

New Hampshire  
Department of Health and Human Services

Substance Use Disorder Serious Mental Illness  
Serious Emotional Disturbance  
Treatment and Recovery Access  
Section 1115(a) Research and Demonstration  
Waiver

## **Extension Request**

September 30, 2022

Demonstration Project No. 11-W-00321/1

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# I. Narrative Summary of the Demonstration Project

## Substance Use Disorder Treatment and Recovery Access

### Executive Summary

The Centers for Medicare and Medicaid Services (CMS) approved the New Hampshire (NH or the State) Substance Use Disorder Treatment and Recovery Access (SUD-TRA) Section 1115 Demonstration on July 10, 2018, for a five-year term ending June 30, 2023. The SUD-TRA demonstration is designed to maintain critical access to opioid use disorder (OUD) and other substance use disorder (SUD) treatment services and continue delivery system improvements to support coordinated and comprehensive OUD/SUD treatment for Medicaid enrollees. The demonstration authorizes NH to provide high-quality, clinically appropriate SUD treatment services for short-term stays in residential and inpatient treatment settings that qualify as Institutions for Mental Diseases (IMDs).

The SUD-TRA demonstration was developed to encourage growth in SUD residential treatment capacity (IMD and non-IMD), to build on existing efforts to improve models of care that focus on supporting enrollees in their homes and communities, and to strengthen the New Hampshire continuum of SUD services. The Department of Health and Human Services (DHHS) identified three overarching goals for the SUD-TRA demonstration:

1. Improve access to OUD and other SUD services;
2. Improve the quality of the SUD treatment delivery system to provide high-quality coordinated and comprehensive OUD/SUD treatment for Medicaid enrollees; and
3. Maintain budget neutrality.

Overall, the New Hampshire SUD-TRA demonstration is associated with improved access to care for those beneficiaries with intensive SUD treatment needs. In all years, Emergency Department (ED) use declined in the 90 days following IMD discharge as compared to the 90 days period prior to admissions. IMD services for those meeting criteria may contribute to stabilization and continuity of care post discharge. This is further evidenced by the percentage of members who have a claim for SUD treatment in the 45, 90, 135 and 180 days following IMD discharge.

Results from the first year of the demonstration indicate that SUD treatment utilization had increased, and overall use of EDs had declined. However, the onset of the Public Health Emergency (PHE) in the second year of the demonstration makes it difficult to draw strong associations between the demonstration and continued reductions in ED use.

An exploratory analysis of expenditures for adults who received IMD services shows a similar pattern with lower per member per month (PMPM) costs during the demonstration period. However, the influence of the PHE on service use may be suppressing utilization and masking the true need for SUD treatment services in the coming years.

## Overall Summary of the Interim Evaluation Findings

Hypotheses	Measures	Interim Findings
<b>Evaluation Question 1: What are the impacts of the demonstration on access to SUD residential treatment services for demonstration enrollees?</b>		
A. Adult enrollees will have better access to residential SUD treatment services	1. Percent of enrollees ages 12-64 with an SUD claim for treatment in an IMD with a discharge date during the year	Statistically significant increases in access to IMD services were seen in each year of the demonstration when compared to the baseline year.
	2. The total number of licensed beds for Medicaid enrolled SUD residential treatment providers each year	Licensed bed capacity for Medicaid-enrolled residential treatment facilities increased from 554 beds at baseline to 697 beds in DY3.
<b>Evaluation Question 2: What are the impacts of the demonstration on quality of care for Medicaid enrollees with an SUD diagnosis?</b>		
A. Enrollees will have fewer ED visits for SUD	1. The total number of ED visits for SUD per 1,000 demonstration enrollees	<ul style="list-style-type: none"> <li>ED use declined over baseline (both for total ED visits and SUD-related ED).</li> <li>There was a slight increase in total ED use for adolescents with an SUD in DY3.</li> </ul>
B. Enrollees will have fewer total ED visits	1. The total number of ED visits for any reason per 1,000 demonstration enrollees	
C. Enrollees will have fewer ED visits post discharge from an SUD IMD	1. ED use 90 days prior to IMD admission and 90 days post discharge	<ul style="list-style-type: none"> <li>DY2 and DY3 showed a statistically significant decline in ED visits in the 90 days following IMD discharge as compared to the 90 days prior to admission.</li> <li>ED use may have been influenced by the PHE.</li> </ul>
D. Enrollees will have improved rates of initiation and engagement in treatment	1. Percentage of enrollees who initiated treatment within 14 days of diagnosis	<ul style="list-style-type: none"> <li>There was a statistically significant increase in DY1 and DY3.</li> </ul>
	2. Percentage of enrollees who engage in treatment within 34 days of initiation	<ul style="list-style-type: none"> <li>There was a statistically significant increase in DY2 and DY3.</li> </ul>
E. Enrollees will have lower IMD readmission rates	1. The percentage of IMD stays followed by a readmission within 30 days	<ul style="list-style-type: none"> <li>Readmissions increased in DY1 and DY2, before declining in DY3.</li> </ul>
F. Enrollees will have improved rates of treatment retention	1. The percentage of enrollees who had SUD treatment visits 45, 90, 135, and 180 days following IMD discharge	<ul style="list-style-type: none"> <li>There was a statistically significant increase over baseline in each year of the demonstration.</li> </ul>

Hypotheses	Measures	Interim Findings
Evaluation Question 3: Will the demonstration maintain or reduce spending in comparison to what would have been spent absent the demonstration?		
A. The demonstration will be cost neutral	A. PMPM trends and per capita costs by Medicaid Eligibility Groups identified in the Special Terms and Conditions (STCs)	<ul style="list-style-type: none"> <li>At the end of DY3, the demonstration was showing a cumulative surplus.</li> </ul>

### History of the Demonstration

At the time of the State’s application to CMS for approval of its SUD-TRA demonstration, New Hampshire was experiencing one of the most significant public health crises in its history. New Hampshire had the third highest overdose death rate in the country (39 per 100,000).

The number of overdose deaths had increased dramatically, from 192 in 2013 to 488 in 2017. Between 2013 and 2017, the number of times emergency medical personnel administered naloxone more than doubled, from 1,039 to 2,774 and ED visits rose by 9.8 percent from 2016 to 2017. The escalation of opiate use and opioid misuse impacted individuals, families, and communities throughout the state.

The scope of the State’s crisis extended beyond individuals with SUD to include family members. New Hampshire was seeing a significant rise in neonatal abstinence syndrome, with the rate reaching 24.4 per 1,000 live births in 2015. Babies born with neonatal abstinence syndrome require more complex medical care, with average hospital stays of twelve days.

The incidence of neonatal abstinence syndrome was higher among Medicaid enrollees than other groups. In 2013, Medicaid paid for 78 percent of neonatal abstinence syndrome births. In 2015, the DHHS Division for Children, Youth, and Families reported that it received 504 reports of children born drug-exposed, representing an increase of 37 percent from 2014.

In addition to the high rate of opioid use among the adult population, the State ranked among the top five for binge drinking among persons ages 12 to 20 years. According to the 2015-2016 National Survey on Drug Use and Health, illicit drug use among individuals ages 12 to 17 in New Hampshire was higher than in the broader New England region and the United States. In 2015-2016, 8.98 percent (95 percent confidence interval: 7.32-10.96) of New Hampshire’s adolescents (ages 12 to 17) reported illicit drug use in the past month.

In response to the opioid crisis, New Hampshire invested more than \$30 million in the years prior to its SUD-TRA demonstration request to build service capacity and support a full continuum of care to treat individuals with SUD. These investments included those that maintain existing prevention, treatment, and recovery capacity, while also expanding access to medication assisted treatment (MAT), peer recovery support services, direct prevention services, and coordination of care through a statewide crisis hotline.

The State also established nine regional treatment “Hubs” to serve as 24/7 access points to addiction treatment. The Hubs provide screening, evaluation, care management, social service referral and addiction treatment services across the state.

These investments were made in support of a robust, resiliency- and recovery-oriented system of care for individuals with SUD. Although capacity for services increased, the limited availability of treatment in all settings, particularly residential treatment, was challenging.

The State implemented the SUD-TRA demonstration to address critical unmet needs for residential SUD treatment; improve quality of SUD treatment; and maintain or reduce cost of care for Medicaid enrollees with an SUD.

### Demonstration Approval and Evaluation Period

CMS approved the New Hampshire SUD-TRA Section 1115 Demonstration on July 10, 2018, for a five-year term ending June 30, 2023. Clarifying, non-substantive revisions were approved on August 3, 2018. On June 16, 2021, an amendment was approved by CMS to update the demonstration's budget neutrality terms and conditions. CMS agreed to prospectively adjust the State's hypothetical budget neutrality limits to reflect actual expenditures more accurately. Additionally, CMS updated Sections III, XI, and XII of the STCs to align with recent CMS requirements for 1115(a) demonstration approvals.

The demonstration's Evaluation Design was approved by CMS on May 22, 2019. This is cited from the first Interim Evaluation report as required in STC 36. Preliminary findings are offered, based on the approved Evaluation Design, for the baseline period (July 1, 2017-June 30, 2018) through DY3 (ending June 30, 2021).

### Demonstration Description

New Hampshire's demonstration is designed to maintain critical access to OUD and other SUD treatment services and continue delivery system improvements to support coordinated and comprehensive OUD/SUD treatment for Medicaid enrollees. The demonstration authorizes New Hampshire to provide high-quality, clinically appropriate SUD treatment services for short-term stays in residential and inpatient treatment settings that qualify as IMDs.

The demonstration also was designed to encourage growth in SUD residential treatment capacity (IMD and non-IMD) and build on existing efforts to improve models of care focused on supporting enrollees in their homes and communities and strengthen the New Hampshire continuum of SUD services.

New Hampshire's statutes and rules require that treatment decisions and delivery system innovations be based on the use of the American Society of Addiction Medicine (ASAM) criteria and other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines, making the CMS SUD IMD demonstration requirements a good fit for the State.

The CMS-defined goals for all section 1115 SUD demonstrations include:

- Increased rates of identification, initiation, and engagement in treatment;
- Increased adherence to, and retention in, treatment;
- Reduced overdose deaths, particularly those due to opioids;
- Reduced utilization of ED and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services;
- Reduced readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate; and
- Improved access to care for physical health conditions among beneficiaries.

## Serious Mental Illness (SMI) & Serious Emotional Disturbance (SED) Treatment and Recovery Access

### Executive Summary

On June 2, 2022, CMS approved the DHHS request to amend the SUD-TRA demonstration in line with its approach to address the ongoing challenge of psychiatric ED boarding and to support the comprehensive, integrated continuum of mental health treatments and care available in the state. Over many years, 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 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 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 requested authority for Medicaid reimbursement for short-term medically necessary residential and inpatient treatment services within settings that qualify as IMDs. The State's goal is to increase access to treatment options for Medicaid eligible adults ages 21-64 with 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 two years, the State has demonstrated its commitment to a responsive and coordinated statewide system of care by (1) implementing a Critical Time Intervention (CTI) program statewide and (2) launching a Rapid Response system featuring a centralized access point with regional rapid response teams (e.g., mobile crisis teams) that the State integrated with 9-8-8 on July 16, 2022.

### Demonstration Goals and Objectives

The approved goals of this demonstration per the STCs are to:

1. Reduce utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings;
2. Reduce preventable readmissions 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/SED, 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.

## Demonstration Milestones

The approved SMI/SED Implementation Plan (Attachment G to the STCs) describes the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

### Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

- i. Participating hospitals must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the State claiming Federal Financial Participation (FFP) for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and be either: a) certified by the state agency as being in compliance with those conditions through a state agency survey, or b) deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.
- ii. Participating residential treatment providers must be licensed, or otherwise authorized, by the State to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the State claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
- iii. Establishment of an oversight and auditing process that includes unannounced visits for ensuring psychiatric hospitals and residential treatment settings in which beneficiaries receiving coverage pursuant to the demonstration are residing meet applicable state licensure or certification requirements as well as a national accrediting entity's accreditation requirements.
- iv. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities.
- v. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, the State must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR § 431.407, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues).
- vi. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and substance use disorders (SUDs) and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

### Improving Care Coordination and Transitions to Community-Based Care

- i. Implementation of a process to ensure that psychiatric hospitals and residential treatment



facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that community-based providers participate in transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings and/or by hiring peer support specialists to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment).

- ii. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who have been experiencing or are likely to experience homelessness or who would be returning to unsuitable or unstable housing with community providers that coordinate housing services, where available.
- iii. Implementation of a requirement that psychiatric hospitals and residential treatment settings that are discharging beneficiaries who have received coverage pursuant to this demonstration have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary and the community-based provider to which the beneficiary was referred within 72 hours of discharge to encourage the beneficiary to receive appropriate follow-up care after leaving those facilities.
- iv. Implementation of strategies to prevent or decrease the length of stay in EDs among beneficiaries with SMI/SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers).
- v. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI.

#### Increasing Access to Continuum of Care Including Crisis Stabilization Services

- i. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability.
- ii. Commitment to implementation of the financing plan described in STC 18(d).
- iii. Implementation of strategies to improve the State's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible.
- iv. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

### Earlier Identification and Engagement in Treatment Including Through Increased Integration

- I. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs.
- II. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers.
- III. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI/SED.

### SMI/SED Health IT Plan

Components of the SMI/SED Health IT Plan include:

- I. The SMI/SED Health IT Plan, as applicable, describes the State's capabilities to develop and leverage an event notification system (ENS) and closed-loop referrals (CLR) in support of SMI/SED to promote high-quality care coordination and the delivery of appropriate services. The ENS should allow for identification of patients across separate clinical, financial, and administrative systems to allow for information exchange to improve care coordination. In this plan, the State also indicates how current efforts or plans to develop and/or utilize the ENS and CLR support the programmatic objectives of the demonstration.
- II. The SMI/SED Health IT Plan describes the State's current and future capabilities to support providers implementing or expanding SMI/SED Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

### SMI/SED Financing Plan

Components of the SMI/SED Financing Plan include:

- I. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers.
- II. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment (ACT), and services delivered in integrated care settings.
- III. A plan to ensure the on-going maintenance of effort (MOE) on funding outpatient community-based services to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

## II. Changes Requested

### Tailored Medicaid State Plan Services to Support Community Reentry

#### Program Summary

As part of this extension submission, the State is requesting approval from CMS for a change to the demonstration to authorize federal Medicaid matching funds for the provision of a tailored set of services targeting those incarcerated in NH Department of Corrections (NHDOC) custody in state prisons with behavioral health (BH) disorders (i.e., SUD, OUD, SMI, or SED) transitioning to community release. The targeted services primarily involve care coordination: (i) MCO enrollment, (ii) peer recovery supports or counseling, and (iii) new prescribing provider appointments with identified community BH providers (i.e., one telehealth or in-person intake appointment and one or two peer support or counseling sessions). These connection points are critical to building stronger transitional bridges to the community in the 45-day period prior to release from incarceration.

Upon approval of this demonstration, the NHDOC system of state prisons will modify its already existing case management process to accomplish the activities outlined above for the 45-day period prior to release. These activities will be documented in NHDOC's client management system as well as the clinical encounter coded and included in NHDOC's electronic health record, if appropriate. Community-based partners will then bill NH Medicaid or the beneficiary's selected MCO (depending on timing) for the service encounter. Some of the encounters may be facilitated by telehealth.

The State's objective is to increase continuity of care for those being released from NHDOC facilities with BH conditions, building on the services that have been rendered during incarceration and establishing strong connectivity with community-based treatment providers and other supports. Establishing these linkages prior to release is expected to reinforce beneficiaries' continued participation in treatment services post-release and enhance prospects for abstinence from substance abuse as well as continued adherence to BH treatment plans. In line with the services identified above, this program is not meant to replace in any way the health care services the State is responsible for providing to all incarcerated individuals but rather to supplement pre-release treatment activities.

#### Proposed Monitoring and Evaluation

This demonstration is designed to test the following hypothesis: by providing a tailored set of Medicaid services 45 days prior to release, re-integration rates will increase and recidivism will be reduced among Medicaid beneficiaries who receive the pre-release transitional services. The demonstration is focused on the NHDOC system of state prisons and represents a preliminary opportunity to trial this intervention within the relatively standardized system of NHDOC to evaluate the opportunity for future statewide deployment in more varied settings.

The following are among the measures being considered by the State for this demonstration:

- Time in Community: length of time individual remains in the community or percentage of intervention population remaining in the community at 30, 60, 90, 120 days;
- Relative Recidivism: comparison across similarly controlled individuals who opt out of pre-release transitional services vs. those who opt in; and
- Parole Violations: reduction in parole violations associated with SUD/relapse or mental health treatment non-adherence.

## Background

NHDOC has a strong history of providing BH treatment services and meeting the State's 8<sup>th</sup> Amendment constitutional healthcare access requirements during incarceration. NHDOC continues to provide those diagnosed with BH disorders with access to a diverse milieu of treatment services including but not limited to psychiatric assessment, psychological evaluations, individual and group therapies, medications, and prison-based modified therapeutic communities. Incarcerated adults participate in their treatment plan development and engagement with the clinical staff.

The following data show that, of the BH disorders, SUD continues to be the primary driver of reincarceration, suggesting persistence of strong barriers to continuity of care across community reintegration transitions. Almost 15 percent of incarcerated men and 30 percent of incarcerated women in New Hampshire have a mental illness<sup>1</sup>, and NHDOC estimates that over 50 percent of people incarcerated in NHDOC facilities have an OUD<sup>2</sup>. Between December 2019 and December 2020, over half of all parole revocation hearings listed “substance abuse” as a reason for revocation<sup>3</sup>, and failure to comply with treatment and substance use were among the top three reasons for parole revocations in 2017<sup>4</sup>.

Pre-2014, individuals released from incarceration would leave NHDOC and, upon transition to the community, in most cases these services would become out of pocket fee-for-service treatments. Many of those released from incarceration experienced a “benefits cliff,” where access to services in the community ceased due to their inability to pay even with many providers offering a sliding-scale fee schedule.

With Medicaid Expansion in NH in late 2014, the State was able to reduce the “benefits cliff” experienced by those transitioning to the community from incarceration. All who are eligible for Medicaid are assisted by NHDOC case managers in their application for Medicaid coverage in compliance with Medicaid law and regulation. In NH, Medicaid eligibility is suspended rather than terminated when a Medicaid beneficiary is incarcerated. This allows case managers to establish re-entry plans for healthcare services as well as other primary elements of a person's life (e.g. employment, housing, transportation, etc.).

Medicaid Expansion has removed some of the known barriers to access to community care for those involved in the justice system and NHDOC has strengthened the use of their treatment staff and case management staff in working with incarcerated persons on re-entry plans. But several national and state-specific trends have limited the impact achieved so far, notably: the State has been severely impacted by the opioid epidemic and OUD is highly prevalent among the incarcerated.

A June 2017 article in *US News*, “[New Hampshire: Ground Zero for Opioids](#)”, profiled the high rates of overdoses and challenges experienced by NH. It highlighted opportunities for (and criticized lack of) general fund investment in SUD treatment services. Since the writing of this article, NH has invested significantly in state-based SUD treatment infrastructure and made great

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<sup>1</sup> Executive Order 2019-02 establishing Governor's Advisory Commission on Mental Illness and the Corrections System; <https://www.governor.nh.gov/sites/g/files/ehbemt336/files/documents/2019-02.pdf>.

<sup>2</sup> Opioid Task Force, *Status of Treatment of Opioid Use Disorder among Individuals Involved with the New Hampshire Justice System* (Concord, NH: NH Governor's Commission on Alcohol and Other Drugs, 2019).

<sup>3</sup> New Hampshire Department of Corrections, *NH DOC Monthly Parole Hearings Summary Report* (Concord, NH: New Hampshire Department of Corrections, 2020). Numbers are for December 1, 2019 to December 1, 2020. There were 643 parole revocation hearings during this period, 593 of which resulted in revocation. Revocations can be due to multiple reasons.

<sup>4</sup> New Hampshire Department of Corrections, *2018 Annual Report* (Concord, NH: New Hampshire Department of Corrections, 2019). Information on parole revocation reasons was based on Parole Board activity during calendar year 2017.

strides to build a hub and spoke model deployed in 2019 and referred to as "[The Doorways](#)".

