>Hypothesis 1:</b> 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.</p> <p><i>Example Monitoring Metric:</i></p> <ul style="list-style-type: none"> <li>All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit from Integrated Physical and Behavioral Health Care</li> </ul>	<ul style="list-style-type: none"> <li>Interviews or focus groups with ED and state demonstration staff</li> <li>Interviews or focus groups with affected beneficiaries and / or their family members / caregivers</li> </ul>	<ul style="list-style-type: none"> <li>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</li> </ul>
<p><b>Evaluation Question(s):</b> 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?</p>			
<p><b>Goal 2:</b> Reduced preventable readmissions to acute care hospitals and residential settings</p>	<p><b>Hypothesis 2:</b> The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.</p> <p><i>Example Monitoring Metric:</i></p> <ul style="list-style-type: none"> <li>30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility</li> </ul>	<ul style="list-style-type: none"> <li>Claims</li> <li>Interviews or focus groups with hospital / residential staff and community-based service providers</li> <li>Interviews or focus groups with affected beneficiaries and / or their family members / caregivers</li> <li>Electronic / paper medical records</li> <li>State-specific beneficiary survey</li> </ul>	<ul style="list-style-type: none"> <li>Difference-in-difference models</li> <li>Qualitative analysis to identify themes associated with the effectiveness of demonstration activities for reducing preventable readmissions to acute care hospitals and residential settings</li> <li>Descriptive quantitative analysis comparing baseline and demonstration midpoint and end date</li> </ul>
<p><b>Evaluation Question(s):</b> 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?</p>			
<p><b>Goal 3:</b> Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services</p>	<p><b>Hypothesis 3:</b> The demonstration will result in improved availability of crisis stabilization services throughout the state.</p> <p><i>Example Monitoring Metrics:</i></p> <ul style="list-style-type: none"> <li>Mental Health Services Utilization – Inpatient, Intensive Outpatient and Partial</li> </ul>	<ul style="list-style-type: none"> <li>Annual assessments of availability of mental health services</li> <li>State administrative data or state-specific provider survey</li> <li>AHRF data on psychiatric care beds set up in short-term general hospitals</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive quantitative analysis of trends over time during the demonstration</li> <li>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</li> </ul>

<p>provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state</p>	<p><i>Hospitalization, Outpatient, ED, Telehealth</i></p> <ul style="list-style-type: none"> <li>• <i>Average Length of Stay in IMDs</i></li> <li>• <i>Beneficiaries With SMI Treated in an IMD for Mental Health</i></li> </ul>		<ul style="list-style-type: none"> <li>• 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</li> </ul>
<p><b>Evaluation Question(s):</b> 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?</p>			
<p><b>Goal 4:</b> 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</p>	<p><b>Hypothesis 4:</b> 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.</p> <p><i>Example Monitoring Metrics:</i></p> <ul style="list-style-type: none"> <li>• <i>Access to Preventative / Ambulatory Health Services for Medicaid Beneficiaries with SMI</i></li> <li>• <i>Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication</i></li> </ul>	<ul style="list-style-type: none"> <li>• Claims</li> <li>• Annual assessments of availability of mental health services</li> <li>• State administrative data</li> <li>• Adult Core Set</li> <li>• AHRF county data Hybrid claims and medical records or electronic medical records</li> </ul>	<ul style="list-style-type: none"> <li>• Difference-in-differences regression model</li> <li>• Descriptive quantitative analysis of trends over time during the demonstration</li> <li>• Descriptive quantitative analysis comparing baseline and demonstration midpoint and end date</li> <li>• 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</li> <li>• 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</li> </ul>
<p><b>Evaluation Question(s):</b> 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?</p>			
<p><b>Goal 5:</b> Improved care coordination, especially continuity of care in the community following episodes</p>	<p><b>Hypothesis 5:</b> The demonstration will result in improved care coordination, especially continuity of care in the</p>	<ul style="list-style-type: none"> <li>• Claims</li> <li>• Adult Core Set</li> <li>• Interviews with state demonstration and / or inpatient / residential and outpatient provider staff</li> </ul>	<ul style="list-style-type: none"> <li>• Difference-in-differences</li> <li>• Qualitative analysis to identify themes associated with the effectiveness of</li> </ul>

of acute care in hospitals and residential treatment facilities	community following episodes of acute care in hospitals and residential treatment facilities.  <i>Example Monitoring Metrics:</i> <ul style="list-style-type: none"> <li>• <i>Follow-up After Hospitalization for Mental Illness</i></li> <li>• <i>Medication Continuation Following Inpatient Psychiatric Discharge</i></li> <li>• <i>Follow-up After Emergency Department Visit for Mental Illness</i></li> </ul>	<ul style="list-style-type: none"> <li>• Facility records</li> <li>• Interviews or focus groups with state demonstration and / or inpatient / residential and outpatient provider staff</li> <li>• Interviews or focus groups with affected beneficiaries or their families / caregivers</li> </ul>	demonstration activities to improve data sharing systems, processes, and policies to support care coordination <ul style="list-style-type: none"> <li>• Descriptive quantitative analysis comparing baseline and demonstration midpoint and end date</li> <li>• 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</li> </ul>
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## 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

### Public Notice & Public Hearings

The State conducted public notice in accordance with 42 CFR §431.408. Public Notice of the State’s request for this demonstration amendment and notice of Public Hearing were advertised in the newspapers of widest circulation (*Union Leader, The [Nashua] Telegraph*) and sent to an electronic mailing list maintained by Division for Behavioral Health. In addition, the public notice was posted to the State’s Medicaid website at <https://www.dhhs.nh.gov/sud-imd/comment.htm>, which was subsequently advertised on social medial (Facebook). See Attachment 2 for a copy of the website and social media content, public notice, slides used at the hearings, and newspaper tear sheets.

DHHS held three public hearings on this proposal (including virtual options) as follows:

Public Hearing #1 in Concord, NH with Zoom link  
August 9, 2021, at 5:30pm

Public Hearing #2 in Nashua, NH with Zoom link  
August 11, 2021, at 6pm

Public Hearing #3 in Concord, NH with Zoom link

August 16, 2021, at 5:30pm

Due to technical difficulties experienced with the Zoom link and dial-in during Public Hearing #1, the State decided to add a third public hearing to accommodate any interested parties who were unable to participate due to the technical difficulties.

Comments on the amendment were also considered at the August Medical Care Advisory Committee (MCAC) meeting held on August 16, 2021 at 10:00am in Concord, NH. All MCAC meetings are open to the public and include an option for virtual participation. The agenda and minutes from the MCAC meeting are included in Attachment 2.

### Tribal Notice & Consultation

New Hampshire does not have any federally recognized tribes.

### Public Comment Period

The State offered a 30-day public comment period that was open from 4:30pm on August 2, 2021 through 4:30pm on August 31, 2021. The following options were available for the public to share feedback:

1. E-mail
  - a. John Poirier was the designated point of contact to receive public comments and monitored the following email address: [IMDSMIAmendment@DHHS.NH.Gov](mailto:IMDSMIAmendment@DHHS.NH.Gov) in addition to his own individual email, [John.E.Poirier@DHHS.NH.Gov](mailto:John.E.Poirier@DHHS.NH.Gov).
  - b. See Attachment 2 for emailed stakeholder letters received from the following organizations / individuals:
    - i. NAMI NH;
    - ii. New Futures NH;
    - iii. Disability Rights Center NH;
    - iv. DRC Protection and Advocacy for Individuals with Mental Illness (PAIMI) Advisory Council; and
    - v. NH Community Behavioral Health Association.
2. Mailed
  - a. John Poirier was the designated point of contact for public comments and received mail at the following address:

John Poirier  
NH Department of Health and Human Services  
Attn: SUD-TRA Demonstration Amendment #2  
129 Pleasant Street  
Concord, NH 03301
  - b. There were no comments received by mail during the public comment period.
3. Testimony at Public Hearings
  - a. See Attachment 2 for a summary of testimony from the public hearings

Summary of comments received and response from the State:

<b>Comment Theme</b>	<b>Interested Parties</b>	<b>State Response</b>
The 10-Year Mental Health Plan continues to be the blueprint for moving NH's mental health system forward.	NAMI NH, NH CBHA, New Futures NH	DHHS appreciates the ongoing advocacy and partnership on implementation of the 10-Year Mental Health Plan (including continued investments in community-based services) from groups like NAMI NH, NH CBHA, and New Futures NH.
Clarification on the ED boarding situation in NH.	NAMI NH	The text of the narrative was changed in response to feedback received.
Focus on prevention in addition to reduction of utilization and lengths of stay.	NAMI NH	The text of the narrative was changed in response to feedback received.
Inclusion of objectives around preventing suicide and drug overdose deaths.	NAMI NH	DHHS agrees that these are important objectives and there are programs in the Department that focus on suicide prevention and the substance use disorder treatment system.
Acknowledging the special needs of people experiencing homelessness or housing instability.	NAMI NH, New Futures NH	DHHS appreciates the ongoing support of advocacy groups like NAMI NH and New Futures NH. DHHS has submitted to CMS for approval a 1915(i) Plan Amendment with the goal of addressing housing instability.
Potential to require follow up within 72 hours from anyone who receives a mental health evaluation in an ED.	NAMI NH	DHHS will address this comment directly with NAMI NH in a follow-up discussion. DHHS would also note that the MCO quality program tracks follow-up after ED visits as a HEDIS measure and the State's directed payments to CMHCs within the MCO program encourage post-discharge follow up.
Request to include mention of justice-involved persons.	NAMI NH, New Futures NH	Notwithstanding the demonstration does not

Comment Theme	Interested Parties	State Response
		include justice-involved persons, DHHS acknowledges the importance of this integration work outside the demonstration.
Request to include mention of role for peer support, particularly in community-based transitions.	NAMI NH	DHHS agrees on the importance of peer support, particularly in the case of community-based transitions. The specific role of peer support in this demonstration will be addressed in the more detailed implementation plan included as Attachment 4.
Potential to add a milestone regarding data and tracking.	NAMI NH	Objectives align with CMS technical guidance on this type of demonstration. DHHS will address this comment directly with NAMI NH in a follow-up discussion.
Acknowledging the benefit of early identification and supports including supported employment and education as well as the importance of specialty settings and treatments for young adults.	NAMI NH	DHHS appreciates the ongoing support of advocacy groups like NAMI NH.
Acknowledging the value of soliciting information from beneficiaries as well their family members/caregivers.	NAMI NH	DHHS appreciates the ongoing support of advocacy groups like NAMI NH.
Request to track peer support services as a specific measure of Goal 3.	NAMI NH	Goals and evaluation measures align with CMS technical guidance on this type of demonstration. DHHS will address this comment directly with NAMI NH in a follow-up discussion.
Potential for greater role to be played by FQHCs and other non-behavioral health-focused providers.	NAMI NH	The Provider Availability Assessment Template (PAAT), as defined by CMS, includes a category for FQHCs that also offer behavioral health services. The PAAT is intended as a broad assessment of mental health services offered in NH.
Request to track continuity of	NAMI NH	Goals and evaluation

Comment Theme	Interested Parties	State Response
<p>care for individuals with SMI who experience homelessness or housing insecurity or are incarcerated as a specific measure of Goal 5.</p>		<p>measures align with CMS technical guidance on this type of demonstration. DHHS will address this comment directly with NAMI NH in a follow-up discussion. As noted previously, notwithstanding the demonstration does not include justice-involved persons, DHHS acknowledges the importance of this integration work outside the demonstration.</p>
<p>Prioritizing funding of institutional treatment capacity is inconsistent with the ADA and NH mental health statute.</p>	<p>DRC NH, DRC PAIMI Advisory Council</p>	<p>Additional federal support for mental health strengthens the State’s capacity to maintain and increase its investment in community-based services.</p>
<p>Additional inpatient mental health treatment capacity is not needed in NH.</p>	<p>DRC NH, DRC PAIMI Advisory Council</p>	<p>DHHS disagrees with the assertion that additional inpatient mental health treatment capacity is not needed in NH. The 10-Year Mental Health Plan called for an increase in inpatient psychiatric beds. Furthermore, the ongoing persistence of a waitlist for inpatient admission, as noted by other public commenters, is evidence of the need for additional capacity.</p> <p>A fully-developed mental health system includes community-based care and meets a range of needs, including acute psychiatric care. While we continue to invest significant dollars and effort into the community-based system of care, we do not currently have enough capacity to address the more acute needs of NH residents.</p>
<p>New inpatient treatment providers would put</p>	<p>DRC NH</p>	<p>More completely building out the continuum of care will</p>

Comment Theme	Interested Parties	State Response
<p>additional demands on an inadequate labor pool.</p>		<p>make NH a more attractive practice environment. One tool utilized by DHHS in this approach is the State Loan Repayment Program (SLRP), which is described in detail on DHHS website. Additional workforce development activities remain an ongoing and key priority for DHHS. Additionally, DHHS is working with state leaders to assess the opportunity for ARPA funds to support health care workforce development.</p>
<p>Expanding unneeded inpatient treatment capacity is inconsistent with the State’s obligation to improve the community-based treatment system.</p>	<p>DRC NH, DRC PAIMI Advisory Council</p>	<p>DHHS continues to implement the 10-Year Mental Health Plan, which addresses many aspects of the Community Mental Health Agreement. DHHS believes the solution to our mental health crisis is a combination of more community-based programs, as evidenced by the investments over the past three years (e.g., expanding mobile crisis, adding community residential capacity, implementing CTI) <u>and</u> additional inpatient capacity geographically located within communities, which is important for supporting the evidence-based, community-based programming that DHHS has implemented and will be implementing as well as family supports. A key requirement of the demonstration is maintenance of effort on community-based services, which will be subject to evaluation and monitoring by CMS.</p>

X. Attachments

1. Compliance with Budget Neutrality Requirements



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Mathieu Doucet, FSA, MAAA  
 Senior Consulting Actuary

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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](mailto: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

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.

### [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.

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

DRAFT

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 Residential Beds	Total
		SFY 2022	SFY 2022	CY 2019	SFY 2022	CY 2019	CY 2019	CY 2019	CY 2019	SFY 2022	CY 2019	SFY 2022	
Time Period of PMPM Costs													
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
<b>Summary by MEG</b>													
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
<b>Summary by MEG Trended to SFY 2022</b>													
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

## 2. Public Notice

A – Public Comment Website & Social Media Post

DHHS Home > Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and

Demonstration Waiver >

## SMI IMD Amendment to SUD-TRA Section 1115(a) Research and Demonstration Waiver Comment Period

The State of New Hampshire Department of Health and Human Services (DHHS), as the single-state Medicaid agency, is seeking an amendment to its 1115(a) Substance Use Disorder Treatment and Recovery Access Demonstration Waiver to expand the scope of the demonstration to increase access to short-term inpatient and residential treatment services for beneficiaries with a mental health diagnosis (Serious Mental Illness or "SMI").

### Amendment to the Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver

The New Hampshire Department of Health and Human Services (DHHS) announces its intent to request from the Centers for Medicare and Medicaid Services (CMS) an amendment to the Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver. The proposed amendment will expand the scope of the waiver to include coverage for short-term inpatient and residential treatment services for beneficiaries with Serious Mental Illness (SMI).

Public Notice  (08/02/2021, amended 08/11/2021)

Public Hearings Presentation 

Draft Plan Amendment 

#### Public Hearings

DHHS will host three public hearings during the public comment period:

##### Monday, August 9, 2021 – Concord

5:30 – 7:00PM

Brown Building Auditorium

129 Pleasant Street

Concord, NH

##### Wednesday, August 11, 2021 – Nashua

6:00 - 7:30 pm

Harbor Homes – Partnership for Successful Living

77 Northeastern Blvd.

Nashua, NH

Join Zoom Meeting

<https://nh-dhhs.zoom.us/j/5215124074?pwd=S3hGOWh6QXp1Z2tpRWtTRUNKR1F2QT09>

Meeting ID: 521 512 4074

Passcode: 371154

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+1 253 215 8782 US (Tacoma)

+1 346 248 7799 US (Houston)

Meeting ID: 521 512 4074

Passcode: 371154

Find your local number: <https://nh-dhhs.zoom.us/j/5215124074?pwd=S3hGOWh6QXp1Z2tpRWtTRUNKR1F2QT09>

##### Monday, August 16, 2021 – Concord

5:30 – 7:00 PM

Brown Building Auditorium

129 Pleasant Street

Concord, NH

Join Zoom Meeting

<https://nh-dhhs.zoom.us/j/95015594141?pwd=bWVnSnBNSeg0Zjg0N3FaWXZtUk8vUT09>

Meeting ID: 950 1559 4141

Passcode: 280862

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Meeting ID: 950 1559 4141  
Passcode: 280862  
Find your local number: <https://nh-dhhs.zoom.us/j/abBDNdcxIL>

If accommodations are needed for communication access such as interpreters, CART (captioning), assistive listening devices, or other auxiliary aids and/or services, please contact John Poirier at [John.E.Poirier@dhhs.nh.gov](mailto:John.E.Poirier@dhhs.nh.gov) or (603) 271-9628. Every effort will be made to accommodate needs identified with advance notice.

## SUD IMD Waiver Federal Comment Period – Updated June 14, 2018

As part of New Hampshire's statewide effort to combat the ongoing opioid crisis, and in response to the nation's recently-extended public health emergency, the NH Department of Health & Human Services submitted an application for the "New Hampshire Substance Use Disorder Treatment and Recovery Access" Section 1115(a) Research Demonstration. The goal of the demonstration is to improve access to, and quality of, residential substance use disorder (SUD) treatment for Medicaid beneficiaries in our State. Due to the declared public health emergency, comments on the budget neutrality may be submitted concurrently with the federal comment period which is open April 26, 2018 through May 26, 2018. Please see the Department and CMS letters below as well as the link to the federal comment process.

Public Comment and Responses from NH DHHS Federal Comment Period April 26, 2018 – May 26, 2018 

Letters of Comment April 26, 2018 to May 26, 2018

### New Hampshire SUD Treatment and Recovery Access Application

[View/Submit Public Comment](#)

Federal Comment Process Correspondence 

## SUD IMD Waiver Submitted to CMS

As part of statewide effort to combat the ongoing opioid crisis, the State of New Hampshire's application for a Section 1115(a) Demonstration Waiver, the "New Hampshire Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver," to improve access to and quality of residential substance use disorder (SUD) treatment for Medicaid beneficiaries, has been submitted. Please see the application for a Section 1115(a) Demonstration Waiver and Waiver Application Cover Letter below.

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

Waiver Application Cover Letter 

## February 27, 2018 Notice

Notice is hereby given that the DHHS is seeking public input on a *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver*  that will enable New Hampshire to provide Medicaid payments for individuals receiving SUD services in an IMD.

Specifically, New Hampshire is requesting:

The Center for Medicare and Medicaid Services (CMS) waive Section 1905(a)(29)(B), 42 CFR 438.6(e), and 42 CFR 435.1010 to allow a waiver of the IMD exclusion for Medicaid-eligible individuals ages 21-64 receiving residential SUD treatment in an IMD as long as is medically necessary.

CMS expand the exception to the IMD exclusion in 42 CFR 441.11(c)(5) to the provider type, Comprehensive SUD Program, as described in He-W 513.02(b), to allow New Hampshire to claim federal financial participation (FFP) for individuals under 21 receiving residential substance use disorder treatment in these facilities for as long as is medically necessary.

Expenditure authority is being requested for individuals who meet the criteria above who are either covered as Medicaid fee-for-service or enrolled in Medicaid managed care.

The Demonstration will further the objectives of Title XIX of the Social Security Act by increasing access to, stabilizing, and strengthening providers and provider networks, available to serve Medicaid and low-income populations in the state. This will be accomplished by ensuring continuity of care for individuals receiving SUD treatment, increasing access to residential treatment services for adolescents with SUD, and ensuring consistency between public and private coverage for SUD services in New Hampshire.

Read the DHHS Press Release

Read CMS Guidance: Strategies to Address the Opioid Epidemic 

### 30-Day Public Comment Period and Waiver

The 30-day public comment period for the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver*  is from **Tuesday, February 27, 2018 until Friday, March 30, 2018 at 12 Noon (Eastern)**. All comments must be received by **12 Noon (Eastern) on Friday, March 30, 2018**.

Written comments may be submitted to [imsudwaiver@dhhs.nh.gov](mailto:imsudwaiver@dhhs.nh.gov).

Public Comment and DHHS Responses 

Comments: National Alliance on Mental Illness (NAMI) New Hampshire 

### Public Hearings

DHHS will host two public hearings during the public comment period.

#### **Tuesday, March 6, 2018 – Manchester**

**6:00 - 7:30 pm**

Manchester Health Department  
1528 Elm Street Manchester, NH

**Call-in option:** To participate by phone, call in at 6:00 pm to: 1-866-470-8024

When prompted, use this code: 965 412 0884

**Snow Date:** Thursday, March 8, 2018, 6 - 7:30 pm, Manchester Health Department

#### **Tuesday, March 13, 2018 - Nashua**

**POSTPONED TO MARCH 14 (same time and location)**

**1:00 - 2:30 pm**

Harbor Homes - Partnership for Successful Living  
77 Northeastern Blvd, Nashua, NH

**Snow Date: Wednesday, March 14, 2018, 1-2:30 pm, Harbor Homes Partnership for Successful Living**

View Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration" public hearing presentation 

If accommodations are needed for communication access such as interpreters, CART (captioning), assistive listening devices, or other auxiliary aids and/or services, please contact Leslie Melby at [Leslie.Melby@dhhs.nh.gov](mailto:Leslie.Melby@dhhs.nh.gov) or 603-271-9074, no later than March 1, 2018. Every effort will be made to accommodate needs identified with advance notice.

Comments will also be considered at the Monday, March 12, 2018 Medical Care Advisory Committee Meeting, from 10-12 p.m. All Medical Care Advisory Committee Meetings are open to the public.

Medical Care Advisory Committee Meeting location:

NH Hospital Association  
125 Airport Rd, Conference Room 1  
Concord NH 03301

### Ways to Submit Comments

DHHS would like to hear your comments about the changes it is proposing. After hearing the public's ideas and comments about the proposed changes, DHHS will make final decisions about what changes to make to the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver* and then submit to CMS. The summary of comments will be posted for public viewing on this page, along with the waiver application when it is submitted to CMS.

**There are several ways to submit your comments to DHHS:**

Attend either of the two public hearings to be held at the dates/locations noted above. At the public hearings, you may give verbal or written comments to DHHS;

Email comments to [IMDSMIAmendment@dhhs.nh.gov](mailto:IMDSMIAmendment@dhhs.nh.gov); or

Mail written comments to:

John Poirier

New Hampshire Department of Health and Human Services

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

129 Pleasant Street

Concord, NH 03301

When mailing or emailing please specify the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver*.

**Additional Information**

Requests for a hard copy of the Waiver application should be submitted by mail to:

John Poirier  
NH Department of Health and Human Services  
Attn: SUD-TRA Demonstration Amendment #2  
129 Pleasant Street  
Concord, NH 03301

A hard copy of the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver* can also be picked up at DHHS, which is located at:

New Hampshire Department of Health and Human Services  
Fred H. Brown Building  
129 Pleasant Street  
Concord, NH 03301

 Adobe Acrobat Reader format. You can download a free reader from Adobe (<http://get.adobe.com/reader/>) .



NH Department of Health and Human Services

August 5 at 1:49 PM · 🌐



DHHS is seeking public comment for a proposed amendment to its Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver (SUD-TRA).

The amendment will enable New Hampshire to claim federal reimbursement for services provided to Medicaid beneficiaries ages 21-64 receiving short-term inpatient psychiatric treatment or short-term residential mental health treatment in an Institution for Mental Disease (IMD).

Learn more at <https://www.dhhs.nh.gov/sud-imd/comment.htm>.



4

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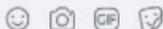
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B – Public Notice

NH Department of Health and Human Services

**Public Notice for Proposed**

Substance Use Disorder Treatment and Recovery Access  
Section 1115(a) Research and Demonstration Waiver  
Amendment #2 Request

**August 2nd, 2021 (Amended August 11, 2021)**

Notice is hereby given that, as part of its overall approach to address the increase in Emergency Department boarding and to support the comprehensive, integrated continuum of mental health treatments and care available in the state, the NH Department of Health and Human Services (DHHS) is applying for an amendment to its Section 1115(a) Research and Demonstration Waiver from the Centers for Medicare and Medicaid Services (CMS). This amendment will enable DHHS to claim federal reimbursement for payment of services provided to Medicaid beneficiaries ages 21-64 receiving short-term inpatient psychiatric treatment or short-term residential mental health treatment in an Institution for Mental Disease (IMD). Specifically, New Hampshire is requesting that:

- CMS waive Section 1905(a)(30)(B) of the Social Security Act, 42 CFR 438.6(e), and 42 CFR 435.1010 to allow reimbursement for Medicaid beneficiaries ages 21-64 receiving short-term inpatient psychiatric treatment or short-term residential mental health treatment in IMDs; and
- Expenditure authority be applied to individuals who meet the criteria above who are either covered as Medicaid fee-for-service or enrolled in Medicaid managed care.

This amendment will further the objectives of Title XIX of the Social Security Act by increasing access to and strengthening providers and provider networks available to serve Medicaid populations in the state. This will be accomplished by enhancing mental health treatment supports and by supporting the comprehensive, integrated continuum of mental health treatments and care for residents of New Hampshire.

The complete version of the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Amendment #2 Request* is available for public review at:

<https://www.dhhs.nh.gov/ombp/medicaid/documents/smi-demo-amendment-draft.pdf>

CMS guidance regarding opportunities to design innovative service delivery systems for adults and children with mental illness can be found at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.

**30-Day Public Comment Period and Amendment #2**

The 30-day public comment period for the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Amendment #2 Request* is from Monday, August 2, 2021 until Tuesday, August 31, 2021. All comments must be received by 4:30 p.m. (Eastern) on August 31, 2021.

**Public Hearings**

DHHS will host three public hearings during the public comment period:

**Monday, August 9, 2021 – Concord**

**5:30 – 7:00PM**

Brown Building Auditorium

129 Pleasant Street

Concord, NH

**Call-In option:** To participate by phone, call in at 5:30 pm to: 1 (646) 558-8656

When prompted, use this code: 280862#

Join Zoom Meeting:

<https://nh-dhhs.zoom.us/j/95015594141?pwd=bWVnSnBNSEg0Zjg0N3FaWXZtUk8vUT09>

**Wednesday, August 11, 2021 – Nashua**

6:00 - 7:30 pm

Harbor Homes – Partnership for Successful Living

77 Northeastern Blvd.

Nashua, NH

Join Zoom Meeting

<https://nh-dhhs.zoom.us/j/5215124074?pwd=S3hGOWh6QXp1Z2tpRWtTRUNKR1F2QT09>

Meeting ID: 521 512 4074

Passcode: 371154

One tap mobile

+16465588656,,5215124074#,,,,\*371154# US (New York)

+13017158592,,5215124074#,,,,\*371154# US (Washington DC)

Dial by your location

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- +1 301 715 8592 US (Washington DC)
- +1 312 626 6799 US (Chicago)
- +1 669 900 9128 US (San Jose)
- +1 253 215 8782 US (Tacoma)
- +1 346 248 7799 US (Houston)

Meeting ID: 521 512 4074

Passcode: 371154

Find your local number: <https://nh-dhhs.zoom.us/j/5215124074>

**Monday, August 16, 2021 – Concord**

5:30 – 7:00 PM

Brown Building Auditorium  
129 Pleasant Street  
Concord, NH

Join Zoom Meeting

<https://nh-dhhs.zoom.us/j/95015594141?pwd=bWVnSnBNSEg0Zjg0N3FaWXZtUk8vUT09>

Meeting ID: 950 1559 4141

Passcode: 280862

One tap mobile

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Meeting ID: 950 1559 4141

Passcode: 280862

Find your local number: <https://nh-dhhs.zoom.us/j/95015594141>

If accommodations are needed for communication access such as interpreters, CART (captioning), assistive listening devices, or other auxiliary aids and/or services, please contact John Poirier at [John.E.Poirier@dhhs.nh.gov](mailto:John.E.Poirier@dhhs.nh.gov) or (603) 271-9628 no later than August 4, 2021. Every effort will be made to accommodate needs identified with advance notice.