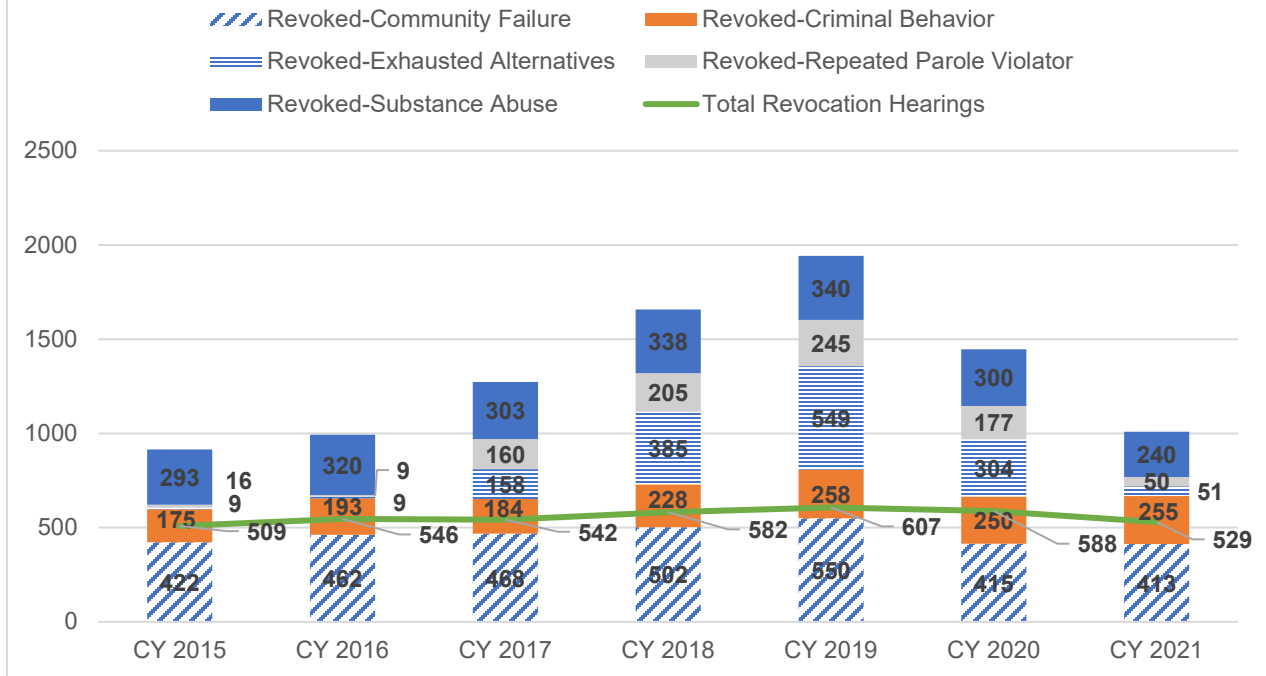
The Doorway model has been sustained and advanced through not only the work of the DHHS but also the [NH Governors' Commission on Alcohol and Other Drugs](#), which has invested in prevention, diversion, treatment, and intervention initiatives to benefit justice-involved populations with SUD. The Commission's Three-Year Action Plan (2019-2021) addresses treatment needs for those "citizens returning to the community from incarceration" and calls for the State to "expand services and increase care coordination for citizens returning to the community from incarceration." In addition to the recommendations of the Governor's Commission on Alcohol and other Drugs, the [Governor's Advisory Commission on Mental Illness and the Correctional System](#) has published reports since November 2019 to promote implementation of the State's [10-Year Mental Health Plan](#) with inclusion of justice-involved individuals.

The Governor's Advisory Commission on Mental Illness and the Correctional System in their most recent 2021 report highlighted as primary targets "strong reintegration and re-entry plans" to advance the collaboration with community mental health providers to streamline re-entry and create timely access to care and divert people from reincarceration. The care coordination gap identified in the Governor's Commission on Alcohol and Other Drugs' Three-Year Action Plan would be reduced with the approval of this demonstration request.

This demonstration will assist NHDOC in supporting a more seamless, clinically-stable transition for those with BH conditions being released from incarceration. NHDOC has known for some time that the primary drivers of recidivism in NH are centered on SUD and treatment non-compliance resulting in parole violations. Recidivism is defined, by the Correctional Leaders Association (CLA), as the "Number of Inmates released from the DOC during the calendar year (e.g. 2011) for which recidivism is calculated who returned to a DOC prison system for a new conviction within 36 months (3 years) after release divided by the number of inmates released during the calendar year. This includes the number of inmates who were released during the calendar year who were returned to prison for a technical violation within 36 months of release (3 years)."

## Parole Revocation Reason Outcomes CY2015 - CY2021

Source: Adult Parole Board Data, Trended by the NH Department of Corrections

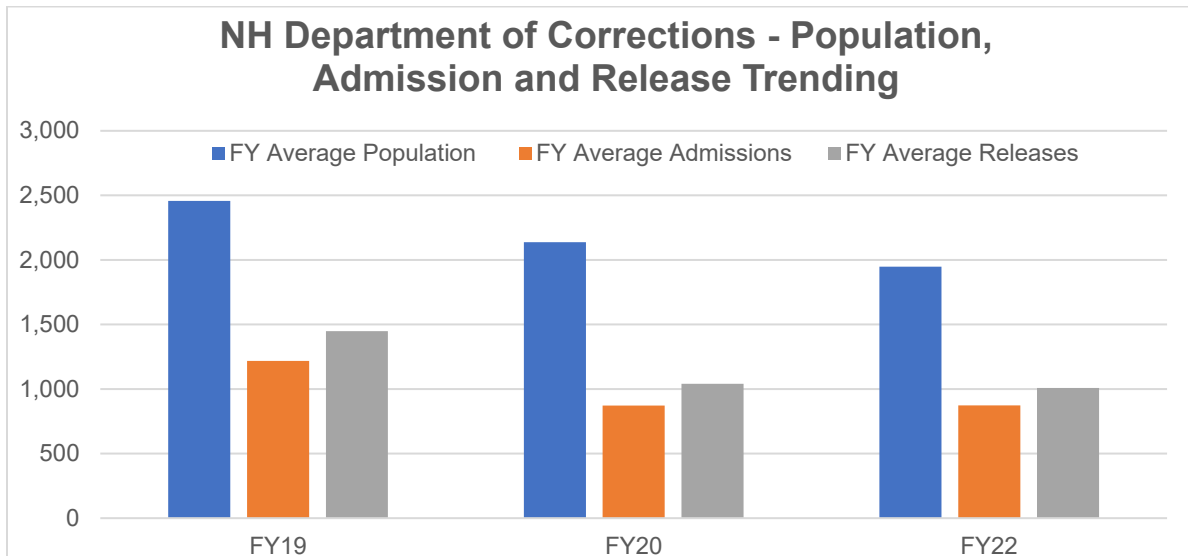


### NHDOC Overview

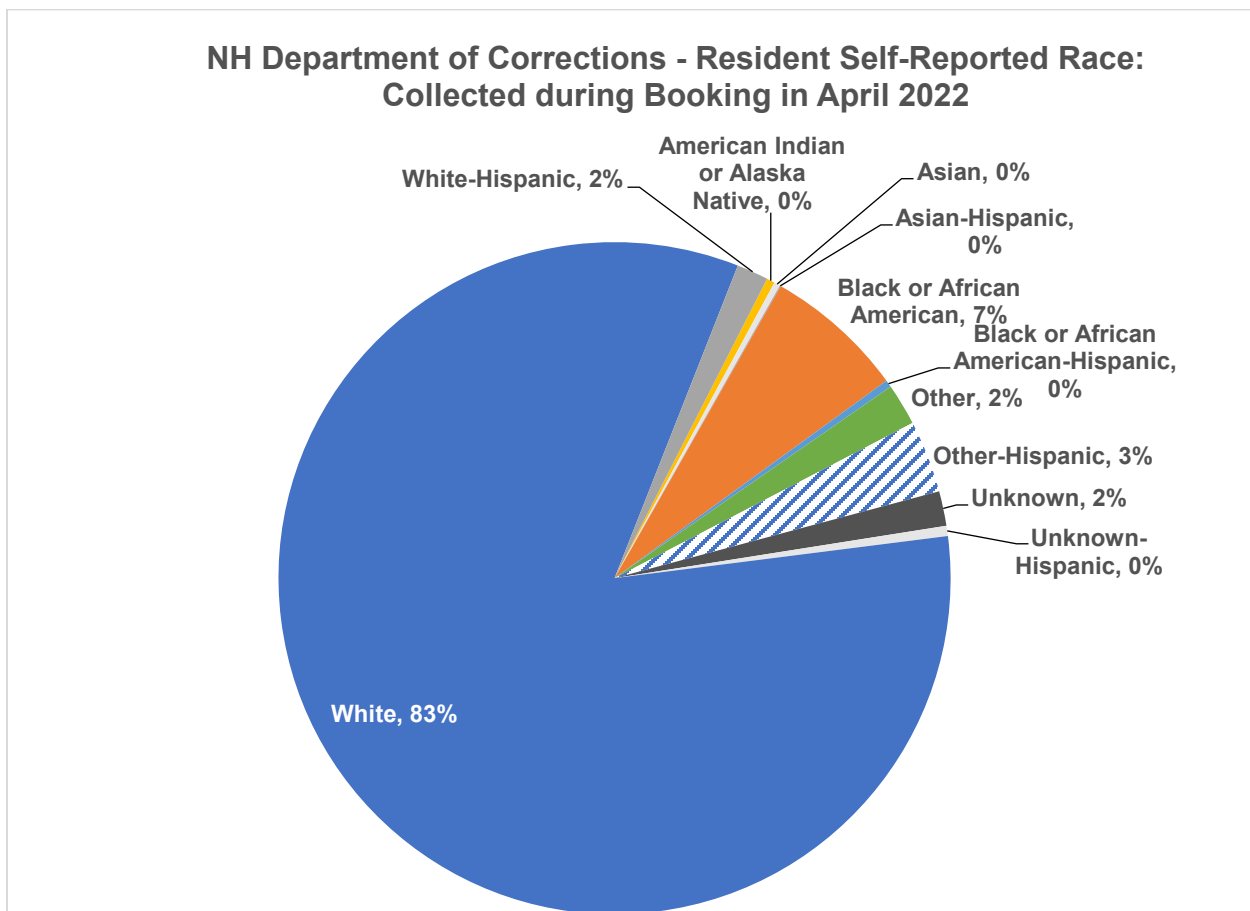
NHDOC operates the following facilities:

NH Department of Corrections Correctional Facilities		
<b>Northern Correctional Facility (NCF)</b>	138 East Milan Rd	Berlin, NH 03750
<b>NH State Prison-Men (NHSP-M)</b>	281 North State St	Concord, NH 03301
<b>Secure Psychiatric Unit (SPU)/Residential Treatment Unit (RTU)</b>	281 North State St	Concord, NH 03301
<b>NH Correctional Facility for Women (NHCF-W)</b>	42 Perimeter Rd	Concord, NH 03301
NH Department of Corrections Transitional Housing Units		
<b>North End Transitional Housing Unit (NEH/THU)</b>	1 Perimeter Rd	Concord, NH 03301
<b>Concord Transitional Work Center (TWC)</b>	275 North State St	Concord, NH 03301
<b>Shea Farm, Transitional Housing Unit (THU)</b>	60 Iron Works Rd	Concord, NH 03301
<b>Calumet House, Transitional Housing Unit (THU)</b>	126 Lowell St	Manchester, NH 03104

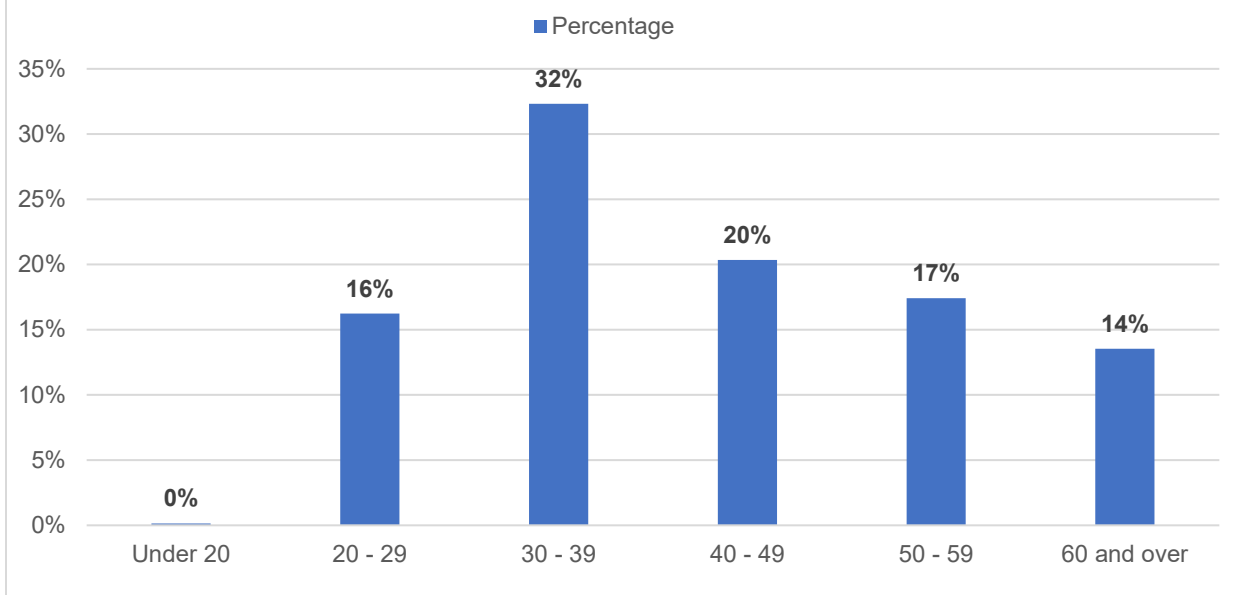
NHDOC average population has been declining:



The demographics of NHDOC's incarcerated population are as follows:



## NH Department of Corrections - Age Ranges of Residents Incarcerated April 2022



### NHDOC System of Behavioral Health Care

As of July 2022, the NHDOC incarcerated population exhibited the following characteristics with respect to SUD:

NHDOC Facility/Program	Primary SUD Diagnosis (% of Population)	Receiving MAT (Count of Individuals)
Transitional Housing Units/Work Center	29%	25
NH Correctional Facility for Women	68%	33
NH State Prison for Men	26%	141
Northern NH Correctional Facility	44%	129
Secure Psychiatric Unit	14%	4

Psychiatric medication prescribing patterns are summarized as follows:

As of April 2022	Count	Total Population	% on Psychiatric Medications
<b>Males</b>	763	1,772	43%
<b>Females</b>	90	124	73%
<b>Total</b>	853	1,896	45%

The NHDOC organizational structure includes the Division of Medical and Forensic Services (DMFS) which provides a wide range of physical and mental health services designed to enhance wellness, teach new skills, and encourage behavioral change. These individualized services include psychiatric treatment, sexual offender treatment, and treatment for SUD, SMI, or SED. Emergency behavioral health services are available and delivered via a crisis intervention model resulting in a short-term crisis management plan.



DMFS has a complement of 32 clinical staff across all sites, not inclusive of contracted positions, to deliver the diversity of treatment services described herein. These full-time staff are broken out as follows:

Site	Total Allocated	Clinical Licensure
Northern NH Correctional Facility (NNHCF)	6	LADC, LCSW
Secure Psychiatric Unit/Residential Treatment Unit (SPU/RTU)	7	LCSW, LMHC
NH State Prison for Men (NHSPM)	13	LADC, LCSW, LMHC
NH Correctional Facility for Women (NHCFW)	2	LADC, LMHC
Clinical Supervisors	4	MLADC, MCSW
<b>Total</b>	<b>32</b>	

A complement of contracted clinical staff including psychiatric providers is engaged by NHDOC using general funds. An outline of current contracted staffing is as follows:

Required Staffing by Position	Service Area/Facility	FTEs
Chief Psychiatric Medical Director	All Sites	1
Chief Forensic Evaluator	HQ	1
Psychiatric Nurse Practitioner	NHCF-W	1
Staff Psychiatrist	NHSP-M/CC	2
Staff Psychiatrist	SPU/RTU	1
Psychiatric Nurse Practitioner	NNHCF	1
Psychiatric Nurse Practitioner	NHSP-M	2
Psychiatric Nurse Practitioner	SPU/RTU	2
Mental Health Clinician	NHSP-M	1
Mental Health Clinician	NHCF-W	2
Mental Health Clinician	NNHCF	1
Mental Health Clinician	CC	1
Staff Psychologist	All Sites	1
Forensic Evaluators (FE) – Psychologists	HQ	4
Forensic Office Manager/Data Analysis– FE	HQ	1
Forensic Office Records Clerk	HQ	1
Licensed Alcohol and Drug Counselors	NHSP-M, NHCF-W	2
NGRI Clinical Coordinator	HQ	1
<b>Total FTEs</b>		<b>26</b>

Through this comprehensive staffing, DMFS has implemented a community behavioral health model adapted to a correctional setting to assist residents in the management of behavioral health issues. The range of services offered is designed to address both acute and chronic needs. Acute needs are managed on both an inpatient and outpatient basis. Exacerbation of a chronic behavioral health issue or onset of suicidal feelings can be managed by emergency assessment visits from NHDOC clinicians or with an inpatient admission to the Secure Psychiatric Unit (SPU). Ongoing needs are addressed through medication management, individual therapy, group therapy, and skill-building activities.

Other levels of care offered in the NHDOC system include several behavioral health residential units: the Residential Treatment Unit (RTU) for men located in Concord; the Wellness Block for men located in Berlin; and the Wellness Block for women located in Concord (collectively, the Wellness Units). The Wellness Units continue to show that a combination of clinical services based on a commitment to change yields positive results for those incarcerated with SUD, SMI, or SED. These units are designed to support residents with SUD, SMI, or SED toward the achievement of personal goals while emphasizing the power that is derived from a positive group and milieu experience. Participation in the Wellness Units is voluntary.

Promoting a sense of community is the philosophy driving the Wellness Units to prepare participants to be part of a positive culture while in prison as well as for life after prison. Participants in these units identify the value of good communication skills as problem-solving techniques versus the use of violence. They also have to participate in at least one of the following committees: Steering, Welcome, Activities, Health and Safety, Art, Peer Support, and Changing Social Norms. These modified therapeutic communities within a prison environment create a safe environment for those who are incarcerated to deal with long-term SUD, SMI, or SED and establish treatment plans and supports to create a path to long-term treatment compliance. Creating stronger community treatment transition initiatives prior to anticipated release for those with SUD, SMI, or SED will only serve to strengthen treatment adherence and stabilization.

NHDOC provides quality intervention services to assist residents in managing behavioral health issues. The system offers a dedicated treatment path for those with SUD including different levels of care starting with, if needed, withdrawal management in a prison medical unit. SUD intensive interventions are offered at each facility as well as a less intensive curriculum. Relapse prevention and aftercare services are also offered via support groups for those who have completed substance use treatment. NHDOC has mapped their service delivery to the ASAM as demonstrated below:

### ASAM Mapping to Correctional Treatment Programs, Effective Date 2019

Level of Care Assessed	Type of Treatment		Description
<b>OTP</b>	Opioid Treatment Program		Daily or several times weekly opioid medication and counseling available (MAT)
<b>Level 1</b>	Outpatient Treatment		Adults: less than 9 hours of service per week
<b>Level 2.1</b>	Intensive Outpatient Treatment		Adults: more than 9 hours of service per week
<b>Level 2.5</b>	Partial Hospitalization Services <sup>5</sup>		20 or more hours of service per week
<b>Level 3.1</b>	Clinically Managed Low-Intensity Residential Services		24-hour structure with available personnel, at least 5 hours of clinical service per week
<b>Level 3.3</b>	Not available because all adolescent levels	Clinically Managed Population-specific	24-hour care with trained counselors, less intense

<sup>5</sup> A partial hospitalization program (PHP) is a type of outpatient treatment program that caters to SUD patients who require a higher level of care than standard outpatient care can provide. People in a PHP receive comprehensive treatment services and medical monitoring during the day, but they don't stay overnight at the facility.

Level of Care Assessed	Type of Treatment		Description
	address cognitive/other impairments	High-Intensity Residential Services	environment and treatment for those with cognitive and other impairments
<b>Level 3.5</b>	Clinically Managed Medium-Intensity Residential Services	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors
<b>Level 3.7</b>	Medically Monitored High-Intensity Inpatient Services	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability, 16 hours per day counselor availability
<b>Level 4</b>	Medically Managed Intensive Inpatient Services		24-hour nursing care and daily physician care, counseling available

**ASAM Mapping to NHDOC Treatment Services: Programs Offered by Facility that Align to the Level of Care (LOC) Assessed, Effective Date 2019**

LOC	NHSP-M	NHCF-W	NCF	TWC	Shea Farm*	Calumet*	North End House*
<b>OTP</b>	MAT/ Naloxone Education	MAT/ Naloxone Education	MAT/ Naloxone Education	MAT/ Naloxone Education	MAT/ Naloxone Education	MAT/ Naloxone Education	MAT/ Naloxone Education
<b>Lev. 1</b>	Relapse Prevention & Outpatient	Relapse Prevention & Outpatient	Relapse Prevention & Outpatient	Relapse Prevention & Outpatient	Connect to Community Provider	Connect to Community Provider	Connect to Community Provider
<b>Lev. 2.1</b>	Not Available – Refer to Focus	Not Available – Refer to Focus	Not Available – Refer to Focus	Focus Unit or Consult with clinical lead	Connect to Community Provider	Connect to Community Provider	Connect to Community Provider
<b>Lev. 2.5</b>	Co-Occurring Group & Detox.	Co-Occurring Group & Detox.	Co-Occurring Group & Detox.	Triage to Men's Prison HSC or Hospital if Emergent – Detox. Services	Triage to Women's Prison HSC or Hospital if Emergent – Detox. Services	Triage to Men's Prison HSC or Hospital if Emergent – Detox. Services	Triage to Men's Prison HSC or Hospital if Emergent – Detox. Services
<b>Lev. 3.1</b>	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
<b>Lev. 3.3</b>	SPU	SPU	SPU	SPU	SPU	SPU	SPU
<b>Lev. 3.5</b>	Focus Unit	Focus Unit	Focus Unit	Refer back to Focus	Refer back to Focus	Refer back to Focus	Refer back to Focus
<b>Lev. 3.7</b>	Withdrawal Mgmt.	Withdrawal Mgmt.	Withdrawal Mgmt.	Withdrawal Mgmt.	Withdrawal Mgmt.	Withdrawal Mgmt.	Withdrawal Mgmt.
<b>Lev. 4</b>	Withdrawal Mgmt.	Withdrawal Mgmt.	Withdrawal Mgmt.	Withdrawal Mgmt.	Withdrawal Mgmt.	Withdrawal Mgmt.	Withdrawal Mgmt.

**\* Triage by NHDOC staff is available for all services**

The Focus Unit, which is a residential unit (ASAM 3.5) that provides SUD treatment services with

### **Focus Unit**

The focus program is delivered similar to a residential intensive treatment intervention program treating substance use disorders using a whole person approach but in a designated housing unit. The curriculum used is the Co-occurring Disorders Program (CDP) Dartmouth Medical School and is offset with other modalities that are evidence-based including but not limited to: Motivational Interviewing, Motivational Enhancement Therapy, Cognitive Behavioral Therapy, Stages of Change (Gender Specific resources such as Women in Recovery or Helping Men Recover) and Modified Dialectical Behavior Therapy.

Residents are required to participate in peer driven community committee supervised by staff (i.e. motivation, activities, community), clinical groups led by LADCs, provider appointments and as appropriate medication assisted treatment.

an emphasis on rehabilitation and wellness, is available to men at NCF and NHSP-M as well as women at NHCF-W. Goals of the Focus Unit are to help incarcerated individuals learn new positive adaptive behaviors and develop coping skills/wellness strategies for managing substance use disorders. Participants are assisted with follow-up services after completion of the Focus Unit program.

Even during the COVID-19 pandemic, NHDOC continued to provide SUD groups through tablet-based curricula called Breaking

Free and through paper workbooks delivered by clinicians to incarcerated participants and picked up for review/feedback. These modalities allowed for ongoing treatment while ensuring social distancing and reducing the spread of COVID-19 in NHDOC facilities. [Breaking Free](#) is an online program of evidence-based interventions designed to treat root causes of addiction through use of interactive content that offers targeted psychosocial strategies.

MAT services remain a vital component of NHDOC's SUD treatment services, especially for those with OUD. This service is available to residents at all facilities, including those who are booked with active prescriptions that are verified and continued by NHDOC providers, as well as newly referred incarcerated residents who complete the screening process and demonstrate a readiness for change, and others who are prescribed MAT by their NHDOC provider through the normal course of treatment.

In addition to staff-based efforts summarized in the table below, NHDOC applied for and was awarded funding under the State Opioid Response (SOR) grant starting in 2018, which added assertive case management (3 new full-time equivalents or "FTEs" of Re-Entry Care Coordinators) for inmates being released with OUD. Assertive case management helps recently-incarcerated persons maintain connections with community resources and overcome barriers impeding continuity of care for treatment of their SUD. Also, through this grant funding, NHDOC began deploying harm reduction principles with voluntary access and education on the use of naloxone as a life saving measure. With the additional federal funding, NHDOC started a peer-to-peer recovery training program. Training incarcerated people to provide peer recovery supports, combined with the opportunity to become Certified Recovery Peer Specialists (CRPS), has led to some formerly incarcerated persons becoming employed in NH communities as CRPS coaches. NHDOC has also implemented (with state general fund resources) long-term use of peer supports for those in acute distress and under observation. These incarcerated persons are trained and certified in psychological first aid and have aided in reducing acute observation stays of their peers.

**NHDOC Monthly Facility Behavioral Health Clinical Appointments Summary Report  
August 1, 2020 – July 1, 2021, Category Totals**

<b>EMR-Mental Health</b>	<b>Appointment Totals</b>	<b>Distinct Clients</b>
<b>Behavioral Health-Psychiatric</b>	8,781	1,475
<b>Behavioral Health-Clinician</b>	6,625	1,301
<b>Behavioral Health-Addiction Services</b>	601	417
<b>Behavioral Health-Interview</b>	1,945	1,066
<b>Behavioral Health-Sex Offender Treatment</b>	191	134
<b>Behavioral Health-Sick Call</b>	1,921	796

NHDOC provides all individuals released from custody with a minimum of two weeks' supply of prescription medications (including psychopharmacological agents).

The charts below represent a sample data set of NHDOC distribution of naloxone at time of release and through NHDOC community-based field services offices:

**NHDOC Distribution of Naloxone at Release: Offer Counts  
Data from November 2019 – October 2020 Reports**

<b>Report Month</b>	<b>Report Start Date</b>	<b>Report End Date</b>	<b>Offer Female</b>	<b>Offer Male</b>	<b>Total Offer</b>
<b>October 2020</b>	9/1/2020	9/30/2020	1	9	10
<b>September 2020</b>	8/1/2020	8/31/2020	8	28	36
<b>August 2020</b>	7/1/2020	7/31/2020	8	46	54
<b>July 2020</b>	6/1/2020	6/30/2020	12	42	54
<b>June 2020</b>	5/1/2020	5/31/2020	4	38	42
<b>May 2020</b>	4/1/2020	4/30/2020	16	64	80
<b>April 2020</b>	3/1/2020	3/31/2020	9	51	60
<b>March 2020</b>	2/1/2020	2/29/2020	19	100	119
<b>February 2020</b>	1/1/2020	1/31/2020	15	68	83
<b>January 2020</b>	12/1/2019	12/31/2019	18	88	106
<b>December 2019</b>	11/1/2019	11/30/2019	26	86	112
<b>November 2019</b>	10/1/2019	10/31/2019	60	234	294

**NHDOC Distribution of Naloxone at Release: Accepted and Declined Counts  
Data from November 2019 – October 2020 Reports**

<b>Report Month</b>	<b>Accepted Female</b>	<b>Accepted Male</b>	<b>Total Accepted</b>	<b>Declined Female</b>	<b>Declined Male</b>	<b>Total Declined</b>
<b>October 2020</b>	0	6	6	1	3	4
<b>Sept. 2020</b>	8	23	31	0	5	5
<b>August 2020</b>	8	36	44	0	10	10
<b>July 2020</b>	9	32	41	3	10	13
<b>June 2020</b>	4	31	35	0	7	7

Report Month	Accepted Female	Accepted Male	Total Accepted	Declined Female	Declined Male	Total Declined
May 2020	13	52	65	3	12	15
April 2020	9	42	51	0	9	9
March 2020	13	87	100	6	13	19
Feb. 2020	12	50	62	3	18	21
January 2020	17	64	81	1	24	25
Dec. 2019	18	53	72	7	33	40
Nov. 2019	38	124	162	22	110	132

**NHDOC Distribution of Naloxone at Release: Summary of Offers, Accepted, and Declined Data from November 2019 – October 2020 Reports**

Report Month	Total Offers	Total Accepted	Total Declined	Total Kits Accepted: Facility	Total Kits Accepted: Field Services
Oct. 2020	10	6	4	4	2
Sept. 2020	36	31	5	21	10
August 2020	54	44	10	37	7
July 2020	54	41	13	40	1
June 2020	42	35	7	33	2
May 2020	80	65	15	65	0
April 2020	60	51	9	47	4
March 2020	119	100	19	89	11
Feb. 2020	83	62	21	50	12
Jan. 2020	106	81	25	81	0
Dec. 2019	112	72	40	72	0
Nov. 2019	294	162	132	162	0

Literature reports that evidence-based practice treatment during justice involvement increases treatment retention post-release (AHRQ, 2020; Ferguson et al., 2019; NCBH, 2020; SAMHSA, 2020). NHDOC has been demonstrating, with resources available, that continued support post release reinforces continued engagement in treatment and increases reintegration time in the community for those released with OUD or SUD from correctional facilities. This demonstration seeks to build on NHDOC SOR outcomes described in the following section by further strengthening continuity of care during a known high-risk period for relapse and overdose.

## NHDOC SOR Program Outcomes

The charts below reflect data from reentry care coordinators providing services to females and males who were released while receiving Targeted Case Management (TCM) and their ability to stay in the community post release from the start of the program in June 2018 for women & August 2019 for men until the program was put on hold in September 2020 due to funding issues. Female participants remained in the community at rates of 90% after 3 months, 81% after 6 months, 70% after 9 months, and 60% after 12 months. Male participants had community retention rates of 87%, 83%, 75%, and 71%, respectively.

### Females Released from Incarceration Receiving TCM, 2018-2020

Month/Year	Released # of Individuals Receiving TCM (Females)	3 Month	6 Month	9 Month	12 Month
June 2018	3	3	3	2	2
July 2018	5	5	4	3	2
August 2018	6	6	5	3	3
September 2018	5	4	2	1	1
October 2018	10	10	10	8	8
November 2018	3	3	2	1	1
December 2018	8	8	7	6	5
January 2019	7	6	5	4	3
February 2019	5	5	3	2	2
March 2019	12	12	12	11	9
April 2019	15	13	11	9	8
May 2019	13	13	11	11	10
June 2019	14	14	11	11	9
July 2019	10	9	9	9	8
Aug 2019	6	4	4	4	2
Sept 2019	11	9	8	8	8
October 2019	10	9	8	8	N/A
November 2019	12	10	10	7	N/A
December 2019	7	6	6	5	N/A
January 2020	12	11	11	N/A	N/A
February 2020	6	5	4	N/A	N/A
March 2020	7	5	5	N/A	N/A
April 2020	4	4	N/A	N/A	N/A
May 2020	4	2	N/A	N/A	N/A
June 2020	6	6	N/A	N/A	N/A
July 2020	8	N/A	N/A	N/A	N/A
August 2020	8	N/A	N/A	N/A	N/A
September 2020	6	N/A	N/A	N/A	N/A
<b>Total</b>	<b>217</b>	<b>182 of 201</b>	<b>151 of 187</b>	<b>113 of 162</b>	<b>81 of 133</b>
<b>% in Community</b>		<b>90%</b>	<b>81%</b>	<b>70%</b>	<b>60%</b>

### Males Released from Incarceration Receiving TCM, 2019-2020

Month/Year	Released # of Individuals Receiving TCM (Males)	3 Month	6 Month	9 Month	12 Month
August 2019	30	28	26	26	22
September 2019	32	26	24	24	22
October 2019	32	25	21	19	N/A
November 2019	21	20	20	19	N/A
December 2019	36	32	30	25	N/A
January 2020	25	25	22	N/A	N/A
February 2020	11	11	11	N/A	N/A
March 2020	2	2	2	N/A	N/A
April 2020	3	1	N/A	N/A	N/A
May 2020	4	3	N/A	N/A	N/A
June 2020	12	9	N/A	N/A	N/A
July 2020	16	N/A	N/A	N/A	N/A
August 2020	18	N/A	N/A	N/A	N/A
September 2020	13	N/A	N/A	N/A	N/A
<b>Total</b>	<b>255</b>	<b>182 of 209</b>	<b>156 of 189</b>	<b>113 of 151</b>	<b>44 of 62</b>
<b>% in Community</b>		<b>87%</b>	<b>83%</b>	<b>75%</b>	<b>71%</b>

The Charts below reflects data from reentry care coordinators providing services to males and females who were released while receiving TCM and their ability to stay in the community post release. These data are from the program restart of April 2021 through December 2021.

### Females Released from Incarceration Receiving TCM, 2021

Month/Year	Released # of Individuals Receiving TCM (Females)	3 Month	6 Month	9 Month	12 Month
April 2021	7	7	7	N/A	N/A
May 2021	4	4	4	N/A	N/A
June 2021	4	3	2	N/A	N/A
July 2021	6	6	N/A	N/A	N/A
August 2021	5	4	N/A	N/A	N/A
September 2021	2	2	N/A	N/A	N/A
October 2021	6	N/A	N/A	N/A	N/A
November 2021	8	N/A	N/A	N/A	N/A
December 2021	7	N/A	N/A	N/A	N/A
<b>Total</b>	<b>49</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>% in Community</b>	<b>100%</b>	<b>93%</b>	<b>93%</b>	<b>N/A</b>	<b>N/A</b>



### Males Released from Incarceration Receiving TCM, 2021

Month/Year	Released # of Individuals Receiving TCM(Males)	3 Month	6 Month	9 Month	12 Month
April 2021	9	7	7	N/A	N/A
May 2021	16	16	10	N/A	N/A
June 2021	3	3	3	N/A	N/A
July 2021	4	4	N/A	N/A	N/A
August 2021	13	10	N/A	N/A	N/A
September 2021	15	N/A	N/A	N/A	N/A
October 2021	15	N/A	N/A	N/A	N/A
November 2021	16	N/A	N/A	N/A	N/A
December 2021	10	N/A			
<b>Total</b>	101	N/A	N/A	N/A	N/A
<b>% in Community</b>	<b>100%</b>	<b>89%</b>	<b>77%</b>	<b>N/A</b>	<b>N/A</b>

In comparison with NHDOC’s trending recidivism rates by year post release, the SOR outcomes show that TCM helps increase reintegration rates for those with SUD post release.

### III. Waiver and Expenditure Authorities Requested

The State requests expenditure authority for Medicaid State Plan services furnished to otherwise eligible individuals who are primarily receiving treatment for SUD, OUD, SMI, or SED who are short-term residents in hospitals or residential facilities that meet the definition of an IMD as defined in section 1905(i) of the *Social Security Act* (as amended). This authority requires waiver of requirements specified within §1905(a)(31)(B) of the *Social Security Act* (as amended), 42 CFR §438.6(e), 42 CFR §435.1010, and 42 CFR §441.11(c)(2) and (5), as well as any other related federal regulations.

The State also requests expenditure authority for a tailored package of Medicaid State Plan services furnished to otherwise eligible individuals who are receiving treatment for SUD, OUD, SMI, or SED who are inmates of a public institution. This authority requires waiver of §1905(a)(31)(A) of the *Social Security Act* (as amended), 42 CFR §435.1010, as well as any other related federal regulations.

No additional waivers of Title XIX are requested through this extension application. All other initiatives and proposed program enhancements will be implemented through other authorities outside of this demonstration.

The State is requesting a five-year extension of the authorities granted by the currently approved STCs dated June 2, 2022. This demonstration extension would be effective from July 1, 2023, through June 30, 2028. The State looks forward to discussing with CMS the timing for implementing demonstration authority for the Community Reentry component of the demonstration, which would take effect upon approval and be effective through June 30, 2028.

## IV. Documentation of Quality of and Access to Care Provided Under the Demonstration

### EQRO Reports

The State's External Quality Review Organization (EQRO) has not conducted any special studies specific to the SUD component of the demonstration. The SMI/SED component of the demonstration has not been effective long enough to be reflected in any potential EQRO reporting.

### Access and Quality of Care Measures

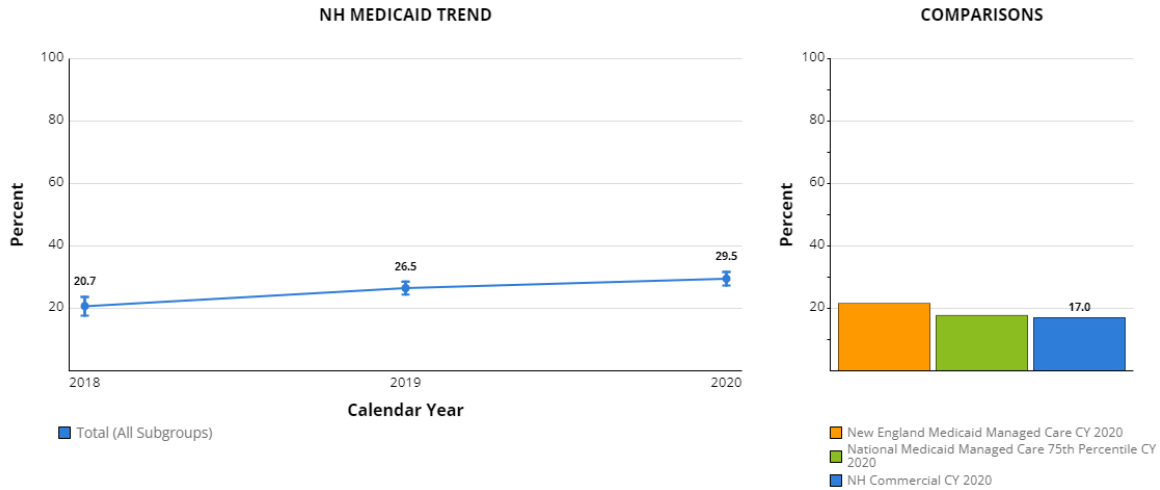
The State's Medicaid Quality Program (MQP) supports DHHS in improving the health and well-being of Medicaid beneficiaries through data-driven oversight and development of policy and programs, while leading quality assurance and improvement activities.

MQP created a website with funding provided by the grant program outlined under the Catalog of Federal Domestic Assistance Number 93.609 from CMS. This website is a platform for the Medicaid Quality Information System (MQIS) to manage the submission, storage, evaluation and publishing of information. MQIS provides robust capabilities for MQP to conduct a wide variety of data analysis, quality program, and activities. Specifically, MQIS tracks the following metrics that relate to access and quality of care under the SUD component of the demonstration.

See the next few pages for charts and descriptions of select metrics from MQIS.

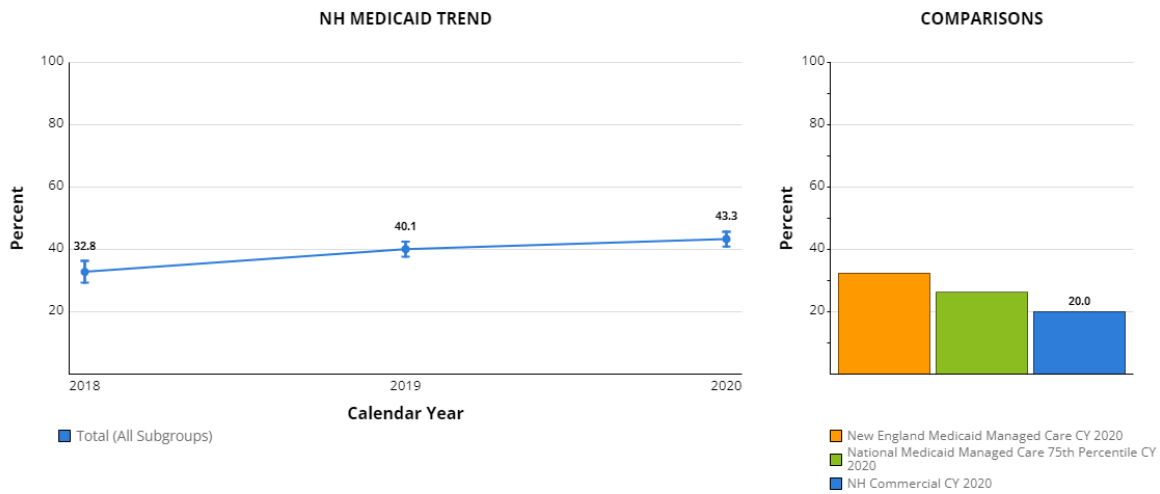
**Follow-up after ED visit for alcohol and other drug dependence (FUA) – 7-Day and 30-Day rates have increased and are above the national 75<sup>th</sup> percentile of Medicaid health plans.**

Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) Within 07 days



Data Qualifiers:  
The aggregated values do not include data for all organizations. Customize this report by organization for details.

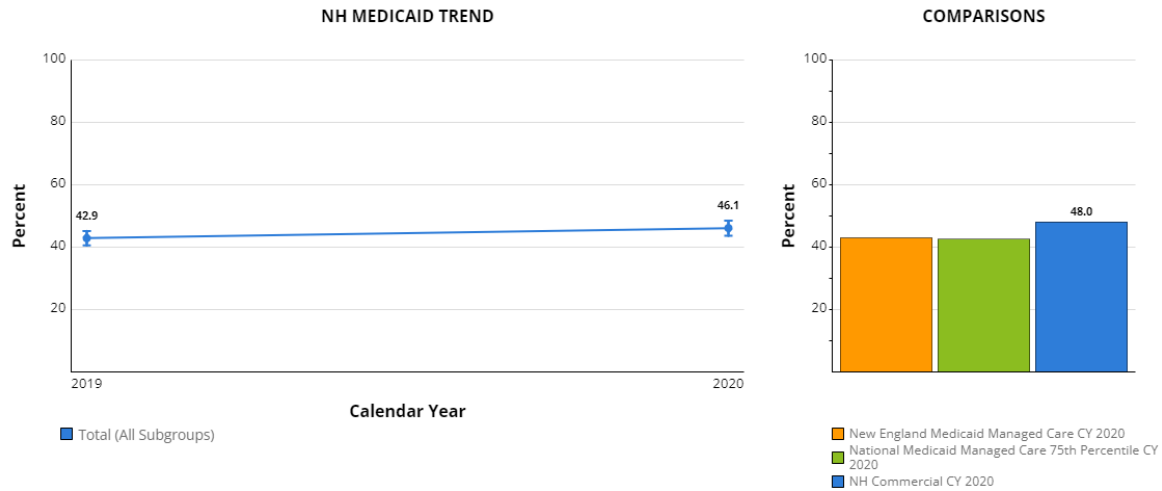
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) within 30 days



Data Qualifiers:  
The aggregated values do not include data for all organizations. Customize this report by organization for details.