**Medical Care Advisory Committee Meeting**

Comments will also be considered at the Monday, August 16, 2021 Medical Care Advisory Committee (MCAC) meeting, from 10 a.m. - 12 p.m. All MCAC meetings are open to the public. The MCAC meeting location is:

Fred H. Brown Building Auditorium  
129 Pleasant Street  
Concord, NH 03301

### **Ways to Submit Comments**

DHHS would like to hear your comments about the changes it is proposing. After hearing the public's ideas and comments about the proposed changes, DHHS will make final decisions about what changes to make to the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Amendment #2 Request* and then submit to CMS for approval. The summary of comments will be posted for public viewing at <https://www.dhhs.nh.gov/> along with the amendment application when it is submitted to CMS.

There are several ways to give your comments to DHHS:

- Attend any of the two public hearings or MCAC meeting held at the dates / locations noted above. At these events, you can give verbal or written comments to DHHS. Additional information about providing comments is noted below.
- Email comments to [IMDSMIAmendment@DHHS.NH.Gov](mailto:IMDSMIAmendment@DHHS.NH.Gov).
- Mail written comments to:  
John Poirier  
NH Department of Health and Human Services  
Attn: SUD-TRA Demonstration Amendment #2  
129 Pleasant Street  
Concord, NH 03301

When mailing or emailing please specify the subject as "SUD-TRA Demonstration Amendment #2."

### **Additional Information**

Requests for a hard copy of the amendment application should be submitted by mail to:

John Poirier  
NH Department of Health and Human Services  
Attn: SUD-TRA Demonstration Amendment #2  
129 Pleasant Street  
Concord, NH 03301

A hard copy of the *Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Amendment #2 Request* can also be picked up at DHHS, which is located at:

NH Department of Health and Human Services  
Fred H. Brown Building  
129 Pleasant Street  
Concord, NH 03301

All information regarding the proposed amendment can be found on the DHHS web site at <https://www.dhhs.nh.gov> under "Quick Links". DHHS will update this website throughout the public comment and application process.

C – Public Hearing Slides



**STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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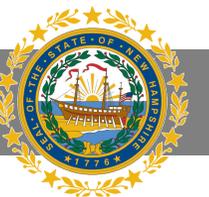
**PUBLIC HEARING FOR:  
SUBSTANCE USE DISORDER TREATMENT AND RECOVERY ACCESS SECTION 1115(a)  
RESEARCH AND DEMONSTRATION WAIVER**

**AMENDMENT #2 REQUEST  
MENTAL HEALTH SERVICES FOR MEDICAID BENEFICIARIES WITH SERIOUS MENTAL ILLNESS**

Public Forums:	August 9, 2021	Concord
	August 11, 2021	Nashua
	August 16, 2021	Concord

## Table of Contents

1. Background
2. Comprehensive Strategy to Address Psychiatric Boarding in NH
3. Demonstration Request
4. Current Mental Health System
5. Budget Neutrality
6. Evaluation
7. Timeline
8. Opportunities for Public Input
  1. Public Hearings
  2. Email or Mail Communication
9. Draft Amendment Application
10. Contact Information



## New Hampshire has observed an increasing number of individuals who present in hospital EDs in mental health crisis.

- The State has observed an increasing number of individuals who present in hospital Emergency Departments (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 New Hampshire Hospital (NHH).
- While the ED wait list had fallen 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 Public Health Emergency (PHE)<sup>1</sup>.
- 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<sup>2</sup> 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 on May 13, 2021<sup>3</sup>, requiring NH Department of Health and Human Services (DHHS) to adopt 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.

<sup>1</sup> 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>

<sup>2</sup> *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>

<sup>3</sup> Executive Order 2021-09, May 13, 2021, <https://www.governor.nh.gov/sites/g/files/ehbemt336/files/documents/2021-09.pdf>



# Comprehensive Strategy to Address Psychiatric Boarding in NH

Amendment is part of NH's strategy to address ED boarding and increase inpatient and community-based capacity.



**Expanding Community-based Settings / Step-down Capacity**



**Increasing & Decentralizing Inpatient Capacity**  
*through this amendment*



**Reducing Readmissions**



# Demonstration Request

## NH DHHS is applying for an amendment to its Section 1115(a) Demonstration.

- As part of its overall approach to addressing the increase in Emergency Department boarding and to support the comprehensive, integrated continuum of mental health treatments and care available in the state, the NH Department of Health and Human Services (DHHS) is applying for an amendment to its Section 1115(a) Demonstration from the Centers for Medicare and Medicaid Services (CMS).
- This amendment will enable DHHS to claim federal reimbursement for payment of services provided to Medicaid beneficiaries ages 21-64 receiving short-term inpatient psychiatric treatment or short-term residential mental health treatment in an Institution for Mental Disease (IMD).
- Specifically, New Hampshire is requesting that:
  - CMS waive Section 1905(a)(30)(B) of the Social Security Act (commonly known as the “IMD Exclusion Rule”), 42 CFR 438.6(e), and 42 CFR 435.1010 to allow reimbursement for Medicaid beneficiaries ages 21-64 receiving short-term inpatient psychiatric treatment or short-term residential mental health treatment in IMDs; and
  - Expenditure authority be applied to individuals who meet the criteria above who are either covered as Medicaid fee-for-service or enrolled in Medicaid managed care.
- The services proposed within this amendment include those that are in alignment with the existing mental health delivery system for inpatient psychiatric and residential mental health treatment and are not intended to reduce or replace services provided in less restrictive settings.

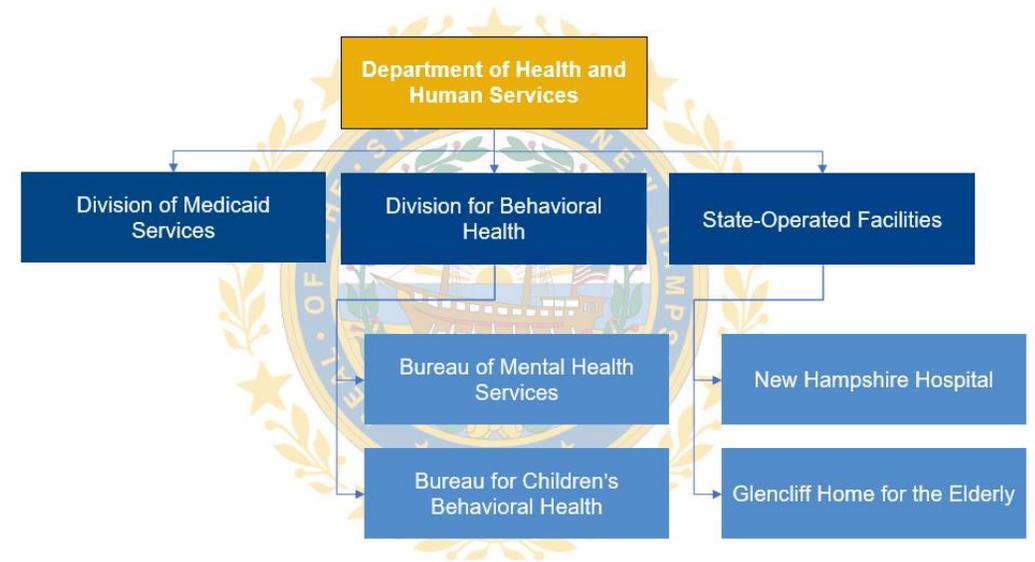


# Current Mental Health System

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 SFY 2020.

- 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).
- The following facilities operated by New Hampshire meet the regulatory definition of an Institution for Mental Disease (IMD):
  - One psychiatric hospital serving adults, New Hampshire Hospital (NHH), with 187 beds; and
  - One nursing facility primarily serving the elderly, Glenclyff Home for the Elderly, with 115 beds.
- The following facility operated by a private sector provider meets the regulatory definition of an IMD:
  - One hospital primarily serving youth, Hampstead Hospital, with 76 beds.
- New Hampshire also contracts with a regional network of ten (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.

## Simplified Organizational Structure



NH DHHS worked with its actuarial partners at Milliman to project budget neutrality limits for this amendment.

## **Projected Annual Budget Neutrality Expenditures**

- \$10,259,104 in SFY23 (final year of demonstration)
- Achievable based on NH DHHS assessment

## **Estimated Federal Share**

- \$4,396,873 in SFY23
- Based on reimbursement for stays > 15 days and ≤ 60 days

## **Other Expected Benefits**

- Creates financially viable opportunity for private sector providers to enhance access to short-term inpatient treatment in NH
- Favorable economic benefits from reduced psychiatric boarding in EDs



**NH DHHS will submit a draft evaluation design no later than 180 days after CMS approves this amendment application.**

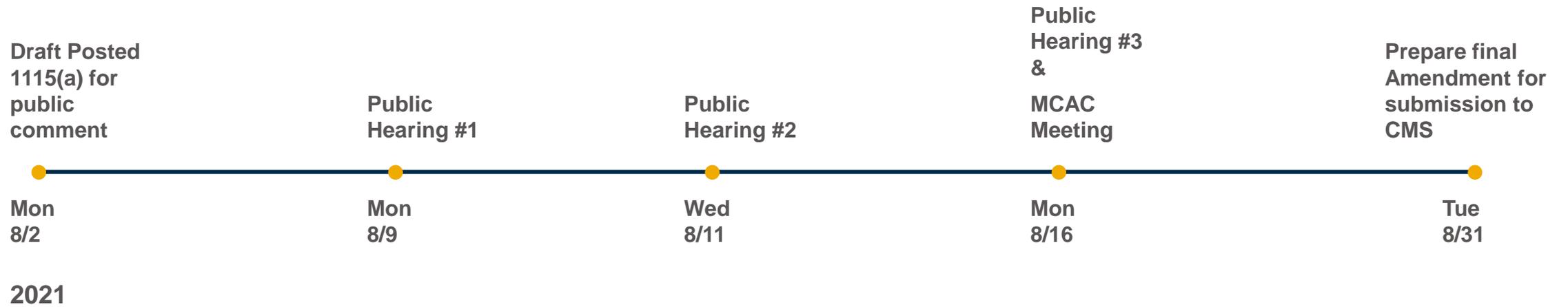
The State will test the following research hypotheses through this amendment:

1. The SMI amendment will result in reductions in utilization and length of stay in EDs among Medicaid beneficiaries with SMI while awaiting mental health treatment.
2. The amendment will result in reductions in preventable readmissions to acute care hospitals and residential settings.
3. The amendment will result in improved availability of crisis stabilization services throughout the state.
4. Access of beneficiaries with SMI to community-based services to address their chronic mental health care needs will improve under the amendment, including through increased integration of primary and behavioral health care.
5. The amendment will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.



# Timeline

The timeline for this amendment application is outlined below.



# Opportunities for Public Input | Public Hearings

DHHS will offer three opportunities for public hearing and include the amendment on the upcoming MCAC meeting agenda.

## **Public Hearing #1**

**Monday, August 9, 2021 – Concord**

5:30 - 7:00 pm

Fred H. Brown Building Auditorium

129 Pleasant Street

Concord, NH 03301

**Call-In option:** To participate by phone, call in at 5:30 pm to 1 (646) 558-8656

When prompted, use this code: 280862#

## **Public Hearing #2**

**Wednesday, August 11, 2021 – Nashua**

6:00 - 7:30 pm

Harbor Homes – Partnership for Successful Living

77 Northeastern Boulevard

Nashua, NH 03062

**Call-In option:** To participate by phone, call in at 6:00 pm to 1 (646) 558-8656

When prompted, use this code: 371154#

## **Public Hearing #3**

**Monday, August 16, 2021 – Concord**

5:30 - 7:00 pm

Fred H. Brown Building Auditorium

129 Pleasant Street

Concord, NH 03301

**Call-In option:** To participate by phone, call in at 5:30 pm to 1 (646) 558-8656

When prompted, use this code: 280862#

## **MCAC Meeting**

**Monday, August 16, 2021 – Concord**

Fred H. Brown Building Auditorium

129 Pleasant Street

Concord, NH 03301

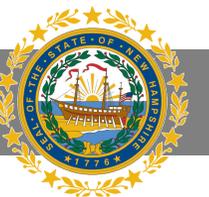


## Opportunities for Public Input | Email or Mail

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Public comment can also be sent to the following email and / or physical addresses.

- Email: [IMDSMIAmendment@DHHS.NH.Gov](mailto:IMDSMIAmendment@DHHS.NH.Gov)
- Mail: John Poirier  
NH Department of Health and Human Services  
Attn: SUD-TRA Demonstration Amendment #2  
129 Pleasant Street  
Concord NH 03301



# Draft Amendment Application

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The current draft of the amendment and other supporting materials can be found online.

- The proposed amendment to the SUD-TRA Research and Demonstration Waiver is available for public review at: <https://www.dhhs.nh.gov/ombp/medicaid/documents/smi-demo-amendment-draft.pdf>.
- Relevant CMS guidance is available at: <https://www.medicare.gov/federal-policy-guidance/downloads/smd18011.pdf>.
- Other notices, demonstration documents, and information about the demonstration are available on the DHHS website at: <https://www.dhhs.nh.gov>.



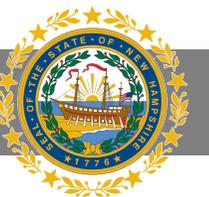
## Contact Information

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To reach all stakeholders, please use the following contact information.

- Non-electronic copies of all aforementioned documents are available by contacting John Poirier at (603) 271-9628.

Public Comment may be submitted until 4:30 p.m. (Eastern) on Tuesday, August 31, 2021.



D – MCAC Meeting Agenda

# Medical Care Advisory Committee (MCAC)

Monday, August 16, 2021

10:00am – 12:00pm

Brown Building Auditorium, 129 Pleasant Street, Concord NH

Zoom call-in available. See email for instructions.

## AGENDA

**10:00-10:05**

**Introductions/Announcements**

Carolyn Virtue, Chair

**10:05-10:10**

**Review/Approval: July 19, 2021 Minutes**

Carolyn Virtue, Chair

**10:10-10:15**

**Agenda Items for September 13, 2021**

Members

**10:15-10:55**

**Substance Use Disorder Treatment and Recovery Access  
1115(a) Research and Demonstration SMI IMD Waiver**

Joe Caristi, CFO, NH Hospital  
Henry Lipman, Medicaid Director

**10:55-11:30**

**Department Updates**

- DHHS Budget/HB2 Implementation Updates
  - Nursing Facility Rate Changes
  - Home Visiting
  - Genetic Testing
- Legislation Summary 2021
- Out-of-State professional licensure phase-out
- Home and Community Based Services ARP Spending Plan

Henry Lipman, Medicaid Director

John Williams, Esq, Director, Legislative Affairs

Henry Lipman, Medicaid Director

Nancy Rollins, Interim Director, LTSS

See [Home and Community-Based Services \(HCBS\) American Rescue Plan Spending Plan Proposal to CMS](#) 

- Appendix K Flexibilities – CFI and DD
- Long Term Care Commission
- Disability Determinations
- Supportive Housing 1915i Request Status

Nancy Rollins, Interim Director, LTSS

Nancy Rollins, Interim Director, LTSS

Deb Sorli, Bureau Chief, Family Assistance

Dawn Landry, Policy Administrator, Medicaid

**11:30-11:50**

**Public Health Emergency**

- Unwind Planning - Next Steps
- COVID-19 Vaccination Outreach

Lucy Hodder, Deb Fournier, UNH Health  
Law & Policy

Beth Daly, Chief, Bureau of Infectious Disease  
Control

**11:50– 12:00**

**MCAC Subcommittees**

- Membership Committee
- He-E 801, CFI
- Dental
- Closed Loop Referral and Blanket Consent Subcommittee(s)

Carolyn Virtue, Chair

Jonathan Routhier, Vice Chair

Michelle Winchester

**12:00 Adjourn**

E – MCAC Meeting Minutes

**August 16, 2021 MCAC Meeting Minutes re: Substance Use Disorder Treatment and Recovery Access 1115(a) SMI IMD Waiver, Joe Caristi, CFO, NH Hospital and Henry Lipman, Medicaid Director**

NH has an increasing number of individuals in mental health crisis who present in hospital emergency departments (EDs) resulting in a demand for inpatient psychiatric beds. This has caused ED psychiatric boarding, long wait times for treatment, and a substantial waitlist for admission to New Hampshire Hospital (NHH). NH has 3 dedicated inpatient psychiatric facilities – NHH, Glenclyff, and Hampstead Hospital.

The waiver amendment will address ED boarding and increase inpatient and community-based capacity by expanding community-based settings, increasing and decentralizing inpatient capacity, and reducing readmissions. The amendment will waive the Institution for Mental Disease (IMD) exclusion rule thereby allowing DHHS to claim federal reimbursement for services for beneficiaries ages 21-64 who receive short-term inpatient psychiatric treatment or short-term residential mental health treatment in an IMD. Proposed services will not reduce or replace services provided in less restrictive settings.

The waiver includes a budget neutrality component. \$10.3 million will be used to add capacity to IMD settings. The federal incentive is not intended just to add inpatient capacity, but to build upon a substantial investment in community-based services including CTI, mobile crisis, and PRTF facilities. If the Amendment is approved, FFP will pay for stays of > 15 days and ≤ 60 days. That will result in additional \$4.4 million for the State of NH.

The waiver research hypothesis is that additional investment by the federal government will have long term benefits on quality of care in inpatient and community settings by providing the right care, in the right place, at the right time. We anticipate reduced utilization of EDs, reduced readmissions, improved availability of crisis stabilization services, improved access to community services, and improved care coordination and continuity of care.

Three public hearings were held Aug 9, 11, 16. During the 30-day comment period, comments, suggestions, and letters of support can be sent to [IMDSMIAmendment@dhhs.nh.gov](mailto:IMDSMIAmendment@dhhs.nh.gov) or mailed to John Poirier at DHHS. After the comment period, the proposal will be submitted to CMS, to be followed by 30-day federal comment period. The [waiver amendment proposal](#) is posted online. Requests for a hard copy should go to John Poirier at [John.E.Poirier@dhhs.nh.gov](mailto:John.E.Poirier@dhhs.nh.gov). Comments will be accepted through Aug 31, 2021.

F – Newspaper Tear Sheets

## Legal Notice

**THE STATE OF NEW HAMPSHIRE JUDICIAL BRANCH SUPERIOR COURT**  
Rockingham Superior Court  
Rockingham City Courthouse  
PO Box 1258  
Kingston NH 03848-1258  
Telephone: 1-855-212-1234  
TTY/TDD Relay: (800) 735-2964  
<http://www.courts.state.nh.us>  
**CITATION FOR PUBLICATION COMPLAINT TO QUIET TITLE Superior Court Rule 4(d)**  
Case Name: **King's Grant LLC v Persons Unknown**  
Case Number: **213-2021-CV-00098**  
Date Complaint Filed: July 09, 2021

A Complaint to Quiet Title to a certain tract of land with any attached buildings located in Deerfield, in the State of New Hampshire has been filed with this court. The property is described as follows: **Tax Map 420 Lot 021**  
**The Court ORDERS:**  
King's Grant LLC shall give notice to Persons Unknown of this action by publishing a verified copy of this Citation for Publication once a week for three successive weeks in the Union Leader, a newspaper of general circulation. The last publication shall be on or before August 29, 2021.

Also, **ON OR BEFORE 30 days after the last publication** - Persons Unknown shall electronically file an Appearance and Answer or responsive pleading with this court. A copy of the Appearance and Answer or other responsive pleading must be sent electronically to the party/parties listed below.

**September 19, 2021** - King's Grant LLC shall electronically file the Return of Publication with this Court. Failure to do so may result in this action being dismissed without further notice.

**Notice to Persons Unknown:** If you are working with an attorney, they will guide you on the next steps. If you are going to represent yourself in this action, go to the court's website: [www.courts.state.nh.us](http://www.courts.state.nh.us), select the Electronic Services icon and then select the option for a self represented party. Complete the registration/log in process then select "I am filing into an existing case". Enter the case number above and click Next. Follow the instructions to complete your filing.

Once you have responded to the Complaint, you can access documents electronically filed through our Case Access Portal by going to <https://odypa.nhccourt.us/portal> and following the instructions in the User Guide. In that process you will register, validate your email, request access and approval to view your case. After your information is validated by the court, you will be able to view case information and documents filed in your case.

**If you do not comply with these requirements, you will be considered in default and the Court may issue orders that affect you without your input.**

Send copies to:  
Jason A. Bielagus, ESQ  
Bielagus Law Offices PLLC  
28 Grove St  
PO Box 3091  
Peterborough NH 03458  
BY ORDER OF THE COURT  
July 15, 2021  
Jennifer M. Hagggar  
Clerk of Court  
(126987)  
(UL - July 23, 30; Aug. 6)

## Legal Notice

**Public Auction Queen City Towing LLC 142 Maple Street Manchester, NH 03103 August 6th 2021 at 12:00 pm**  
2009 Nissan Versa  
VIN:3N1BC13E99L397143  
2006 Honda Accord  
VIN:1HGCM65586A027914  
2002 Saturn SL2  
VIN:1G8ZJ52722183910  
1998 Honda Accord  
VIN:1HGCG6688Y155444  
2005 Jeep Liberty  
VIN:1J4GL48K35W540931  
2007 Chevy Aveo  
VIN:KL1TD56667B190905  
2012 Subaru Legacy  
VIN:4S3BMB6C0C3003007  
2008 Ford Escape  
VIN:1FMCU94128KE64296  
2005 Mercury Mountaineer  
VIN:4M2DU86K65UJ06007  
2001 Jeep Grand Cherokee  
VIN:1J4GW58N31C610513  
1989 Ford E-Series Chassis (Beige)  
VIN:1FDKE30G1KHA43707  
(UL - Aug. 6)

## Legal Notice

**MORTGAGEE'S NOTICE OF SALE OF REAL PROPERTY**  
By virtue of a Power of Sale contained in a certain mortgage given by **R. Corinne Guevin** (the Mortgagor(s)) to Financial Freedom Senior Funding Corporation, a Subsidiary of IndyMac Bank, FSB, dated November 21, 2005 and recorded in the Rockingham County Registry of Deeds in Book 4587, Page 1105 and as affected by a judgment dated May 28, 2021 and recorded with said Registry on June 7, 2021, in Book No. 6287, at Page 2957 (the "Mortgage"), which mortgage is held by Bank of New York Mellon Trust Company, N.A. as Trustee for Mortgage Assets Management Series I Trust, the present holder of said Mortgage, pursuant to and in execution of said power and for breach of conditions of said Mortgage and for the purposes of foreclosing the same will sell at:  
**Public Auction on August 27, 2021 at 12:00 PM**  
Said sale being located on the mortgaged premises and having a present address of 61 Walker Rd, Atkinson, Rockingham County, New Hampshire. The premises are more particularly described in the Mortgage.  
For mortgagor(s)'s title see

deed recorded with the Rockingham County Registry of Deeds in Book 3068, Page 792.

**NOTICE**  
PURSUANT TO NEW HAMPSHIRE RSA 479:25, YOU ARE HEREBY NOTIFIED THAT YOU HAVE A RIGHT TO PETITION THE SUPERIOR COURT FOR THE COUNTY IN WHICH THE MORTGAGED PREMISES ARE SITUATED, WITH SERVICE UPON THE MORTGAGEE, AND UPON SUCH BOND AS THE COURT MAY REQUIRE TO ENJOIN THE SCHEDULED FORECLOSURE SALE.

The address of the mortgagee for service of process is 1 Old Loudon Road, Concord, NH 03301 and the name of the mortgagee's agent for service of process is Capitol Corporate Services, Inc. You can contact the New Hampshire Banking Department by e-mail at [nhbd@banking.nh.gov](mailto:nhbd@banking.nh.gov). For information on getting help with housing and foreclosure issues, please call the foreclosure information hotline at 1-800-437-5991. The hotline is a service of the New Hampshire Banking Department. There is no charge for this call.

The Property will be sold subject to all unpaid real estate taxes and all other liens and encumbrances which may be entitled to precedence over the Mortgage. Notwithstanding any title information contained in this notice, the Mortgagee expressly disclaims any representations as to the state of the title to the Property involved as of the date of the notice of the date of sale. The property to be sold at the sale is "AS IS WHERE IS".

**TERMS OF SALE**  
A deposit of Ten Thousand (\$10,000.00) Dollars in the form of a certified check or bank treasurer's check or other check satisfactory to Mortgagee's attorney will be required to be delivered at or before the time a bid is offered. The successful bidder(s) will be required to execute a purchase and sale agreement immediately after the close of the bidding. The balance of the purchase price shall be paid within thirty (30) days from the sale date in the form of a certified check, bank treasurer's check or other check satisfactory to Mortgagee's attorney. The Mortgagee reserves the right to bid at the sale, to reject any and all bids, to continue the sale and to amend the terms of the sale by written or oral announcement made before or during the foreclosure sale. The description of the premises contained in said mortgage shall control in the event of an error in this publication.

Dated at Newton, Massachusetts, on July 9, 2021.  
Bank of New York Mellon Trust Company, N.A. as Trustee for Mortgage Assets Management Series I Trust  
By its Attorney,  
Allison West Dalton  
Harmon Law Offices, P.C.  
PO Box 610389  
Newton Highlands, MA 02461  
603-669-7963  
19835  
(UL - July 30; Aug. 6, 13)

## Legal Notice

**NH Department of Health and Human Services Substance Use Disorder Treatment Recovery Access Section 111.5(a) Research and Demonstration Waiver Proposed Amendment #2 Request: Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness (SMI)**  
Notice is hereby given that, as part of its overall approach to address the increase in Emergency Department boarding and to support the comprehensive, integrated continuum of mental health treatments and care available in the state, the NH Department of Health and Human Services (DHHS) is applying for an amendment to its Section 111.5(a) Research and Demonstration Waiver from the Centers for Medicare and Medicaid Services (CMS). This amendment will enable DHHS to claim federal reimbursement for payment of services provided to Medicaid beneficiaries ages 21-64 receiving short-term inpatient psychiatric treatment or short-term residential mental health treatment in an Institution for Mental Disease (IMD). DHHS is interested in public input on this proposed amendment to the Substance Use Disorder Treatment and Recovery Access (SUD-TRA) Section 111.5(a) Research and Demonstration Waiver. DHHS is convening two public hearings to seek public input on this amendment that will enable New Hampshire to support its continuum of mental health treatments and care and receive federal reimbursement for individuals receiving short-term mental health services at IMDs. Comments will also be considered at the Medical Care Advisory Committee (MCAC) meeting in August. All MCAC meetings are open to the public.

The hearings will be held:  
• Monday, August 9, 2021 from 5:30 - 7:00 pm at Fred H. Brown Building Auditorium, 129 Pleasant Street, Concord, NH 03301  
• Wednesday, August 11, 2021 from 6:00 - 7:30 pm at Harbor Homes - Partnership for Successful Living, 77 Northeastern Boulevard, Nashua, NH 03062  
The Medical Care Advisory Committee meeting will be held:  
• Monday, August 16, 2021 from 10 a.m. - 12 p.m. at Fred H. Brown Building Auditorium, 129 Pleasant Street, Concord, NH 03301

The proposed amendment is available for public review at: <https://www.dhhs.nh.gov/ombp/medicaid/documents/smi-demo-amendment-draft.pdf>. The services proposed within the amendment include those that are in alignment with the existing mental health delivery system for inpatient psychiatric and residential mental health treatment and are not intended to reduce or replace services provided in less restrictive settings. All public comments must be received by 4:30 pm on Tuesday, August 31, 2021.