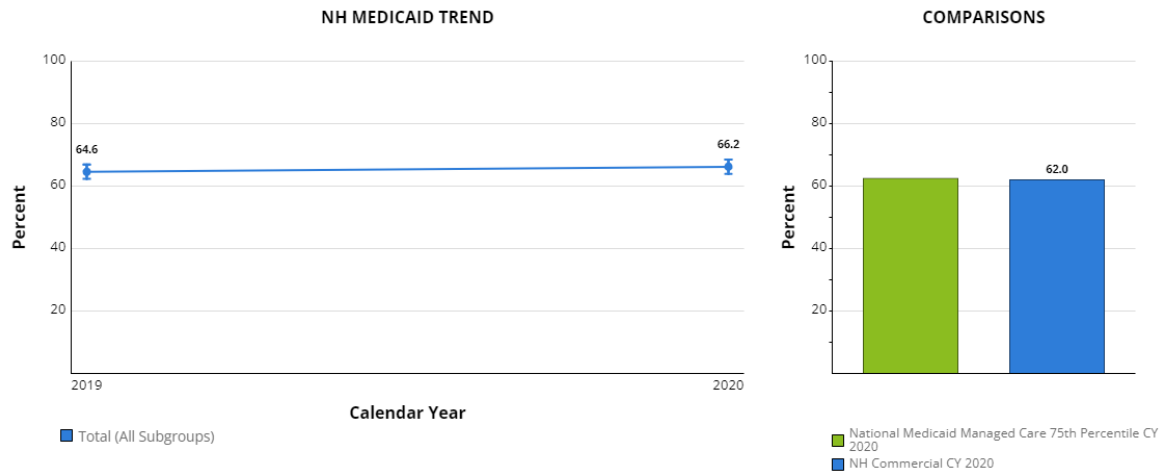
**Follow-up after acute inpatient hospitalization, residential treatment or detoxification visit for substance use disorder (FUI) – 7-Day and 30-Day rates have increased and are above the national 75<sup>th</sup> percentile of Medicaid health plans.**

Follow-Up after High-Intensity Care for Substance Use Disorder (FUI) within 07 Days



Data Qualifiers:  
The aggregated values do not include data for all organizations. Customize this report by organization for details.

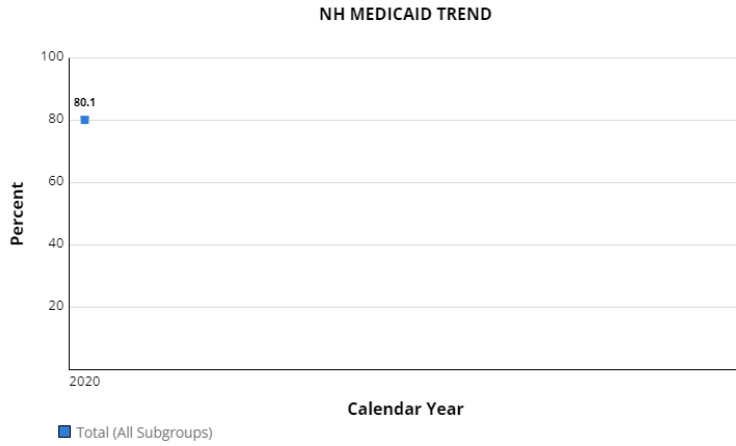
Follow-Up after High-Intensity Care for Substance Use Disorder (FUI) within 30 Days



Data Qualifiers:  
The aggregated values do not include data for all organizations. Customize this report by organization for details.

**Use of pharmacotherapy for OUD. 2020 data show that 80% of individuals with an OUD accessed pharmacotherapy for their treatment.**

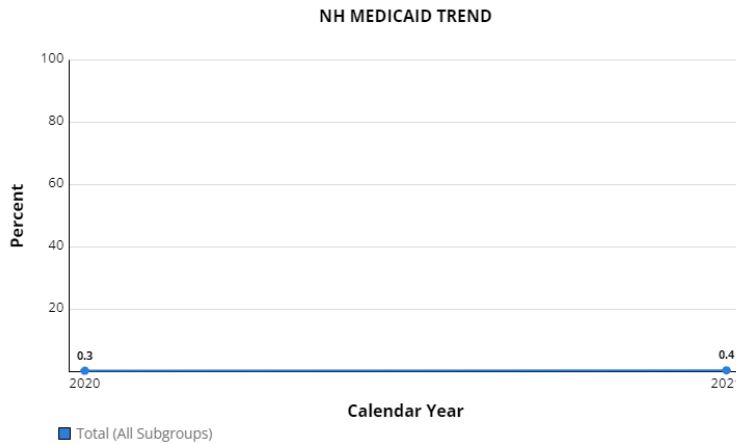
### Use of Pharmacotherapy for Opioid Use Disorder - Total



*Data Qualifiers:  
The aggregated values do not include data for all organizations. Customize this report by organization for details.*

**Medicaid members seeking treatment for an SUD in an IMD has increased from 2020 to 2021.**

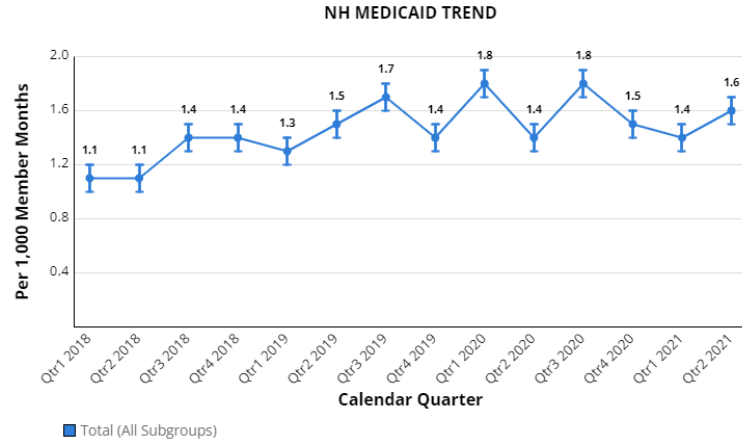
### SUD Diagnosis Treated in an IMD by Subpopulation



*Data Qualifiers:  
The aggregated values do not include data for all organizations. Customize this report by organization for details.*

## Use of the ED for SUD continues to stabilize.

### Emergency Department Visits - Substance Use Disorder and Substance Misuse Related Conditions

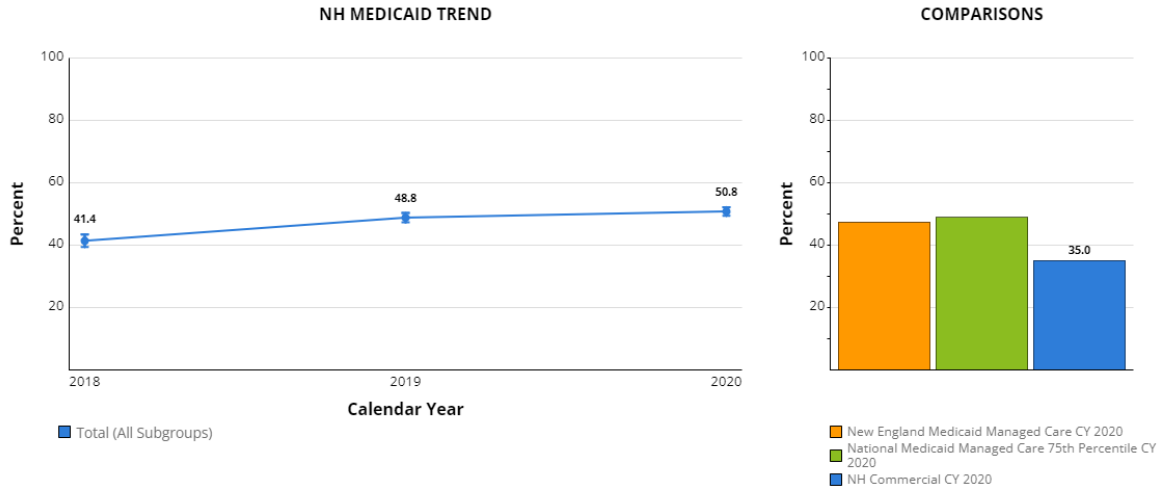


Data Qualifiers:

The aggregated values do not include data for all organizations. Customize this report by organization for details.

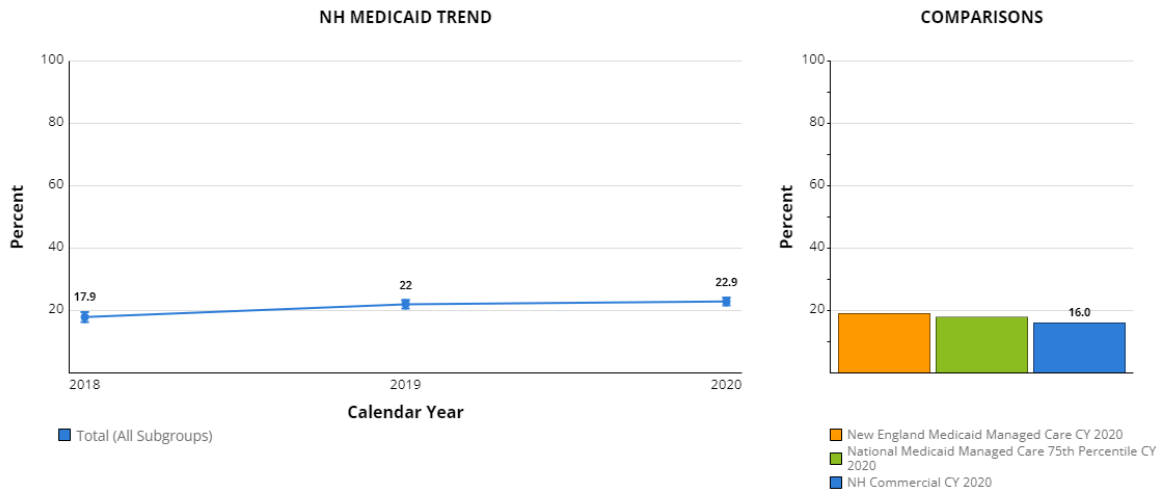
**Initiation and engagement of alcohol and other drug abuse or dependence treatment continues to increase and is above the national 75<sup>th</sup> percentile of Medicaid health plans.**

Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET)



Data Qualifiers:  
The aggregated values do not include data for all organizations. Customize this report by organization for details.

Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)



Data Qualifiers:  
The aggregated values do not include data for all organizations. Customize this report by organization for details.

**CMS 416**

The CMS 416 report doesn't provide data related to the demonstration population.

## V. Historical and Projected Expenditures

### Projected Enrollment and Expenditures

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

Below are the projected enrollment and expenditures for each year of the demonstration extension by component of the demonstration.

#### Substance Use Disorder IMD Component

	SFY24	SFY25	SFY26	SFY27	SFY28
Member Months	5,772	5,888	6,005	6,125	6,248
Average Monthly Members	481	491	500	511	521
Expenditures	\$7,582,263	\$8,109,905	\$8,674,266	\$9,277,899	\$9,923,539

#### Serious Mental Illness/Serious Emotional Disturbance IMD Component

	SFY24	SFY25	SFY26	SFY27	SFY28
Member Months	990	1,010	1,030	1,051	1,072
Average Annual Members	523	533	544	554	566
Expenditures	\$9,041,187	\$9,670,334	\$10,343,261	\$11,063,016	\$11,832,856

#### Community Reentry Component

	SFY24	SFY25	SFY26	SFY27	SFY28
Member Months	869	887	904	923	941
Individual Members	588	599	611	624	636
Expenditures	\$212,557	\$227,432	\$243,347	\$260,378	\$278,598

### Budget Neutrality

Refer to Attachments 1 (IMD) and 2 (Community Reentry) for the State's historical and projected expenditures for the requested period of the demonstration extension.

### Maintenance of Effort

New Hampshire's rationale for requesting this authorization is not limited to increasing inpatient bed capacity. 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 expansion of the CTI program to all 10 regions of the state as of July 1, 2022, and the integration of statewide mobile crisis response services with 9-8-8 within the NH Rapid Response Access Point.



## VI. Draft Interim Evaluation Report

See Attachment 3 for the [Draft Interim Evaluation Report](#).

## VII. 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 extension and notice of public hearings was advertised in the newspapers of widest circulation (*Union Leader*, *The Telegraph*) and sent to an electronic mailing list maintained by DHHS. In addition, the public notice was posted to the State's Medicaid website at <https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-waivers-and-demonstrations>, which was subsequently advertised on social media (Facebook and Twitter). See Attachment 4 for a copy of the website and social media content, public notice, slides used at the hearings, and newspaper tear sheets.

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

Public Hearing #1 in Manchester, NH  
August 10, 2022, at 5:30pm

Join Zoom Meeting

<https://nh-dhhs.zoom.us/j/88652187407?pwd=NGdGejFVMXlQd243WWw3NUtNZXlSdz09>

Meeting ID: 886 5218 7407

Passcode: 704376

One tap mobile

+13126266799,,88652187407#,,,,\*704376# US (Chicago)

+16465588656,,88652187407#,,,,\*704376# US (New York)

Public Hearing #2 in Littleton, NH

August 18, 2022, at 5:00pm

Join Zoom Meeting

<https://nh-dhhs.zoom.us/j/84904266940?pwd=Sk9tbjVRT29KdE5RRitxOE9qVXh6dz09>

Meeting ID: 849 0426 6940

Passcode: 704376

One tap mobile

+13017158592,,84904266940#,,,,\*704376# US (Washington DC)

+13126266799,,84904266940#,,,,\*704376# US (Chicago)

Comments on this extension request were also considered at the August Medical Care Advisory Committee (MCAC) meeting held on August 8, 2022, 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 4.

### 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 9:00am on August 8, 2022, through 5:00pm on September 6, 2022. The following options were available for the public to share feedback:

### 1. E-mail

- a. Carolyn Richards was the designated point of contact to receive public comments and monitored her own individual email, [carolyn.s.richards@dhhs.nh.gov](mailto:carolyn.s.richards@dhhs.nh.gov), as well as [SUD-SMI.1115.Extension@dhhs.nh.gov](mailto:SUD-SMI.1115.Extension@dhhs.nh.gov), a dedicated mailbox for comments.
- b. See Attachment 4 for emailed stakeholder letters received from the following organizations/individuals:
  - i. Mr. Germano Martins, MBA;
  - ii. Governor's Commission on Alcohol & Other Drugs;
  - iii. Mr. Kenneth Norton, LICSW;
  - iv. findhelp;
  - v. NAMI | New Hampshire; and
  - vi. Disability Rights Center – NH.

### 2. Mailed

- a. Carolyn Richards was the designated point of contact for public comments and received mail at the following address:

Carolyn Richards  
NH Department of Health and Human Services  
Attn: SUD-SMI-SED-TRA Demonstration Extension  
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 4 for a summary of testimony from the public hearings. There were no attendees either in person or using virtual options for the public hearing in Manchester. A meeting record for the public hearing in Littleton is included in Attachment 4.
- b. The following individuals offered verbal comments that are summarized in the table below:
  - i. Ms. Holly Stevens, MCAC Chair;
  - ii. Ms. Carolyn Virtue, Granite Case Management;
  - iii. Ms. Susan Stearns, NAMI | New Hampshire;
  - iv. Ms. Karen Rosenberg, Disability Rights Center – NH;
  - v. Ms. Kelley Capuchino, NH Behavioral Health Association;
  - vi. Ms. Jodi Nelson, Candidate for State Representative from Keene;
  - vii. Mr. Jarrett Stern, Vice President at Littleton Regional Healthcare; and
  - viii. Mr. Nicholas Germana, Candidate for State Representative from Keene.

The following table summarizes the comments received (verbally and in writing) and responses

from the State:

Comment Theme	Interested Parties	State Response
Generally supportive of extending existing demonstration authorities with no specific modifications requested to those existing authorities.	Governor’s Commission on Alcohol & Other Drugs; Mr. Kenneth Norton, LICSW; findhelp; NAMI   New Hampshire; Ms. Jodi Nelson; Mr. Nicholas Germana	DHHS very much appreciates the support and looks forward to partnering together with these and all stakeholders to implement the demonstration authority.
Generally supportive of adding proposed Community Reentry component to the demonstration.	Governor’s Commission on Alcohol & Other Drugs; Mr. Kenneth Norton, LICSW; findhelp; NAMI   New Hampshire; Mr. Nicholas Germana	DHHS very much appreciates the support and looks forward to partnering together with these and all stakeholders to implement the demonstration authority.
Recommendation for further clarification regarding the acronym “SUD-SMI-SED-TRA.”	Mr. Germano Martins, MBA	DHHS acknowledges this feedback and observes that this acronym is defined in the public comment materials posted on the website and in the newspapers. Additionally, DHHS modified future public hearing reminder emails to spell out this acronym.
What will be the impact of this demonstration on DRFs [Designated Receiving Facilities]?	Ms. Holly Stevens	Typically, the term DRF refers to a small, specialized unit within a larger general hospital. In such cases, this type of DRF would not be impacted by the demonstration. Currently, no existing DRFs—with the exceptions of New Hampshire Hospital and Hampstead Hospital—are considered to be IMDs in New Hampshire.
How does the demonstration impact mental health supports for the aging and elderly whose needs can’t always be met through the CFI waiver?	Ms. Carolyn Virtue	Although beneficiaries directly impacted by the demonstration are those under 65 years of age, ongoing investments in community-based care that are indirectly associated with the demonstration are designed to expand access

Comment Theme	Interested Parties	State Response
		to community-based services for all individuals regardless of age.
What is the likelihood that the Community Reentry program would be expanded to the county jails in the future?	Mss. Susan Stearns and Holly Stevens	The State aims to first demonstrate success in the distinct environment and population associated with the state prison system. NH may seek to expand the option to the ten county jail systems to participate once NH has demonstrated success in the state prison system.
Would this demonstration provide FMAP only for SMI stays? What authorities would this demonstration grant?	Ms. Karen Rosenberg	The demonstration extension would continue all the original authorities (SUD & SMI/SED IMD stays), while also adding the newly proposed Community Reentry component. In this context, the term SMI encompasses the admitting criteria for an acute psychiatric hospitalization, inclusive of patient need regardless of involuntary or voluntary status or other legal proceedings.
Would this demonstration include settings outside New Hampshire Hospital and Hampstead Hospital?	Ms. Kelley Capuchino	New Hampshire Hospital and Hampstead Hospital are the only two IMDs currently included in the SMI/SED component of the demonstration. Future IMDs seeking to participate would need to meet DHHS requirements for participation. Such facilities are in addition to the existing IMDs that operate under the SUD component of the demonstration.
Clarification regarding whether Doorways funding is	Mr. Jarrett Stern	Doorways funding is primarily provided at the federal level

<b>Comment Theme</b>	<b>Interested Parties</b>	<b>State Response</b>
distinct from state funding for community-based programs.		through SAMHSA, although some other funds have also been provided to support Doorways.
Request for further information regarding member months and how the projection for budget neutrality is calculated.	Mr. Nicholas Germana	Member months are the number of collective months in which members are in an IMD, counted as a full month regardless of the stay duration. For example, an individual who stayed in the IMD for 1.5 months would count for 2 member months since that person was in an IMD during two separate months. Member months are then aggregated together for all individuals. On average, CMS wants the stay to be less than 30 days, with a limit of 60 days to have federal participation. This measures the number of days and people in the institutionalized setting. Then they look at the cost of funding them actual vs projected. If it's less than projected, it's budget neutral. If the State does not achieve budget neutrality, there is a risk they would be obligated to pay some of that money back to the federal government. DHHS, with input from its actuaries, negotiated a cap for expenditures with CMS.
Extending a demonstration waiver which incentivizes the development and placement of individuals with mental illness in IMDs will not solve the fundamental deficiencies in New Hampshire's behavioral health system for individuals who are enrolled in Medicaid.	Disability Rights Center – NH	DHHS does not concur. Ensuring that individuals who are enrolled in Medicaid have access to the services that meet their needs, inclusive of inpatient psychiatric needs, is the fundamental purpose of this demonstration. Short-term stays are an integral part of the demonstration but are combined with enhanced

Comment Theme	Interested Parties	State Response
		<p>discharge planning that includes community-based providers. Continuing Medicaid eligibility for those services streamlines access to the full continuum of care and expedites transition to community-based services. There is no incentivization because there is no increase in reimbursement rates for this demonstration and there are significant budget neutrality requirements. In fact, CMS monitors budget neutrality on a quarterly basis, which serves as a financial circuit breaker to ensure that reliance on institutional levels of care is not expanded.</p>
<p>New Hampshire has an adequate supply of psychiatric hospital beds.</p>	<p>Disability Rights Center – NH</p>	<p>DHHS does not concur. The 10-Year Mental Health Plan, a public document approved by the NH Legislature in 2019, was the product of an extensive, two-year process of consultation and collaboration that engaged a broad group of stakeholders. Part of this Plan involved the expansion of the demonstration waiver to include beneficiaries with SMI/SED (Plan Recommendation #2). One of the goals of the SMI/SED component of the demonstration is to reduce wait times in EDs prior to admission to an IMD, which occurs in part due to an inadequate supply of psychiatric hospital beds. The SUD-TRA demonstration had shown sufficiently positive benefits that the SMI/SED stakeholders sought an equitable approach for their</p>

Comment Theme	Interested Parties	State Response
		population.
<p>New Hampshire continues to add beds rather than expend the necessary resources to ensure [it] has an adequate array of community-based treatment options and supports for individuals with serious mental illness.</p>	<p>Disability Rights Center – NH</p>	<p>DHHS does not concur. As discussed in the row above, the 10-Year Mental Health Plan set a comprehensive direction for the State to move forward. It includes multiple improvements to community-based treatment options. As a result, NH has expanded non-psychiatric hospital beds such as supported residential beds and crisis beds, step-up and step-down beds, expanded community crisis services to all regions of the state and supported these services with modern technological advancements, and raised provider reimbursement rates to incentivize providers and provide funding that may help address the workforce shortages. Additionally, post conclusion of the 1115(a) DSRIP Demonstration, the State authorized the continuation of promising practices, such as CTI (which is currently being expanded from that initial pilot program to all regions of the state), event notification and closed loop referrals, all of which expand community-based treatment options and support streamlined access thereto. At the same time, the public health emergency has greatly increased the number of people experiencing a mental health crisis for the first time and who are in need of acute care such as short-term stays in psychiatric hospitals. Limiting expansion of services to community-based services alone would</p>

Comment Theme	Interested Parties	State Response
		restrict access to needed care for this expanded population.
Publicly available data does not support expansion of New Hampshire's IMD beds.	Disability Rights Center – NH	DHHS does not concur. In addition to the 10-Year Mental Health Plan and the expanded demand noted in the row above, there is litigation related to the fact that individuals subject to involuntary emergency admission (IEA) certificates are waiting in hospital EDs for IMD beds to become available. Expediting individuals' access to acute psychiatric care such as that offered by IMDs will reduce the number of individuals waiting for such services in EDs, which are typically not equipped to provide acute psychiatric care. These individuals have been clinically certified to be in need of inpatient-level psychiatric care; providing only community-based care would be insufficient to meet their needs.
Over the last two years New Hampshire's reliance on institutionalization of individuals with mental illness has continued to increase.	Disability Rights Center – NH	DHHS does not concur. DHHS has been reducing reliance on institutionalization since at least December 2018. As detailed on page 3 of the <a href="#">most recent NH Community Mental Health Agreement quarterly data reporting</a> , a higher percentage of community-based services are being provided and reliance on inpatient psychiatric service has been reduced.
The Emergency Room Boarding Problem should be	Disability Rights Center – NH	DHHS concurs in part and does not concur in part for



<b>Comment Theme</b>	<b>Interested Parties</b>	<b>State Response</b>
<p>addressed through further development of New Hampshire's Community-Based Treatment and Support options; not by increasing the State's reliance on institutional psychiatric beds.</p>		<p>the reasons noted in the rows above. While DHHS is further developing community-based treatment, the individuals waiting in a hospital ED for acute psychiatric care have been clinically certified to need inpatient-level psychiatric care. Providing only community-based care would be insufficient to meet their needs.</p>
<p>New Hampshire's community-based behavioral health providers are facing unprecedented workforce challenges. Increasing the State's investment in inpatient psychiatric services will further strain the ability of community-based providers to recruit and retain staff and exacerbate challenges to the development of an adequate array of community-based treatment and support services.</p>	<p>Disability Rights Center – NH</p>	<p>DHHS concurs in part and does not concur in part. NH, like many states, is experiencing behavioral healthcare workforce shortages. That does not mean DHHS should not continue to seek to provide the services that are necessary. Individuals have access to the right level of care at the right time. The demonstration will contribute to that balance in the continuum of care. NH, like other states, is pursuing a variety of initiatives to develop the behavioral healthcare workforce. Having a more robust and diverse continuum of behavioral health care in NH would be a positive factor in terms of drawing more clinical and professional talent to the State (i.e., talent acquisition), which, in turn, creates more options for career development and advancement for the existing workforce (i.e., talent retention).</p> <p>In addition, in an effort to help address the workforce shortage, NH is allocating ARPA 9817 HCBS Spending</p>

Comment Theme	Interested Parties	State Response
		Plan funds to direct care workers in Community Mental Health Centers (CMHCs) through a \$5.16 million directed payment to help stabilize the HCBS workforce overall. There has also been another directed payment in place to the CMHCs under the MCO contract since July 1, 2018, that includes fidelity requirements for ACT teams. This payment is used to strengthen the sustainability of the ACT teams and incentivize qualified professionals to join and remain in the CMHC workforce.

### Changes Subsequent to Public Comment

Following conclusion of the public comment period, DHHS made the following changes to the version of this document that was first made available to the public on August 8, 2022:

1. [Section VII – Public Notice and Tribal Consultation](#) was updated to reflect the final logistical details of the public notice and comment period, summary of all feedback received, the State’s response to that feedback, and information regarding the October 2021 post-award forum public input process;
2. [Section V – Historical and Projected Expenditures](#) was updated to reflect the final budget neutrality analysis and projected expenditures received from the State’s actuaries, which was updated as more current information on expenditures became available; and
3. Multiple sections were revised to correct minor typographical errors as well as to standardize the usage of certain acronyms and defined terms for purposes of enhancing readability without changing the meaning.

### Post-award Public Forum

The State held the SUD-TRA demonstration post-award public forum in accordance with 42 CFR §431.420. The post-award public forum was conducted at the MCAC meeting held on October 18, 2021. Notice of this public forum was published on the DHHS website, along with a copy of the presentation slides. There were no questions or concerns received from the public that were related to the SUD-TRA demonstration. See Attachment 4 for a screenshot of the public forum notice that was posted on the DHHS website, the minutes from the MCAC meeting, a copy of the slides from the presentation, and the DY4 Q2 Monitoring Report that included information about the post award public forum and was submitted to CMS on February 28, 2022.

## VIII. Attachments

## 1. Compliance with Budget Neutrality Requirements – IMD



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 Senior Consulting Actuary

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September 28, 2022

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: 1115 IMD Waiver Renewal Budget Neutrality Limits**

Dear Henry:

At your request, we are providing the New Hampshire Department of Health and Human Services (DHHS) with budget neutrality limits for the 1115 waiver renewal of the Substance Use Disorder Treatment and Recovery Access (SUD-TRA) 1115 Demonstration including the SMI/SED amendment. We prepared these budget neutrality limit estimates for final submission to CMS for the waiver renewal process. The waiver renewal will allow DHHS to continue to claim federal financial participation (FFP) for Medicaid enrollees residing in an IMD for substance use disorder and mental health treatment through SFY 2028.

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.

**RESULTS**

Table 1A shows the projected budget neutrality limits by Medicaid Eligibility Group (MEG) for the SFY 2024 through SFY 2028 renewal period for the SUD related MEGs.

<b>Table 1A</b> <b>New Hampshire Department of Health and Human Services</b> <b>1115 IMD Demonstration Waiver Renewal</b> <b>SFY 2024-SFY 2028 Budget Neutrality Limits</b> <b>Substance Use Disorder Related MEGs</b>					
<b>MEG</b>	<b>SFY 2024</b>	<b>SFY 2025</b>	<b>SFY 2026</b>	<b>SFY 2027</b>	<b>SFY 2028</b>
Medicaid Adults	\$1,675	\$1,756	\$1,842	\$1,931	\$2,025
Expansion Adults	1,266	1,328	1,392	1,460	1,531
Adolescents	1,023	1,073	1,126	1,181	1,239

Table 1B shows the projected budget neutrality limits by MEG for the SFY 2024 through SFY 2028 renewal period for the mental health related MEGs.

<b>Table 1B</b> <b>New Hampshire Department of Health and Human Services</b> <b>1115 IMD Demonstration Waiver Renewal</b> <b>SFY 2024-SFY 2028 Budget Neutrality Limits</b> <b>Mental Health Related MEGs</b>					
<b>MEG</b>	<b>SFY 2024</b>	<b>SFY 2025</b>	<b>SFY 2026</b>	<b>SFY 2027</b>	<b>SFY 2028</b>
Medicaid Adults	\$10,243	\$10,741	\$11,263	\$11,811	\$12,385
Expansion Adults	7,183	7,532	7,898	8,282	8,684

Our projections of historical data through the demonstration period use estimates of the President's Budget trend rates developed from the 2018 Actuarial Report on the Financial Outlook for Medicaid prepared by CMS' Office of the Actuary (OACT), as follows:

- 4.9% for Medicaid Adults
- 4.9% for Expansion Adults
- 4.9% for Adolescents

Please note, the MEG structure is consistent with the current amended SUD-TRA 1115 IMD Waiver.

## METHODOLOGY

We developed historical base year costs in the budget neutrality template separately for the SUD and mental health related MEGs.

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.
- Alternate Development: The bottom section requires the input of the total estimated expenditures services provided while 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.

### 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 individual is a patient in an IMD for 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

For the SUD related MEGs, we summarized actual CY 2019 costs and member months under the current waiver from supplemental files supporting the quarterly waiver monitoring reports.

For mental health related MEGs, we summarized actual CY 2019 FFS 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. We included the CY 2019 MCM capitation payments to the historical costs for MCM enrollees.

### Alternate Development

We developed an estimated projected 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 2023 costs and is discussed in more detail below.

Under the waiver, there will continue to be some eligible individuals who will be enrolled in FFS; therefore, we included the FFS and MCM data to calculate a blended PMPM using the historical proportion of MCM and FFS member months eligible for this waiver.

### [Estimated Eligible Member Months for All Medical Assistance Provided in an IMD](#)

We used estimated SFY 2023 member months Medicaid enrollees who could be eligible for medical assistance provided in an IMD for both the SUD and mental health related MEGs.

### [Managed Care PMPM](#)

We calculated the expenditures for individuals enrolled in standard FFS Medicaid and MCM separately and combined them to create our projected SFY 2023 costs.

For SUD related MEGs, we summarized waiver experience from Demonstration Year 4 (DY 4) which represents SFY 2022 (July 2021 through June 2022) to which we applied a completion factor to adjust for claims liability runout and annualized the results. We also applied an adjustment at the rate cell level to convert the capitation rate base data from SFY 2022 to SFY 2023. We also applied an adjustment to account for anticipated changes in the rate cell mix by MEG following the end of the COVID-19 pandemic and public health emergency. The underlying rate cell mix will be impacted by the end of public health emergency and resumption of Medicaid enrollment redeterminations.

For the mental health related MEGs, we summarized SFY 2023 MCM capitation rate expenditures for the CY 2019 membership distribution of individuals residing in a IMD for mental health purposes.

The capitation expenditures include base rates, directed payments and an estimate for hospital inpatient psychiatric admission kick payments.

Additionally, we added expenditures for known expansions to Medicaid covered services and / or program changes including:

- Non-Emergency Medical Transportation (NEMT) provider reimbursement increases
- Critical Access Hospital (CAH) provider reimbursement increases

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

For the mental health related MEGs, we summarized carved-out non-IMD expenditures currently covered on a FFS basis outside the MCM program that reflect the average cost by MEG for these services. We used the actual cost for these services while Medicaid enrollees are 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 found that IMD residents do not incur any expenditures for any carved-out services while residing in an IMD. Therefore, no additional adjustments were necessary.

For the SUD related MEGs, we trended the SFY 2022 (July 2021 through June 2022) expenditure labeled as FFS to the same SFY 2023 base period using the estimated change in capitation rates between SFY 2022 and SFY 2023.

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

For the SUD related MEGs, we have not reported IMD costs separately since they have been included in the MCM capitation rates for several years. As for IMD expenditures for the FFS population, the data provided by DHHS did not separately identify these expenses, so we are unable to report them separately.

For the mental health related MEGs, we only included the IMD expenditures for the FFS population. The IMD expenditures for the MCM population are included in the SFY 2023 MCM capitation rates and reporting those separately would be challenging.

## CAVEATS AND LIMITATIONS ON USE

This letter is designed to assist DHHS with developing budget neutrality limits for the 1115 IMD demonstration waiver renewal. 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 1115 IMD demonstration waiver renewal. 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.

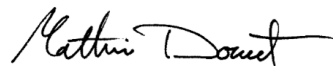
Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this letter.

The terms of Milliman's contract with the New Hampshire Department of Health and Human Services effective July 1, 2022, apply to this letter and its use.



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

Sincerely,



Mathieu Doucet, FSA, MAAA  
Senior Consulting Actuary

MD/laa

Attachment



EXHIBITS  
(Provided in Excel)



2. Compliance with Budget Neutrality Requirements – Community Reentry



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Mathieu Doucet, FSA, MAAA  
 Senior Consulting Actuary

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September 28, 2022

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: 1115 Waiver Budget Neutrality Limit for Department of Correction Population**

Dear Henry:

At your request, we are providing the New Hampshire Department of Health and Human Services (DHHS) with budget neutrality limits for the proposed 1115 IMD demonstration waiver addition for community transition services targeted for those incarcerated in NH Department of Corrections (NHDOC) custody with mental disorders inclusive of substance use disorders transitioning to community release. This addition is included as part of the 1115 waiver renewal of the Substance Use Disorder Treatment and Recovery Access (SUD-TRA) 1115 Demonstration including the SMI / SED amendment.

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 the CMS template forms and related worksheets. The populated CMS budget neutrality template is provided in Excel format.

**RESULTS**

Table 1 shows the projected budget neutrality limits by Medicaid Eligibility Group (MEG) for the SFY 2024 through SFY 2028 renewal period for the substance use disorder (SUD) and mental health related MEGs.

<b>Table 1</b> <b>New Hampshire Department of Health and Human Services</b> <b>1115 IMD Demonstration Waiver Renewal</b> <b>SFY 2024-SFY 2028 Budget Neutrality Limits</b> <b>Department of Correction Population</b>					
<b>MEG</b>	<b>SFY 2024</b>	<b>SFY 2025</b>	<b>SFY 2026</b>	<b>SFY 2027</b>	<b>SFY 2028</b>
Substance Use Disorder	\$235.75	\$247.30	\$259.42	\$272.13	\$285.46
Mental Health	251.21	263.52	276.43	289.98	304.19

**METHODOLOGY**

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
- Alternate Development: The bottom section requires the input of the total estimated expenditures services provided, while in an IMD

Since this population is not currently covered by Medicaid, there is no available historical data to report. Therefore, we used the Alternate Development section of the template to report our cost projections.

### Alternate Development

We developed an estimated projected cost by MEG in the Alternate Development section of the “IMD Historical” tab using information provided by DHHS and NHDOC. Each component of this development represents SFY 2023 costs and is discussed in more detail below.

Table 2 below shows the detailed assumptions used in developing projected costs under this new program.

<b>Table 2</b> <b>New Hampshire Department of Health and Human Services</b> <b>1115 IMD Demonstration Waiver Renewal</b> <b>SFY 2024-SFY 2028 Budget Neutrality Limits</b> <b>Department of Correction Population – Base Projected Costs Development</b>		
Rate Development Component	Substance Use Disorder	Mental Health
Number of Eligible Participants	327	426
Percentage of Eligible Inmates Released per Year	85%	85%
Participation Rate	90%	90%
Program Duration (Days)	45	45
Estimated Member Months	370.1	482.2
Peer Recovery Support Services Per Participant	1.30	N/A
Mental Health Support Services Per Participant	N/A	1.40
New Patient Appointment Services Per Participant	1.00	1.00
Peer Recovery Support Services Fee	\$99.74	N/A
Mental Health Support Services Fee	N/A	108.20
New Patient Appointment Fee	202.77	202.77
<b>Total Estimated Annual Spending</b>	<b>\$83,174</b>	<b>\$115,482</b>
<b>Total Estimated PMPM Cost</b>	<b>\$224.74</b>	<b>\$239.47</b>

Out of the 991 individuals incarcerated as of July 2022, NHDOC estimates that approximately 33% and 43% have substance use disorder and mental health related issues, respectively. Further, NHDOC expects about 85% of inmates are released every year and that 90% of them would participate in the new program for a period of 45 days.

From conversations with NHDOC, we determine that:

- 70% of SUD program participants will get one, one-hour peer recovery support service (H0038), while 30% will get two, one-hour peer recovery support service
- 60% of mental health program participants will get one, one-hour mental health support service (H2015), while 40% will get two, one-hour mental health support service

We also assumed that all participants would also get a one-hour new patient telehealth appointment with a community mental health center (CMHC) provider (99205-HE) before being released from the facility.

All costs are included in the “Absent 1115 Authority, Not Otherwise Eligible for FFP Under Title XIX, or “Costs Not Otherwise Matchable” (“Non-IMD” or “Non-Hypo” CNOMs)” column since all costs included in our projections are not currently eligible for FFP.

Our projections of base program costs through the demonstration period use estimates of the President’s Budget trend rates developed from the 2018 Actuarial Report on the Financial Outlook for Medicaid prepared by CMS’ Office of the Actuary (OACT), as follows:

- 4.9% for Medicaid Adults
- 4.9% for Expansion Adults

These trend estimates are consistent with trends used for the 1115 IMD Waiver renewal.

**Program Funding**

Table 3 shows a summary of Federal and state share funding under different enrollment scenarios between the standard Medicaid population and the Granite Advantage Health Care Program (GAHCP) populations. Results for other enrollment scenarios can be interpolated from the information below.

<b>Table 3            New Hampshire Department of Health and Human Services            1115 IMD Demonstration Waiver Renewal            Program Funding Based on Enrollment Scenarios</b>				
Enrollment Scenario	State Share		Federal Share	Total
	General Funds	Other Funds		
100% Standard Medicaid / 0% GAHCP	\$99,328	\$0	\$99,328	\$198,655
50% Standard Medicaid / 50% GAHCP	29,798	29,798	139,059	198,655
0% Standard Medicaid / 100% GAHCP	0	19,886	178,790	198,655

**CAVEATS AND LIMITATIONS ON USE**

This letter is designed to assist DHHS with developing budget neutrality limits for the addition of the New Hampshire Department of Correction population to the 1115 IMD demonstration waiver renewal. 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 Department of correction population as part of the 1115 IMD demonstration waiver renewal. 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, 2022, apply to this letter and its use.





If you have any questions, please call me at 262 784 2250.

Sincerely,

A handwritten signature in black ink that reads 'Mathieu Doucet'.

Mathieu Doucet, FSA, MAAA  
Senior Consulting Actuary

MD/laa

Attachment - (Provided in Excel)



EXHIBITS  
(Provided in Excel)

### 3. Draft Interim Evaluation Report

***PHPG***

**THE PACIFIC HEALTH POLICY GROUP**

**State of New Hampshire  
Substance Use Disorder Treatment and  
Recovery Access Section 1115 Medicaid  
Demonstration 11-W-00321/1**



**Draft Interim Evaluation Report**

**Submitted to CMS June 24, 2022**



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## List of Abbreviations

<b>ANOVA</b>	Analysis of Variance
<b>AOD</b>	Alcohol and Other Drug
<b>ASAM</b>	American Society of Addiction Medicine
<b>BN</b>	Budget Neutrality
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>CY</b>	Calendar Year
<b>DHHS</b>	New Hampshire Department of Health and Human Services
<b>DSRIP</b>	Delivery System Reform Incentive Program
<b>DY</b>	Demonstration Year
<b>ED</b>	Emergency Department
<b>FFS</b>	Fee-for-Service
<b>HCPCS</b>	Healthcare Common Procedure Coding System
<b>HEDIS</b>	Healthcare Effectiveness Data and Information Set
<b>IDN</b>	Integrated Delivery Network
<b>IET</b>	Initiation and Engagement in Treatment
<b>IMD</b>	Institution for Mental Diseases
<b>IP</b>	Inpatient
<b>LTC</b>	Long Term Care
<b>MAT</b>	Medication Assisted Treatment
<b>MCO</b>	Managed Care Organization
<b>MMIS</b>	Medicaid Management Information System
<b>NCQA</b>	National Committee for Quality Assurance
<b>NPI</b>	National Provider Identifier
<b>ODU</b>	Opioid Use Disorder
<b>PAP</b>	Premium Assistance Program
<b>PHE</b>	Public Health Emergency
<b>PHPG</b>	Pacific Health Policy Group
<b>PMPM</b>	Per Member Per Month
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SFY</b>	State Fiscal Year
<b>STC</b>	Special Terms and Conditions
<b>SUD</b>	Substance Use Disorder

## EXECUTIVE SUMMARY

CMS approved the New Hampshire Substance Abuse Treatment and Recovery Access Section 1115 Demonstration on July 10, 2018, for a five-year term ending June 30, 2023. The New Hampshire Demonstration is designed to maintain critical access to opioid use disorder (OUD) and other substance use disorder (SUD) treatment services and continue delivery system improvements to support coordinated and comprehensive OUD/SUD treatment for Medicaid enrollees. The Demonstration authorizes New Hampshire to provide high-quality, clinically appropriate SUD treatment services for short-term stays in residential and inpatient treatment settings that qualify as Institutions for Mental Disease (IMDs).