Comments will be accepted: (1) at either of the two scheduled public hearings referenced above; (2) at the MCAC meeting referenced above; (3) emailed to [IMDSMIAMendment@DHHS.NH.Gov](mailto:IMDSMIAMendment@DHHS.NH.Gov);

or (4) mailed to John Poirier, NH Department of Health and Human Services, Attn: SUD-TRA Demonstration Amendment #2, 129 Pleasant St, Concord, NH 03301. (UL - Aug. 6)

## Legal Notice

**MORTGAGEE'S NOTICE OF SALE OF REAL PROPERTY**  
By virtue and in execution of the Power of Sale contained in a certain mortgage given by **Paul E. Joyce** (the "Mortgagor") to Mortgage Electronic Registration Systems, Inc. as nominee for Stearns Lending, Inc. and now held by **Citibank, N.A., not in its individual capacity but solely as Owner Trustee of New Residential Mortgage Loan Trust 2020-RPL2** (the "Mortgagee"), said mortgage dated April 14, 2014, and recorded with the Hillsborough County Registry of Deeds in Book 8653 at Page 2114 (the "Mortgage"), pursuant to and for breach of the conditions in said Mortgage and for the purpose of foreclosing the same will be sold at:

Public Auction  
On  
September 15, 2021 at 11:00 AM  
Said sale to be held on the mortgaged premises described in said mortgage and having a present address of 115 Annand Drive, Milford, Hillsborough County, New Hampshire.

**NOTICE**  
PURSUANT TO NEW HAMPSHIRE RSA 479:25, YOU ARE HEREBY NOTIFIED THAT YOU HAVE A RIGHT TO PETITION THE SUPERIOR COURT FOR THE COUNTY IN WHICH THE MORTGAGED PREMISES ARE SITUATED, WITH SERVICE UPON THE MORTGAGEE, AND UPON SUCH BOND AS THE COURT MAY REQUIRE TO ENJOIN THE SCHEDULED FORECLOSURE SALE.

YOU ARE ALSO NOTIFIED THAT THE ADDRESS OF THE MORTGAGEE FOR SERVICE OF PROCESS IS: 75 BEATTIE PLACE, SUITE 300, GREENVILLE, SC 29601. THE NAME OF THE MORTGAGEE'S AGENT FOR SERVICE OF PROCESS IS: NEW REZ LLC, A/B/A SHELLPOINT MORTGAGE SERVICING.

For information on getting help with housing and foreclosure issues, please call the foreclosure information hotline at 1-800-437-5991. The hotline is a service of the New Hampshire banking department. There is no charge for this call. The contact information for the New Hampshire banking department is 53 Regional Drive, Suite 200, Concord, NH 03301, with an email address of [nhbd@banking.nh.gov](mailto:nhbd@banking.nh.gov).

The Property will be sold subject to all unpaid real estate taxes and all other liens and encumbrances, which may be entitled to precedence over the Mortgage. Notwithstanding any title information contained in this notice, the Mortgagee expressly disclaims any representations as to the state of the title to the Property involved as of the date of the notice of the date of sale. The property to be sold at the sale is "AS IS WHERE IS".

**TERMS OF SALE**  
A deposit of Five Thousand (\$5,000.00) Dollars in the form of a certified check, bank treasurer's check or other check satisfactory to Mortgagee's attorney will be required to be delivered at or before the time a bid is offered. The successful bidder(s) will be required to execute a purchase and sale agreement immediately after the close of the bidding. The balance of the purchase price shall be paid within sixty (60) days from the sale date in the form of a certified check, bank treasurer's check or other check satisfactory to Mortgagee's attorney. The Mortgagee reserves the right to bid at the sale, to reject any and all bids, to continue the sale and to amend the terms of the sale by written or oral announcement made before or during the foreclosure sale.  
Dated at Farmington, CT on July 22, 2021

Citibank, N.A., not in its individual capacity but solely as Owner Trustee of New Residential Mortgage Loan Trust 2020-RPL2  
By its Attorney,  
/s/ Mark Lamper  
Bendett & McHugh, P.C.  
270 Farmington Avenue, Ste. 151  
Farmington, CT 06032  
(860) 677-2868  
(UL - July 23, 30; Aug. 6)

## Legal Notice

**CITY OF MANCHESTER**  
Please be advised that the Board of Mayor and Aldermen of the City of Manchester, NH adopted the following ordinances at a meeting held on August 3, 2021:  
"Amending Chapter 39: Procurement Code of the City of Manchester by adding a new item under §39.05 (C) to include language regarding inclusion."  
"Amending Chapter 32: Boards, Commissions and Departments of the Code of Ordinances of the City of Manchester by adding Section 32.130 to establish a Housing Commission."  
"Amending Section 33.025 & 33.026 (Traffic Operations Superintendent) of the Code of Ordinances of the City of Manchester."  
"Amending Section 33.025 & 33.026 (Assistant WWTP Maintenance Supervisor) of the Code of Ordinances of the City of Manchester."  
"Amending Section 33.026 (Equipment Mechanic I) of the Code of Ordinances of the City of Manchester."  
"Amending Section 33.026 (Civil Engineer III) of the Code of Ordinances of the City of Manchester."  
Board of Mayor and Aldermen  
s/Matthew Normand  
City Clerk  
(UL - Aug. 6)

## Legal Notice

**NOTIFICATION OF AQUATIC TREATMENT Long Pond - Danville, NH**  
S Litude Lake Management, 590 Lake Street, Shrewsbury, MA 01545, Telephone 508-865-1000, has been contracted by the Danville Long Pond Protective Association to chemically treat portions of the Long Pond in Danville, for control of non-native/invasive aquatic plant growth. Portions will be treated with the USEPA/State registered herbicide Sonar One (fluridone) EPA Registration Number 67690-45 on or about Monday, August 16, 2021, in accordance with Special Permit SP-336 issued by the NH Division of Pesticide Control. A follow-up treatment with Sonar One (fluridone) will be performed on or about Monday, August 30th 2021.

The following temporary water use restrictions will be imposed on the day of treatment for all treatments:

- No swimming for 6 hours following each treatment
- Do not use this water for irrigation or for mixing sprays for agricultural or ornamental plants, established row crops / turf and plants until further notice. Irrigation restrictions will be lifted according to a timetable specified on the product label and/or, as applicable, on the basis of analyses of the water to determine that herbicide concentration has dropped to acceptable levels. These restrictions apply to all intakes within 1,320 feet downstream of the treatment area, and to all wells within 50 feet of shoreline that itself is within 1,320 feet downstream of a treatment area. Contact Peter Beisler at S Litude Lake Management, 590 Lake Street, Shrewsbury, MA 01545, Telephone 508-865-1000, email [NewHampshire@SolitudeLake.com](mailto:NewHampshire@SolitudeLake.com) or go to <https://www.solitudelake.com/newhampshire> for information on the release dates of these restrictions or for additional information on the irrigation restrictions.

The shoreline will be posted with signs warning of the temporary water use restrictions that will be imposed, immediately prior to treatment. If you have any questions concerning this treatment, contact S Litude Lake Management using the information above. (UL - Aug. 6, 13)

Going Online?  
More notices at [www.unionleader.com](http://www.unionleader.com)

## Legal Notice

**NOTIFICATION OF AQUATIC TREATMENT Big Island Pond Hampstead, NH**  
SOLitude Lake Management, 590 Lake Street, Shrewsbury, MA 01545, Telephone 508-865-1000, has been contracted by the Big Island Pond Corp to chemically treat portions of Big Island Pond in Hampstead, NH, for control of nuisance aquatic weed growth. Portions will be treated with the USEPA/State registered herbicide Tribune (Diquat), EPA Registration Number 100-1091 on or about Monday, August 9, 2021, in accordance with Special Permit SP-258 issued by the NH Division of Pesticide Control.

The following temporary water use restrictions apply to all intakes within 200 feet of the treatment areas, drawing water for drinking or irrigation purposes, and to all wells and points within 50 feet of the treated areas:

- No swimming for 6 hours following treatment, within 200 feet of treated areas.
  - Do not use this water for livestock/domestic animal consumption for 1 day, within 200 feet of treated areas
  - Do not use this water for drinking, irrigation or for mixing sprays for turf or landscape ornamental plants for 3 days
  - Do Not Use this water for irrigation to food crops or for mixing sprays for agricultural or production ornamental plants for 5 days
- The shoreline will be posted with signs warning of the temporary water use restrictions that will be imposed, immediately prior to treatment. If you have any questions concerning this treatment, contact Pete Beisler at SOLitude Lake Management, 590 Lake Street, Shrewsbury, MA 01545, Telephone 508-865-1000, email [NewHampshire@SolitudeLake.com](mailto:NewHampshire@SolitudeLake.com) or go to <https://www.solitudelake.com/newhampshire>. (UL - July 30; Aug. 6)

## Legal Notice

**THE STATE OF NEW HAMPSHIRE JUDICIAL BRANCH SUPERIOR COURT**  
Merrimack Superior Court  
5 Court Street  
Concord NH 03301  
Telephone: 1-855-212-1234  
TTY/TDD Relay: (800) 735-2964  
<http://www.courts.state.nh.us>  
**CITATION FOR PUBLICATION COMPLAINT TO QUIET TITLE Superior Court Rule 4(d)**  
Case Name: **Anthony Paul LaRosa v Town of Northfield, Daniel and MaryAnn Clarke, Heirs of Guy B. Huckins, Heirs of Harold Dias and All unknown persons who claim any interest or estate in and to the subject matter of this action**  
Case Number: **217-2021-CV-00380**  
Date Complaint Filed: July 16, 2021

A Complaint to Quiet Title to a certain tract of land with any attached buildings located in Northfield, in the State of New Hampshire has been filed with this court. The property is described as follows: **Parcels 2 and 3 of 617 Shaker Road, Northfield, Merrimack County, New Hampshire**  
**The Court ORDERS:**  
Anthony Paul LaRosa shall give notice to All unknown persons who claim any interest or estate in & to the subject matter; Heirs of Guy B. Huckins; Heirs of Harold Dias of this action by publishing a

verified copy of this Citation for Publication once a week for three successive weeks in the Union Leader, a newspaper of general circulation. The last publication shall be on or before September 03, 2021.

Also, **ON OR BEFORE 30 days after the last publication** - All unknown persons who claim any interest or estate in & to the subject matter; Heirs of Guy B. Huckins; Heirs of Harold Dias shall electronically file an Appearance and Answer or responsive pleading with this court. A copy of the Appearance and Answer or other responsive pleading must be sent electronically to the party/parties listed below.

**September 24, 2021** - Anthony Paul LaRosa shall electronically file the Return of Publication with this Court. Failure to do so may result in this action being dismissed without further notice.

**Notice to All unknown persons who claim any interest or estate in & to the subject matter; Heirs of Guy B. Huckins; Heirs of Harold Dias:** If you are working with an attorney, they will guide you on the next steps. If you are going to represent yourself in this action, go to the court's website: [www.courts.state.nh.us](http://www.courts.state.nh.us), select the Electronic Services icon and then select the option for a self represented party. Complete the registration/log in process then select "I am filing into an existing case". Enter the case number above and click Next. Follow the instructions to complete your filing.

Once you have responded to the Complaint, you can access documents electronically filed through our Case Access Portal by going to <https://odypa.nhccourt.us/portal> and following the instructions in the User Guide. In that process you will register, validate your email, request access and approval to view your case. After your information is validated by the court, you will be able to view case information and documents filed in your case.

**If you do not comply with these requirements, you will be considered in default and the Court may issue orders that affect you without your input.**

Send copies to:  
Jonathan M. Flagg, ESQ  
Flagg Law PLLC  
93 Middle Street  
Portsmouth NH 03801  
Town of Northfield  
21 Summer Street  
Northfield NH 03276  
Daniel Clarke  
285 Knowles Pond Road  
Northfield NH 03276  
MaryAnn Clarke  
285 Knowles Pond Road  
Northfield NH 03276  
BY ORDER OF THE COURT  
July 20, 2021  
Catherine J. Ruffie  
Clerk of Court  
(126564)  
(UL - July 23, 30; Aug. 6)

## Legal Notice

**NOTICE OF CONTINUED FORECLOSURE SALE**  
Please be advised that the Foreclosure Sale scheduled for July 30, 2021 at 4:00 p.m. in the matter of **Pensco Trust Company and Thomas A. Konan, Sr.** regarding the premises at 549 Gilsun Mine Road, Alstead, New Hampshire has been continued to August 31, 2021 at 4:00 p.m.  
Dated at Keene, New Hampshire this 2nd day of August, 2021.

Pensco Trust Company  
By its attorneys,  
Law Office of  
Steve J. Bonnette, P.C.  
By: Steve J. Bonnette, Esquire  
20 Central Square, Suite 2A  
Keene, NH 03431  
(603) 355-2900  
(UL - Aug. 6)

## Legal Notice

**THE STATE OF NEW HAMPSHIRE JUDICIAL BRANCH SUPERIOR COURT**  
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Rockingham City Courthouse  
PO Box 1258  
Kingston NH 03848-1258  
Telephone: 1-855-212-1234  
TTY/TDD Relay: (800) 735-2964  
<http://www.courts.state.nh.us>  
**CITATION FOR PUBLICATION Superior Court Rule 4(d)**  
Case Name: **Wilmington Savings Fund Society, FSB, as Trustee of Upland Mortgage Loan Trust A v Heirs, Devisees, and Legal Representatives of Robert P. Morin, Sr., et al**  
Case Number: **218-2020-CV-00363**

The above entitled action is now pending in this Court. The original pleading is on file and may be examined by interested parties. The Court has issued an Order for Service by Publication on defendant(s) Karen Bolger and Heirs, Devisees, and Legal Representatives of Robert P. Morin, Sr.

**The Court ORDERS:**  
Wilmington Savings Fund Society, FSB, as Trustee of Upland Mortgage Loan Trust A shall give notice to Karen Bolger and Heirs, Devisees, and Legal Representatives of Robert P. Morin, Sr. of this action by publishing a verified copy of this Citation for Publication once a week for three successive weeks in the Union Leader, a newspaper of general circulation. The last publication shall be on or before September 22, 2021.

Also, **ON OR BEFORE 30 days after the last publication** - Karen Bolger; and Heirs, Devisees, and Legal Representatives of Robert P. Morin, Sr. shall electronically file an Appearance and Answer or other responsive pleading with this Court. A copy of the Appearance and Answer or other responsive pleading must be sent electronically to the party/parties listed below.

**October 12, 2021** - Wilmington Savings Fund Society, FSB, as Trustee of Upland Mortgage Loan Trust A shall electronically file the Return of Publication with this Court. Failure to do so may result in this action being dismissed without further notice.

**Notice to Karen Bolger and Heirs, Devisees, and Legal Representatives of Robert P. Morin, Sr.:** If you are working with an attorney, they will guide you on the next steps. If you are going to represent yourself in this action, go to the court's website: [www.courts.state.nh.us](http://www.courts.state.nh.us), select the Electronic Services icon and then select the option for a self represented party. Complete the registration/log in process then select "I am filing into an existing case". Enter the case number above and click Next. Follow the instructions to complete your filing.

Once you have responded to the Complaint, you can access documents electronically filed through our Case Access Portal by going to <https://odypa.nhccourt.us/portal> and following the instructions in the User Guide. In that process you will register, validate your email, request access and approval to view your case. After your information is validated by the court, you will be able to view case information and documents filed in your case.

**If you do not comply with these requirements, you will be considered in default and the Court may issue orders that affect you without your input.**

BY ORDER OF THE COURT  
June 09, 2021  
Jennifer M. Hagggar  
Clerk of Court  
(1075)  
(UL - July 23, 30; Aug. 6)

## INVITATION FOR BIDS NASHUA HOUSING AND REDEVELOPMENT AUTHORITY INSURANCE

The Nashua Housing and Redevelopment Authority, the awarding Authority, invites sealed bids in accordance with the Contract Documents prepared by the Nashua Housing and Redevelopment Authority, hereinafter referred to as NHRA, for the provision of Insurance Coverage.

The coverage needs for the Public Housing properties are: Comprehensive/Commercial General Liability, Directors and Officers Liability, Public Officials Errors and Omissions, Employment Practice, Automobile, Real and Personal Property, Fidelity Bond, Monies and Securities, Small Business Computer and Boiler and Machinery. The Public Housing properties consist of fourteen site locations with 256 units of family housing, 188 units of elderly housing, 221 units of non-elderly disabled housing and two office buildings.

The coverage needs for Nashua Park View Apartments, LLC are: Comprehensive/Commercial General Liability and Real and Personal Property. Park View Apartments consists of three apartment buildings with 17 units of general occupancy housing.

**Due to COVID-19 and the need to socially distance, NHRA will publicly announce the bid results by teleconference. Bidders may dial in to the teleconference number on Tuesday, September 7, 2021 at 2:00 p.m. To participate in the bid opening, please call the following number:**

**Dial 1-848-777-1212, and when prompted enter 0025661#**  
Bids will be received at the Nashua Housing and Redevelopment Authority, 40 East Pearl St., Nashua, New Hampshire 03060-3462 until 2:00 p.m. **Tuesday, September 7, 2021** and then opened and read aloud **via teleconference**. If mailed, the NHRA must receive bids no later than the time and date stated above. Bids shall be sealed in an envelope and marked with the words "**Bid Documents - Insurance**", and the bidder's company name in order to guard against premature opening. Bids submitted electronically or facsimile (fax) machines will not be considered.

An **Informational Teleconference** is scheduled to occur at **10:00 a.m. on Monday, August 23, 2021**. During the teleconference the bid process will be reviewed, and questions will be addressed. Participation is recommended, but not mandatory. To participate in the Informational Teleconference, please call the following number:

**Dial 1-848-777-1212, and when prompted enter 0025661#**  
Copies of the bid documents and specifications may be obtained by contacting our Purchasing Department at (603) 883-5661 ext. 306. The NHRA reserves the right to reject any and all bids and waive any informalities in bidding and reserves the right to award the Contract as it deems in its best interest.

**NASHUA HOUSING AND REDEVELOPMENT AUTHORITY**  
Thomas F. Monahan, Chairperson  
Dates: August 6 and 13, 2021



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## Public Notices

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To place a notice contact **Monique Savoie**  
**603.594.1218**    [msavoie@nashuatelegraph.com](mailto:msavoie@nashuatelegraph.com)

**PUBLIC NOTICE - MONT VERNON PLANNING BOARD**  
 You are hereby notified that the Mont Vernon Planning Board will hold a hearing on **Tuesday, August 24, 2021** in the Town Hall Meeting Room to discuss a proposed lot line adjustment by Michelle Folan on Parcel Tax Map 2, Lot 39 & 2-40 on Old Amherst Road. The meeting is scheduled to begin at **7:00PM**. *The public is invited to attend.*

**PUBLIC AUCTION** to be held on  
**8/13/2021 @7AM** at Lightspeed Towing,  
 76 Valley Hill Rd, Pelham, NH 03076  
 for a 1995 GMC Sierra

**PUBLIC AUCTION**  
 Monday, August 9th at 8am for the following vehicles:  
**2001 Honda Accord** 1HGCF85401A075185  
**2019 Dong Moped** LXDTCARAXK1051136  
**For more information call:**  
**North Country Towing @ 603-913-4416 or 603-583-9464**

**Request for Proposals**  
 The Hudson School District is requesting proposals for  
**Snow Removal Services**  
 Sealed bids are due by 11:00 A.M. Monday, September 14, 2021  
 Bid documents are available at [www.sau81.org](http://www.sau81.org) or by contacting:  
 John Pratte  
 20 Library Street, Hudson, NH 03051  
[jpratte@sau81.org](mailto:jpratte@sau81.org)

**LEGAL NOTICE FOR AUCTION BEING HELD** Saturday, August 14, 2021 by virtue of the right granted by statute of New Hampshire Self Service Lien Law RSA 451C and all other rights, for the purpose of satisfying the lien of Currier's Self Storage, LLC for storage and other expenses, all contents of storage lockers will be sold at public or private auction at 515 NH Rt. 13 South, Milford, New Hampshire Saturday, August 14, 2021 at 10:00AM all and singular contents of lockers of Matt Judge, Donald Miner, Andrea Shamp, and Jonathan Tucker. Starting at 10:45 a.m same day Saturday, August 14, 2021 at 248 Mont Vernon Rd., Milford, New Hampshire all and singular contents of lockers of Andrew Knowlton and Benjamin Philbrick will be sold at public or private auction. Seller reserves the right to reject any and all bids, cash only. Goods must be removed the same day. Currier's Self Storage, LLC, PO Box 881, Milford, NH 03055, tel. 673-9538

**NH Department of Health and Human Services**  
**Substance Use Disorder Treatment Recovery Access Section**  
**1115(a) Research and Demonstration Waiver**  
**Proposed Amendment #2 Request: Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness (SMI)**  
 Notice is hereby given that, as part of its overall approach to address the increase in Emergency Department boarding and to support the comprehensive, integrated continuum of mental health treatments and care available in the state, the NH Department of Health and Human Services (DHHS) is applying for an amendment to its Section 1115(a) Research and Demonstration Waiver from the Centers for Medicare and Medicaid Services (CMS). This amendment will enable DHHS to claim federal reimbursement for payment of services provided to Medicaid beneficiaries ages 21-64 receiving short-term inpatient psychiatric treatment or short-term residential mental health treatment in an Institution for Mental Disease (IMD). DHHS is interested in public input on this proposed amendment to the Substance Use Disorder Treatment and Recovery Access (SUD-TRA) Section 1115(a) Research and Demonstration Waiver. DHHS is convening two public hearings to seek public input on this amendment that will enable New Hampshire to support its continuum of mental health treatments and care and receive federal reimbursement for individuals receiving short-term mental health services at IMDs. Comments will also be considered at the Medical Care Advisory Committee (MCAC) meeting in August. All MCAC meetings are open to the public.



## NashuaTelegraph.com

**LEGAL NOTICE**  
**(A-1 Self Storage, Inc.) Auction of Tenants' Personal Property**  
 In accordance with the provisions of: New Hampshire: RSA451-C, 311-B, 358-A&G, 444:1, & Uniform Commercial Code  
 NOTICE IS HEREBY GIVEN to the person herein after named and to all whom it may concern. The contents of leased units are subject to our lien for non-payment of rent and other charges. You are denied access to that unit.  
 You can redeem such goods on or before ( August 19, 2021 ). The goods you have stored after this time will be sold at auction to the highest bidder. The sale will take place at: (7 Able Street, Hudson, NH 03051 603-882-2617), on (August 20, 2021). The facility/auctioneer reserves the right to cancel a sale at any time for any reason.  
 Robert Christensen-U219 & U326, David Columbus-U411, Diocelina Jimenez-U503, Reginald Thompson- U837.  
 Auctioneer: Storage Auction Solutions; NH  
 978-777-5850  
 Paul Maglio, Lic. #4001  
 PAY AS SOON AS POSSIBLE-CHARGES CONTINUE TO ACCUMULATE  
 Manuel D. Sousa  
 A-1 Self Storage, Inc.  
 46 Lowell Road, Hudson, NH 03051  
 603-882-2617

**CITY OF NASHUA**  
**Notice of Filing with the Federal Energy Regulatory Commission**  
  
 The City of Nashua (City) hereby provides notice of its filing with the Federal Energy Regulatory Commission (FERC) of its Application for Licensing for the Mine Falls Project (FERC No. 3442) (Project). The FERC filing was made on July 30, 2021. The Application provides details of the 3.0- megawatt (MW) Project located on the Nashua River in New Hampshire. The infrastructure associated with the Project including dam, power canal, intake, powerhouse, and tailrace is in Nashua, New Hampshire. The Project impoundment extends approximately 4.3 miles (mi) upstream to Runnells Bridge Road in Hollis, New Hampshire. The Project is an existing constructed Project. No new construction is planned.  
 The applicant's name is the City of Nashua; its address is 229 Main Street, PO Box 2019, Nashua, NH 03060; and its phone number is (603) 589-3092. The Project is located in the City of Nashua in Hillsborough County, New Hampshire on the Nashua River. A copy of the Application is available for inspection by appointment at the Nashua City Hall, Community Development Office by calling (603) 589-3092.  
 The FERC will publish a subsequent notice soliciting public participation if the License Application is accepted.

The hearings will be held:  
 • Monday, August 9, 2021 from 5:30 - 7:00 pm at Fred H. Brown Building Auditorium, 129 Pleasant Street, Concord, NH 03301  
 • Wednesday, August 11, 2021 from 6:00 - 7:30 pm at Harbor Homes – Partnership for Successful Living, 77 Northeastern Boulevard, Nashua, NH 03062  
 The Medical Care Advisory Committee meeting will be held:  
 • Monday, August 16, 2021 from 10 a.m. - 12 p.m. at Fred H. Brown Building Auditorium, 129 Pleasant Street, Concord, NH 03301  
 The proposed amendment is available for public review at: <https://www.dhhs.nh.gov/omb/medicaid/documents/smi-demo-amendment-draft.pdf>. The services proposed within the amendment include those that are in alignment with the existing mental health delivery system for inpatient psychiatric and residential mental health treatment and are not intended to reduce or replace services provided in less restrictive settings. All public comments must be received by 4:30 pm on Tuesday, August 31, 2021.  
 Comments will be accepted: (1) at either of the two scheduled public hearings referenced above; (2) at the MCAC meeting referenced above; (3) emailed to [IMDSMIAmendment@DHHS.NH.Gov](mailto:IMDSMIAmendment@DHHS.NH.Gov); or (4) mailed to John Poirier, NH Department of Health and Human Services, Attn: SUD-TRA Demonstration Amendment #2, 129 Pleasant St, Concord, NH 03301.

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## G – Letters of Comment Received

Mr. John Poirier  
NH Department of Health and Human Services  
Attn: SUD-TRA Demonstration Amendment #2  
129 Pleasant Street Concord, NH 03301

August 26, 2021

Dear Mr. Poirier,

On behalf of NAMI NH, I am offering our enthusiastic support for the New Hampshire Department of Health and Human Services waiver application to the Center for Medicare and Medicaid Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Amendment #2 Request. NAMI Nationally has had a long standing policy position that the Institutions for Mental Disorder (IMD) exclusion is discriminatory against people with mental illness and/or substance use disorders and toward that end, NAMI NH sees this waiver application as an important step in the right direction for improving treatment for people with severe mental illness in New Hampshire.

Specific comments from NAMI NH on the proposal are listed below.

**Page 4, #1:** NAMI NH fully endorsed the NH State Mental Health 10 year plan when it was released in 2019. We believe that via the workgroups and extensive public hearings and input that the recommendations of the plan accurately reflected the key steps needed to rebuild NH's mental health system. Many of those recommendations have been or are in the process of being implemented and toward that end, NAMI NH believes that the 10 Year Plan continues to be THE blueprint for moving NH's mental health system forward.

**Page 7 #7:** In talking about emergency department boarding the proposal states *"While the ED waitlist 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"* This is a mischaracterization of what the ED boarding situation was in NH. Although dropping over the previous year, the average number of adults waiting each day in Feb of 2020 was about 40. Children's numbers were rising and were often over 10. The reduction of adults to "virtual zero" was the result of a combination of the state of emergency being declared and no one going to Emergency Departments, and the transfer of children from New Hampshire Hospital to Hampstead Hospital around March 20, 2020, which opened up 25+ adult beds and briefly brought the wait list down. Adult daily numbers were in the 20's in May and continued climbing from there. Children's numbers were dramatically increased during the pandemic hitting new quarterly highs from July of 2020, through the Spring of 2021.

**Page 8 #1:** Under Goals and Objectives:

- We would like to see the first objective be to *"Prevent* utilization and lengths of stay rather than *"Reduce"*
- Not sure if this is the correct place for this to be added, but it would be nice to see an objective added, and inclusion in this waiver process about reducing or preventing suicide and drug overdose deaths – rates of both are higher than the national average in NH

*Find Help, Find Hope.*

**Page 8 Milestone 2:** We are pleased to see specific mention of the special needs of people who are homeless or have unstable or unsuitable housing. These individuals have much higher rates of hospitalizations/readmissions than the general population. More needs to be done to insure they are connected with community-based services in a timely manner, as well as insuring they receive intensive follow up.