The SUD Demonstration was developed to encourage growth in SUD residential treatment capacity (IMD and non-IMD), to build on existing efforts to improve models of care that focus on supporting enrollees in their homes and communities, and to strengthen the New Hampshire continuum of SUD services. The Department of Health and Human Services (DHHS) identified three overarching goals for the SUD Demonstration:

1. Improve access to OUD and other SUD services;
2. Improve the quality of the SUD treatment delivery system to provide high-quality coordinated and comprehensive OUD/SUD treatment for Medicaid enrollees; and
3. Maintain budget neutrality.

Evaluation questions, hypothesis and performance measures are associated with each of the overarching goals of Demonstration. This is the Interim Evaluation report as required by the SUD Demonstration's Special Terms and Conditions (STC 36). The evaluation was performed in accordance with the approved Evaluation Design for Demonstration Years One through Three (July 1, 2018 - June 30, 2021), with an established baseline period of July 1, 2017 - June 30, 2018.

The approved evaluation design examines service utilization (Emergency Department and IMD) and engagement in treatment for Medicaid members with an SUD. In addition, adults receiving treatment in an IMD were identified to provide a focus on the utilization trends and outcomes for those members receiving IMD services specifically authorized under the Demonstration.

Overall, the New Hampshire SUD Treatment and Recovery Access Demonstration is associated with improved access to care for those beneficiaries with intensive SUD treatment needs. In all years, ED use declined in the 90 days following IMD discharge as compared to the 90 days period prior to admissions. IMD services for those meeting criteria may contribute to stabilization and continuity of care post discharge. This is further evidenced by the percent of members who have a claim for SUD treatment in the 45, 90, 135 and 180 days following IMD discharge.

Results from the first year of the Demonstration indicate that SUD treatment utilization had increased, and overall use of ED had declined. However, the onset of the Public Health Emergency in the second year of the Demonstration makes it difficult to draw strong associations between the Demonstration and continued reductions in ED use.

An exploratory analysis of expenditures for adults who received IMD services shows a similar pattern with lower per member per month costs during the Demonstration period. However, the influence of the Public Health Emergency on service use may be suppressing utilization and masking the true need for SUD treatment services in the coming years.

Exhibit ES-1 provides an overall summary of the interim evaluation findings.

**Exhibit ES-1: Evaluation Findings**

Hypotheses	Measures	Interim Findings
<b>Evaluation Question 1: What are the impacts of the Demonstration on access to SUD residential treatment services for Demonstration enrollees?</b>		
A. Adult enrollees will have better access to residential SUD treatment services.	1. Percent of enrollees ages 12-64 with an SUD claim for treatment in an IMD with a discharge date during the year	Statistically significant increases in access to IMD services were seen in each year of the Demonstration when compared to the baseline year.
	2. The total number of licensed beds for Medicaid enrolled SUD residential treatment providers each year	Licensed bed capacity for Medicaid-enrolled residential treatment facilities increased from 554 beds at baseline to 697 beds in DY3.
<b>Evaluation Question 2: What are the impacts of the Demonstration on quality of care for Medicaid enrollees with an SUD diagnosis?</b>		
A. Enrollees will have fewer ED visits for SUD	1. The total number of ED visits for SUD per 1,000 Demonstration enrollees	<ul style="list-style-type: none"> <li>ED use declined over baseline (both for total ED visits and SUD-related ED).</li> <li>There was a slight increase in total ED use for adolescents with an SUD in DY3.</li> <li>DY2 and DY3 showed a statistically significant decline in ED visits in the 90 days following IMD discharge as compared to</li> </ul>
B. Enrollees will have fewer total ED visits	1. The total number of ED visits for any reason per 1,000 Demonstration enrollees	
C. Enrollees will have fewer ED visits post discharge from an SUD IMD	1. ED use 90 days prior to IMD admission and 90 days post discharge	

Hypotheses	Measures	Interim Findings
		<p>the 90 days prior to admission.</p> <ul style="list-style-type: none"> <li>ED use may have been influenced by the PHE.</li> </ul>
D. Enrollees will have improved rates of initiation and engagement in treatment	1. Percentage of enrollees who initiated treatment within 14 days of diagnosis	<ul style="list-style-type: none"> <li>There was a statistically significant increase in DY1 and DY3.</li> </ul>
	2. Percentage of enrollees who engage in treatment within 34 days of initiation	<ul style="list-style-type: none"> <li>There was a statistically significant increase in DY2 and DY3.</li> </ul>
E. Enrollees will have lower IMD readmission rates	1. The percent of IMD stays followed by a readmission within 30 days	<ul style="list-style-type: none"> <li>Readmissions increased in DY1 and DY2, before declining in DY3.</li> </ul>
F. Enrollees will have improved rates of treatment retention	1. The percent of enrollees who had SUD treatment visits 45, 90, 135, and 180 days following IMD discharge	<ul style="list-style-type: none"> <li>There was a statistically significant increase over baseline in each year of the Demonstration.</li> </ul>
<p><b>Evaluation Question 3: Will the Demonstration maintain or reduce spending in comparison to what would have been spent absent the demonstration?</b></p>		
A. The Demonstration will be cost neutral	1. PMPM trends and per capita costs by Medicaid Eligibility Groups identified in the STCs.	<ul style="list-style-type: none"> <li>At the end of DY3, the Demonstration was showing a cumulative surplus.</li> </ul>

## I. GENERAL BACKGROUND INFORMATION

Section I provides an overview of the SUD Demonstration and general background information. The overview includes: the magnitude of the problem and the rationale for the Demonstration request; a summary of the SUD Demonstration and its implementation history; and a description of the population groups impacted by the SUD Demonstration.

### HISTORY AND MAGNITUDE OF ISSUES ADDRESSED UNDER THE DEMONSTRATION

At the time of the State's application to the Centers for Medicare and Medicaid Services (CMS) for its SUD Demonstration, New Hampshire was experiencing one of the most significant public health crises in its history. New Hampshire had the third highest overdose death rate in the country (39 per 100,000).

The number of overdose deaths had increased dramatically, from 192 in 2013 to 488 in 2017. Between 2013 and 2017, the number of times emergency medical personnel administered Narcan more than doubled, from 1,039 to 2,774 and emergency department visits rose by 9.8 percent from 2016 to 2017. The escalation of opiate use and opioid misuse impacted individuals, families, and communities throughout the State.

The scope of the State's crisis extended beyond individuals with SUD to include family members. New Hampshire was seeing a significant rise in neonatal abstinence syndrome, with the rate reaching 24.4 per 1,000 live births in 2015. Babies born with neonatal abstinence syndrome require more complex medical care, with average hospital stays of twelve days.

The incidence of neonatal abstinence syndrome was higher among Medicaid enrollees than other groups. In 2013, Medicaid paid for 78 percent of neonatal abstinence syndrome births. In 2015, the DHHS Division for Children, Youth, and Families reported that it received 504 reports of children born drug-exposed, representing an increase of 37 percent from 2014.

In addition to the high rate of opioid use among the adult population, the State ranked among the top five for binge drinking among persons ages 12 to 20 years. According to the 2015-2016 National Survey on Drug Use and Health, illicit drug use among individuals ages 12 to 17 in New Hampshire was higher than in the broader New England region and the United States. In 2015-2016, 8.98 percent (95 percent confidence interval: 7.32-10.96) of New Hampshire's adolescents (ages 12 to 17) reported illicit drug use in the past month.

In response to the opioid crisis, New Hampshire invested more than \$30 million in the years prior to its SUD Demonstration application to build service capacity and support a full continuum of care to treat individuals with SUD. These investments included those that maintain existing prevention, treatment, and recovery capacity, while also expanding access to medication assisted treatment (MAT), peer recovery support services, direct prevention services, and coordination of care through a statewide crisis hotline.

The State also established nine regional treatment “Hubs” to serve as 24/7 access points to addiction treatment. The Hubs provide screening, evaluation, care management, social service referral and addiction treatment services across the state.

These investments were made in support of a robust, resiliency- and recovery-oriented system of care for individuals with SUD. Although capacity for services increased, the limited availability of treatment in all settings, particularly residential treatment, was challenging.

The State implemented the New Hampshire Substance Use Disorder Treatment and Recovery Access Demonstration (SUD Demonstration) to: address critical unmet needs for residential SUD treatment; improve quality of SUD treatment; and maintain or reduce cost of care for Medicaid enrollees with an SUD.

#### DEMONSTRATION APPROVAL AND EVALUATION PERIOD

CMS approved the New Hampshire Substance Abuse Treatment and Recovery Access Section 1115 Demonstration on July 10, 2018, for a five-year term ending June 30, 2023. Clarifying, non-substantive revisions were approved on August 3, 2018. On June 16, 2021, an amendment was approved by CMS to update the Demonstration’s budget neutrality terms and conditions. CMS agreed to prospectively adjust the State’s hypothetical budget neutrality limits to reflect actual expenditures more accurately. Additionally, CMS updated Sections III, XI, and XII of the Special Terms and Conditions (STCs) to align with recent CMS requirements for 1115(a) Demonstration approvals.

The Demonstration’s Evaluation Design was approved by CMS on May 22, 2019. This is the first Interim Evaluation report as required in STC 36. Preliminary findings are offered, based on the approved Evaluation Design, for the baseline period (July 1, 2017-June 30, 2018) through DY3 (June 30, 2021).

#### DEMONSTRATION DESCRIPTION

New Hampshire’s Demonstration is designed to maintain critical access to opioid use disorder (OUD) and other (SUD) treatment services and continue delivery system improvements to support coordinated and comprehensive OUD/SUD treatment for Medicaid enrollees. The Demonstration authorizes New Hampshire to provide high-quality, clinically appropriate SUD treatment services for short-term stays in residential and inpatient treatment settings that qualify as Institutions for Mental Disease (IMDs).

The Demonstration also was designed to encourage growth in SUD residential treatment capacity (IMD and non-IMD) and build on existing efforts to improve models of care focused on supporting enrollees in their homes and communities and strengthen the New Hampshire continuum of SUD services.

New Hampshire’s statutes and rules require that treatment decisions and delivery system innovations be based on the use of the American Society of Addiction Medicine (ASAM) criteria and other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines making the CMS SUD IMD Demonstration requirements a good fit for the State. DHHS identified three overarching goals of the Demonstration:

1. To improve access to OUD and other SUD services;
2. To improve the quality of the SUD treatment delivery system to provide high-quality coordinated and comprehensive OUD/SUD treatment for Medicaid enrollees; and
3. To maintain budget neutrality.

The CMS-defined goals for all Section 1115 SUD Demonstrations include:

- Increased rates of identification, initiation, and engagement in treatment;
- Increased adherence to, and retention in, treatment;
- Reduced overdose deaths, particularly those due to opioids;
- Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services;
- Reduced readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate; and
- Improved access to care for physical health conditions among beneficiaries.

## DEMONSTRATION IMPLEMENTATION

The Demonstration was effective as of July 10, 2018. At the outset of the Demonstration, New Hampshire’s existing service array, program requirements, and delivery system were in alignment with many of the milestones identified by CMS for SUD IMD Section 1115 Demonstrations. DHHS also anticipated enhancements to the State oversight structure and in residential capacity for youth. An overview of implementation activities is provided below.

---

### REGULATORY ENHANCEMENTS

In the first year of the Demonstration, the New Hampshire Medicaid program’s SUD coverage rule and Bureau of Health Facilities’ licensing rule for residential SUD treatment facilities were revised and updated to:

- Align the rules with each other and to support ASAM, Substance Abuse and Mental Health Services Agency (SAMHSA) and other evidence-based practices, including explicit ASAM level of care staffing and service expectations;
- Update the New Hampshire Health Facilities Licensing Rule for SUD providers to include specific staffing, physical space, program design, and compliance requirements, including annual compliance audits;



- Explicitly require MAT access for enrollees served in residential SUD treatment facilities; and
- Expand requirements regarding best practices in discharge planning to all SUD treatment providers.

---

#### ADOLESCENT RESIDENTIAL CAPACITY

Under the SUD Demonstration, the State planned capacity at the Sununu Youth Services Center for a 36-bed residential SUD treatment facility available for adolescents under 18 years old. Services included both low and medium-intensity residential treatment for adolescents ages 12 to 18 years who qualify for such levels of care using the ASAM patient placement criteria.

In June of 2019 (the end of DY1), the Legislature adopted Senate Bill 14-FN (an act relating to child welfare). This legislation supported enhancements in the children’s behavioral health system, which included: expanding Case Management Entity requirements to create a new system of transitional support and oversight; developing a single statewide behavioral health assessment tool; redesigning and contracting for the youth residential treatment array; expanding the eligible population for wraparound services; establishing children’s mobile crisis services; developing a plan to address infant mental health; creating a parent information clearinghouse and online treatment and support locator; implementing the Prevention/First Episode Psychosis program; and providing Evidenced-Based Practice Technical Assistance and training support.

In addition, the federal Families First Prevention Services Act made residential treatment options - historically available to youth in State’s custody or through school districts - increasingly accessible to all youth who require that level of care, without the necessity of entering the child welfare system. This work involves a large-scale transformation of New Hampshire’s residential treatment system with the goal of providing effective short-term treatment and stabilization, while diverting as many youths as possible from State custody, hospital emergency departments, and inpatient psychiatric hospitalizations.

In June of 2020, the adolescent SUD treatment program at the Sununu Youth Services Center closed when DHHS terminated its contract with the vendor. New levels of integrated behavioral health care have been developed to ensure in-state resources for children and youth with a wide range of stabilization and treatment needs. The expanded array outlines five levels of care, with level 1 being the least intensive, with more community based and supportive living options and 5 being the most intensive (e.g., accredited Psychiatric Residential Treatment Facility). DHHS has begun work to clearly articulate the desired future state of residential treatment.

As discussed in more detail in Section III, the closure of the Sununu adolescent treatment program resulted in an insufficient population size related to IMD services. DHHS and the evaluation team are assessing options for better identifying and evaluating co-occurring mental

health and SUD adolescent services as part of a revised Evaluation Design following the SUD Demonstration renewal.

---

## BUDGET NEUTRALITY

During implementation, DHHS identified utilization trends and other factors that were adversely impacting the original Budget Neutrality (BN) calculation. In addition, provider rate increases occurring each year following approval and other payment changes impacted BN.

DHHS followed up with CMS by providing an impact analysis completed by the State's actuary. Impacts were analyzed for: actual enrollment experience; retroactive coverage; provider rate changes; and changes in the Sununu Youth Center timelines.

On August 21, 2020, DHHS submitted an amendment request to CMS as part of its Corrective Action Plan to adjust the BN limits. The request identified adjustments for the following items, not originally anticipated during Demonstration development.

***Unanticipated retroactive enrollment under Fee-For-Service (FFS).*** Due to the small size of the FFS population, the IMD costs incurred during the retroactive eligibility period distorted the Per Member Per Month (PMPM) expenditure values.

***Enrollment Experience.*** Actual experience with IMD enrollment showed that the mix of individuals in IMDs are more heavily weighted than originally assumed within higher cost rate cells.

***Provider Rate Increases.*** The Legislature approved the following rate increases to ensure access to SUD and other treatment services:

- Effective January 1, 2019, DHHS increased reimbursement for high-intensity residential treatment services for adults (H0018) from \$162.60 to \$247.82 per day. As of January 1, 2021, the per diem is \$255.50.
- Effective July 1, 2019, DHHS increased reimbursement for residential sub-acute detoxification (H0010) from \$230.00 to \$340.32 per day. As of January 1, 2021, the per diem is \$350.87.
- Effective January 1, 2020, New Hampshire House Bill 4 required a 3.1 percent provider rate increase applicable to nearly all Medicaid services. Rates were increased by another 3.1 percent on January 1, 2021.

***Hospital-directed payments.*** Effective July 1, 2020, the Medicaid Managed Care capitation rates included a hospital-directed payment to promote access to high-quality acute care services provided by critical access hospitals across New Hampshire.

On June 16, 2021, CMS approved a prospective adjustment to the State's hypothetical budget neutrality limits to more accurately reflect actual expenditure data reported under the SUD Demonstration.

## DEMONSTRATION POPULATION

Medicaid beneficiaries with an SUD requiring residential treatment, based on ASAM placement criteria, are eligible for the Demonstration.

## II. EVALUATION QUESTIONS AND HYPOTHESES

Section II describes how the State's Demonstration goals are translated into quantifiable targets for improvement, including the CMS-approved driver diagrams that depict the rationale behind Demonstration activities and intended outcomes. This section also includes descriptions of the State's evaluation questions and hypotheses, as well as the alignment of evaluation questions and hypotheses with the goals of the Demonstration. A discussion of how the Demonstration promotes the objectives of Title XIX also is provided.

### QUANTIFIABLE TARGETS AND DRIVER DIAGRAMS

The New Hampshire SUD Demonstration is specifically designed to maintain and enhance access to treatment for enrollees with an SUD, support high quality care, and to maintain budget neutrality. The evaluation is designed to examine the Demonstration's impact in each of these areas.

It is hypothesized that access to residential care will improve for both adults and adolescents under the Demonstration. The SUD Demonstration is expected to maintain and encourage growth in adult capacity.

It also is hypothesized that the quality of care will improve under the Demonstration as evidenced by: fewer Emergency Department (ED) admissions, both in total use and for SUD related visits; improved rates of initiation and engagement in alcohol and other drug dependence treatment; lower hospital and IMD readmission rates; and improved rates of treatment retention.

New Hampshire's residential SUD treatment system is a critical component of the overall ASAM level of care framework in the State. Maintaining and enhancing capacity under the Demonstration is expected to support treatment success resulting in improved health outcomes.

Residential providers are also expected to assess the comprehensive needs of participants and use the results in the development of high-quality discharge plans for enrollees. As such, residential SUD treatment providers are responsible for: supporting enrollee referral and engagement with community-based SUD treatment providers, including Medication Assisted Treatment; PCP engagement; recovery supports (e.g., Alcoholics/Narcotics Anonymous and peer recovery support specialist) and relapse prevention plans. It is expected that maintaining and enhancing access to residential SUD treatment under this Demonstration will support high quality care and improve health outcomes for enrollees.

To further enhance the quality of residential treatment, the Demonstration's SUD Implementation Plan (STC Attachment D) included revisions to New Hampshire rules to clarify SUD provider program expectations and licensing requirements, including additional specificity

in the use of ASAM criteria and best practices in discharge planning across all levels of SUD treatment. Rule changes included:

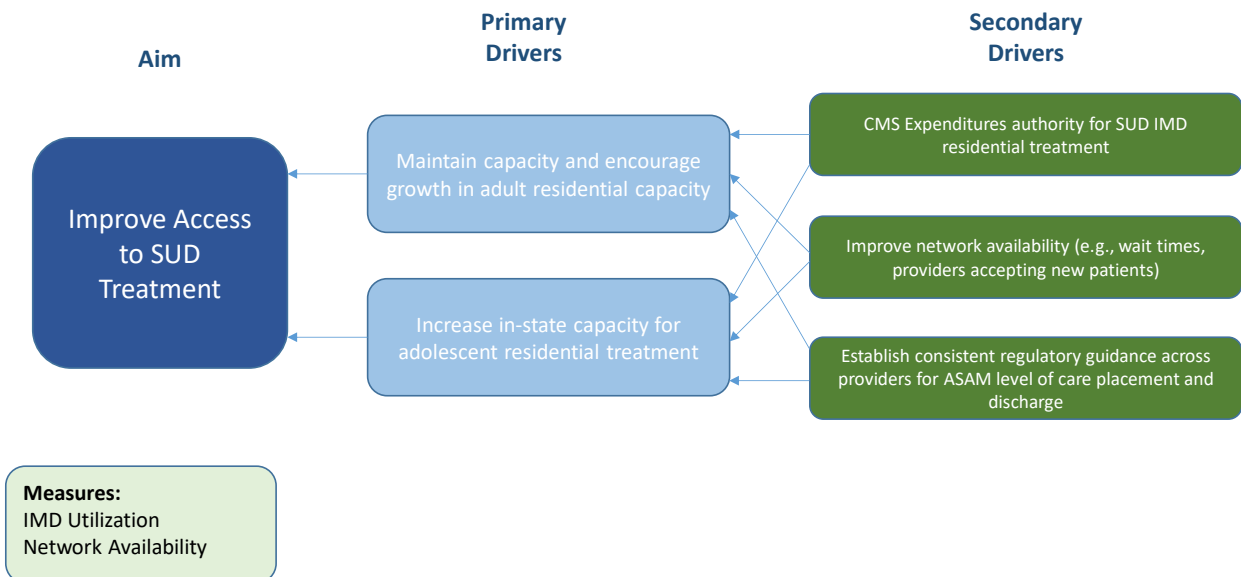
- Medicaid Substance Use Disorder Treatment and Recovery Support Services rule (He-W 513), effective November 15, 2018.
- Bureau of Health Facility SUD Residential Provider licensing rule, effective November 1, 2018.
- BDAS SUD Treatment Provider rule (to be completed by the close of the Demonstration).

Improvements in quality expected to result from rule changes will be examined through structured provider interviews and surveys in the final year of the Demonstration.

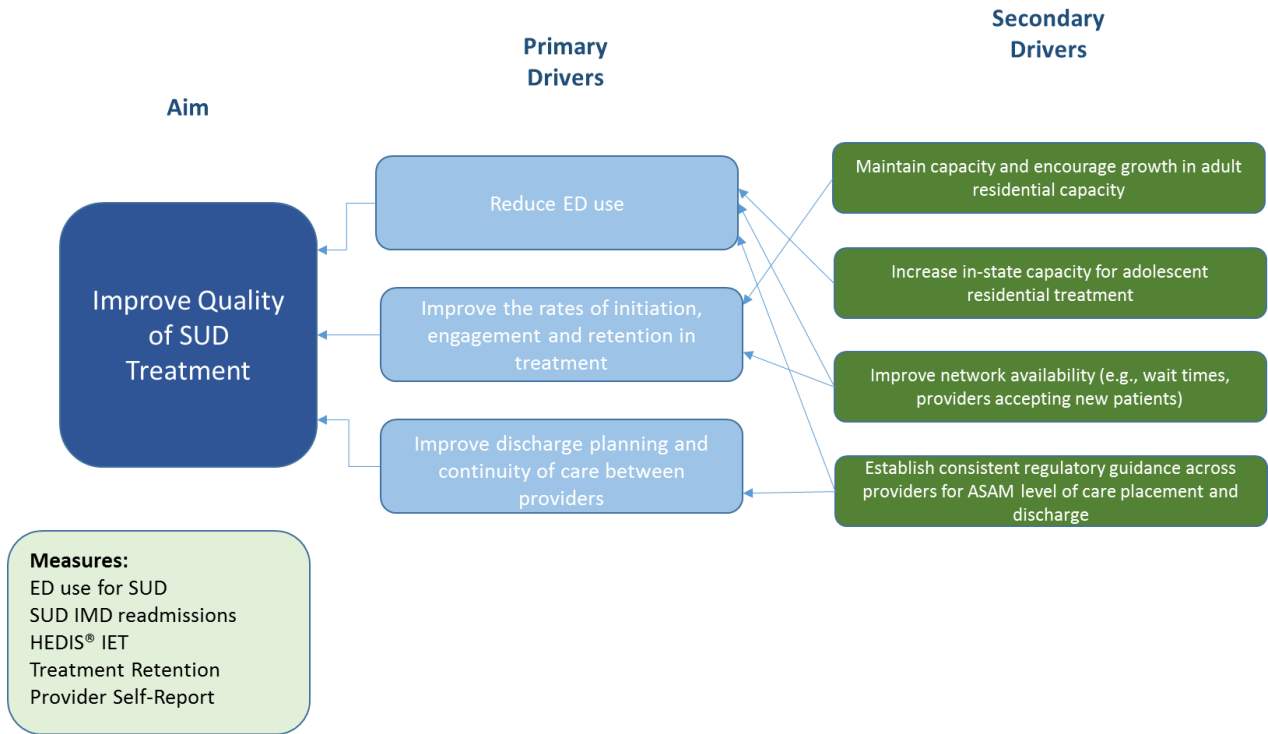
Related to cost of care, the State is expected to maintain or reduce spending in comparison to what would have been spent absent the Demonstration.

Exhibit II-1 below and Exhibits II-2 and II-3 on the following page provide a visual depiction, from the approved Evaluation Design, of the relationship between the Demonstration’s purpose, the primary drivers that contribute to realizing that purpose and the secondary drivers that are necessary to achieve the primary drivers.

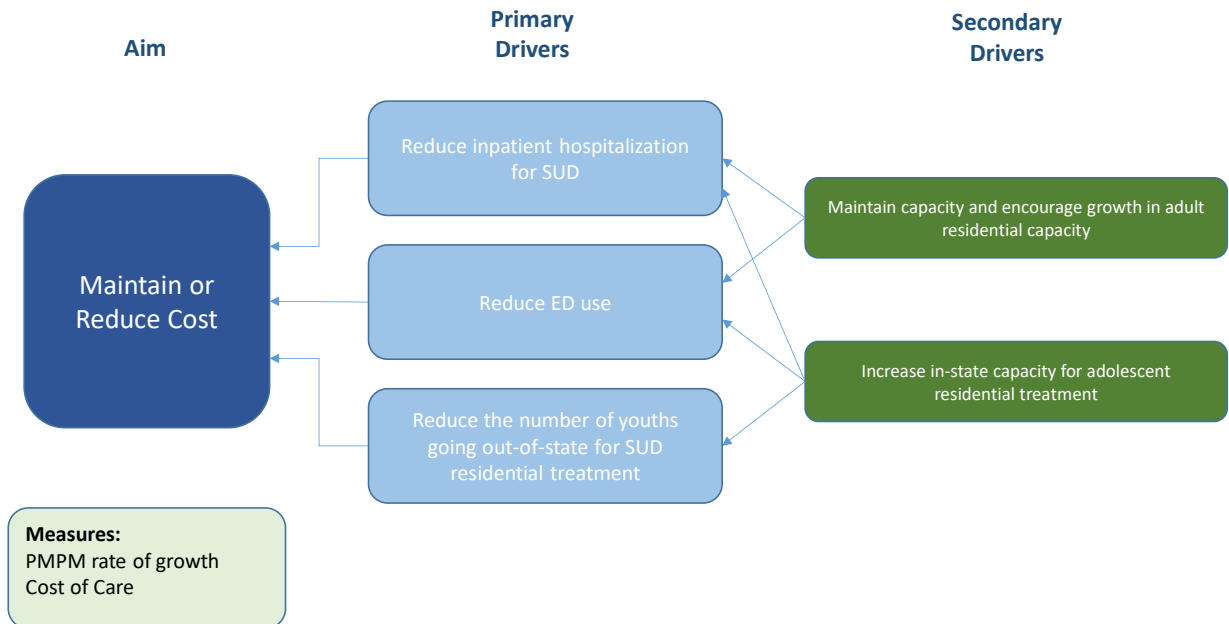
**Exhibit II-1: Access Driver Diagram**



**Exhibit II-2: Quality Driver Diagram**



**Exhibit II-3: Cost Driver Diagram**



EVALUATION QUESTIONS AND HYPOTHESES

The evaluation is designed to study the impact of the Demonstration on participation in SUD treatment and specifically IMD treatment services. Exhibit II-4 offers an overview of evaluation questions, hypotheses, and study groups. As noted elsewhere in the report, hypotheses related to the adolescent IMD study group were not included in this interim analysis.

**Exhibit II-4: Evaluation Questions and Hypotheses**

Evaluation Question	Hypothesis	Study Group
<b>Demonstration Goal 1. To improve access to OUD and other SUD services</b>		
1. What are the impacts of the Demonstration on access to SUD residential treatment services for Demonstration enrollees?	A. Adult enrollees will have better access to residential SUD treatment services	Enrollees with an SUD
	B. Adolescent enrollees will have better access to in-state residential SUD treatment services	Suspended due to program changes
<b>Demonstration Goal 2. To improve the quality of the SUD treatment delivery system to provide high-quality coordinated and comprehensive OUD/SUD treatment for Medicaid enrollees</b>		
2. What are the impacts of the Demonstration on quality of care for Medicaid enrollees with an SUD diagnosis?	A. Enrollees with SUD will have fewer ED visits for SUD	Enrollees with an SUD; and adult IMD service recipients
	B. Enrollees with SUD will have fewer total ED visits	
	C. Enrollees with SUD will have fewer ED visits post discharge from an SUD IMD	Adult IMD service recipients
	D. Enrollees with SUD will have improved rates of initiation and engagement in alcohol and other drug treatment	Enrollees with an SUD
	E. Enrollees with SUD will have lower IMD readmission rates	Adult IMD service recipients
	F. Enrollees with SUD will have improved rates of treatment retention	Adult IMD service recipients
<b>Demonstration Goal 3. To maintain budget neutrality</b>		
3. Will the Demonstration maintain or reduce spending in comparison to what would have been spent absent the demonstration?	A. The Demonstration will be cost neutral	IMD Service Recipients
	B. The cost of adolescent residential SUD treatment services will be reduced	Suspended due to program changes
<b>Exploratory Analysis</b>		
Expenditure Trends	A. What are the PMPM trends related to Medicaid payments for SUD IMD enrollees, including breakouts for SUD-related and non-SUD-related services and age groups?	Adult IMD service recipients



## DEMONSTRATION ALIGNMENT WITH TITLE XIX OBJECTIVES

The SUD Demonstration supports the federal Medicaid program in its core mission: to meet the health and wellness needs of our nation's vulnerable and low-income individuals and families. Demonstration goals align with the Title XIX objectives: to improve access to high-quality, person-centered services that produce positive health outcomes for individuals.

### III. METHODOLOGY

Section III provides an overview of the evaluation methodology, including the evaluation design, target and comparison populations, evaluation period, evaluation measures, data sources and analytic methods. This section also offers a summary of methodological and data limitations identified by the evaluator during data collection and validation and how they were addressed, where applicable, during the implementation of the CMS approved Evaluation Design.

#### EVALUATION DESIGN

The approved Evaluation Design includes both quantitative and qualitative design techniques. Per the approved Design, qualitative techniques will be employed in the final year of the Demonstration and are not included in this Interim Evaluation Report. As a result of not having a viable comparison group (discussed below), the evaluation utilizes a quasi-experimental pre-test/post-test design with annual observation points. The pre/post design was selected to characterize differences over time for participants. The length of the pre-intervention period was twelve months.

The quantitative analysis (described in more detail below) utilized logistic and linear regressions and t-tests to measure the significance of change for each year of the Demonstration. Due to the nature of the target group and construction of evaluation measures, there are no applicable national benchmarks for comparison.

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#### TARGET AND COMPARISON POPULATIONS

The approved Evaluation Design does not include comparison groups. Prior to conducting the planned analysis, the independent evaluator reviewed the evaluation methodology with the State and confirmed that a viable comparison group was not available.

Enrollees with an SUD were identified using the criteria for SUD Monitoring Protocol Metric #4 (Medicaid members with an SUD annually) found in the Mathematica Policy Research Manual developed specifically for CMS (1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics Version 4, August 2021). This includes Medicaid members who were enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period and who had a claim for service with an SUD diagnosis and an SUD-related treatment service during the measurement period and/or in the 12 months preceding the period. Diagnosis from any of the following HEDIS 2020 Value Sets were included:

- Alcohol Abuse and Dependence;
- Opioid Abuse and Dependence; and
- Other Drug Abuse and Dependence.

SUD Demonstration enrollees were further stratified into subgroups as outlined in Exhibit III-1.

**Exhibit III-1: SUD Evaluation Enrollee Study Groups**

Group	Definition	Population Size			
		Baseline	DY1	DY2	DY3
Adults w/SUD	Individuals who are ages 18 through 64 at any time in the measurement period	25,478	27,363	27,520	27,331
Adolescents w/SUD	Individuals who are between the ages of 12 through 17 on the first and last day of measurement period	357	383	399	384
SUD IMD Recipients	Adults ages 18 to 64 who have at least one IMD discharge during the measurement period	1,674	2,350	2,372	2,152
	Adolescents ages 12 to 17 who have at least one IMD discharge during the measurement period	*	*	*	*

All Demonstration enrollees who met measurement criteria were included in the analyses. The evaluation did not employ random sample, representative sample, or other sampling methods.

As noted in the approved Design, population size was a concern for certain measures and analyses. The identification of the adolescent IMD group yielded a population size of fewer than ten participants annually. The evaluation team explored the feasibility of revising the adolescent IMD sub-group definition by looking at individuals served in an IMD for SUD who were ages twenty-one and under (in alignment with Early Periodic Screening Diagnosis and Treatment age criteria). However, population sizes for the 12-21 age group ranged only from 37 to 62 enrollees annually.

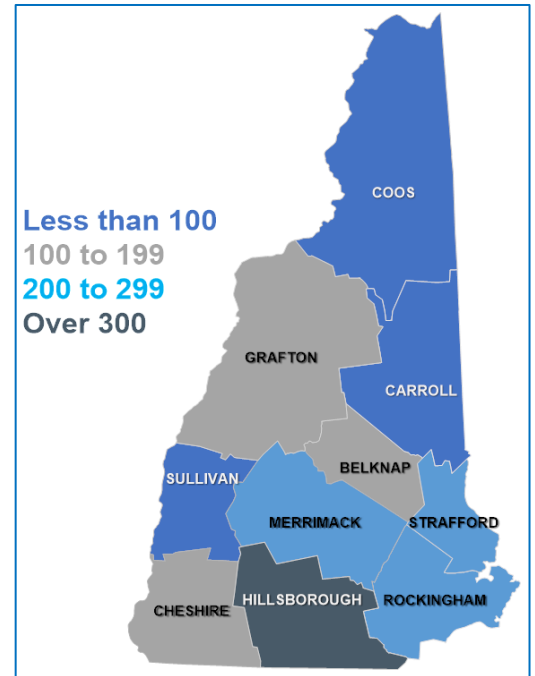
Given the implementation plan changes identified in Section III and small population sizes, the adolescent IMD subgroup measures and analysis were not included in this analysis.

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**ADULT IMD STUDY GROUP**

Several measures examine service utilization and engagement in treatment for Medicaid members with an SUD. In addition, adults receiving IMD were identified to provide a focus on the trends and outcomes for those members receiving IMD services specifically authorized under the Demonstration.

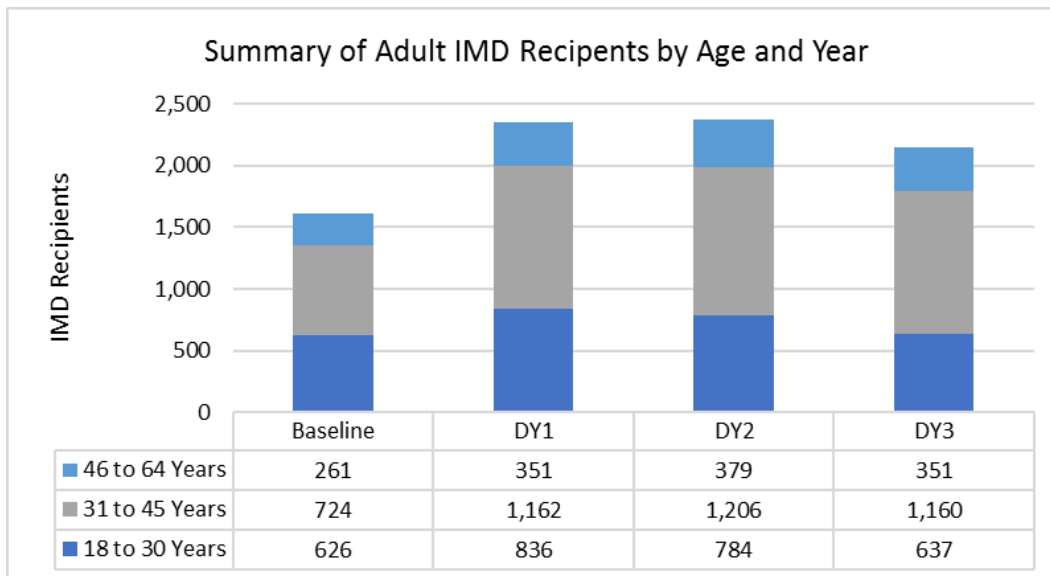
In Demonstration Year 3 (SFY21), more than 800 individuals who received IMD treatment services resided in Hillsborough County, representing nearly 40 percent of IMD service recipients statewide. Between 200 and 299 individuals in Merrimack, Rockingham and Strafford County received IMD treatment services. Between 100 and 199 IMD participants resided in Grafton, Belknap, and Cheshire County, while less than 100 participants reside in Coos, Carroll, and Sullivan County.



Adults using IMD services were 94 percent white, two percent Black or African American, one percent American Indian or Alaskan Native, and three percent “other” or more than two races.

Most of the members using IMD services were between the ages of 31 to 45 years, with 724 members at baseline, 1,162 during DY1, 1,206 during DY2 and 1,160 during DY3. The second largest age group was 18 to 30 years with 626 members at baseline, 836 members during DY1, 784 during DY2 and 637 during DY3. Members ages 46 to 64 years were the smallest group with 261 at baseline, 351 in DY1, 379 during DY2, and 351 during DY3. Exhibit III-2 provides a summary of IMD recipients by Age and Demonstration Year.

**Exhibit III-2: Summary of Adult IMD Recipients by Age and Year**



Adults using IMD services included more males than females in each year of the Demonstration and in each age group. Males represented 58 percent of participants ages 18 to 30 years old, over 62 percent of members ages 31 to 45 and 70 percent of members ages 46 to 64 years old.

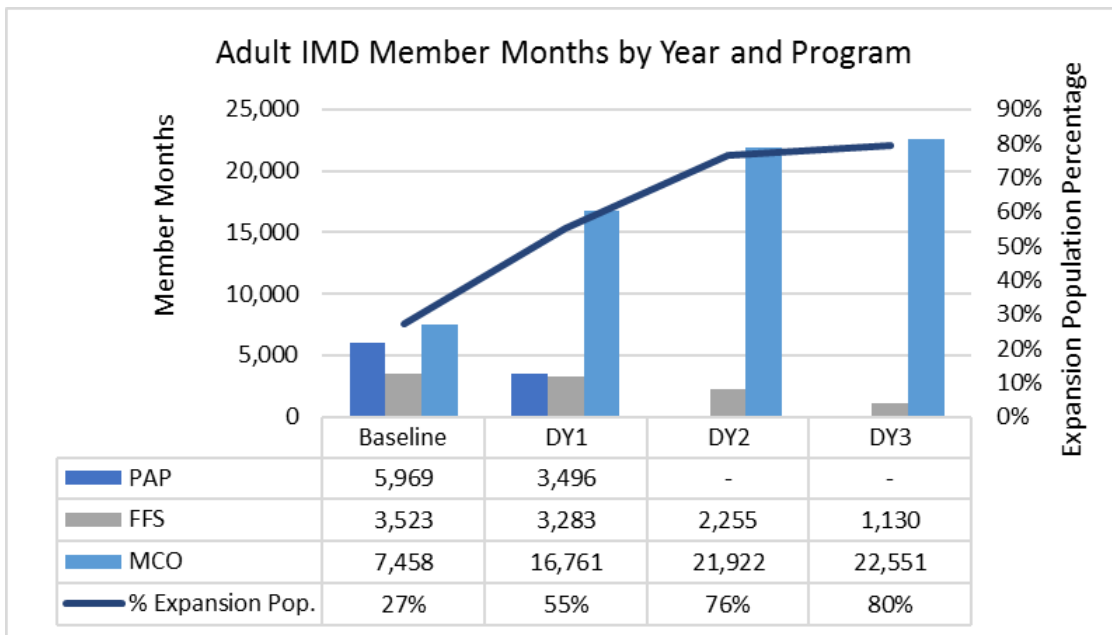
**Exhibit III-3: Summary of IMD Recipients by Age and Gender**

Age Range	Gender	Baseline	DY1	DY2	DY3	Total
18 to 30 Years	F	309	348	311	247	1215
	M	317	488	473	390	1668
31 to 45 Years	F	319	433	435	409	1596
	M	405	729	771	751	2656
46 to 64 Years	F	88	106	97	109	400
	M	173	245	282	242	942

Members using IMD services were largely served in MCO programs in each year of the Demonstration. MCO member months ranged from 7,458 at baseline to 16,761 in the first year of the Demonstration and rose to 22,551 in DY3 after the transition of the premium assistance program (PAP) into the MCO framework.

As the PAP program terminated halfway through DY1, (December 31, 2018) the member months for beneficiaries in the Adult Expansion population increased from 27 percent of the total at baseline to 55 percent in DY1 and to 80 percent in DY3. Exhibit III-4 provides a summary of participation by program.

**Exhibit III-4: Summary of Member Months by Program**



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## EVALUATION PERIOD

The evaluation spans the Demonstration approval period (July 10, 2018 - June 30, 2023) with a baseline period beginning one year prior to the Demonstration (July 1, 2017 - June 30, 2018). This Interim Evaluation Report presents preliminary findings from July 1, 2017 - June 30, 2021.

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## EVALUATION MEASURES

The measure specifications for Initiation and Engagement are derived from the Mathematica Policy Research Manual developed specifically for CMS 1115 Substance Use Disorder Demonstrations (Technical Specifications for Monitoring Metrics, Version 4, August 2021). The original design anticipated that the measure would be calculated on a Calendar Year basis. After discussion with the evaluation team, all measures were calculated using the Demonstration Year as the measurement period. This revision allows for findings to draw upon the same populations, measurement periods, data sets and service delivery context.

One measure, retention in treatment, was originally developed by DHHS as an extension to the initiation and engagement measurement framework. Since the CMS approval of the Evaluation Design, DHHS was asked by NCQA not to use the framework of the HEDIS metrics to design new performance metrics. The evaluation team worked with DHHS to develop a state-specific measure of retention that focuses on continuity of treatment following an IMD discharge. This measure is described in detail as part of the findings.