**Page 9 Milestone 2:**

- #3 It would be great to see a plan/requirement for some type of follow up within 72 hours from anyone who receives a mental health evaluation in an Emergency Department
- NAMI NH is disappointed to see no mention of people who are transitioning from being incarcerated back to the community. There is a very high spillover effect of people with serious mental illness who end up in the criminal justice system. This is particularly true for young adults who have frequent jail admissions and readmissions. While Medicaid is now suspended rather than terminated in our state for people during incarceration, problematic gaps often remain in accessing timely treatment during the transition process to the community. Additionally, individuals transitioning to from incarceration are also at high risk for suicide and drug overdose deaths.

**Page 9 Milestone #2 and #3** We are hopeful you will consider adding to this section the important role peer supports can play in successful community based transitions as well as part of the continuum of care and particularly in the area of crisis stabilization and the step up and step down programs which they are now offering.

**Page 9 Milestone 3 #3** We are pleased to see the inclusion of “Implementation of strategies to improve state tracking of availability of inpatient and crisis stabilization beds.” Better real time data and tracking of beds is something which NAMI NH has long since advocated for as a critical component for improving admission planning. A central component of an effective system is good data and tracking capabilities. Perhaps there should be a milestone 5 added that specifically addresses data and tracking. There also does not seem to be anything in the milestones that tracks the availability of voluntary beds for Medicaid recipients. This is an important consideration as it is likely now that some Medicaid beneficiaries who would voluntarily accept hospitalization end up being involuntarily hospitalized due to lack of available beds.

**Page 10 Milestone 4:** We are pleased to see the inclusion of earlier identification and supports including supported employment and education, as well as the recognition of the importance of specialty settings and treatments for young adults experiencing early serious mental illness.

**Page 12 #1, 2 and 5:** NAMI NH is pleased to see under “data Source” the inclusion of soliciting information from beneficiaries as well their family members/caregivers

**Page 12 #3:** We suggest including/tracking peer support services as a key category of this goal. Also (per comment above on Milestone #3, the inclusion as a data source tracking the availability of voluntary beds/admissions.

**Page 13 #4:** While the evaluation questions are generally focused on community-based care, the goal seems to focus exclusively on integration of primary care/behavioral health. We are glad to see the importance of moving mental health and physical health integration forward recognized. Might this also include the roles that Federally Qualified Health Centers (FQHC's) should play in serving the population of people with serious mental illness? It would also seem this goal should include more general review of access to mental health care such as wait times and availability of outpatient treatment for Medicaid beneficiaries.

**Page 14# 5** Please consider including tracking continuity of care for individuals with SMI who are homeless/housing insecure, or incarcerated. Also, as we begin to move further upstream in diverting people from Emergency Departments and hospitalizations, perhaps consideration should be given to including data and tracking on what type of follow up people who call the HUB/centralized call center or who receive mobile crisis response services receive and when they receive it.

NAMI NH is very excited to see this waiver move forward, and we appreciate the ability to offer feedback. Please feel free to contact me if there is anything I or NAMI NH can do to assist with the waiver process.

Respectfully,

A handwritten signature in black ink, appearing to read 'Kenneth Norton', with a stylized flourish at the end.

Kenneth Norton, LICSW  
NAMI NH Executive Director

August 31, 2021

John Poirier  
N.H. Department of Health and Human Services  
129 Pleasant Street  
Concord NH 03301

Via e-mail only: [john.e.poirier@dhhs.nh.gov](mailto:john.e.poirier@dhhs.nh.gov)

Re: Section 1115(a) Research and Demonstration Waiver Amendment

Dear Mr. Poirier,

New Futures appreciates the opportunity to offer the following comments regarding the N.H. Department of Health and Human Services' amendment request for the Section 1115(a) Research and Demonstration Waiver from the U.S. Centers for Medicare and Medicaid Services (CMS). New Futures is a nonpartisan, nonprofit organization that advocates, educates and collaborates to improve the health and wellness of all New Hampshire residents. We envision a state where public policies support timely access to quality and affordable healthcare for all who call the Granite State home.

New Futures appreciates the work the Department has done to prepare this amendment request and believes, if approved and fully implemented, it will play an important role helping to reduce waitlists and address the ongoing Emergency Boarding crisis. We hope that the resources coming into the state by waiving the so-called "TMD exclusion" will be leveraged in concert with New Hampshire's emerging Mobile Response system to reinforce and support the full Continuum of Care, including community alternatives, for individuals experiencing serious mental illness.

To that end, New Futures appreciates that DHHS does not intend to use the waiver solely to increase residential bed capacity but rather to expand access to treatment options across the spectrum. In accordance with New Hampshire's 10-year Mental Health Plan, we believe that, to the extent possible, individuals with mental health concerns should be treated close to home in community-based settings. Accordingly, we appreciate the commitment expressed in Milestone 3 and throughout the waiver application to increase access to the Continuum of Care, including crisis stabilization and other community-based services. Further, the focus on Care Coordination, referenced in Milestone 2 and throughout the application, will go far to help individuals and families transition effectively to care in their home communities.

As noted in the application (Milestone 2), Care Coordination and transition planning must include specific efforts to assess the housing situation of individuals as they return to their communities. Given the prevalence of mental health concerns among those who experience homelessness or housing insecurity, housing supports are critical for many individuals experiencing serious mental illness. We would like to see similar efforts to assess housing and other needs extended to individuals who have been incarcerated or otherwise justice-involved, among other specialized populations.

The resources made available by this waiver amendment could go far to address these and other needs facing individuals and families impacted by serious mental illness. But, to fully realize the benefits and end the Emergency Boarding crisis, New Futures feels they must be used not only to increase access to residential beds, but to expand our network of community-based services to support individuals and families before and after they experience mental health crisis. Only then can we assure the levels of support needed to prevent crisis events before they occur.

We look forward to working with you to implement this plan, and to increasing access to treatment for all Granite Staters. Thank you for your consideration of these comments.

Respectfully submitted,

A handwritten signature in blue ink, appearing to read 'Jake Berry', with a long, sweeping underline.

Jake Berry  
Vice President of Policy  
New Futures

# DISABILITY RIGHTS CENTER - NH

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64 North Main Street, Suite 2, Concord, NH 03301-4913 • [mail@drcnh.org](mailto:mail@drcnh.org) • [drcnh.org](http://drcnh.org)

(603) 228-0432 • (800) 834-1721 voice or TTY • FAX: (603) 225-2077

August 31, 2021

John Poirier  
New Hampshire Department of Health and Human Services  
Attn: SUD-TRA Demonstration Amendment #2  
129 Pleasant Street  
Concord, NH 03301

**By Electronic Mail Only to: [IMDSMIAmendment@DHHS.NH.Gov](mailto:IMDSMIAmendment@DHHS.NH.Gov)**

RE: SUD-TRA Demonstration Amendment #2

Dear Mr. Poirier:

On behalf of Disability Rights Center-NH, I am writing with comments about the state's draft request to amend its Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver.

The Disability Rights Center is the state's Protection and Advocacy System for Individuals with Mental Illness. As such, our office's charge includes the obligation to "protect and advocate [for] the rights of . . . individuals [with mental illness]. . . to ensure the enforcement of the Constitution and Federal and State statutes . . ." <sup>1</sup>

We regularly provide assistance to New Hampshire residents with serious mental illness, and have represented many of them in recent years, both in individual cases and in class actions regarding the nature and quality of the state's mental health service system. Our representation has included the Amanda D. v. Hassan litigation that resulted in the Community Mental Health Agreement, in which the state committed to expanding community mental health services. We also regularly investigate incidents involving the abuse and neglect of treatment facility residents with mental illness.

It is our view that increasing federal financial participation for institutional psychiatric treatment, particularly when the state has an inadequate community-based service system, will be detrimental to the people of the state with serious mental illness, put stress on the state's already struggling community mental health service system, and

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<sup>1</sup> 42 U.S. Code § 10801 (b)

would be inconsistent with the state's existing obligations to provide an integrated mental health service system.

**A. The Proposed Waiver Amendment Prioritizes the Funding of Institutional Treatment Capacity, Which is Inconsistent with the Americans with Disabilities Act and New Hampshire's Mental Health Statute**

The department's draft waiver amendment request is clearly aimed at increasing the publicly funded institutional treatment capacity in the state. Although it is not in the proposal's listed goals and objectives, by stating that the "rationale for requesting this authorization is not limited to increasing inpatient bed capacity,"<sup>2</sup> the proposal acknowledges that such an increase is a significant part of the actual rationale. It states an expectation that an IMD waiver will induce new private IMD providers to enter the state, and the department's consultants have relied in part on such an expectation in making the recommendation that the waiver be requested.<sup>3</sup>

As discussed below, an increase in such capacity is not needed in New Hampshire, and without substantial increases in housing and other community resources for persons clinically ready for discharge from institutional settings, there is a significant risk that any increase in capacity will be utilized by persons whose needs can be met in less restrictive settings. The institutionalization of such person would be fundamentally inconsistent with the integration mandate of the Americans with Disabilities Act.

The requested waiver would also reduce the financial incentive to use scarce public treatment funding in the most cost-effective manner, which is nearly always in community-based rather than institutional settings.<sup>4</sup> The existing financial incentive promotes the development of services which are consistent with the ADA.

Reducing the need for institutional treatment by expanding the availability of community-based services is also required by the state's principal mental health treatment statute. RSA 135-C:1 establishes as the state's policy the requirement that, whenever possible, care be provided "within each person's community," in a manner that is "[l]east restrictive of the person's freedom of movement and ability to function" and which "promot[es] the person's independence." There is ample evidence that this requirement is not being met, including the noncompliance with the requirements of the Community Mental Health Agreement and the failure to discharge patients who no longer require a hospital level of care. If the proposed waiver is granted, we expect that

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<sup>2</sup> See Draft Request at 11.

<sup>3</sup> See the **NH DHHS Operations Assessment, November 2020, Phase IA**, prepared by Alvarez and Marsal Public Sector Services, LLC, accessible at <https://www.dhhs.nh.gov/ocom/documents/dhhs-operations-assessment-phase-1a-report.pdf>. The discussion of the IMD waiver and the expectation that it would attract new inpatient providers is at page 10.

<sup>4</sup> The only mention of actual expansion of community based care is at page 11 of the draft application: "The State will request that any parties seeking to add to IMD capacity also consider enhancing community-based care. . . ." (emphasis added).

the state's service system will become even less consistent with the policy established in 135-C:1.

## **B. Additional Inpatient Mental Health Treatment Capacity is Not Needed in New Hampshire**

New Hampshire's inpatient treatment capacity is sufficient for current and reasonably anticipated demand, particularly if existing acute treatment resources are reserved for persons with a clinical need for that level of treatment. The draft waiver request is based in part on the assertion that the demand for inpatient services is on the rise, as evinced by the persistence in recent years of a waitlist for DRF beds.<sup>5</sup> However, there is significant evidence that the state's inpatient service capacity is adequate for the existing demand.

Four years ago, the state commissioned the Human Service Research Institute to conduct an Evaluation of the Capacity of the New Hampshire Behavioral Health System. The resulting report concluded that it was at least as important to increase community services as it was to add to inpatient bed capacity. This conclusion was based in significant part on the observations of providers of mental health services and other experts in the New Hampshire system:

It is important to note that in our interviews with key informants for this report, nearly everyone viewed the solution to be rooted in enhanced community support services. Few individuals advocated for more inpatient beds; while some indicated that a modest increase in beds may help, simply adding beds would do nothing to address what they saw as the root cause of the current situation: the reduced continuum of care at the local levels.<sup>6</sup>

The report further found that “[b]ased purely on population size, New Hampshire currently has an adequate number of inpatient beds available,”<sup>7</sup> and concluded that the identified barriers to timely community-based services and the lower costs of such care “strongly support the view that increasing capacity of outpatient services and supports, especially housing, is at least as important—and significantly more cost effective—as increasing the number of inpatient beds.”<sup>8</sup>

In response to the report's release, Governor Sununu stated that “[t]he perception is that extended wait times for behavioral health services in hospital emergency departments are due to there being too few inpatient beds at New Hampshire Hospital . . . Importantly, this report shows that we can take steps to increase availability of these

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<sup>5</sup> See Draft Request at 7 (“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.”).

<sup>6</sup> See HSRI report at 21. Accessible at <https://www.dhhs.nh.gov/dcbcs/bbh/documents/nh-final-report-12222017.pdf>.

<sup>7</sup> See HSRI report at 22. The total number of inpatient beds in the state has increased since the HSRI determination.

<sup>8</sup> See HSRI report at 23.

inpatient services by expanding community interventions for those ready to leave New Hampshire Hospital.” The report’s findings prompted the department and the Governor to “redirect[ ] funds set aside for designated receiving facility beds for involuntary admissions to housing services.”<sup>9</sup>

Representatives of the department have also repeatedly made it clear in their presentations to the state legislature that the state’s challenge is not one of increasing bed capacity to meet an increase in demand for that capacity, but rather one of increasing community services, especially services that can allow the discharge of patients that no longer require a hospital level of care. One of the most recent instances of this was on March 1 of this year, when Heather Moquin, the Chief Executive Officer of the New Hampshire Hospital stated to a panel of the House of Representatives Finance Committee that “adult referrals [for hospital services] have been steady” while the waitlist has been growing over time. Ms. Moquin also pointed out that “at least half of the patients at New Hampshire Hospital could be better served in a less restrictive environment.”<sup>10</sup>

This presentation followed a similar one in 2019, when the department presented information during the budget process that 58 of the 144 then-available adult beds at New Hampshire Hospital were occupied by persons who had been ready for discharge for more than 15 days. Since the 2019 presentation, the number of adult beds at New Hampshire Hospital has significantly increased, with Ms. Moquin reporting to the legislature in March that the average census since the previous July was 168, and a higher proportion of them are filled by persons ready for discharge to a less restrictive setting. In fact, it appears that although the total number of NHH beds available for adult treatment increased by 24 during the year after the 2019 presentation, the number of beds filled by person actually in need of a hospital level of care was essentially unchanged. In 2019, 86 of 144 beds were used for their intended purpose, and in 2021 approximately 84 of 168 were being used.

These figures are consistent with the statements that department representatives have repeatedly made to the legislature and in other public settings describing how past additions to the New Hampshire Hospital bed count have only temporarily alleviated the emergency department waitlist, as the real problem is the inadequacy of community resources for successful discharge. This means that until the appropriate housing and other community services are in place there will be a continuing overuse of the state’s publicly funded psychiatric hospital beds, and as a result, unnecessary institutionalization.

There are also strong indications that the emergency department waitlist is composed in significant part of persons who are inappropriate for admission to a DRF,

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<sup>9</sup> See December 22, 2017 press release at <https://www.dhhs.nh.gov/media/pr/2017/12222017-mental-health-report.htm>.

<sup>10</sup> A link to the recording of Ms. Moquin’s presentation is at [http://www.gencourt.state.nh.us/LBA/Budget/HF\\_Division\\_III.aspx](http://www.gencourt.state.nh.us/LBA/Budget/HF_Division_III.aspx).

as they either have been subjected to IEAs without a statutorily permitted basis, or have been released at the local hospital level through rescission of their involuntary admission status and referred to community-based services without ever being admitted to a DRF. At a June 8, 2021 hearing before the Health and Human Services Committee of the New Hampshire Senate, Commissioner Shabinette testified that in the previous 3 weeks, 25 persons on the waitlist were deferred from admission due to their ineligibility for involuntary admission. Their ineligibility was due to their condition not being a mental illness which could meet the statutory requirements for involuntary status. The conditions included developmental disabilities, substance use disorders, and dementia. During the same period, 19 persons were taken off the wait list and either released or referred to community services through the rescission process. That is a total of 44 persons in 21 days who were held in emergency rooms to await admission to a DRF but that were not actually candidates for a hospital-level of psychiatric treatment.<sup>11</sup>

These descriptions are not of a system in need of new capacity to respond to increased demands for acute psychiatric treatment, but rather one that is unable to meet steady demands on its resources because it is crowded at the pre-admission stages with persons who are not actual candidates for inpatient treatment, and at the post-admission stage with persons who are ready for discharge. The system may be inadequate to meet the housing needs of persons who are ready to leave inpatient treatment settings, but the evidence does not support a conclusion that it is inadequate to meet the need for the services its inpatient facilities are actually designed to provide.

### **C. New Inpatient Treatment Providers in the State Would Put Additional Demands on an Inadequate Labor Pool for Community Mental Health Services**

As discussed above, one of the apparent purposes of the waiver amendment request is to induce private providers of inpatient psychiatric treatment to enter the state. Inducing private inpatient treatment providers to the state will force the providers of more integrated and community-based mental health treatment services into even more competition to fill their workforce needs. This will put further obstacles in the state's path toward compliance with its obligations under the Community Mental Health Agreement and the Americans with Disabilities Act.

In the past several years, several of the department's Requests for Proposals have failed to induce bidders, reportedly due to provider concerns about low reimbursement rates and difficulty staffing existing services. The Community Behavioral Health Association regularly reports 200 or more total clinical vacancies in the Community Mental Health Centers. Press reports have recently documented concern on the part of some of the Centers about their ability to hire the staff necessary for the establishment

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<sup>11</sup> Commissioner Shabinette's testimony can be accessed at <https://www.youtube.com/watch?v=0sBAbHg950Y&t=4632s>.

of the planned statewide mobile crisis response system.<sup>12</sup> Any additional private inpatient programs can be expected to increase the competition for clinical and other staff, increasing the difficulty in establishing the community programming that can prevent unnecessary hospitalization.

#### **D. The Draft Waiver Request is Inconsistent with the Obligation of the State to Improve the Community-Based Treatment System Rather Than Expand Unneeded Inpatient Treatment Capacity**

The state should focus its system improvement efforts on integrated, community-based services rather than treatment in institutions. As described above, the existing inpatient capacity in the state is sufficient to meet the needs of persons actually in need of a hospital level of care.

There are several unmet obligations to provide community-based services that the state should address prior to considering an expansion of inpatient treatment capacity. The first of these is the Community Mental Health Agreement, which came about as a result of litigation which followed investigations by the Disability Rights Center and the United States Justice Department. That agreement was approved by the United States District Court in 2014. Although the parties expressed an expectation that the state would fulfill its commitments under the agreement within 5 years, it is now 7 years later and the state is not yet in full compliance. In his most recent report,<sup>13</sup> the Expert Reviewer (ER) monitoring performance of the agreement summarized his findings as follows:

The ER has emphasized in this report that the State continues to be far from compliant with the CMHA requirements for [Assertive Community Treatment]. For the last four and one half years, the ER has reported that the State is out of compliance with the ACT requirements . . . that the State provide ACT services that conform to CMHA requirements and have the capacity to serve at least 1,500 people in the Target Population at any given time.

Other areas of non-compliance identified in this report include:

1. With regard to [the Glencliff Home], the ER has documented failure to provide effective transition planning and in-reach activities, failure to transition residents of Glencliff into integrated community settings in accordance with the CMHA, and failure to expand community residential and other service capacity to meet the needs of Glencliff residents in alternative community settings. In addition, the ER cannot document or certify that residents of Glencliff have written transition plans in accordance with CMHA requirements; and

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<sup>12</sup> See, e.g., Doyle-Burr, Nora, **Mobile Crisis Initiative Can't Find Staff**, Concord Monitor, August 3, 2021, accessible at <https://www.concordmonitor.com/West-Central-launches-mobile-crisis-response-41789654>.

<sup>13</sup> The report is accessible at <https://drcnh.org/wp-content/uploads/2021/03/January-27-2021.pdf>; the quoted section is at page 53.

2. Although the State technically meets the statewide CMHA standard for [Supported Employment] penetration, the ER notes six of the ten CMHC regions of the state have penetration rates lower than the standard. At the very least, the ER considers that this demonstrates that Target Population members do not have equal access to SE services throughout New Hampshire."

In addition to the Mental Health Agreement, the state is required by 2019's Senate Bill 14<sup>14</sup> to provide mobile crisis services to all persons under age 21. The state has not yet established those services, although procurement was apparently recently completed, and the plans provide for a system of combined services for adults and children. This would be consistent with the 10-year Mental Health Plan, issued earlier in 2019, with its recommendation of expanded mobile crisis services. Should the planned expansion be successful, it can be expected that there will be a significant increase in the hundreds of diversions from hospitals which are reported monthly by the existing mobile crisis teams in Concord, Nashua, and Manchester. Focusing on completion of this important service rather than on institutional expansion should reduce the need for institutional treatment in the long term.

The state's waiver request should not be pursued, and if pursued, should not be approved. It would reduce the incentives to develop the community services that are widely accepted as the principal need of the state's mental health service system and prioritize the funding of institutional treatment settings in a way that would be inconsistent with the Americans with Disabilities Act, the Community Mental Health Agreement, and RSA 135-C:1.

Please contact me if you have questions about our concerns about the state's proposed waiver. Thank you for considering the views of the Disability Rights Center.

Sincerely,

/S/

Michael Skibbie  
Policy Director  
[mikes@drcnh.org](mailto:mikes@drcnh.org)

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<sup>14</sup> See RSA 167:3-I III.

The logo for the PAIMI Advisory Council, featuring the letters 'DRC' in a stylized, blue, serif font. The 'D' and 'R' are intertwined, and the 'C' is positioned to the right of the 'R'.

# PAIMI ADVISORY COUNCIL

August 31, 2021

John Poirier  
NH Department of Health and Human Services  
129 Pleasant Street  
Concord, NH 03301

Re: SUD-TRA Demonstration Amendment #2

Dear Mr. Poirier,

Attached is a letter from the DRC-NH PAIMI Advisory Council to Commissioner Shibinette expressing concerns regarding NH's overreliance on institutional services for people with mental illness. As the PAIMI Advisory Council, we believe that these concerns are directly relevant to the state's application to further invest in institutional services for adults with mental illness through the SUD-TRA Demonstration waiver application.

Sincerely,

Dellie Champagne, Chair

# PAIMI ADVISORY COUNCIL

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(603) 228-0432 • (800) 834-1721 voice or TTY • FAX: (603) 225-2077

July 9, 2021

Dear Commissioner Shibinette,

We are writing to express significant concerns about the state's recent emphasis on institutional mental health treatment, rather than community-based treatment. We are members of the NH Protection and Advocacy for Individuals with Mental Illness (PAIMI) Advisory Council, a body established by federal law. We come from a variety of professions and backgrounds, and many of us have lived mental health experience. Our role is to monitor developments in the state related to the well-being of people with mental illness, and to provide independent advice and recommendations to the Disability Rights Center. Today we also want to share our insights with you.

The State of NH has long promised that it would establish a community-based system of supports and services for our vulnerable mentally ill population, rather than rely on oftentimes unnecessary institutional care. This commitment can be found in the Community Mental Health Agreement, 2019's Senate Bill 14, and two 10-year Mental Health Plans. We know that keeping people with mental illness in their communities is not only vastly more cost-effective, but that when people can remain in their homes, schools, and neighborhoods they lead more successful, stable and meaningful lives.

This understanding is the basis for our significant concern about the state's use of federal funds to add more beds in hospitals around the state and neighboring states. We implore you to instead use the funds to build out the evidence-based community supports and services that we know will help people get well. We also ask you and our lawmakers to make investments with state dollars to fund things such as Child-Parent Psychotherapy (CPP), Supported Housing, Employment Counselors, Critical Time Intervention (CTI) programs at all of our community mental health centers (CMHCs), Step Up/Step Down programs, and the Multi-Tiered System of Supports for Behavioral Health and Wellness (MTSSB) Program – a framework to support social and emotional learning in all school districts.

Moreover, we have waited with frustration for over two years for the fully funded and statutorily required statewide system of community-based crisis services to be stood up. This has had dire consequences. We cannot wait that long for authorized and funded programs to be stood up when we know that suicides are occurring all over our state. Our current system is failing our residents and we cannot settle for Band-Aid solutions.

Additionally, the Americans with Disabilities Act requires that services be provided in least-restrictive environments. This is consistent with our moral obligation to help people remain in their communities. We do know that institutionalization is sometimes necessary, but we also know many folks who are hospitalized could have instead received community-based services if those services existed.

*Protection and Advocacy System for New Hampshire*

We recognize and applaud some of the work that is being done to improve the community-based treatment system, but we implore you to redouble those efforts and ensure that all our residents can receive timely and appropriate care when and where they need it.

Sincerely,

Dellie Champagne, Chair

Deane Kellison, Vice Chair

Holly Fenn

Andrea Jergensen

John Kitchen

Deb Yuknewicz-Boisvert

Katherine Anthony

Juli Hincks

Elizabeth Luna

Jean Lewandowski



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August 30, 2021

NH Department of Health and Human Services  
Commissioner Lori Shibinette  
Office of the Commissioner  
129 Pleasant St  
Concord, NH 03301

Dear Commissioner Shibinette;

Please accept this letter in support of the Medicaid waiver for Substance Use Disorder Treatment and Recovery Access Section 115A Research and Demonstration Waiver Amendment no. 2.

I am writing as the president of the New Hampshire Community Behavioral Health Association (CBHA) on behalf of the ten designated community mental health centers. Collectively, the CBHA recognizes that the ongoing emergency room boarding that occurs, as people wait for an acute inpatient psychiatric bed, has significantly harmed New Hampshire's population. We also recognize that the State's actions over the past year represent a meaningful attempt to begin to undo the structural issues which have caused this problem to occur. The need for acute inpatient psychiatric beds has been an issue for more than a decade and the CBHA applauds the State's pursuit of solutions, including this Section 115A demonstration waiver.

We believe that targeted Medicaid waivers, structured to meet New Hampshire's unique needs, will assist in the overall system of care, and represent an opportunity to advance initiatives identified in the ten-year mental health plan.

We understand the necessity for budget neutrality in this waiver submission. We want to assure every possible resource is being invested in the mental health system to serve the needs of the people with mental illnesses, not other aspects of state government. Our greatest desire is to strengthen our collective capacity in the community to assure the people of New Hampshire have access to the mental health services they need, where they need them, without being driven into a potentially unnecessary hospitalization. The milieu of services identified in the ten-year mental health plan will need to be funded to assure the system can respond to each person's care plan to help them manage their illness. We hope the Department continues to identify the resources needed to stand up community services to the legislature and the public.

Thank you for the opportunity to respond to the waiver submission. This stands as an important next step in our system of care. We look forward to working with you to support of communities.

Sincerely,

A handwritten signature in black ink that reads "Brian Collins".

Brian Collins, President  
NH CBHA

## H – Summary of Testimony from Public Hearings

## SUD-TRA Demonstration Amendment #2 – Public Hearing Record

Date & Time: Monday, August 9, 2021

Location: Brown Building Auditorium (Concord, NH)

Present in Person: Commissioner Lori Shibinette, Henry Lipman, Joe Caristi, Dawn Landry, John Poirier, Wanda Seiler (A&M), Jay Nagy (A&M), Brian Collins (NH Community Behavioral Health Association Board), Susan Paschell (The Dupont Group), Susan Stearns (NAMI NH), Bob Lincoln (NHH Legal Services)

Present on Zoom: Katja Fox, Paula Minnehan (NH Hospital Association), Nicole St Hilaire (AmeriHealth Caritas NH)

### Comment #1

Speaker Name: Brian Collins

Speaker Organization: [NH Community Behavioral Health Association](#)

Summary Remarks: Meeting scheduled next week has an agenda item to discuss this topic.

We recognize that people shouldn't be waiting for care.

We believe Medicaid waivers allow for tailoring of services for the State of NH, not what works in the rest of the country.

With respect to Budget Neutrality, we believe that money saved should be reinvested into mental health system nor bridges and roads (as important as bridges and roads may be).

In terms of aligning with the 10-year Mental Health Plan, the system continues to need investment in community-based services.

This is bringing the state into the 21<sup>st</sup> century in a positive way.

### Comment #2

Speaker Name: Susan Stearns

Speaker Organization: [NAMI NH](#)

Summary Remarks: We are opposed to the IMD Exclusion Rule.

We echo what Brian Collins said regarding the ongoing need for community-based investments.

We only noted one mention regarding reducing the need for inpatient admissions in Milestone 2; can more be done to emphasize this?

We noted no references to the homeless and justice-involved populations; can more be done to emphasize this?

For Milestone 3 we can see the link with improved availability of community-based services, beds tracking, etc.

For Milestone 4 regarding integration of [physical and] behavioral health services, what kind of data will be used?

We expected to see more on peer support, especially given the tie-in with CTI (Critical Time Interventions).

### Comment #3

Speaker Name: Bob Lincoln  
Speaker Organization: New Hampshire Hospital Legal Services  
Summary Remarks: No comments at this time.

### Comment #4

Speaker Name: Paula Minnehan  
Speaker Organization: [NH Hospital Association](#)  
Summary Remarks: Nothing to add at this time.

### Comment #5

Speaker Name: Nicole St Hilaire  
Speaker Organization: [AmeriHealth Caritas NH](#)  
Summary Remarks: Nothing to add; we wanted to hear what the public had to say.

## SUD-TRA Demonstration Amendment #2 – Public Hearing Record

Date & Time: Wednesday, August 11, 2021

Location: Harbor Homes (Nashua, NH)

Present in Person: Henry Lipman, Joe Caristi, John Poirier, Jay Nagy (A&M), Henry Och (Harbor Homes)

Present on Zoom: Katja Fox, Leslie Melby, Representative Megan Murray (Amherst), Richard Sigel (McLane Middleton)

### Comment #1

Speaker Name: Representative Megan Murray

Speaker Organization: [NH House of Representatives](#)

Summary Remarks: Are IMDs & DRFs the same thing?

Joe Caristi: both provide inpatient psychiatric care, but DRFs are generally <17 beds. The state's main IMD is New Hampshire Hospital.

Katja Fox: this is part of our 10-Year Mental Health Plan, which covers all gaps, challenges, and opportunities to improve care across the state. We have heavily emphasized community-based services in the past and will continue to do so. CTI is about transitions to the community and addressing readmissions. DRF beds are measured within the overall bed size of the facility; not comparable for purposes of determining IMD status. Cypress as a standalone facility is limited to 16 beds, but the DRF at Elliot Hospital can have >16 beds because it's a small part of the overall facility.

### Comment #2

Speaker Name: Richard Sigel

Speaker Organization: [McLane Middleton](#)

Summary Remarks: No questions at this time.

### Comment #3

Speaker Name: Henry Och

Speaker Organization: [Harbor Homes](#)

Summary Remarks: No comments or questions at this time.

## SUD-TRA Demonstration Amendment #2 – Public Hearing Record

Date & Time: Monday, August 16, 2021

Location: Brown Building Auditorium (Concord, NH)

Present in Person: Henry Lipman, Joe Caristi, Brooke Belanger, Jay Nagy (A&M)

Present on Zoom: Katja Fox, Kerrin Rounds, Representative Latha Mangipudi (Nashua), Ken Norton (NAMI New Hampshire)

### Comment #1

Speaker Name: Representative Latha Mangipudi

Speaker Organization: [NH House of Representatives](#)

Summary Remarks: What does CTI stand for? (Joe Caristi: Critical Time Interventions.)

Does this impact DRFs? (Henry Lipman: generally hospital-based DRFs do not fall under the IMD Exclusion, but it's possible a standalone DRF could be impacted under certain circumstances.)

Requested PowerPoint presentation by email. (Henry Lipman: the slides are available to all on the website with the public comment details.)

(Katja Fox: I'd like to return to the discussion on DRFs briefly. New Hampshire Hospital is technically a DRF and they are impacted by the demonstration amendment, so yes DRFs can be impacted. Cypress Center is also a DRF but under a different type of licensure and only 16 beds. If Cypress ever exceeded 16 beds, they would be impacted.)

St. Joseph's recently opened a psych unit with 25 beds and are looking at expanding further into pediatrics. How are they impacted? (Katja Fox: their overall patient available beds is high and psychiatric patients occupy <50% of them, so no St. Joseph's does not need this amendment for that expansion.)

Does reimbursement rate remain lower under the 16-bed threshold? (Henry Lipman: today State General Funds pick up the cost of any stay >15 days; this amendment brings in federal financial participation for stays 16-60 days. Medicaid rates are better than Medicare currently; Medicaid is the best mental health payer in the state. Katja Fox: why St. Joe's was willing to open gero-psych beds was also about these higher rates. The Governor and Legislature supported higher rates and it was also part of the 10-Year Mental Health Plan.)

What is the plan for community-based care and reducing readmission rates? (Katja Fox: we will have mobile crisis response teams across the state, there are expectations from IMDs regarding connecting with CMHCs, discharge planning will start at admission and be revisited on a daily basis. CTI is a care coordination program that will be provided by the CMHCs; it follows people for 9 months

after discharge and the level of support titrates down over those 9 months. There are housing requirements under the 10-Year Mental Health Plan including 6 additional supportive housing beds in each of 10 regions. Henry Lipman: new MCO rates for this service will be substantially higher.)

How are we addressing the critical shortage of mental health providers across the state? (Katja Fox: we have new recruiting tools that are being deployed; this is a health system-wide problem for all provider types. We're also doing more marketing for providers to relocate and making it easier to transfer licenses from other states.)

That sounds great on paper. Being brown and an immigrant I know how challenging it is to bring diverse talent.

## Comment #2

Speaker Name: Ken Norton

Speaker Organization: [NAMI New Hampshire](#)

Summary Remarks: In the case of a larger volume psychiatric hospital with over 16 beds, would that be eligible for this? (Henry Lipman: yes. Katja Fox: And DRFs are reimbursed at a higher payment than Medicare.)

We need to do a better job reaching persons of color; we need providers with cultural competencies and experience.

We would also like to see a more intentional message regarding peer support and its role in the continuum.

In terms of metrics, we need to track everyone at the ED, not just those admitted. There's a potential to impact the high suicide rate that may not otherwise be obvious. Also, preventing ED utilization not just reducing it although we think the capability will be there with statewide mobile crisis and the hub.

### 3. Provider Availability Assessment

**Narrative Description (to be completed at baseline)**

**1. In the space below, describe the mental health service needs (e.g. prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. [Limit responses to 500 words if possible]**

New Hampshire (the State) continues to experience high rates of serious mental illness (SMI) within its Medicaid population. 6% of beneficiaries under 18 have an SED diagnosis and 6% of Medicaid beneficiaries 21 and older have an SMI diagnosis, resulting in a 6% overall rate of SMI/SED within New Hampshire's Medicaid enrollees. The state is comprised of three regions: two rural (North Country, Southwest NH) and one mixed rural-urban (Central NH). Central NH is comprised of a mix of urban (Hillsborough, Rockingham, and Strafford) and rural (Belknap and Merrimack) counties. The overall prevalence of SMI and SED is modestly higher in Central NH (7%) than in North Country (5%) and Southwest NH (5%).

**2. In the space below, describe the organization of the state's Medicaid behavioral health service delivery system at the beginning of the demonstration. [Limit responses to 500 words if possible]**

New Hampshire has a comprehensive, evolving continuum of care with an increasingly robust step-up and step-down network characterized by multiple points of entry and exit. Primary Care (PCPs), Doorway Access and Delivery Hubs, Emergency Departments (EDs), Mobile Crisis Units (MCUs), and Community Mental Health Centers (CMHCs) - in addition to the legal system for some individuals admitted on an involuntary basis - serve as entry points. Individuals who enter the service delivery system receive assessments for inpatient/outpatient services at appropriate locations, including residential treatment facilities and psychiatric units if necessary.

Since 2013 the State has operated a Medicaid Managed Care Program for Medicaid eligible beneficiaries delivered through commercial Managed Care Organizations (MCOs). Currently, DHHS contracts with three MCOs which provide Medicaid benefits, including behavioral health services, to recipients in exchange for a monthly payment from the State. MCOs are contractually required to manage and ensure all members receive primary behavioral health care through PCPs and other practitioners connected with a variety of community-based providers.

A major component of the community-based network of providers is the 10 Community Mental Health Centers (CMHCs). MCOs and CMHCs collaborate to provide community mental health services described in He-M 426 Community Mental Health Services, including but not limited to medication-related services (assessments, office visits, follow-up evaluations), psychotherapeutic services (therapy, crisis intervention, assessments/monitoring), partial hospitalization services (individual or group psychotherapy, psychological evaluations, medication monitoring, administration, evaluation, etc.), Individualized Resiliency and Recovery Oriented Services (IROS), and ACT.

DHHS supports the provision of inpatient/outpatient services with a robust behavioral health emergency support system embedded in the community. Such crisis stabilization services include but are not limited to: crisis call centers (including emergency services hotlines at the CMHCs, Mobile Crisis Response Team hotlines, Lifeline Hotlines, Doorway Numbers, and National Hotlines advertised in NH such as Veterans Crisis, Trevor Project, Crisis Text Line, Translifeline, Disaster Distress Helpline, LGBT National Help Center, and 9-1-1); three mobile crisis units (MCUs) each with corresponding crisis apartment beds in Nashua, Concord, and Manchester with ongoing plans to expand to all 10 CMHC regions within the next year; mental health courts; a Behavioral Health Crisis Treatment Center (BHCTC) in Concord; and a disaster behavioral health response team (DBHRT), which can be activated by the Governor or designee at DHHS to operate statewide during federal or state emergencies, or by local municipalities and emergency response systems for local crises. NH

**3. In the space below, describe the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. At minimum, explain any variations across the state in the availability of the following: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. [Limit responses to 1000 words if possible]**

Providers of mental health services for Medicaid beneficiaries in the State tend to be concentrated around urban areas in the Central NH region.

**Inpatient Mental Health Services:** There are 7 Medicaid-enrolled psychiatric units in acute care hospitals (ACHs) and 2 in Critical Access Hospitals (CAHs) in Central NH; 1 psychiatric unit in an ACH and none in CAHs in North Country; and no psychiatric units in ACHs or CAHs in Southwest NH. There is significant centralization of inpatient care options in Central NH. Almost all psychiatric hospital beds are located in Hillsborough, Merrimack, and Rockingham counties - all three which are part of Central NH and comprise urban cities and neighborhoods. In addition to this capacity, the State has two psychiatric hospitals - New Hampshire Hospital (public) and Hampstead Hospital (private), both located in Central NH.

**Outpatient and Community-based Services:** Of the 10 total CMHCs, 8 provide services in at least one county in Central NH; 3 in North Country; and 2 in Southwest NH. There are 4 CMHCs providing IOP services in Central NH; 1 in North Country; and 2 in Southwest NH. Outpatient services are somewhat more decentralized vs. inpatient services, with each of the two CMHCs in Southwest NH providing either restorative partial hospitalization or intensive outpatient treatment. In North Country, however, only one CMHC provides restorative partial hospitalization services, and only to a small part of the area.

**Crisis Behavioral Health Services:** There are 27 crisis call centers, 3 mobile crisis units, and 4 crisis observation/assessments centers (apartments affiliated with 3 mobile crisis units + 1 BHCTC) in Central NH; 17 crisis call centers, no MCUs, and no crisis observation/assessment centers in North Country; and 14 crisis call centers, no MCUs, and no crisis observation/assessment centers in Southwest NW. NH has one Coordinated Community Crisis Response Team, a disaster behavioral health response team (DBHRT) that operates statewide. Given the availability of statewide hotlines, individuals in Southwest NH and North Country have access to a wider range of crisis call centers vs. Central NH, with somewhere between 90-100 Medicaid beneficiaries per call center/hotline in rural areas compared to 400:1 in Central NH. Crisis stabilization is undergoing a significant transformation in NH - though there are currently only three mobile crisis units located in metropolitan areas, the State is expanding access statewide (to all CMHCs) within the next year.

**Care Coordination and Care Transition Planning:** The system requires all behavioral health providers provide care coordination and care transition. These requirements are outlined in administrative rule and in contracts. Care coordination in New Hampshire works best

**4. In the space below, describe any gaps the state identified in the availability of mental health services or service capacity while completing the Availability Assessment. [Limit responses to 500 words if possible]**

As confirmed by this assessment template, rural access is a perennial consideration for a state with NH's geographic and demographic characteristics and can, at times, become a challenge. The State works to address this challenge through its oversight of the CMHC programs and services as well as network adequacy by the MCOs.

**Provider Availability:** The ratio of psychiatrists and other practitioners authorized to prescribe psychiatric medication is especially low relative to the population serviced in Southwest NH, at 25.3 Medicaid beneficiaries to prescribing psychiatrists. By comparison, North Country beneficiaries have on average one prescribing psychiatrist to every 3.8 beneficiaries.

**Community-based Supports:** Community-based supports show gaps in certain areas. FQHCs, for instance, are concentrated in Central NH and North Country. The same is true for crisis stabilization supports; there are currently no MCUs outside of Central NH (although these units are currently being expanded to all 10 CMHCs in all three regions as outlined in this template and application).

**5. In the space below, describe any gaps in the availability of mental health services or service capacity NOT reflected in the Availability Assessment. [Limit responses to 500 words if possible]**

There is a patchwork of IT communications across the State. As is typical in the US health care system, the State's psychiatric hospital uses an EMR which can be accessed only by authorized State employees and not by private practitioners at CMHCs or in private practice. Similarly, CMHCs use a monitoring and reporting system that collects data from the CMHCs' claims processing databases for federal and State reporting, but MCOs have limited, if any, access to the CMHC database. The State has invested in technologies which bring together mental health practitioners in private practice across hospital systems, but this remains an ongoing and early area of investment.

Anecdotally, this can complicate handoffs in care coordination where individuals transition between entire care/service delivery systems or between different levels of the same care/service delivery system.

**6. In the space below, if desired, please add any additional information regarding data sources that is not already included in the "Availability Assessment" tab. Please note that within the "Availability Assessment" tab, there are columns in which to enter brief descriptions of the data source(s) used to report on mental health services, by type, as well as columns in which to describe any data limitations. Additional information regarding data sources can be provided here. [Limit responses to 500 words if possible]**

N/A

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

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

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%
<b>Total</b>			<b>11952</b>	<b>748</b>	<b>115129</b>	<b>7263</b>	<b>6%</b>	<b>93476</b>	<b>5720</b>	<b>6%</b>	<b>220557</b>	<b>13731</b>	<b>6%</b>

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

Geographic Designation			Psychiatrists and Other Pract							
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	Ratio of Medicaid-Enrolled Psychiatrists and Other Practitioners Who Are Authorized to Prescribe Psychiatric Medications 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
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
<b>Total</b>					<b>2279</b>	<b>832</b>	<b>813</b>	<b>16.50360577</b>	<b>2.739182692</b>	<b>1.023370234</b>

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

Geographic Designation			Providers Who Are Authorized to Prescribe Psychiatric Medications				Providers	
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 Treat Mental Illness	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to 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	
<b>Total</b>						<b>3057</b>	<b>1314</b>	

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

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	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		
<b>Total</b>			<b>1261</b>	<b>10.44977169</b>	<b>2.326484018</b>	<b>1.042030135</b>		

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

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 Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled CMHCs	Ratio of Total Medicaid-Enrolled CMHCs to Accepting New Patients	Ratio of Medicaid-Enrolled CMHCs to Medicaid-Enrolled CMHCs	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).	8	8	8	1,350.50	1.00	1.00	NH DHHS Division for Behavioral Health.
North Country	Rural	Carroll, Coos, and Grafton Counties	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.	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	
<b>Total</b>				<b>13</b>	<b>13</b>	<b>13</b>	<b>1056.23077</b>	<b>1</b>	<b>1</b>	

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

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			
<b>Total</b>				<b>7</b>	<b>7</b>	<b>7</b>	<b>1961.571429</b>	<b>1</b>	<b>1</b>			

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

**Geographic Designation** **Residential Mental Health Treatment**

<b>Geographic designation</b>	<b>Is this geographic designation primarily urban or rural?</b>	<b>Additional notes on this sub-section, including data limitations</b>	<b>Additional notes on this section, including data limitations</b>	<b>Number of Residential Mental Health Treatment Facilities (Adult)</b>	<b>Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)</b>	<b>Number of Residential Mental Health Accepting New Medicaid Patients (Adult)</b>	<b>Ratio of Medicaid-Enrolled Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)</b>	<b>Ratio of Total Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)</b>	<b>Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Accepting New Patients</b>	<b>Total Number of Residential Mental Health Treatment Facility Beds (Adult)</b>	<b>Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds (Adult)</b>
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
<b>Total</b>				<b>1</b>	<b>1</b>	<b>1</b>	<b>8011</b>	<b>1</b>	<b>1</b>	<b>16</b>	<b>16</b>

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

Geographic Designation			Residential Mental Health Treatment Facilities									
Geographic designation	Is this geographic designation primarily urban or rural?	Additional notes on this sub-section, including data limitations	Total Facilities (Adult)				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-Accepting New Medicaid Patients
			Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Adult Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI (Adult) 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						
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
<b>Total</b>			<b>16</b>	<b>500.6875</b>	<b>1</b>	<b>1</b>				<b>0</b>	<b>0</b>	<b>0</b>

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

Geographic Designation			Psychiatric Residential Treatment Facilities									Specific type(s) of facilities used to populate this sub-section
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 PTRFs	Ratio of Medicaid-Enrolled PTRFs to Medicaid-Accepting New Medicaid Patients	Total Number of PTRF Beds	Number of Medicaid-Enrolled PTRF Beds	Number of Medicaid-Enrolled PTRF Beds Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PTRF Beds Available to Medicaid Patients	Ratio of Total Number of Medicaid-Enrolled PTRF Beds	Ratio of Medicaid-Enrolled PTRF Beds Available to Medicaid Patients	
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	-	-	-	
<b>Total</b>			-	-	-	0	0	0	-	-	-	

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

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
<b>Total</b>					<b>2</b>	<b>2</b>	<b>6865.5</b>	<b>1</b>			<b>9</b>	<b>2</b>

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

Geographic Designation			Inpatient Psychiatric Units										Brief description of data source(s) used to populate this sub-section
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	
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	-	-	-	-	-	-	
<b>Total</b>			<b>9</b>	<b>2</b>	<b>8</b>	<b>2</b>	<b>1525.666667</b>	<b>6865.5</b>	<b>1</b>	<b>1</b>	<b>1.125</b>	<b>1</b>	

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

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 + Psychiatric Units Available to Medicaid Patients	Ratio of Medicaid Beneficiaries 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
<b>Total</b>				<b>470</b>	<b>460</b>	<b>29.85</b>	<b>1.02173913</b>			<b>0</b>	<b>0</b>	<b>0</b>

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

Geographic Designation			Institutions for Mental Diseases								
			Residential Treatment Facilities That Qualify As IMDs			Psychiatric Hospitals That Qualify As IMDs					
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	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 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	-	
<b>Total</b>			-	-	-				<b>2</b>	<b>6865.5</b>	

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

Geographic Designation				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
<b>Total</b>				<b>58</b>	<b>3</b>	<b>4</b>	<b>0</b>	<b>3</b>	<b>236.7413793</b>	<b>4577</b>	<b>3432.75</b>	<b>-</b>	<b>4577</b>

Medicaid Section 1115 SMI/SED Demonstrations Initial Availability As:

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

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		
<b>Total</b>						<b>15</b>	<b>915.4</b>		

4. Implementation Plan

**Section 1115 SMI/SED Demonstration Implementation Plan**

**July 23, 2019**

**Overview:** The implementation plan documents the state’s approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

**Implementation Plan Instructions:** This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on “Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]” over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state’s implementation plan.

**Memorandum of Understanding:** The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

**State Response:** In accordance with New Hampshire’s approved Medicaid State Plan, the NH Department of Health and Human Services (DHHS) is the single State agency. The Division for Behavioral Health is within DHHS; therefore, no MOU is applicable to this waiver request.

**State Point of Contact:** Please provide the contact information for the state’s point of contact for the implementation plan.

Name and Title: John Poirier  
Telephone Number: (603) 271-9628  
Email Address: John.E.Poirier@dhhs.nh.gov

**1. Title page for the state’s SMI/SED demonstration or SMI/SED components of the broader demonstration**

*The state should complete this transmittal title page as a cover page when submitting its implementation plan.*

<b>State</b>	State of New Hampshire
<b>Demonstration name</b>	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
<b>Approval date</b>	<i>Enter approval date of the demonstration as listed in the demonstration approval letter.</i> TBD
<b>Approval period</b>	<i>Enter the entire approval period for the demonstration, including a start date and an end date.</i> TBD
<b>Implementation date</b>	<i>Enter implementation date(s) for the demonstration.</i> July 1, 2022

**2. Required implementation information, by SMI/SED milestone**

Answer the following questions about implementation of the state’s SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place “NA” in the summary cell if a prompt does not pertain to the state’s demonstration. Answers are meant to provide details beyond the information provided in the state’s special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
<b>SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings</b>	
<p>To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk.</p> <p>To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.</p>	
<b>Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings</b>	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	<p><i>Current Status:</i>            NH Administrative Code details licensure requirements for acute and residential settings:</p> <ul style="list-style-type: none"> <li>• NH Administrative Code <b>He-P 802 Rules for Hospitals</b> and <b>RSA 151:2 Residential Care and Health Facility Licensing: License or Registration Required</b> requires licensure for hospitals.</li> <li>• NH Administrative Code <b>He-P 807 Rules for Residential Treatment and Rehabilitation Facilities (RTRFs)</b> requires licensure for RTRFs that complies with <b>RSA 151:4 Residential Care and Health Facility Licensing: Application for License</b>.</li> <li>• NH Administrative Code <b>He-P 814 Community Residences at Residential Level</b> and <b>RSA 151:4</b> requires licensure for community residences at the residential care and supported residential care level.</li> <li>• NH Administrative Code <b>Part He-P 830 Acute Psychiatric Residential Treatment Programs (APRTPs)</b> and <b>RSA 151:2</b> requires licensure for APRTPs.</li> <li>• NH Administrative Code <b>He-M 405.04 Application Procedure and Designation/Redesignation Criteria</b> states that hospital-based Designated Receiving Facilities (DRFs) which submit an application for (re-)designation shall include a certificate of compliance with the Conditions of Participation (CoPs) for hospital-based psychiatric services set by CMS, obtained from either the department on behalf of CMS or by a national</li> </ul>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan  
 NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration  
 [Demonstration Approval Date]  
 Submitted on September 3, 2021

	<p>accrediting organization deemed by CMS as having standards and a survey process that meets the Medicare CoPs and federal survey requirements.</p> <p>In accordance with NH administrative code, upon the initial enrollment in NH Medicaid, the licensure requirement is a mandatory field and verified with the appropriate licensing entity for the Provider. This information displays the end date of the license and the MMIS staff have an overdue license report that is worked weekly to update and record license dates to maintain current information. This function is done upon expiration of the license and at the time of revalidation every 5 years.</p> <p><i>Future Status:</i>        In addition to continuing operation of current requirements, New Hampshire (the State) plans to more rigorously document accreditation by a nationally recognized accreditation entity.</p> <p><i>Summary of Actions Needed:</i>        The Bureau of Mental Health Services (BMHS) will develop a list of accreditation entities that will be accepted during enrollment. This will ensure that the question is asked during enrollment and revalidation of residential treatment providers.</p> <p>Further, this documentation will also be added to the enrollment record of the entity that accredited the Provider.</p> <p>Lastly, this information and practice will be added to the administrative rule so that the Division of Program Quality and Integrity (DPQI), Program Integrity Unit (PIU) will be able to rely on the rule in any enforcement actions.</p>
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Prompts	Summary
<p>1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state’s licensing or certification and accreditation requirements</p>	<p><i>Current Status:</i>        The Program Integrity Unit performs on-site visits of every <b>moderate and high-risk provider</b> during the initial enrollment process and revalidation every 5 years to assess the meeting of the requirements for each provider type. Additionally, Program Integrity may increase a limited risk provider to moderate or high based on the risk to the Medicaid program. Each provider type under the waiver is moderate or high-risk under our classifications.</p> <p>The State also completes a full designation review of DRFs once every five years.</p> <p>BHFA reviews are conducted pursuant to federal regulations requiring the periodic inspection of all CMS certified hospitals by the NH DHHS Licensing and Certification Unit, specifically the CMS contracted certification unit or</p>

	<p>the accrediting organization. Pursuant to <b>RSA 151:5-b Deemed Licensed</b>, all CMS certified hospitals are deemed licensed and are exempt from inspections required by <b>RSA 151:6 Investigations and Consultations</b> and NH Administrative Rule <b>He-P 802 Rules for Hospitals</b>.</p> <p>NH Administrative Code <b>He-P 405.04 Application Procedure and Designation/Redesignation Criteria</b> requires that the department assign staff to review the application materials and conduct a site visit of any DRF applying for designation or redesignation.</p> <p>NH Administrative Code <b>He-P 830.09 Inspections</b> also requires that the department conduct inspections of AP RTPs to determine full compliance with <b>RSA 151</b> and <b>He-P 830 Acute Psychiatric Residential Treatment Programs</b>.</p> <p>The Licensing and Certification, Community Residence (CR) Unit conducts visits to the community residence pursuant to <b>He-M 1001 Housing</b> and <b>He-M 1002 Certification Standards for Behavioral Health Community Residences</b> in the form of a “quality assurance” review. Both of these rules reference <b>RSA 126-A:19-20 Community Living Facilities / Standards and Certifications for Community Living Facilities</b> as the statutory authority and indicate, in part, that the adopted rules are in place for monitoring the care, treatment, and habilitation provided to all residents of community living facilities. In reference to the adopted administrative rules for certification, both <b>He-M 1001</b> and <b>He-M 1002</b> indicate that the purposes of these rules are to define the standards and procedures for the certification of community residences funded by the State of New Hampshire for persons with a developmental disability, an acquired brain disorder, or a mental illness, and that these rules establish minimum standards governing the operation and continued certification of such residences.</p> <p><i>Future Status:</i>        In addition to the continued operations of current requirements, the State is exploring instituting an annual DRF review during the four years following the Designation period that will focus on a facility’s progress toward remediation of any compliance issues.</p> <p><i>Summary of Actions Needed:</i>        The department aims to ensure that language is identified in administrative rule in support of the oversight process.</p>
<p>1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide</p>	<p><i>Current Status:</i>        NH Administrative Code <b>He-W 520.04 Surveillance and Utilization Review and Control</b> requires the department perform utilization reviews directly or through contracted organizations for the purposes of assessing quality of care, including through random reviews of claims. In the last two years, PIU has internalized its QIO function to perform utilization reviews for inpatient fee-for-service hospital claims only.</p>

<p>oversight on lengths of stay</p>	<p>NH Administrative Code <b>He-W 543.11 Utilization Review</b> requires evaluations of the quality, medical necessity, appropriateness of care, and length of stay determinations for all inpatient hospital services at in-state and border hospitals in accordance with <b>42 CFR 456.100</b>.</p> <p>Operationally, the program area or their designated contractor reviews whether individual beneficiaries are receiving appropriate services. NH DHHS contracts with managed care organizations (MCOs) who employ or contract with licensed health care personnel to perform utilization review activities. These activities are outlined in the written Utilization Management policies included in each MCO contract. At a minimum, MCOs must outline policies which address Second Opinion programs, pre-hospitalization admission certification, pre-inpatient service eligibility certification, concurrent hospital review to determine appropriate lengths of stay, and the process for preserving confidentiality of patient information.</p> <p>Each MCO also maintains a collaborative agreement specific to New Hampshire Hospital (NHH) that includes mutually-developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays both within and external to NHH.</p> <p>New Hampshire Hospital employs Utilization Review as a key function in determining clinical necessity for levels of psychiatric care that patients receive. This process closely follows CMS guidelines outlined in Chapter 2, section 30.2.1 of the <b>Medicare Benefit Policy Manual</b> and <b>Pub 100-01- Medicare General Information, Eligibility, and Entitlement</b>, from the CMS Manual System. Throughout a patient’s stay, utilization review is employed to determine a patients continued medical necessity for inpatient psychiatric care, and when medical necessity is no longer met, Utilization Review staff members partner with Social Workers, Clinicians, and a variety of community-based and step-down facility providers in finalizing a safe and effective discharge plan for patients.</p> <p>New Hampshire’s focus on ensuring patients are served in the most appropriate and least restrictive environment possible is a key reason the state invested in and opened the Philbrook Adult Transitional Housing (PATH) program, a 16-bed transitional housing facility, owned and operated by the State of New Hampshire, that ensures a timely transition to a more appropriate level of care for patients who no longer require acute psychiatric hospitalization. This is just one example of recent and ongoing investments in community-based and step-down facilities that New Hampshire has made to ensure the Mental Health System of New Hampshire can support any individual experiencing mental illness, regardless of the level of care they require. Additional such investments are described in more detail in the amendment application narrative.</p> <p>In its oversight capacity, NH DHHS’s External Quality Review Organization conducts annual MCO contract compliance reviews. NH DHHS also conducts annual contract compliance audits for all state funded treatment</p>
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Medicaid Section 1115 SMI/SED Demonstration Implementation Plan  
 NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration  
 [Demonstration Approval Date]  
 Submitted on September 3, 2021

	<p>facilities to ensure adherence to clinical standards when determining level of care placement.</p> <p><i>Future Status:</i>          The State is developing a Quality Service Review (QSR) process for other entities, in addition to the existing QSR model/process for Community Mental Health Programs (CMHPs).<sup>1</sup></p> <p><i>Summary of Actions Needed:</i>          N/A – milestone met.</p>
<p>1.d Compliance with program integrity requirements and state compliance assurance process</p>	<p><i>Current Status:</i>          In order to receive reimbursement under Medicaid, participating psychiatric hospitals must be enrolled to participate in New Hampshire Medicaid. Provider enrollment processes fully comply with <b>42 CFR Part 455 Subparts B&amp;E</b>. PIU performs audits and investigations when an allegation of fraud, waste, or abuse is reported. PIU also uses data analytic reports to determine whether there are anomalies in billing and/or reimbursement. Further, Program Integrity will investigate an allegation that the program area reports to Program Integrity that includes questions about the accuracy of claim information or questions surrounding utilization. The department has also recently hired a waiver manager to oversee compliance and requirements of all NH waivers.</p> <p><i>Future Status:</i>          In addition to the continued operation of current requirements, PIU will enhance provider monitoring during the period of the waiver.</p> <p><i>Summary of Actions Needed:</i>          PIU will implement a pro-active approach to monitoring the providers that will include a six month random sampling of paid claims from the Fee-for-Service and MCO populations to determine if there are any patterns of irregularity or utilization practices including excessive high coding procedures.</p> <p>As it identifies additional best-practice safeguards over the normal course of business, PIU will work with BMHS to assure integration into the rule-making process.</p>
<p>1.e State requirement that psychiatric hospitals and</p>	<p><i>Current Status:</i>          All screenings and assessments are part of the current documentation process in Administrative rule.</p> <ul style="list-style-type: none"> <li>• Pursuant to <b>He-M 613.03 Voluntary Admission of Adults to NHH</b> applicants shall be referred by his or her</li> </ul>

<sup>1</sup> The terms Community Mental Health Programs (CMHPs) and Community Mental Health Centers (CMHCs) are used interchangeably in this Implementation Plan in order to preserve historical references in statute or regulation.

<p>residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions</p>	<p>regional CMHP and be certified by that CMHP as eligible for community mental health services.</p> <ul style="list-style-type: none"> <li>• Pursuant to <b>He-M 401.04 Eligibility Determination</b> the CMHP is required to make an eligibility determination<sup>2</sup>. Part of this eligibility determination includes diagnosis of Serious Mental Illness (SMI) as outlined in <b>He-M 401.05 Eligibility Criteria for Adults with Severe and Persistent Mental Illness</b>.</li> <li>• Pursuant to <b>He-M 613.04 Involuntary Admission of Adults to NHH</b> Involuntary Emergency Admissions (IEAs) shall be made if the official current Judicial Branch form<sup>3</sup> is complete.</li> <li>• Non-emergency involuntary admissions shall be made according to the following criteria:       <ul style="list-style-type: none"> <li>○ Pursuant to <b>RSA 135-C:34</b>, the person being admitted shall be in such mental condition as a result of mental illness as to create a potentially serious likelihood of danger to self or others; and</li> <li>○ Admissions shall not occur unless ordered by a probate court pursuant to <b>RSA 135-C:45</b>.</li> </ul> </li> </ul> <p>The State contracts with MCOs that are required by contract to screen for mental health conditions:</p> <ul style="list-style-type: none"> <li>• MCOs are required to make a Welcome Call to new members within 30 calendar days, which should include a screening for depression, mood, suicidality, and Substance Use Disorder (SUD).</li> <li>• In addition, MCOs are required to ensure that providers under contract to provide SUD services shall conduct an Initial Eligibility Screening for services as soon as possible, ideally at the time of first contact with the member / beneficiary. If screened positive, members will receive an ASAM LOC Assessment and a clinical evaluation.</li> <li>• MCOs are required to conduct a Health Risk Assessment (HRA) Screening of all existing and newly enrolled members within 90 calendar days to identify members with unmet health care needs and/or special health care needs. Part of this health screen must include, at minimum, questions about behavioral health needs including “depression or other Substance Use Disorders” [<i>sic</i>].<sup>4</sup> The State’s MCO contracts include rewards (incentives) for high performance and penalties (liquidated damages) for low performance on completion of the HRA Screening.</li> <li>• MCOs are also required to help members arrange Wellness Visits with the members’ PCPs which include a) appropriate assessments of both physical and behavioral health and b) screening for depression, mood, suicidality, and SUD.</li> </ul> <p>During a PIU review, the required documentation will be requested from the provider so that PIU may review claims for compliance with the plan of care and ensure that the provider is following proper qualifications for the staff performing the functions. If there were a screening requirement as part of a service, PIU would request the documentation specific to the screening.</p>
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<sup>2</sup> Through a psychiatrist, psychologist, pastoral psychotherapist, clinical social worker, a certified nurse or registered nurse, clinical mental health counselor, or marriage and family therapist.

<sup>3</sup> Including the petitioner’s statement, physical examination, mental examination, and certificate of examining physician or APRN requesting admission.

<sup>4</sup> As described in sections, including but not limited to, Section 4.11.1.16 (Comprehensive Assessment and Care Plans for Behavioral Health Needs), Section 4.11.5.4 (Comprehensive Assessment and Care Plans), and Section 4.11.6.6 (Provision of Substance Use Disorder Services).

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan  
 NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration  
 [Demonstration Approval Date]  
 Submitted on September 3, 2021

	<i>Future Status:</i> Continued operation of current requirements.
	<i>Summary of Actions Needed:</i> The Department plans to educate providers on screening requirements.

Prompts	Summary
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	<p><i>Current Status:</i>            PIU provides ongoing monitoring and oversight for adherence to administrative rules in the normal course of provider audits. In addition, DPQI requires and reviews provider submissions of sentinel event reports pertaining to individuals receiving services in residential settings operated by a provider agency receiving DHHS funding, or to individuals in residential treatment directly receiving Community Mental Health Center (CMHC) - or other Department-funded services.</p> <p>The BHFA conducts annual reviews of all licensed residential facilities for compliance with NH Administrative Code <b>He-P 807 Rules for Residential Treatment and Rehabilitation Facilities</b> requirements governing residential facilities licensing. BHFA also follows up on any consumer or provider complaints or concerns reported about a facility. The DHHS Medicaid PIU oversees compliance with NH Administrative Code <b>He-W 513 Substance Use Disorder (SUD) Treatment and Recovery Support Services</b> as part of their pre- and post-enrollment site visits and re-validation processes.</p> <p>DPQI offers a <a href="#">website</a> open to the public that tracks Healthcare Effectiveness Data &amp; Information Set (HEDIS) and other commonly used healthcare quality measures.</p>
	<p><i>Future Status:</i>            PIU will develop a sampling of the enrolled sites to perform program integrity reviews at certain intervals to assess programs for compliance and claim submissions for accuracy. Further, PIU will then inform the Program area of any potential issues.</p> <p>As part of its monitoring capacity, the department plans to track several of the SMI Demonstration Monitoring Metrics identified by CMS as focusing on serious mental illness, such as <i>30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)</i>.</p>

	<p><i>Summary of Actions Needed:</i>          Program Integrity will become part of the on-going monitoring plan for these providers.</p>
<p><b>SMI/SED. Topic 2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care</b></p>	
<p><i>Understanding the services needed to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.</i></p>	
<p><b>Improving Care Coordination and Transitions to Community-based Care</b></p>	
<p>2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.</p>	<p><i>Current Status:</i>          Psychiatric Hospitals:          NH Administrative Code <b>He-P 802.18 Required Services</b> requires hospitals to complete discharge planning on all patients admitted to a hospital. Discharge planning shall include, as applicable:</p> <ul style="list-style-type: none"> <li>• The patient's medication needs upon discharge;</li> <li>• The need for medical equipment, special diets, or potential food-drug interactions;</li> <li>• The need for further placement in another health care hospital;</li> <li>• The need for home health services upon discharge; and</li> <li>• Discharge instructions and education shall be provided to the patient in writing.</li> </ul> <p>New Hampshire Hospital (NHH) complies with <b>He-M 311.06 Rights of Persons in State Mental Health Facilities</b> (a.) (3-7), which states that patients have the right to quality treatment in the least restrictive setting in accordance with the timeframe set forth in their individual service plan developed under <b>RSA 135-C:19</b> and the Joint Commission Comprehensive Accreditation Manual for Hospitals (January 2015) published by Joint Commission Resources, Inc. Joint Commission PC.04.01.03 EP 1-4, 10 requires discharge planning begins early in the patient's episode of care, treatment and services. The hospital identifies any needs the patient may have for psychosocial or physical care, after discharge or transfer.</p> <p>Residential Settings:          NH Administrative Code <b>He-M 405.05 Collaboration with Community Mental Health Programs</b> requires the joint development of discharge plans and referrals for clients served by both the CMHP and a DRF. The discharge plan must include information about community supports such as peer support agencies and the availability of family support and education. In addition, CMHPs must offer an appointment to a discharged client to occur within 7 days of discharge.</p>

	<p>NH Administrative Code <b>He-P 830.15 Client Admission Criteria, Temporary Absence, Transfer, and Discharge Criteria</b> requires that AP RTPs develop a discharge plan with the input of the client and guardian or agent, if any.</p> <p>NH Administrative Code <b>He-M 405.09 Discharge Pursuant to Involuntary Emergency Admission</b> requires the DRF give notice of discharge to the CMHP in the region from which the person was admitted <u>and</u> to the region to which the person was discharged. The DRF is required to issue written notice to the person discharged and their legal guardian, or the division for children, youth, and families if that division has custody of the person. If the person admitted does not consent to be returned to his or her place of residence, the DRF may agree to provide transportation to another location such as the home of a relative or friend, a Peer Support Agency, or a CMHP.</p> <p>NH Administrative Code <b>He-M 405.08 Discharge Pursuant to Voluntary Admission</b> requires that voluntary discharges from a DRF requested by the individual or, if the client is under 18, parent or legal guardian occur within 24 hours of receipt of such request.</p> <p>NHH’s Social Work Discharge Planning standard requires that NHH’s communication with the outpatient CMHC begin the first business day following admission. Transition Care plans are initiated at admission and updated as required based on assessment and as treatment planning progresses. CMHCs are expected to provide an appointment within 7 days of discharge for all discharged individuals and within 48 hours to those who were receiving Assertive Community Treatment (ACT) services prior to the most recent admission.</p> <p>CMHCs are also engaged in a directed payment program authorized through CMS and operating through DHHS MCO agreements. The directed payment arrangement is anticipated to advance the goals of the New Hampshire Quality Strategy by improving CMHP payments which will help ensure and promote continued access to care. A focused measure for these payments targets those individuals discharged from a psychiatric stay who are seen the same day of, or the next day after, discharge. If a CMHC sees an individuals within these times frames, they receive a payment.</p> <p>Each of the 10 regionally-based CMHCs have NHH liaisons. They receive notifications of an individual being admitted to NHH and engage in discharge planning and any other communications that need to be signed off on.</p> <p><i>Future Status:</i> Continued operation of current requirements.</p> <p><i>Summary of Actions Needed:</i> N/A – Milestone met.</p>
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<p>2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.</p>	<p><i>Current Status:</i>          As part of NH Administrative Code <b>He-M 802.18 Required Services</b>, hospitals are required to complete discharge planning that includes, as applicable:</p> <ul style="list-style-type: none"> <li>• The need for further placement in another health care hospital; and</li> <li>• The need for home health services upon discharge.</li> </ul> <p>NH Administrative Code <b>He-M 613.09 Admission to Transitional Housing Service</b> provides a path from NHH to Transitional Housing Service (THS) admission as long as applicants:</p> <ul style="list-style-type: none"> <li>• Have been referred from NHH or have been discharged from the THS within the 30 days immediately preceding application;</li> <li>• Are 18 years of age or older and have a primary diagnosis of:             <ul style="list-style-type: none"> <li>• Psychiatric disorder or severe personality disorder; or</li> <li>• Intellectual disability or pervasive developmental disorder as defined in DSM-5 with a secondary diagnosis of psychiatric disorder or severe personality disorder; and</li> </ul> </li> <li>• Have an individual service plan specifying that he or she:             <ul style="list-style-type: none"> <li>• No longer needs the level of care provided by NHH;</li> <li>• Requires the degree of care and supervision available from the THS; and</li> <li>• Has an identified goal of community placement.</li> </ul> </li> </ul> <p>NH Administrative Code <b>He-M 403.06 CMHP Services and Programs</b> requires CMHPs to provide outreach to persons with mental illness who are homeless for the purpose of engaging such persons in the service system, provide individuals with services at emergency shelters, provide services within an individual's home, and collaboration with state and local housing agencies and providers to promote access to existing housing and the development of housing for persons with mental illness, including home ownership and rental options.</p> <p>NHH employs a full time Housing Specialist to assist social work staff with locating permanent independent housing for patients who are homeless. Social Work staff collaborate with Housing Specialists at the appropriate CMHC to refer patients who are being discharged to either temporary housing or to assist with locating permanent housing. Social Work staff are also required to provide assessment of each patient's need for level of supervision post-discharge and make appropriate referrals to programs offering those supports which may include independent apartments, community residences, transitional housing or long-term care (LTC) facilities.</p> <p>The State provides several supported housing programs to meet the targeted population need. The primary program, Housing Bridge Subsidy Program (HBSP), has established supported, subsidized housing for over 1,000 individuals under the Community Mental Health Agreement (CMHA). The HBSP prioritizes individuals ready for discharge from</p>
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	<p>NHH, Glenclyff Home, and Transitional Housing Programs. Additional prioritized individuals include those being served by ACT teams in the community who are homeless or at risk of becoming homeless due to their economic circumstances, and individuals served by CMHPs currently in community residences who are ready to transition into independent living.</p> <p>HBSP provides individuals with 1:1 assistance with locating and applying for rental opportunities, landlord-tenant relationship management, financial subsidy towards rent, and ongoing supports and access to mental health services (if desired by the individual). At least 400 individuals receive a State subsidy at any one time that, combined with the individual's own contribution toward rent, fulfill monthly rent payments and maintains the individual's access to the apartment. This also allows the individual to remain on a waiting list for traditional Housing and Urban Development (HUD) funded programs, other municipally administered programs, or until the individual's own income exceeds the HBSP's financial eligibility guidelines.</p> <p>Additionally, the State supports individuals who need more intensive supports and services to return to the community post psychiatric hospitalization through transitional housing programs (THP). These programs combine residential, therapeutic, vocational and other services and supports to further prepare individuals for independent living.</p> <p>Lastly, the State provides opportunities for individuals to live as independently as possible through the coordination of voluntary services and providing a choice of subsidized, integrated housing options. The Section 811 Project Rental Assistance (PRA) program provides project-based rental assistance for extremely low income persons within the target population linked with long-term services. The grant is administered in partnership with the Department of Health and Human Services and the NH Housing Finance Authority.</p>
	<p><i>Future Status:</i>          Ongoing efforts to ensure timely access to the necessary beds and supports include meeting with the NH Hospital Association to streamline involuntary referrals to all DRFs.</p>
	<p><i>Summary of Actions Needed:</i>          N/A – milestone met.</p>

Prompts	Summary
<p>2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge</p>	<p><i>Current Status:</i>  MCOs conduct follow-up calls with their members who were admitted for a psychiatric stay. NHH previously had a follow-up call process that was ineffective as the number of patients reached was very low and duplicated efforts with MCOs.</p> <p>As part of their scope of services, the MCOs are obligated to maintain and operate a formalized hospital and/or institutional discharge planning program that includes effective post-discharge Transitional Care Management (TCM), including appropriate discharge planning for short-term and long-term hospital and institutional stays. <b>[42 CFR 438.208(b)(2)(i)]</b></p> <p>TCM is further required in the contracts to include, at minimum:</p> <ul style="list-style-type: none"> <li>• Obtaining a copy of the discharge plan/summary prior to the day of discharge, if available, otherwise, as soon as it is available, and documenting that a follow-up outpatient visit is scheduled, ideally before discharge;</li> <li>• Communicating with the Member's PCP about discharge plans and any changes to the care plan;</li> <li>• Conducting medication reconciliation within forty-eight (48) business hours of discharge;</li> <li>• Ensuring that a Care Manager is assigned to manage the transition;</li> <li>• Follow-up by the assigned Care Manager within forty-eight (48) business hours of discharge of the Member;</li> <li>• Determining when a follow-up visit should be conducted in a Member's home;</li> <li>• Supporting members to keep outpatient appointments; and</li> <li>• A process to assist with supporting continuity of care for the transition and enrollment of children being placed in foster care, including children who are currently enrolled in the plan and children in foster care who become enrolled in the plan, including prospective enrollment so that any care required prior to effective data of enrollment is covered.</li> </ul> <p>In addition, MCOs are required under Exhibit O – Reporting Reference SUD.42 “Emergency Department Discharges for SUD: MCO Contacts and Contact Attempts” to provide a count and percent of members discharged from an Emergency Department (ED) with a substance use disorder (SUD) diagnosis during the measurement period, where the MCO either successfully contacted the member, or attempted to contact the member at least 3 times, within 3 business days of discharge by subpopulation.</p> <p>The MCOs produce a quarterly report that outlines all of their members who have been re-admitted during the quarter within a 30-day and 180-day window. This report is reviewed with the BMHS and cases with high re-admissions and low service utilization are identified, case-consulted with the MCO, and the MCO is required to</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan  
 NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration  
 [Demonstration Approval Date]  
 Submitted on September 3, 2021

	<p>conduct targeted follow up to decrease the likeliness of re-admission. MCOs have also developed algorithms to identify those cases that may be at high risk for a psychiatric admission or re-admission and work to engage these individuals in care coordination ensuring appropriate services are being utilized.</p> <p>The MCOs have contracted with a vendor to help provide intensive in home service to youth waiting for psychiatric hospital beds. This is in effort to redirect care away from EDs and potentially avoid the need for a psychiatric hospital stay.</p> <p><i>Future Status:</i> Continue to work on streamlining the use of the already existing reports and algorithms to operationalize the work being done. Continue to ensure rigorous performance by vendors under vendor contracts.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone met.</p>
<p>2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission</p>	<p><i>Current Status:</i> Division for Behavioral Health (DBH) receives a daily ED waitlist from NHH identifying all individuals – not just Medicaid beneficiaries – awaiting psychiatric beds in the State (self-pay, private insurance, etc.), which is distributed to an array of stakeholders including the MCOs. MCOs are required to review the daily ED waitlist to identify alternative bed solutions for their members. They also have weekly meetings with DBH to report out on the status of members waiting.</p> <p>MCOs also engage in single-case agreements for providers out of network to support alternative bed solutions when necessary.</p> <p>In accordance with Exhibit O, MCOs are required to provide a monthly report on the number of its members awaiting placement in the ED or in a hospital setting for twenty-four (24) hours or more; the disposition of those awaiting placement; and the average length of stay in the ED and medical ward for both children and adult members, and the rate of recidivism for Psychiatric Boarding.</p> <p><i>Future Status:</i> DBH is working to increase the number of non-hospital-based psychiatric beds such as Recovery-Oriented Step Up and Step Down beds. These beds can be used to support an individual in need of increased supports in order to avoid a psychiatric stay or to step down from a psychiatric stay. DBH is contracted with all 10 of the regionally based CMHCs to increase the number of community-based supported housing beds in each region.</p>

	<p><b>Critical Time Intervention.</b> CTI is a time-limited, evidence- and community-based practice that mobilizes support for individuals with serious mental illness during vulnerable periods of transition (e.g., discharge from a psychiatric hospital). CTI providers will work with transitioning individuals to ensure they successfully reintegrate into their home communities. This can entail a broad range of assistance, from helping an individual secure employment, housing, or food; to identifying and accessing mental or physical health care; to reconnecting with family, friends, and peers to ensure strong, supportive relationships.</p> <p><b>Transitional Bed Capacity.</b> By increasing transitional bed capacity in the State, the Hospital will be able to discharge individuals who no longer require hospital LOC and therefore accept more individuals from the ER into the Hospital.</p> <p><b>First Episode Psychosis (FEP) Programs.</b> The state is targeting workforce development to support the staffing of the newly established programs as well as maintaining the Nashua region based program for FEP. By increasing the availability of FEP programs throughout the state, NH increases the likelihood of identifying an individual during their first psychotic episode and providing intense, targeted services that lead to a decrease in psychiatric hospital stays.</p> <hr/> <p><i>Summary of Actions Needed:</i>        DBH plans to increase the number of community-based supported housing beds in each region as contracted.</p> <p><b>Critical Time Intervention.</b> The State is working to implement CTI statewide, with the near-term goal of mitigating the overflowing demand on the State hospital system.</p> <p><b>Transitional Bed Capacity.</b> The additional of these beds are presently happening through a vendor contract.</p> <p><b>First Episode Psychosis (FEP) Programs.</b> Starting in July of 2021 three (3) additional FEP programs within the Derry, Seacoast, and Monadnock regions began standing up their services.</p>
<p>2.e Other State requirements/policies to improve care coordination and connections to community-based care</p>	<p><i>Current Status:</i>        Administrative Code <b>He-M 405.12 Services to be Provided</b> requires case coordination services from either the CMHC or DRF staff upon admission to a DRF and continuing through discharge.</p> <p>NH is undergoing the early stages of an Event Notification System (ENS) implementation, which connects a patient’s entire care team — including hospitals, primary and specialty care, post-acute care, behavioral health providers, community service organizations, and health plans — by offering real-time patient insights that power better decision-making for improved patient outcomes.</p>

	<p>The department encourages education on safe practices for discharging of mental health individuals between clinical teams and mental health professionals.</p> <p>MCO contracts have quality and oversight reporting requirements for “member discharges from a community hospital with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a mental health practitioner within 7 calendar days of discharge”.</p>
	<p><i>Future Status:</i>          The ENS implementation requires more complete engagement from all stakeholders in the state to fully utilize the benefits to coordinate care. All EDs, DRFs, CMHCs, and NHH will enter data necessary to expedite care as patients move between levels of care.</p>
	<p><i>Summary of Actions Needed:</i>          N/A – milestone met.</p>

Prompts	Summary
<p><b>SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services</b></p>	
<p><i>Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.</i></p>	
<p><b>Access to Continuum of Care Including Crisis Stabilization</b></p>	
<p>3.a The state’s strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization,</p>	<p><i>Current Status:</i>          Since 2013 the State has operated a Medicaid Managed Care Program for Medicaid eligible beneficiaries delivered through commercial MCOs with several minor carve-out populations. Currently, DHHS contracts with three MCOs that provide Medicaid benefits, including behavioral health services, to recipients in exchange for a monthly payment from the state. In addition to providing Medicaid benefits to eligible recipients, the MCOs are also required to ensure the availability of mental health providers.</p> <p>MCOs manage and ensure all members receive primary behavioral health care through PCPs and other practitioners connected with a variety of community-based providers. MCOs are required by contract to meet network adequacy</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan  
 NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration  
 [Demonstration Approval Date]  
 Submitted on September 3, 2021

<p>residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state’s demonstration application. The content of annual assessments should be reported in the state’s annual demonstration monitoring reports.</p>	<p>standards for all geographic regions and provider types (e.g. PCPs, specialists, family planning providers, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), hospitals, and mental health and SUD providers).</p> <ul style="list-style-type: none"> <li>• Each MCO is required to prepare and submit a Participating Provider report during the Readiness Review period in a format prescribed by DHHS for determination of the MCO’s network adequacy. The report identifies fully credentialed and contracted providers and prospective participating providers.</li> <li>• MCOs are required to confirm their provider networks with DHHS and post them to their websites within 30 days of the member enrollment period.</li> <li>• MCOs are subject to corrective action plans to restore network adequacy.</li> <li>• MCOs are required to provide the count and percent of member requests for assistance accessing MCO Designated Primary Care Providers per average 1,000 members by county on a quarterly basis.</li> <li>• Should providers give notice, have been issued notice, or left the MCO network, MCOs are required to provide the number of members impacted, impact to network adequacy, and transition plan if necessary.</li> </ul> <p>The network adequacy standards in the State are outlined in the MCO contracts, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Requirements regarding having Participating Providers in sufficient numbers, and with sufficient capacity and expertise for all covered services.</li> <li>• Requirements to maintain an adequate network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.</li> </ul> <p><i>Future Status:</i>          DHHS will monitor the provider network through the annual completion of the CMS-designated Provider Availability Assessment Template.</p> <p><i>Summary of Actions Needed:</i>          By completing the CMS-designated Provider Availability Assessment, the State will fulfill the requirements of this milestone.</p>
<p><b>Prompts</b></p> <p>3.b Financing plan</p>	<p><b>Summary</b></p> <p><i>Current Status:</i>          Please refer to Financing Plan below.</p> <p><i>Future Status:</i>          Please refer to Financing Plan below.</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan  
 NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration  
 [Demonstration Approval Date]  
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	<p><i>Summary of Actions Needed:</i>          Please refer to Financing Plan below.</p>
<p>3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds</p>	<p><i>Current Status:</i>          DHHS currently tracks psychiatric beds in a public daily, point-in-time report of DRF. Information tracked includes the following:</p> <ul style="list-style-type: none"> <li>• Facility name;</li> <li>• Total number of Involuntary Emergency Psychiatric Beds;</li> <li>• Current Unit cap;</li> <li>• Available Involuntary Emergency Psychiatric Beds; and</li> <li>• Number of Adults or Individuals Waiting for a DRF Bed.</li> </ul> <p>In addition to the public report, DHHS also maintains a Bed Inventory that tracks hospital-based voluntary beds.</p> <p><i>Future Status:</i>          DHHS plans to implement a technology solution to provide real-time information about the availability of beds and services. Such as solution would allow DHHS to streamline the behavioral health treatment referral process by having more immediate access to provider availability.</p> <p><i>Summary of Actions Needed:</i>          DHHS plans to assign staff to oversee and follow up on the availability of inpatient and crisis stabilization beds.</p>
<p>3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay</p>	<p><i>Current Status:</i>          DHHS requires an Adults Needs and Strengths Assessment (ANSA), or an equivalent evidence-based tool, to be completed for every adult. These requirements are incorporated into MCO and CMHC contracts, which require initial and updated care plans to be based on a comprehensive assessment conducted using an evidenced-based assessment tool such as the NH version of the Child and Adolescent Needs and Strengths (CANS) and the ANSA.</p> <p>These assessments inform individualized treatment planning and level of care decision making. Individuals are reassessed on a routine basis with adjustments to level of care and or treatment plan being made accordingly. The ANSA also informs individual service needs and level of care that could include inpatient and/or residential services.</p> <p><i>Future Status:</i>          As part of the State’s rollout of the federal 9-8-8 behavioral health crisis number, BMHS launched an initiative (described further in 3.e) to redesign and centralize the State’s crisis response system into a program called the Rapid Response Access Point. Part of this program’s responsibilities is to provide an initial assessment for each individual</p>

	<p>who calls to determine the nature of crisis. The operator engages each individual in brief phone-based counseling and intervention to determine the individual’s appropriate level of need, and to attempt to resolve each situation using tools such as the Patient Health Questionnaire 9 for Depression (PHQ-9), the Mood Disorder Questionnaire (MDQ), the Adverse Childhood Experiences (ACEs) questionnaire, a lethality assessment tool, the Drug Abuse Screening Test (DAST-10), an alcohol use disorder identification test, and other recognized tools for determining the nature of a behavioral health crisis.</p> <p>In addition to the tools above, the state has also contracted with a vendor to provide Comprehensive Assessments for Treatment (CATs) to determine whether children, youth, or young adults are in need of behavioral health residential treatment services and the least restrictive and most appropriate level of care. The vendor is required to conduct interviews using other behavioral health screening tools including, but not limited to: Columbia Suicide Severity Rating Scale (C-SSRS); Patient Health Questionnaire-9 (PHQ-9); Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT); and Juvenile Sex Offender Protocol (JSOP).</p> <p><i>Summary of Actions Needed:</i>        N/A – milestone met.</p>
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Prompts	Summary
<p>3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization</p>	<p><i>Current Status:</i>            Currently only three regions operate mobile crisis response teams for adults with mental illness. As referenced in Topic 5. Financing Plan, DHHS has entered into a contract to establish and operate a centralized access and crisis call center via a single, statewide telephone number for individuals experiencing a mental health and/or substance use disorder crisis. The Rapid Response Access Point, which will receive telephone calls, text messages, and two-way real-time chat, provides clinical crisis resolution services, and acts as a triage center for mental health and/or substance use disorders crises. The Access Point will operate twenty-four hours per day, seven days per week. The contractor will perform centralized triage of incoming calls, texts, and chat messages, conduct initial assessments, brief interventions, and deploy mobile response teams to the caller’s location when necessary. The contractor will also coordinate with regional crisis services, develop a training curriculum, train the Rapid Response workforce, and provide data collection services to promote consistency and quality.</p> <p>The Rapid Response Access Point will serve NH residents of any age, statewide, who may be experiencing a mental health and/or substance use disorder crisis. Approximately 30,000 callers to the Access Point are expected to be served in SFY22 and SFY23.</p>

	<p><i>Future Status:</i>          DHHS has recently included a statewide integrated mobile crisis response teams in crisis services. These teams will be expanded from three (for adults) to ten for all ages. All ten CMHCs will enhance their crisis services to ensure the delivery of integrated mobile crisis response services to individuals experiencing mental health.</p> <p><i>Summary of Actions Needed:</i>          N/A – milestone met.</p>
<p><b>SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration</b></p>	
<p><i>Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.</i></p>	
<p><b>Earlier Identification and Engagement in Treatment</b></p>	
<p>4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs</p>	<p><i>Current Status:</i>          NH DHHS has several strategies to engage beneficiaries with and at risk of SMI/SED in treatment sooner. The State, CMHCs, and private providers work together to provide a comprehensive system of care for early identification and engagement in treatment. A summary of strategies and initiatives across integrated service delivery, special education, supported employment, vocational rehabilitation, and supported housing is outlined below.</p> <p><b>System of Care Strategy / Initiatives.</b>          In 2016, New Hampshire passed Senate Bill 534, the System of Care (SOC) law, a major policy initiative of the Children's Behavioral Health Collaborative, which embedded the system of care approach and accompanying values in <b>RSA 135-F System of Care for Children's Mental Health</b>. The law requires the State to develop and maintain an integrated and comprehensive service delivery system for children with behavioral health needs. 10 CMHCs and other BH providers participate in the SOC initiative. Major initiatives under SoC include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• <b>DHHS Initiatives</b> <ul style="list-style-type: none"> <li>• <u>NH Families and Systems Together (FAST) Forward for Children and Youth</u>: Awarded by SAMSHA to DHHS in 2012, this program supports the expansion and sustainability of a state-level SOC for children, youth, and their families in seven school districts. As of 2017, FAST Forward has been supported by a Care Management Entity (CME) that provides services for the FAST forward program including, but not limited to: oversight and care coordination for children and youth entering/exiting psychiatric hospitalization and/or residential treatment, wraparound coordination and coordinator training, provision of youth peer support, and provision of stipends for customizable goods and services. The CME also contracts with many qualifying provider agencies to ensure children, youth and families have what they</li> </ul> </li> </ul>

	<p>need when they need it. In the past year, DHHS has expanded from one contracted CME to two.</p> <ul style="list-style-type: none"> <li>• <b>Department of Education (DOE) Initiatives</b> <ul style="list-style-type: none"> <li>• Adoption of NH DOE’s MTSS-B model<sup>5</sup> through a SOC grant (awarded 2016), which includes comprehensive early access screening, an integrated delivery system, a tiered prevention network, and other non-Medicaid billable services.</li> <li>• <b>Project Aware (2014-2020)</b><sup>6</sup> which expanded MTSS-B to an additional 12 schools and early childhood settings in NH’s North Country and Lakes Region.</li> <li>• <b>School Climate Transformation Grant (2019-2024):</b> The NH Department of Education, through its SEA School Climate Transformation Grant, has two primary goals: 1) to develop, enhance, and expand a statewide system to support the use of NH’s MTSS-B model by Local Education Agencies (LEAs) to improve school climate and 2) to support the use of best practices to promote positive school culture and climate across the state through partnerships between local communities and Office of Social &amp; Emotional Wellness staff, especially MTSS-B consultants, and local communities. During the reporting period, considerable progress was made in advancing these goals including developing and launching the first ever train-the-trainer for NH’s MTSS-B model, recruiting and hiring state-level MTSS-B consultants, and delivering evidence-based external coaching support to numerous local school districts.</li> </ul> </li> </ul> <p><b>Special Education.</b> Under the provision of the Individuals with Disabilities Education Act (IDEA) youth who are placed in a special education program because of a SED must have an Individual Education Plan (IEP). Many CMHC staff and programs affiliated with systems of care are actively involved in supporting families and children for whom an IEP is needed.</p> <p>In addition, DHHS supports DOE with supported employment and programs:</p> <p><b>Supported Employment.</b> NH CMHCs deliver the following employment-related services:</p> <ul style="list-style-type: none"> <li>• Rehabilitation for Empowerment, Education, and Work (RENEW) intervention with fidelity to transition-aged</li> </ul>
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<sup>5</sup> Multi-Tiered System of Support for Behavioral Health and Wellness Model. <https://www.education.nh.gov/who-we-are/division-of-learner-support/bureau-of-student-wellness/office-of-social-and-emotional-wellness/mtssb>.

<sup>6</sup> NH Department of Education’s Project AWARE initiative shared with the NH SOC the same school-based intervention framework, bringing MTSS-B to an additional set of 12 schools (later reduced to 10 by school closings) in three North Country Local Educational Agencies: Berlin, Franklin, and SAU 7. Funded by a 5-year grant from the federal Substance Abuse and Mental Health Services Administration, AWARE concluded in 2019 after serving more than 2500 children per year of its implementation, however an additional 4 year award was provided by to continue and expand this work. Like NH SOC, NH AWARE made significant advances in the capacity to support the social-emotional well-being of students, linking 76 organizations in formal interagency agreements, providing training to assist teachers and other school staff better understand student behavior and respond with trauma-informed strategies, and training more than 4600 school staff and community members in Youth Mental Health First Aid. Interviews with key informants from each district attested to AWARE resulting in less stigma attributed to emotional distress, less punitive discipline, and more supportive and trauma responsive interventions.

	<p>youth who qualify for state-supported community mental health services, in accordance with the UNH Institute on Disability model.</p> <ul style="list-style-type: none"><li>• CMHCs provide the following Evidence Based Supported Employment (EBSE) services, in accordance with the SAMHSA/Dartmouth Individual Placement and Support (IPS) model, to eligible individuals:<ul style="list-style-type: none"><li>○ Job development;</li><li>○ Work incentive counseling;</li><li>○ Rapid job search; and</li><li>○ Follow along supports for employed clients.</li></ul></li></ul> <p>The NH Bureau of Vocational Rehabilitation (BVR), under NH DOE, assists eligible NH citizens with disabilities to secure suitable competitive integrated employment and financial and personal independence by providing rehabilitation services. Services are provided through seven BVR offices. Vocational rehabilitation has a long history of providing direct and indirect services to youth with disabilities as they transition from school to work. The Bureau is committed to increasing access and improving the overall quality of services offered to school age youth.</p> <p>Additionally, BVR has established a partnership with CMHCs and funded a full-time Work Incentive Benefits Counselor at each of the 10 CMHCs. The benefits counselors assist individuals with mental illness who are pursuing employment to complete applications for vocational rehabilitation services and engage in EBSE. The counselors conduct comprehensive incentives counseling to inform individuals of the impact different levels of income will have on existing benefits and what specific work incentives options individuals might use to increase financial independence, accept pay raises, or increase earned income.</p> <p><b>Supported Housing.</b> CMHCs complete eligibility for individuals in accordance with <b>He-M 401 Eligibility Determination and Individual Service Planning</b> and complete applications for Public Housing, Section 8 subsidy, and Project Rental Assistance (PRA) 811, according to their respective rules, requirements, and filing deadlines. Housing staff are located in all regions of the state to provide housing support services. This includes coordinating with and developing relationships with landlords and other vendors that provide services to individuals receiving the Housing Bridge Subsidy and coordinating housing efforts with the Department and the New Hampshire Housing Finance Authority. CMHCs also provide supported housing services through a variety of options that range from independent apartments to community residences.</p> <p><b>Transitional Housing / Continuum of Care Program.</b> The NH Division of Economic and Housing Stability (DEHS), in collaboration with Housing and Urban Development (HUD), have established a Continuum of Care (COC) program designed to assist individuals (including unaccompanied youth) and families experiencing homelessness and to provide the services needed to help such individuals move into transitional and permanent housing with the goal of long-term</p>
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	<p>stability. NH has three (3) COCs: Harbor Homes (Greater Nashua), Families in Transition (FIT; Manchester) and Bureau of Housing Supports (BHS; Balance of State).</p> <p><b>Transitional Housing / PATH.</b> NH DEHS also receives federal funding for SAMHSA Projects for Assistance in Transition from Homelessness (PATH) that provides homeless street outreach for individuals experiencing homelessness who have a diagnosis of SMI.</p> <hr/> <p><i>Future Status:</i>        NH DHHS will continue operation of existing services.</p> <p><b>System of Care Strategy.</b> In accordance with both <b>RSA 135-F</b>, which established the SOC, and <b>RSA 132:13</b>, which supports services for maternal and infant needs, NH DHHS and stakeholders participated in an infant and early childhood finance strategy technical assistance group through the Zero to Three national policy organization. This work included a work plan on how NH would address and finance these initiatives. The goals are to develop a comprehensive Medicaid benefit to address the needs of infants and young children who have been identified as at risk and who require treatment and support for themselves and their primary caregiver.</p> <p><b>Housing Supports.</b> Since 2019, NH DHHS has been moving forward to amend contracts to expand the Housing Bridge Subsidy program, as a result of HB 1, and to contract for the development of a pilot program for individuals with mental illness transitioning out of the criminal justice system in need of housing support services.</p> <hr/> <p><i>Summary of Actions Needed:</i>        N/A – milestone met.</p>
<p>4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment</p>	<p><i>Current Status:</i>        Currently, the State operates the ProHealth NH grant (2019 through 2024) which aims to improve primary and behavioral health service delivery in NH with the following highlights (as of September 2020) related to integration of behavioral health care in non-specialty settings:</p> <ul style="list-style-type: none"> <li>• Integrated primary and behavioral health care is available at community mental centers for youth and young adults in three of ten regions in NH, with nearly 250 (249) individuals ages 16 to 39 years served in the first year and half of enrollment.</li> <li>• All individuals enrolled and receiving integrated services through ProHealth NH are receiving mental health services.</li> <li>• The CMHCs and FQHCs collect individual health and demographic information to improve outcomes.</li> <li>• The BMHS, CMHCs, and FQHCs have 20 additional full time equivalents of staff time collectively to augment</li> </ul>

	<p>Medicaid and insurance reimbursement in support of integration activities.</p> <ul style="list-style-type: none"> <li>• Staff are cross-trained in evidence-based whole-person health. Over 1,200 (1,201) staff from health settings across NH participated in 115 training opportunities, including two conferences in collaboration with the Integrated Delivery Network.</li> <li>• Integrated teams continuously improve services with peer experts and quality improvement staff.</li> <li>• State and regional plans, policies, and procedures include language to support integrated care. Efforts to sustain integration have resulted in 46 policy-related changes throughout the partnerships and at the state.</li> <li>• Tobacco interventions are available, including web-based motivational enhancement for tobacco and vaping prevention, Breathe Well Live Well in person or virtually, Quitline NH by phone, and Mylifemyquit via the web.</li> <li>• Fitness and nutrition interventions are available, including Healthy Choices Health Changes in person and virtually and the Weight Watchers and Myfitnesspal web apps.</li> <li>• An integrated care sustainability plan has been drafted by the ProHealth NH Administrator in collaboration with the partnerships and is being used to inform ongoing sustainability. Each partnership has completed their own individual sustainability plans, which are actively being utilized for their individual sites.</li> <li>• The CMHCs and FQHCs deliver high quality integrated care, including evidence-based screening, collocation, team meetings, health and wellness goals in treatment plans, integrated shared plans, population health initiatives, and evidence-based interventions.</li> <li>• The CMHCS and FQHCs provide whole health services in person and virtually using telehealth technology.</li> <li>• The CMHCs staff peer experts and community health workers that represent the diverse individuals served.</li> </ul> <p><b>Behavioral Health Integration in School Settings.</b> Funding opportunities through DOE have worked to expand the number of mental health staff integrated in school settings. The presence of community mental health providers as a “regular” part of the school community and culture was viewed as reducing mental health stigma. Students openly talked with each other about seeing school-based mental health providers. NH AWARE was also credited, along with other MTSS-B and SOC initiatives, with contributing to a more supportive community and state policy environment. Stakeholders reported that these projects, by bringing together schools and communities via Community Management Teams and other collaborations, improved community awareness and support for social and emotional learning (SEL) and children’s behavioral health. This, in turn, was viewed as supporting passage of the “System of Care” bill (<b>RSA 135-F</b>), which requires NH DOE and DHHS to work together to create a better, more cohesive system of care for NH youth with behavioral health needs.</p> <p><i>Future Status:</i>      In addition to the continued operation of the same programs above with participating centers, the State also plans to explore implementing the Certified Community Behavioral Health Clinic (CCBHC) model as part of an approach</p>
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	to extend ProHealth-like capabilities across the state in a sustainable way.
	<i>Summary of Actions Needed:</i> N/A – milestone met.

Prompts	Summary
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	<p><i>Current Status:</i>  <b>NH Crisis Response System.</b> As referenced in the Provider Availability Assessment Template and in F.a, the State presently has crisis stabilization services which include but is not limited to:</p> <ul style="list-style-type: none"> <li>• <b>33 Crisis Call Centers</b> – Including emergency services hotlines at the CMHCs, Mobile Crisis Response Team hotlines, Lifeline Hotlines, Doorway Numbers, and National Hotlines advertised in NH (Veterans Crisis, Trevor Project, Crisis Text Line, Translifeline, Disaster Distress Helpline, LGBT National Help Center, and 9-1-1).</li> <li>• <b>3 Mobile Crisis Units (MCU)</b> – There are three mobile crisis units in Nashua, Concord, and Manchester with ongoing plans to expand to all 10 CMHCs within the next year. Each unit is staffed with 24/7 available teams that may receive referrals, and respond to/with, first responders and law enforcement staff of the applicable community. This communication is bidirectional; each unit can support, or be supported by, local law enforcement.</li> <li>• <b>Drug and Mental Health Courts</b> – The State has specialty court programs for offenders with substance abuse or mental health diagnoses, which are available in various Superior and Circuit Court District Division locations in New Hampshire. These treatment courts combine community-based treatment programs with strict court supervision and progressive incentives and sanctions. By linking offenders to treatment services, these programs aim to address offender's substance abuse and mental health diagnoses that led to criminal behavior, thereby reducing recidivism, and protecting public safety. These treatment court programs are designed to promote compliance with treatment programs as an alternative to jail time.</li> <li>• <b>4 Crisis Observation/Assessment Centers</b> –Each MCU has four corresponding crisis apartment beds. Additionally, one standalone Behavioral Health Crisis Treatment Center (BHCTC) provides emergency services with limited walk-in capacity.</li> <li>• <b>1 Coordinated Community Crisis Response Teams</b> – The State maintains a Disaster Behavioral Health Response Team. The Governor or designee at the Department of Health and Human Services-Emergency Services Unit activates this team during Federal or State Emergencies. If an emergency is not declared, local municipalities or emergency response systems may request assistance in order to meet the behavioral health needs of communities in local crises.</li> </ul>

	<p><b>NH Rapid Response Model.</b> The State is in the process of implementing a Rapid Response Model with one statewide access point &amp; call center that provides initial assessments, de-escalation and resolution services, mobile rapid response dispatch services, referrals to location-based face-to-face rapid response services, post-crisis support, and referrals for ongoing services through the Doorways and outpatient mental health and SUD providers. In this model, staff are mobile/deployed to facilitate community-based face-to-face interventions. This would ensure availability of a location-based, drop-in behavioral health treatment location, allowing for stays of up to 23 hours for crisis intervention. The State has contracted with a vendor that was selected through a competitive Request for Proposals (RFP) process.</p> <p><b>NH COVID-19 Rapid Crisis Response Program (NH Rapid Response).</b> As mentioned below in F.a, in April 2020 NH was awarded temporary funding due to COVID-19 from SAMHSA to expand crisis response services for children, youth, and adults.</p> <p><i>Future Status:</i></p> <p><b>Statewide Mobile Crisis Services for Children.</b> The State conducted an RFP for statewide mobile crisis services for children, with implementation expected by August 2021. The development and implementation of mobile crisis and stabilization teams for children will also create efficiencies within the Division for Children, Youth and Families (DCYF) community-based service array by lifting the requirement of those community-based services providers to have a 24/7 crisis phone response within each of their operations.</p> <p><b>Expansion of Residential Treatment.</b> Residential treatment in New Hampshire has historically been available only through DCYF and school districts. The system itself has focused on the concept of placement and education with a lower level of care for the treatment aspect of this service. By aligning the delivery with the Families First Prevention Services Act (FFPSA) guidance, residential treatment in New Hampshire can be transitioned to a model of effective shorter-term treatment and stabilization in the system of care that is available to all children and youth who require that level of care without engaging with DCYF. This is also intended to help children and youth avoid or decrease the use of psychiatric hospitals or emergency rooms.</p> <p><i>Summary of Actions Needed:</i></p> <p>In general, NH DHHS will need to amend contracts and enhance administrative rules to ensure that the new structures and programs described above can be implemented in a high-quality manner.</p>
<p>4.d Other state strategies to increase earlier identification/engagement,</p>	<p><i>Current Status:</i></p> <p>Aside from the programs, strategies, and initiatives already mentioned, NH DHHS has implemented the following state strategies.</p>

<p>integration, and specialized programs for young people</p>	<p><b>The First Episode Psychosis (FEP)/Early Serious Mental Illness (ESMI) Initiative.</b> Bureau for Children's Behavioral Health (BCBH) and BMHS are in the process of planning a needs assessment and work with stakeholders to identify a model for statewide implementation of a First Episode Psychosis specialty care program. In the meantime, the State maintains the Nashua region based program for First Episode Psychosis (FEP). Starting in July of 2021 three (3) additional programs within the Derry, Seacoast, and Monadnock regions began standing up their services. By increasing the availability of FEP programs throughout the state, the State will increase the likelihood of identifying an individual during their first psychotic episode and providing intense, targeted services that lead to a decrease in psychiatric hospital stays.</p> <p><b>Creating Connections NH: A treatment and recovery system of care for youth and young adults with substance use disorders (SUD) or SUD with co-occurring mental health disorders.</b> This initiative is funded through a Cooperative Agreement between BCBH and the Adolescent and Transitional Aged Youth Treatment Implementation grant program administered by SAMHSA. Awarded in 2017, the grant supports evidence-based SUD assessment, treatment, and recovery services for youth aged 12-25. The NH Bureau for Children's Behavioral Health leads the project in collaboration with family, youth, research, and content experts.</p> <p><b>Launch Manchester.</b> Coordinated by a local FQHC, Launch (Linking Actions for Unmet Needs in Children's Health) promotes the well- being of children (birth through age 8) and their families in collaboration with multiple local child and family serving agencies. The primary strategies employed by Launch are: improving access to high-quality early education and care; empowering families; identifying and mitigating the effects of Adverse Child Experiences; and improving access to health, behavioral health, and specialized medical services. In 2019, Launch Manchester developed an Early Learning Collaborative of 12 early childhood programs and the Manchester School District to support transitions into kindergarten, implement developmental screenings, and facilitate access to appropriate supports. The hope is that coordinating transitions will maximize the preservation and expansion of academic and developmental skills these children have attained in early childhood settings. Also in 2019, Launch laid the groundwork for a public awareness campaign through early childhood settings, primary care offices, hospitals and other public spaces.</p> <p><b>Mobile App GoodLife.</b> DOE has partnered with a technology company to begin the planning and development of GoodLife, a mobile application designed to build and strengthen student social and emotional resilience. The GoodLife app's design will ensure that all students across New Hampshire and their families have access to evidence-based resilience cultivation tools. It aligns with the SOC values by providing a youth-driven platform where adolescents are empowered to set goals, join communities of support, and share positive messages with their peers.</p> <p>The app will additionally be trauma-informed in accordance with the SOC values, and builds resilience skills in youth such as empowerment, support, commitment to learning, and positive identity. The app will allow students to join communities, set physical and emotional development goals, and send and receive positive feedback. The GoodLife</p>
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	<p>app is built on the Search Institute’s 40 Developmental Assets for Adolescents, a list of research-based, positive experiences and qualities that influence young people’s development, helping them become caring, responsible, and productive adults. GoodLife anonymizes the identity of users, and does not collect any personally-identifiable information. GoodLife is available free to all NH youth and their families through Google Play and the Apple App Store.</p> <p><b>Project GROW.</b> Through a Learning Community effort known as Project GROW (Generating Resilience, Outcomes, and Wellness), the NH DOE’s Bureau of Student Wellness – Office of Social Emotional Wellness (OSEW) has been providing expert training, consultation, and technical assistance to school districts in MTSS-B aligned, trauma-responsive practices, including district-wide systems change, school-level adoption of new practices and procedures, classroom-level instructional and student support techniques, and individual teacher and specialist professional development. These Project GROW efforts are all designed to promote student social and emotional safety, and thus contribute to the Children’s SOC ecosystem.</p> <p><i>Future Status:</i> N/A – milestone met.</p> <p><i>Summary of Actions Needed:</i> N/A – milestone met.</p>
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Prompts	Summary
<b>SMI/SED.Topic_5. Financing Plan</b>	
<p><i>State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state’s assessment of current availability of mental health services included in the state’s application.</i></p>	
<p>F.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that</p>	<p><i>Current Status:</i>  <b>NH Crisis Response System.</b> As referenced in the Provider Availability Assessment Template and in 4.c (in greater detail), the State presently has crisis stabilization services which include but is not limited to:</p> <ul style="list-style-type: none"> <li>• 33 Crisis Call Centers</li> <li>• 3 Mobile Crisis Units (MCU)</li> <li>• Drug and Mental Health Courts</li> <li>• 4 Crisis Observation/Assessment Centers</li> <li>• 1 Coordinated Community Crisis Response Teams</li> </ul>

<p>involves collaboration with trained law enforcement and other first responders.</p>	<p>To build upon the existing system, the State has recently invested in the following coordinated crisis response initiatives:</p> <ol style="list-style-type: none"> <li>1. <b>NH COVID-19 Rapid Crisis Response Program (NH Rapid Response).</b> In April 2020, NH was awarded temporary funding due to COVID-19 from SAMHSA to expand crisis response services for children, youth, and adults. The \$2M Rapid Response grant award addresses the needs of uninsured or underinsured individuals with SMI/SED or SUD through the State’s existing community mental health system which includes the 10 CHMCs. The program also provided crisis services for other individuals in need of behavioral health supports, including health care personnel.</li> <li>2. <b>Centralized Access and Crisis Call Center.</b> The State has allocated \$9.2M through SFY23 in support of establishing and operating a centralized access and crisis call center via a single, statewide telephone number for individuals experiencing a mental health and/or substance use disorder crisis.</li> <li>3. <b>Mobile Crisis Teams.</b> The State has allocated \$13.2M annually toward the statewide expansion of mobile crisis teams from three to ten teams for SFY22 and SFY23. The expanded statewide service will serve all populations to address all behavioral health needs.</li> </ol> <p>The state has promoted access and coordination through the following changes in funding and reimbursement:</p> <ol style="list-style-type: none"> <li>1. <b>Directed Payments.</b> NH DHHS received authorization from CMS to pay interim enhanced rates to eligible CMHPs for select adult services to improve access and coordination. These directed payments were effective in SFY19 and SFY 20 and subject to the following limits in each state fiscal year:       <ol style="list-style-type: none"> <li>a. \$3M – Assertive Community Treatment (ACT) Services – payments to improve access and support ACT program fidelity.</li> <li>b. \$1.2M – NHH Discharges – payments for a face-to-face service the same-day/next-day of discharge from NHH to enhance care coordination for transitions.</li> <li>c. \$200K – Specialty Residential Services – to support specialized services for individuals who have co-occurring mental health and developmental disabilities.</li> <li>d. \$600K – Mobile Crisis Teams – to support face-to-face crisis response services provided by mobile crisis teams (e.g., MCUs).</li> </ol> </li> <li>2. For SFY21, the directed payments were as follows:       <ol style="list-style-type: none"> <li>a. \$3M – ACT – to strengthen and maintain fidelity to enhance quality of care.</li> <li>b. \$1.2M – NHH Discharges – to reduce the 30-day and 90-day readmission rates.</li> <li>c. \$200K – Specialty Residential Services – to improve quality of care by encouraging inpatient discharge when medically appropriate for patients with co-occurring disorders and DD who need a less acute level of care.</li> <li>d. \$600K – Mobile Crisis Teams – crisis intervention for adults with primary mental health but also those with co-occurring mental health and substance use disorders.</li> </ol> </li> </ol>
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	<p><b>3.</b> For SFY22, the directed payments are as proposed (subject to CMS approval):</p> <ul style="list-style-type: none"> <li>e. \$2.4M – ACT – to strengthen and maintain fidelity to enhance quality of care.</li> <li>f. \$1.2M – NHH Discharges – reduce the 30-day and 90-day readmission rates to a DRF or NHH.</li> <li>g. \$650K – Timely Prescriber Services Following Intake – to reduce ED visits and readmissions by emphasis on early contact upon intake.</li> <li>h. \$600K – Illness Management and Recovery Services (IMR) – to reduce ED visits and readmissions.</li> <li>i. \$200K – Specialty Residential Services – to improve quality of care by encouraging inpatient discharge when medically appropriate for patients with co-occurring disorders and DD who need a less acute level of care.</li> </ul> <p><i>Future Status:</i></p> <p>The State has implemented a system transformation for statewide integrated crisis response services (NH Rapid Response). This transformation includes two core components: a singular NH Rapid Response Access Point, which is a crisis call center with 1 statewide number (screen calls, complete initial assessments, triage, deploy mobile response, and provide information and referral services) and launches January 1, 2022; and regional Rapid Response/Mobile Crisis Response Teams (RR/MCRT; at least one team in each CMHC region in the State), which launched July 1, 2021 with teams initially responding to calls coming from within their applicable regional crisis hotlines. This legislatively-approved and -funded transformation fundamentally shifts NH’s crisis response services from primarily being a hospital-based ED- delivered system to a mobile crisis team-delivered service provided directly to individuals within the community where they are at (e.g. home, work, etc.). This transformation incorporates an approach that meets the requirements necessary to draw down enhanced federal funding envisioned in the American Rescue Plan Act, as well as expanded community-based stabilization supports. These expanded stabilization supports include: capacity for walk-in stabilization and peer living room models that may also serve as a drop-off location for first responders, crisis apartment beds, follow-up phone contact for all who interact with the crisis system, in-home and out-of-home options for brief services after the crisis response, and access to 60 new community-based supported housing beds (six per region) for those who may need longer term supported housing.</p> <p>With the approval of increased funding for mental health services in the state, including statewide mobile crisis services, CMHCs in New Hampshire will be better equipped to implement a vision that is: recovery-oriented, trauma-informed, integrates peer staff, aligned with suicide care best practices, committed to safety, available to children and adults, includes integrated mental health and substance use care, and has collective and cooperative coverage.</p> <p>In addition, the State has secured an additional \$2.6M and an extension of the NH COVID-19 Rapid Crisis Response Program and anticipates continuing providing crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for youth and adults impacted by the COVID-19 pandemic.</p>
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	<p>Finally, the crisis response system transformation includes transitioning 33 crisis call lines, which are currently maintained by various providers in regions across the state, to an integrated call model that will meet the federal mandate to shift to 9-8-8 in July 2022. This effort maximizes collaboration between the National Suicide Prevention Lifeline, with the State’s provider also being empowered to directly connect callers with the Veterans Crisis Line or the Rapid Response Access Point, as applicable to the caller’s needs, and ensuring real-time linkage to meet their behavioral health crisis response needs, whether child or adult.</p> <p><i>Summary of Actions Needed:</i>          The Rapid Response Access Point call center will launch January 1, 2022, and the Rapid Response Access Point and all crisis call center lines will be integrated with 9-8-8.</p>
<p>F.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.</p>	<p><i>Current Status:</i>  <b>Increased CMHC and Mobile Crisis Funding.</b> As noted throughout this template, and as outlined in the Provider Availability Assessment, NH offers a comprehensive continuum of community-based services. For the SFY22 / SFY23 biennium, DHHS received funding to allocate \$52.4M to the ten CMHCs. This represents a \$24.5M increase over the prior contract. Part of this funding will be for statewide mobile crisis services. As part of their contract, CMHCs are required to stand up an additional six beds per region (60 statewide) for supported housing for individuals with SMI.</p> <p><b>Assertive Community Treatment.</b> The State continues to support ACT services through the existing CMHC contracts. There were 1,234 unique clients receiving ACT services at CMHCs between 4/1/2020 and 3/31/2021. In addition, the CMHCs screened 8,935 unique clients not already receiving ACT services from 10/2020-12/2020 and 8,899 from 07/2020-09/2020. The CMHCs provided ACT services to 95 new clients between 10/2020-12/2020 and 132 new clients between 1/2021-3/2021.</p> <p><b>Partial Hospitalization / Day Treatment.</b> The State is exploring ways to assess more precisely which providers currently offer Intensive Outpatient Programs (IOPs)/Partial Hospitalization Programs (PHPs). The State’s current understanding is that five of the ten CMHCs currently maintain, or partner with hospitals to maintain, IOPs/PHPs with behavioral health services. This is an area of continued interest and potential expansion.</p> <ul style="list-style-type: none"> <li>• Intensive Outpatient Treatment – There are three intensive outpatient treatment programs in New Hampshire.</li> <li>• Partial Hospitalization – There are three restorative partial hospitalization programs in New Hampshire.</li> </ul> <p><b>Certified Community Behavioral Health Clinics.</b> The Mental Health Center of Greater Manchester (MHCGM) is the recipient of a \$4 million grant from SAMHSA, to implement a comprehensive mental health and substance use treatment program by becoming a Certified Community Behavioral Health Clinic (CCBHC). The population of MHCGM’s service area makes up about 15% of the population of NH, while 56% of clients are from medically underserved areas.</p>

	<p><i>Future Status:</i>          In addition to the continued operation and expansion of existing programs, the State is currently implementing Critical Time Intervention. CTI is a time-limited, evidence- and community-based practice that mobilizes support for individuals with serious mental illness during vulnerable periods of transition (e.g., discharge from a psychiatric hospital). CTI providers work with transitioning individuals to ensure they successfully reintegrate into their home communities. This can entail a broad range of assistance, from helping an individual secure employment, housing, or food; to identifying and accessing mental or physical health care; to reconnecting with family, friends, and peers to ensure strong, supportive relationships. CTI is backed by \$4.2M in state and federal funding for SFY22 and SFY23.</p>
	<p><i>Summary of Actions Needed:</i>          The State plans to monitor the operations of existing programs and ensure oversight over the implementation of new programs like CTI.</p>

Prompts	Summary
<b>SMI/SED. Topic_6. Health IT Plan</b>	<p><i>As outlined in State Medicaid Director Letter (SMDL) #18-011, “[s]tates seeking approval of an SMI/SED demonstration ... will be expected to submit a Health IT Plan (“HIT Plan”) that describes the state’s ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration’s goals.”<sup>1</sup> The HIT Plan should also describe, among other items, the:</i></p> <ul style="list-style-type: none"> <li>• <i>Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and</i></li> <li>• <i>Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.</i></li> </ul> <p><i>Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state’s demonstration proposal.</i></p>
<b>Statements of Assurance</b>	

<p>Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period</p>	<p>The State of New Hampshire has an established health IT infrastructure that supports the continuum of care and measurement of the health care system. The State’s health IT infrastructure includes, but is not limited to, three managed care organizations (Well Sense, NH Health Families and Amerihealth Caritas), an Event Notification System (ENS) for admissions, discharges and transfers (ADTs) to/from inpatient care, a statewide closed loop referral (CLR) system, an All Payer Claims Database (APCD), an aging and disability resource center (ADRC), and an integrated eligibility system (NH EASY).</p> <p><b>Managed Care Organizations.</b> The State contracts with three Managed Care Organizations that file claims, perform medical necessity, and share encounter information with the State. They are responsible for managing or conducting the utilization review of health and medical records.</p> <p><b>Event Notification System.</b> In partnership with seven geographically established Integrated Delivery Networks, the ENS system was implemented in New Hampshire to coordinate admission, discharge and transfer event notification to improve shared care planning for individuals. Currently, 19 of 26 hospitals’ systems and 9 of 10 Community Mental Health Centers’ (CMHC) systems have access to a platform to access and contribute to an electronic plan of care for their patients.</p> <p><b>Closed Loop Referral System.</b> The State has implemented a service referral care coordination network that encompasses the NH Department of Health and Human Services, federally qualified health centers, 10 CMHCs, and nine Doorway locations, providing single points of entry for people seeking help for substance use and/or mental health crises.</p> <p><b>All Payer Claims Database.</b> The State’s APCD provides access to the majority of the claims from the commercially insured adult population in New Hampshire and provides a comparative resource for monitoring change in rates of hospitalization, emergency department visits, and community services in the Medicaid population.</p> <p><b>Aging and Disability Resource Center.</b> ADRCs are a collaborative effort of the Administration on Community Living and the Centers for Medicare &amp; Medicaid Services (CMS). ADRCs serve as single points of entry into the long-term supports and services system (LTSS) for older adults and people with disabilities of all income levels. In New Hampshire, ADRCs are called ServiceLink and are state contracted, regionally based offices and partners to help individuals: a) access and make connections to long term services and supports, b) access family caregiver information and supports, c) explore options, and d) understand and access Medicare and Medicaid. Presently, the ServiceLink contractors access New HEIGHTS and NH EASY. At this time, ServiceLink does not push eligibility information to the MMIS system or to the MCOs for enrollment.</p>
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	<p><b>New HEIGHTS and NH EASY.</b> New HEIGHTS is the integrated eligibility system for NH DHHS. Eligibility programs determined within New HEIGHTS include Medicaid, TANF, SNAP, Child Care, Foster Care and more. Eligibility information such as demographics, income, resources, family composition and relationships, disability information, and much more is collected and stored in New HEIGHTS. In addition, LTSS, including eligibility for the various waiver programs, is contained within New HEIGHTS. New HEIGHTS is also the MCO enrollment broker for Medicaid. Eligibility, enrollment and client demographic information is sent to the MMIS via a nightly interface. The MMIS passes this information on to the MCOs.</p> <p>NH EASY is the online portal for clients to manage their accounts. Functionality within NH EASY includes applications for all programs in New HEIGHTS, redeterminations, change reports, etc. In addition, clients can upload documentation for their case, see what is due, read their notices, change their MCO, etc. NH EASY is tightly integrated with New HEIGHTS, so information entered in NH EASY is immediately available in New HEIGHTS.</p> <p>NH EASY also is used by providers and other community partners for a variety of reasons. Providers are able to (with client permission) act on behalf of their clients and assist them with upcoming events such as redeterminations, providing assistance with understanding notices, etc. Community partners who assist DHHS with determination for the Choices for Independence (CFI) waivers do so within NH EASY. The functionality allows both community partners within NH EASY as well as DHHS LTSS workers within New HEIGHTS to manage medical determinations for clients, as well as services they need when eligible. Dashboards are available in both systems so that there is transparency regarding the list of next steps and the key personnel assigned to each step. When services are approved by both entities, New HEIGHTS sends this information to the MMIS. This information is then passed to the MCOs.</p>
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Prompts	Summary
<p>Statement 2: Please confirm that your state’s SUD Health IT Plan is aligned with the state’s broader State Medicaid Health IT Plan and, if applicable, the state’s Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.</p>	<p>The SUD Health IT Plan is closely aligned with DHHS IT planning efforts. DHHS leverages common platforms for reporting, data analytics, and analysis; is working on a standard case management platform; and, where necessary, is working towards interoperability between systems.</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan  
 NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration  
 [Demonstration Approval Date]  
 Submitted on September 3, 2021

<p>Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)<sup>2</sup> and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state’s Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.</p>	<p>New Hampshire has reviewed the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B and, as a result, the MCOs who operate in New Hampshire are required by contract to develop and implement a strategy to address how the Interoperability Standards Advisory standards, from the Office of the National Coordinator for Health Information Technology, informs the MCO system development and interoperability.</p>
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Prompts	Summary
	<p><i>To assist states in their health IT efforts, CMS released <a href="#">SMDL #16-003</a> which outlines enhanced federal funding opportunities available to states “for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers.” For more on the availability of this “HITECH funding,” please contact your CMS Regional Operations Group contact.<sup>3</sup></i></p> <p><i>Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established “No Wrong Door System.”<sup>4</sup></i></p>
<b>Closed Loop Referrals and e-Referrals (Section 1)</b>	
<p>1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider</p>	<p><i>Current State:</i>          All 10 CMHCs are utilizing EHRs. Additionally, the CMHCs are utilizing an ENS implemented statewide for shared care plan coordination and secure messaging associated with EDT functions. The State has also implemented a CLR system and the 10 CMHCs, and an additional 40 behavioral health service providers, are engaged in utilizing the secure messaging of outcome-based referrals in conjunction with their in house EHR for clinical care.</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan  
 NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration  
 [Demonstration Approval Date]  
 Submitted on September 3, 2021

	<p><i>Future State:</i>          The State will continue to engage and expand the CLR system to behavioral health providers, as well as to all: hospitals; federally qualified health centers (FQHCs); community-based organizations; local government, education, and justice systems; and MCOs.</p> <p><i>Summary of Actions Needed:</i>          Additional funding to support the expansion of the CLR system is being sought to support future contracting and expansion. DHHS anticipates the following preliminary target milestones for delivery:</p> <ol style="list-style-type: none"> <li>1. Allocation of funds – September 2021</li> <li>2. Procurement and Contracting – September through November 2021</li> <li>3. Finalization of network governance – December 2021</li> <li>4. Finalization of Interoperability Standards – January 2022</li> <li>5. Expansion to targeted providers (CBOs, FQHC, Hospitals) geographically – December 2021 to June 2022</li> <li>6. Expansion to Local Government, Education and Justice systems – July to October 2022</li> <li>7. Expansion to Manage Care Organizations – July to December 2023</li> </ol>
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Prompts	Summary
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	<p><i>Current State:</i>            In December 2020, the State implemented a CLR system for the community based organizations, FQHCs, CMHCs, and the nine Doorways providing a receiving location for Substance Use Disorder (SUD) treatment. The CLR system was deployed and currently has over 90 providers utilizing it to obtain client consent and submit electronic referrals to providers of clinical and social services. The CLR not only supports referrals, but also focuses on ensuring the provider receives, accepts, and provides an outcome for the referral. This allows DHHS and the network of participating providers to track the health of the network and follow up with clients when a referral was not accepted or completed. Additionally, the hospitals, institutions, clinics and mental health providers are all using an ENS with secure messaging to support ADT referrals between the EHRs employed at each provider.</p> <p><i>Future State:</i>            Milestones are met for ADTs; however, the goal of the State is to take the CLR system and expand it to hospitals, local government, education systems, and MCOs to complete the circle of services and opportunities to send and receive referrals, thereby eliminating arduous manual processes.</p>

	<p><i>Summary of Actions Needed:</i> See section 1.1 summary of actions needed.</p>
<p>1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports</p>	<p><i>Current State:</i> The CLR, described above in section 1.2, Current State, is inclusive of physician/mental health provider to community-based supports referrals.</p>
	<p><i>Future State:</i> The CLR, described above in section 1.2, Future State, is the same for section 1.3.</p>
	<p><i>Summary of Actions Needed:</i> See section 1.1 summary of actions needed.</p>
<p><b>Electronic Care Plans and Medical Records (Section 2)</b></p>	
<p>2.1 The state and its providers can create and use an electronic care plan</p>	<p><i>Current State:</i> The current state-operated psychiatric hospital, New Hampshire Hospital (NHH), the CMHC’s systems, and the New Hampshire’s acute care hospitals (required to have event notification) can each create and use electronic care plans. NHH’s electronic care plan is accessible by the patient’s care team, including mental health providers where there is a treating relationship and the patient has consented to sharing data. NHH providers currently enter care insights to the patient care plan. These insights include level of certainty of diagnosis, treatments including medications that work well for the patient, and the insights a provider gained during the hospitalization that would have been helpful to know at admission.</p> <p><b>Event Notification System.</b> In addition, the State is in the early stages of implementing ENS which is capable of supporting event notification and shared care plans. Providers can access and/or contribute to an electronic SCP and receive ADTs related to ED, urgent/immediate care, and inpatient visits through the system. Currently, 19 of 26 hospitals’ systems and 9 of 10 CMHCs’ systems have access to a platform to access and contribute to an electronic plan of care for their patients. In 2020, this includes NHH, which is a major contributor of information to the system and whose entry brings value to the rest of the partners. Also as of 2020, key accomplishments regarding ENS implementation include:</p> <ul style="list-style-type: none"> <li>• Addition of 2 hospitals, including NHH, added to the network, bringing the total to 19 hospitals connected and contributing ADT data.</li> <li>• Increase of 69 ambulatory facilities on the network, bringing the total to 115 (additional facilities may have been added in the past year). Ambulatory facilities, include behavioral health clinics, Skilled Nursing Facilities (SNFs), CMHCs, and primary care providers (PCPs).</li> </ul>

	<ul style="list-style-type: none"> <li>• 3.66% increase in patient records viewed by ambulatory providers.</li> <li>• More than 2,800 logins per months to the platform.</li> <li>• ED utilization dropped 2% and inpatient utilization dropped 10% statewide, March 2019-March 2020 (pre COVID-19).</li> </ul> <p><b>Medicaid EHR Incentive Program.</b> For several years, NH DHHS has also provided incentive payments to eligible professionals and eligible hospitals as they adopted, implemented, upgraded, or demonstrated meaningful use of certified EHR technology. The program, which began in 2012 and ends in 2021, encourages Certified Electronic Health Record Technology (CEHRT) for use in a meaningful manner to improve public health. From 2012 to 2017, DHHS has disbursed 45 payments to 26 eligible hospitals, the most that were eligible to participate. In the same time period, the State disbursed 445 incentive payments to 667 eligible professionals.</p> <p><i>Future State:</i>        DHHS and the intended healthcare stakeholders will agree to a statewide strategy for consistent use for clinical outcome improvement and realized value. DHHS will also onboard to the platform, where there is a beneficiary HIPAA-covered treatment, payment, or operations relationship to use and contribute to electronic care plans in collaboration with providers.</p> <p><i>Summary of Actions Needed:</i>        The State must ensure continuation of the platform and implement it at the state level. The State also needs to plan and execute a statewide implementation to include all providers, a strategy to standardize key components of a plan of care, and workflows that leverage the information to improve patient care.</p>
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Prompts	Summary
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	<p><i>Current State:</i>            The current state is outlined in section 2.1. The early stages of ENS implementation key in on the following relationships between systems:</p> <ul style="list-style-type: none"> <li>• <b>NHH EHR and ENS:</b> NHH staff manually enter record data into its EHR. NHH staff download extracts from the EHR and submit the extracts to the ENS, at least once a day.</li> <li>• <b>Eligibility System and ENS:</b> There is currently no interface between NEW HEIGHTS and ENS. NH Medicaid beneficiaries are in New Heights, and Medicaid claims are processed through MMIS. If a beneficiary seeks treatment at an emergency department (ED), the care is attributed to that hospital and both the hospital and the ED have access to the same record; MMIS will eventually receive data regarding</li> </ul>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan  
 NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration  
 [Demonstration Approval Date]  
 Submitted on September 3, 2021

	<p>received services that are paid under either Fee-for-Service or MCO. ENS, being patient focused, restricts access only to those providers who have attestation.</p> <p><i>Future State:</i>          The State’s providers have begun leveraging the Interoperability Standards to implement ENS within the EHRs of hospitals and CMHCs, and other ambulatory systems that have joined the network. This integration will make ENS more accessible by providers, as they will not need to go through multiple systems to access the data. Providers are using the actual EHR system to pull in relevant data (SCP notes, ADT detail, etc.). Including ENS as part of their EHR allows for smoother communication between providers in a real time environment.</p> <p>More broadly, the State seeks to ensure consistent documentation in care plans for patients discharged from NHH and additions to plan of care by other providers, adding value for NH providers to access. The goal for the State is to consolidate and build an interoperable E-plan of care system to allow for the accessibility and streamlined services to be performed to include a single state network for E-referrals for services, including outcomes and a centralized resource coordination center to manage shared care plans for the State’s clients.</p> <p><i>Summary of Actions Needed:</i>          Execution on a statewide plan to address key pieces of information that provide high value for continuity of care for patients. In general, there is a need to inventory the disparate systems, build an interoperability standard from/to which all systems can connect and share data, create data sharing agreements with all providers, implement an informed consent process to protect the privacy of individual’s data, implement and replace existing systems where needed (specifically the Behavioral Health SUD Treatment system), update contracts for services to leverage the new interoperability standards and systems.</p>
<p>2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications</p>	<p><i>Current State:</i>          CMHCs and inpatient facilities serve both children and adults. As a result, they have an EHR that provides medical records and treatment plans to the care teams serving the individual, including during transitions from youth services to adult behavioral health services. If an individual is being served by a different provider as an adult than as a youth, then releases of information would need to be employed.</p> <p><i>Future State:</i>          N/A – milestone met.</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan  
 NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration  
 [Demonstration Approval Date]  
 Submitted on September 3, 2021

	<i>Summary of Actions Needed:</i> N/A – milestone requirement already met.
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	<i>Current State:</i> See response for section 2.3 above.
	<i>Future State:</i> N/A – milestone met.
	<i>Summary of Actions Needed:</i> N/A – milestone requirement already met

Prompts	Summary
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	<i>Current State:</i> All CMHCs have electronic health records that serve both children and adults. As individuals transition between systems, information pertaining to the transition can be shared between providers on an individual, case-by-case basis.
	<i>Future State:</i> See responses for 1.1 and 1.2.
	<i>Summary of Actions Needed:</i> See responses for 1.1 and 1.2.

<b>Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)</b>	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	<i>Current State:</i> Consent is captured on providers EHR systems as well as on the CLR system.
	<i>Future State:</i> N/A – milestone met.
	<i>Summary of Actions Needed:</i> N/A – milestone met.

<b>Interoperability in Assessment Data (Section 4)</b>	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	<p><i>Current State:</i>            All documentation is included in the provider’s EHR and, as defined in the template (notes field) for information that is agreed to be shared, is interoperable via ENS.</p>
	<p><i>Future State:</i>            Future interoperability between providers EHR systems and the CLR system will connect the referrals with the rest of the HIT ecosystem; the goal of the State is to take the CLR system and expand it to hospitals, local government, education systems, and MCOs to complete the circle of services and opportunities to send and receive referrals, thereby eliminating arduous manual processes.</p>
	<p><i>Summary of Actions Needed:</i>            See section 1.1 summary of actions needed.</p>

<b>Prompts</b>	<b>Summary</b>
<b>Electronic Office Visits – Telehealth (Section 5)</b>	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	<p><i>Current State:</i>            In July 2020, the State Legislature passed <b>HB 1623</b>, which greatly expanded how care providers interact with telehealth technologies. The bill:</p> <ul style="list-style-type: none"> <li>• Ensured reimbursement parity, expands site of service, and enables all providers to provide services through telehealth for Medicaid and commercial health coverage, with limited exceptions.</li> <li>• Enabled access to medication assisted treatment (MAT) in specific settings by means of telehealth services.</li> <li>• Amended the Physicians and Surgeons Practice Act to expand the definition of telemedicine.</li> <li>• Amended the relevant practice acts to expand the definition of telemedicine.</li> <li>• Enabled the use of telehealth services to deliver Medicaid reimbursed services to schools.</li> </ul> <p>According to <b>RSA 167:4-d Medicaid Coverage of Telehealth Services</b>, Medicaid provides coverage and reimbursement for health care services provided through telemedicine on the same basis as the Medicaid program provides coverage and reimbursement for health care services provided in person, with limited exceptions.</p> <p>Medicaid providers are allowed to perform health care services through all modes of telehealth, including video and audio, audio-only, or other electronic media. This includes mental health practitioners governed by <b>RSA 330-A</b> and psychologists governed by <b>RSA 329-B</b> and community mental health providers employed by CMHPs pursuant to <b>RSA 135-C:7</b>.</p>

	<p>American Rescue Plan Act funds were used to pay for increased broadband connectivity for rural and HRSA-defined medically underserved areas of New Hampshire.</p> <p><i>Future State:</i> Continued operation of telehealth policy, and continued promotion of telehealth technologies, in accordance with statutes. Expansion of outreach to support medication assisted treatment providers for the treatment of opioid use / mental health disorders via telehealth.</p> <p><i>Summary of Actions Needed:</i> Evaluate long-term uptake of telehealth service provision, particularly in rural areas of the State. Evaluate the evidence to provide coverage for remote patient monitoring and store-and-forward billing codes, and consider the need for submitting a State Plan Amendment.</p>
<b>Alerting/Analytics (Section 6)</b>	
<p>6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment<sup>5</sup>)</p>	<p><i>Current State:</i> NH Administrative Code <b>He-M 405.05 Collaboration with Community Mental Health Programs</b> require the joint development of discharge plans and referrals for clients whom CMHPs and Designated Receiving Facilities (DRFs) both serve. The discharge plan must include information about community supports, such as peer support agencies, and the availability of family support and education, and CMHPs must offer an appointment to a discharged client to occur within 7 days of discharge.</p> <p><i>Future State:</i> As part of its Critical Time Intervention (CTI) implementation, DHHS will be working with CTI providers to ensure transitioning individuals successfully reintegrate into their home communities. This can entail a broad range of assistance, from helping an individual secure employment, housing, or food; to identifying and accessing mental or physical health care; to reconnecting with family, friends, and peers to ensure strong, supportive relationships. DHHS has developed CTI metrics for CMHCs to track key information such as appointments, readmissions, and other health and treatment metrics. CMHCs are responsible for routinely updating their clients' EHRs and should help the State better track individuals who are discharged from NHH and DRFs to ensure proper follow-up is provided.</p> <p>In addition to better visibility into discharges and follow-up, the State plans to improve linkages between its eligibility system and the CLR/ENS systems mentioned above to better identify whether patients: 1) are eligible for services, 2) have a referral, 3) have been discharged from treatment, and 4) have received follow-up. Doing so will provide the State better visibility into patient care.</p> <p>Finally, the State has recently discussed examining data from assessment tools like CANS and ANSA, which may help identify patients who are at risk of discontinuing engagement in their treatment.</p>

Medicaid Section 1115 SMI/SED Demonstration Implementation Plan  
 NH Mental Health Services for Medicaid Beneficiaries with Serious Mental Illness Demonstration  
 [Demonstration Approval Date]  
 Submitted on September 3, 2021

	<p>The analytics described in this response will be used to notify the centralized resource coordination system and care teams (outlined in the Future State section of 2.2) for outreach.</p> <p>All patients have the right to consent to treatment, to their release of information, and the State will leverage the best programs and services possible in order to provide the treatment consented to by each individual. In doing so, the State will leverage the systems of care to not only analyze the information the State has, but to also provide a notification process to update the client as to their eligibility for services and how the State can help them.</p> <p><i>Summary of Actions Needed:</i>          The State will need to stand up a trend-based analytics environment platform to extract the data sources outlined above, and to establish a process for care team notification.</p>
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Prompts	Summary
<p>6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis</p>	<p><i>Current State:</i>            The Bureau of Children’s Behavioral Health and Bureau of Mental Health Services is in the process of planning a needs assessment and work with stakeholders to identify a model for statewide implementation of a First Episode Psychosis (FEP) specialty care program. In the meantime, the State maintains the Nashua region based program for FEP.</p> <p><i>Future State:</i>            Starting in July of 2021, three additional programs within the Derry, Seacoast, and Monadnock regions began implementing FEP programs. By increasing the availability of FEP throughout the State, NH increases the likelihood of identifying an individual during their first psychotic episode and providing intense, targeted services that lead to a decrease in psychiatric hospital stays. The coordination of care is a key requirement in this effort.</p> <p>Because Nashua is the only region that has an FEP program, they currently accept clients from other regions for this specific program.</p> <p>The State anticipates CMHCs will utilize their EHRs for the coordination of care with the SCPs already implemented in the ENS. The State will leverage referrals in the CLR.</p> <p><i>Summary of Actions Needed:</i>            The State is currently contracting with a technical assistance and consultation resource to assist the applicable CMHCs in implementing FEP. Any other IT needs would be identified as the State embarks upon those additional programs. In addition, see 1.1 for summary of actions needed.</p>

<b>Identity Management (Section 7)</b>	
7.1 As appropriate and needed, the care team has the ability to tag or link a child’s electronic medical records with their respective parent/caretaker medical records	<p><i>Current State:</i>          If appropriate and needed, the State is capable of linking a child’s electronic medical record with that of their respective parent’s or caretaker’s medical record.</p>
	<p><i>Future State:</i>          The State’s goal is to build interoperability standards to allow for providers to consume the standards subsequent to creation of necessary data sharing agreements to allow for the linkage of child’s electronic medical records with their respective parent/caretaker medical records.</p>
	<p><i>Summary of Actions Needed:</i>          N/A – milestone met.</p>
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	<p><i>Current State:</i>          NHH’s EHR is reliable in capturing all episodes of care. When NHH’s EHR links to other data systems, it is capable of providing detail at the admissions and discharge level from NHH. Episodes of care can be aggregated and summarized by individual. NHH’s EHR validates data with NHH and updates old data periodically to ensure information is up-to-date.</p>
	<p><i>Future State:</i>          N/A – milestone met.</p>
	<p><i>Summary of Actions Needed:</i>          N/A – milestone met.</p>

**Section 3: Relevant documents**

*Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.*