In addition to hypothesis testing, the evaluation monitors the impact of IMD stays on total Medicaid expenditures for Demonstration enrollees. Cost of care measures not associated with a hypothesis are examined for year-over-year change and utilization trends and relative to drivers, such as ED utilization, inpatient hospitalization, and pharmacy services.

As noted earlier, the adolescent subgroup measures and analyses were not included due to insufficient population size and changes in the SUD program implementation for the adolescent group.

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## DATA SOURCES, CLEANING AND VALIDATION

The quantitative evaluation measures rely on New Hampshire Medicaid claims and managed care encounter data stored in the Medicaid Management Information System (MMIS). Fee-for-service data for members previously enrolled in the New Hampshire Health Protection Program/Premium Assistance Program (PAP) were extracted from the State's premium assistance program encounter database for dates of service between July 1, 2016, and December 31, 2018. After the first six months of the Demonstration, PAP members were transitioned to the MCO program. Information on member characteristics (e.g., category of eligibility, eligibility start and end dates, race/ethnicity, county of residence) was obtained through the State eligibility and enrollment system maintained by DHHS.

DHHS provided the evaluation team with Medicaid data extracts for each year. Extracts contained member eligibility data, fee-for-service claims data and encounter data for Medicaid members enrolled for the period July 1, 2016, through December 31, 2021. PHPG removed claims with dates of service outside of the evaluation period. Enrollees who did not receive full Medicaid benefits were also removed from the data set.

DHHS provided the evaluation team with the methodology to identify residential and IMD services. The methodology includes identifying residential providers using a list of National Provider Identifiers (NPI) for New Hampshire residential SUD treatment facilities and their status as an IMD. The evaluation team identified claims with a primary diagnosis of SUD from each IMD provider. A secondary check was completed using DHHS specific billing, revenue, and modifier codes as illustrated in Exhibit III-5.

**Exhibit III-5: DHHS Medicaid SUD Residential Billing, Revenue and Claims Modifier Codes**

New Hampshire Billing Code	Billing Code Type	Informational IMD Code	Informational Code Type
H0010 - Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient)	HCPCS	V1	Procedure Modifier
H0018 - Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem			
H2034 - Alcohol and/or drug abuse halfway house services, per diem			
T1006 - Specialty Residential Services for Pregnant & Parenting Women			
0116 - Detox	Revenue	A3	Condition
0126 - Detox			
0136 - Detox			
0146 - Detox			
0156 - Detox			
1002 - Residential treatment – chemical dependency			

Preliminary member counts and utilization results were validated against data reports produced independent of the evaluation (e.g., SUD Monitoring Protocol, DHHS quality monitoring reports and HEDIS audited results).

Bed counts for Medicaid-enrolled SUD residential treatment providers were obtained through a combination of MMIS provider enrollment files and the DHHS Bureau of Health Facilities licensing reporting system. The total number of beds were recorded for Medicaid-enrolled facilities as of July 1 of each year. PHPG validated residential SUD treatment provider NPIs against claims detail (type of services billed each SFY). In addition, a licensing report was obtained that included provider name, date of the provider’s initial license, and bed counts for each residential SUD treatment provider regardless of Medicaid enrollment status. The list was cross walked to the MMIS list and served as another source of validation.

The data analysis included exploratory and descriptive strategies and incorporated causal inference methods for the observational data. Descriptive statistics were used to describe the basic features of the data and what they depict, and to provide simple summaries about the sample and the measures. The causal inference methods included univariate and multivariate regressions, t-test, and analysis of variance (ANOVA).

Outcomes were calculated annually for the baseline period and for Demonstration Years 1-3. Regression models accounting for members in more than one year (clustering) were used to assess the rate of change over time in evaluation outcomes. To assess change over time, the evaluation used ANOVA for the utilization measures and logistic regression for the quality measures. Age and gender were controlled for in the models examining cost and ED utilization measures. To address concerns of multiple hypothesis testing, the evaluation used either a Bonferroni adjustment or ANOVA instead of multiple t-tests on the same data series. Statistically significant results are reported based on  $p \leq 0.05$ , with adjustments made when necessary to address concerns around multiple hypothesis testing.

The evaluators estimated a binary (Bernoulli) response variable  $Y$  here (i.e., whether the patient received the care, follow up, or visit of interest), which is denoted as  $p = P(Y = 1)$ . Assuming a linear relationship between the predictor variable (year) and the log-odds of the event  $Y=1$ , the relationship is denoted as:

$$l = \log_b \frac{p}{1-p} = \beta_0 + \beta_1(\text{year})$$

which when solved algebraically for  $p$  comes out to:

$$p = \frac{1}{1 + b^{-(\beta_0 + \beta_1(\text{year}))}}$$

Where  $l = \log$  odds,  $b = \text{base of the logarithm (we default to natural log)}$ , and  $\beta_i$ 's are the parameters for the predictors.

The evaluators estimated a linear response between a response,  $Y$ , and multiple explanatory variables (age, gender, year). For explanatory variables that take on a finite number of discrete levels, the evaluators one-hot encoded the responses. For example, for "gender," the evaluators have two factors: "gender male" and "gender female" which can take on only values of 0 and 1. Each patient can only be one gender and the gender reported will take on the value "1" and the other one will take on the value "0." The relationship is denoted as for all years as follows:

$$Y = \beta_0 + \beta_1(\text{age}) + \beta_2(\text{gender}_F) + \beta_3(\text{year19}) + \beta_4(\text{year20}) + \beta_5(\text{year21})$$



Doorway services, available to all New Hampshire residents, began in DY2. When controlling for Doorway services for Demonstration enrollees in DY2 (SFY20) and DY3 (SFY21) the relationship is denoted as:

$$Y = \beta_0 + \beta_1(\text{age}) + \beta_2(\text{gender}_F) + \beta_3(\text{year21}) + \beta_4(\text{Doorway}_Y)$$

Where age represents age in years, and gender\_F, year19, year20, year 21 and Doorway\_Y are all binary variables that take on value 1 when true and value 0 when not true.

Note that gender\_M and year\_18 are left out from the first linear estimation equation (just as year\_20, gender\_M and Doorway\_N are left out of the second one) because they are perfectly correlated and collinear with the other variables. Given that one of the assumptions of Ordinary Least Squares is no multicollinearity, these variables are dropped to avoid multicollinearity and because they cannot otherwise be estimated.

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### Isolation from Other Initiatives

Three initiatives ran concurrent with the SUD demonstration. These included the State Opioid Response Grant; the transition of the Medicaid expansion group from premium assistance to MCOs; and the final years of the DHHS Delivery System Reform Incentive Program (DSRIP) Demonstration, entitled Building Capacity for Transformation. Methods for isolating the impact of each initiative, where possible, are described below.

The Doorway (State Opioid Response Plan): The State of New Hampshire implemented a State Opioid Response Program, the Doorway, funded through SAMHSA, on January 1, 2019. Nine Doorway providers across the State began offering a combination of services, based on population and service system priorities in each region. These services included, but were not limited to:

- SUD screening and evaluation;
- SUD treatment services, including MAT;
- Prevention and harm reduction services (e.g., naloxone distribution);
- Recovery services and supports; and
- Peer recovery services.

The Doorway providers may receive reimbursement for Medicaid enrollees when a covered service is provided. The evaluation team controlled for the State Opioid Response Plan by identifying Medicaid members with a claim from one of the nine Doorway providers. Results were calculated with and without Doorway recipients to assess the potential program impact on the Demonstration. However, members may receive Doorway services that are not Medicaid reimbursable, limiting the extent to which the impact of these programs can be isolated from the SUD Demonstration results.

Where feasible, a linear regression was performed to control for members who received Medicaid reimbursable Doorway services. The evaluators one-hot encoded the Doorway

(binary) variable and estimated the coefficient of receiving Doorway services (i.e., Doorway-yes) versus not receiving Doorway services to control for the impact of a member being in the Doorway program. The analysis of Doorway services is limited to SFY20 and SFY21; the 12-month periods concurrent with SUD Demonstration Years 2 and 3.

Expansion Group Transition: On December 31, 2018, DHHS terminated the State's Premium Assistance Program (PAP) for the Medicaid Expansion population. Subsidies for Medicaid Expansion enrollees to purchase a Qualified Health Plan on the marketplace were eliminated and enrollees were transitioned to one of two existing Medicaid MCOs operating in New Hampshire. (This rose to three MCOs in September 2019 following the State's managed care re-procurement.) The SUD Demonstration was developed with the understanding that many of the service recipients would be in the Medicaid expansion population. Adult IMD enrollees in the expansion population represented nearly 80 percent of member months by DY2 and 3.

Delivery System Reform Incentive Program (DSRIP): The DSRIP Demonstration was authorized January 5, 2016, through December 31, 2020. The project period ran concurrent with SUD Demonstration for two- and one-half years, July 1, 2018 – December 31, 2020. DSRIP project activities spanned the health care delivery system and were not exclusive to SUD programs. However, the program included a focus on the integration of physical and behavioral health and building capacity for SUD treatment across the State.

The DSRIP project supported the formation of community partnerships known as Integrated Delivery Networks (IDN), IT infrastructure and direct services to address local service gaps and population health needs. The IDN host agencies were not expected to identify or track services received by individual Medicaid members, nor did the DSRIP evaluation design include provisions to isolate the impact of services rendered by IDN members. While it is likely SUD Demonstration enrollees benefited from local IDN activities, it is not possible to isolate the impact between the two Demonstrations.

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#### METHODOLOGICAL LIMITATIONS

The SUD Demonstration evaluation is limited by several factors, including:

Lack of true experimental comparison groups: IMD facilities in New Hampshire serve residents from across the State. Thus, regional comparison groups are not available. In addition, residential placement decisions are made based on nationally recognized ASAM level of care guidelines; thus, individuals admitted to a residential SUD program have a clinically different profile and level of care need than those who are not admitted. These clinical differences eliminate the possibility of matched sample of enrollees who received services versus those who did not. Lastly, all Medicaid enrollees who meet SUD criteria are eligible for the Demonstration.

The approved Evaluation Design recognizes this limitation and utilizes a pre/post design with annual observation points. Where the outcome variable is not binary, the evaluators also used

multivariate linear regression that includes demographic factors (age and gender) to account for additional variances attributable to those factors and not the Demonstration.

Continuity of Services: New Hampshire residential SUD IMD treatment facilities are existing statewide providers who have been delivering care to Medicaid enrollees prior to the implementation of the SUD demonstration. The approved Evaluation Design recognizes this limitation and utilizes a logistic regression model to analyze the significance of change for each year against the baseline period. Therefore, these findings are longitudinal and should not be interpreted as causal evidence for the impacts of the demonstration.

Reliance on Administrative Data: The evaluation may be limited by its reliance on claims and diagnostic codes to identify the beneficiary population with SUD. These codes may not capture all participants especially if the impact or severity of the SUD is not evident on initial assessment. For example, an ED visit for a broken arm due to inebriation may not be coded as SUD related if the member does not present as inebriated, the ED provider has not ascertained causation, or the member fails to disclose the cause. This type of limitation is inherent in claims-based analysis. However, the potential for missing data is random. There is no reason to believe that any given Demonstration group is more or less likely to have missing data.

Population Size: The evaluation may be limited by the small size of the New Hampshire SUD Demonstration population and IMD capacity. This limitation is especially apparent as it relates to creating sub-populations for adolescents and IMD recipients. Due to the small population size and the changes in Demonstration implementation related to adolescent programs, the evaluation team eliminated the adolescent IMD study group from the analyses.

Public Health Emergency (PHE). In addition to recognizing the limitations above in the design stage, the evaluation findings are impacted by the novel coronavirus pandemic and the State's PHE response. The pandemic began 18 months after the start of the Demonstration and had not dissipated by the end of DY3. As disease surges persist and the virus moves to an endemic phase, it is expected to have a continual impact on service delivery and member behavior. This limits the ability of the evaluators to study a before/after impact on the Demonstration during this interim report period. The evaluators will revisit potential design adjustments and analytic methods in the summative report.

## IV. RESULTS

This section presents the findings for the New Hampshire SUD Treatment and Recovery Access Demonstration by evaluation question and hypothesis. Many of the New Hampshire residential SUD IMD treatment facilities were existing statewide providers at the outset of the Demonstration. Most residential SUD treatment facilities had been delivering care to Medicaid enrollees prior to the implementation of the SUD Demonstration. Therefore, these findings are longitudinal and should not be interpreted as causal evidence for the impacts of the Demonstration.

The remainder of this section provides detailed findings, including the statistical analyses used for each evaluation measure.

### EVALUATION QUESTION 1 (ACCESS)

Evaluation Question One asks, “What are the impacts of the Demonstration on access to SUD residential treatment services for Demonstration enrollees?” Exhibit IV-1 provides an overview of the hypothesis and measures associated with Evaluation Question One.

#### ***Exhibit IV-1. Evaluation Question 1 Hypotheses and Measures***

Hypotheses	Measures
A. Adult enrollees will have better access to residential SUD treatment services.	1. Percent of enrollees ages 12-64 with an SUD claim for treatment in an IMD with a discharge date during the year
	2. The total number of licensed beds for Medicaid enrolled SUD residential treatment providers each year

**Measure 1.A.1. Percent of enrollees ages 12-64 with an SUD claim for treatment in an IMD with a discharge date during the year.**

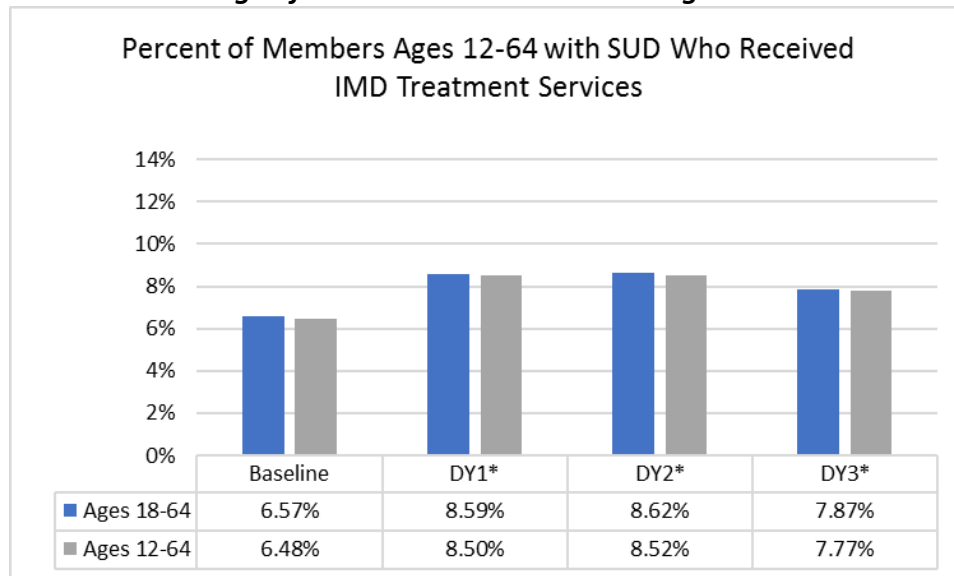
**Measure Description:** This measure follows the SUD Monitoring Protocol methodology for Metric #4 (Medicaid Beneficiaries with SUD diagnosis annually). The number of unique beneficiaries with full benefits enrolled in Medicaid for at least one month (30 days) who receive Medication Assisted Treatment (MAT) or have a qualifying facility claim, provider or pharmacy claim with an SUD diagnosis and an SUD related treatment service during the measurement period and/or in the 12 months before the measurement period were included in the denominator. The numerator was created by counting enrollees with an IMD discharge date during the measurement period using the DHHS list of SUD residential providers designated as IMDs.

**Data Source and Time Period:** PAP and MMIS paid claims, and MCO encounters SFY2017-21.

**Analytical Approach:** Logistic Regression

**Findings:** During the baseline period, 6.48 percent of all members ages 12 to 64 and 6.57 percent of adult members (ages 18 to 64) received IMD treatment services. Members ages 12 to 64 with an SUD receiving IMD services rose above baseline to 8.50 percent in DY1, 8.52 percent in DY2, and 7.77 percent in DY3. The adult age group showed a similar increase above baseline to 8.59 percent in DY1, 8.62 percent in DY2, and 7.87 percent in DY3. Although the DY3 rates fell slightly from the prior year in both age groups, the increase over baseline was statistically significant in each year of the Demonstration.

**Exhibit IV-2: Percentage of Members with SUD Receiving IMD Treatment Services**



*\*Statistically significant change from baseline period*

**Measure 1.A.2 The total number of licensed SUD treatment beds for Medicaid Enrolled SUD residential treatment providers each year.**

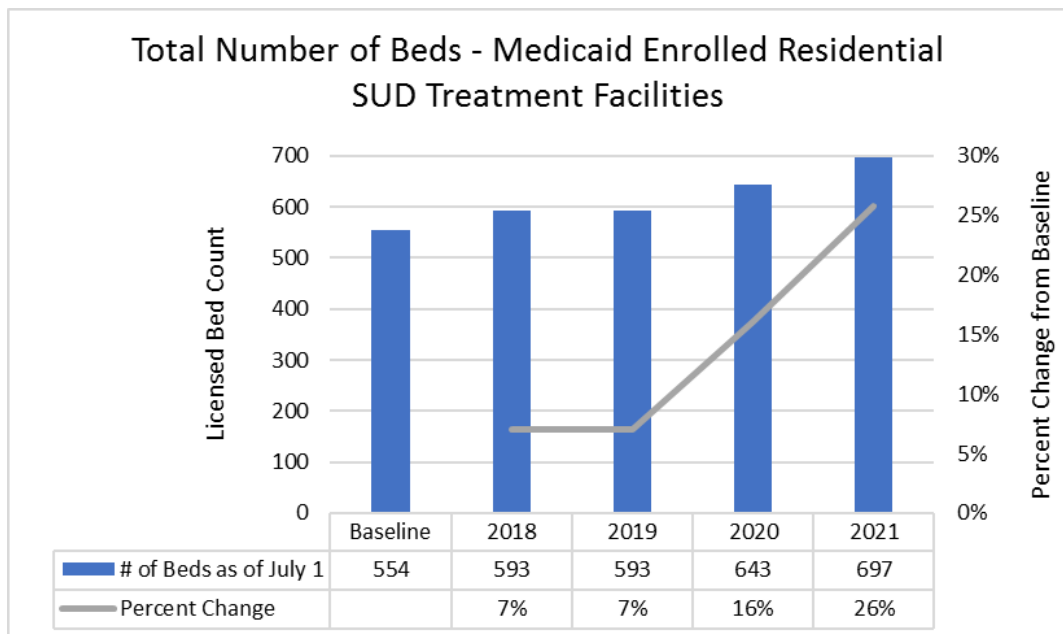
**Measure Description:** This measure was calculated using a licensed bed count and MMIS provider enrollment detail for all Medicaid enrolled residential SUD treatment programs as of July 1 of each year. Total beds were summed annually and the percent change year over year calculated.

**Data Source and Time Period:** MMIS provider enrollment files; Bureau of Health Care Licensing SUD Facility Reports as of July 1 of each year.

**Analytical Approach:** Descriptive

**Findings:** New Hampshire results show that residential SUD treatment capacity has increased over time. On July 1, 2018, at the start of the Demonstration, there were 593 Medicaid enrolled beds; in 2019 there were 593 beds; in 2020 there were 643 beds. By 2021 the residential SUD treatment capacity rose to 697, a 26 percent increase over baseline.

**Exhibit IV-3: Bed Capacity for Medicaid-Enrolled Residential Treatment Providers**



EVALUATION QUESTION 2 (QUALITY)

Evaluation Question Two asks, “What are the impacts of the Demonstration on quality of care for Medicaid enrollees with an SUD diagnosis?” Exhibit IV-4 provides an overview of six hypotheses and seven measures associated with Evaluation Question Two.

**Exhibit IV-4: Evaluation Question 2 Hypotheses and Measures**

Hypotheses	Measures
A. Enrollees with SUD will have fewer ED visits for SUD	1. The total number of ED visits for SUD per 1,000 SUD Demonstration enrollees
B. Enrollees with SUD will have fewer total ED visits	1. The total number of ED visits for any reason per 1,000 SUD Demonstration enrollees
C. Enrollees with SUD will have fewer ED visits post discharge from an SUD IMD	1. The frequency and rate of ED use, for enrollees receiving SUD IMD services, 90 days prior to their IMD admission and 90 days post their IMD discharge
D. Enrollees with SUD will have improved rates of initiation and engagement in alcohol and other drug treatment	1. Percentage of enrollees who initiated treatment within 14 days of diagnosis
	2. Percentage of enrollees who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit
E. Enrollees with SUD will have lower IMD readmission rates	1. The percent of SUD IMD stays during the measurement period followed by an SUD IMD readmission for SUD within 30 days
F. Enrollees with SUD will have improved rates of treatment retention	1. The percent of enrollees who had SUD treatment visits 45, 90, 135 and 180 days following IMD discharge

**Measure 2.A.1. The total number of ED visits for SUD per 1,000 SUD Demonstration enrollees.**

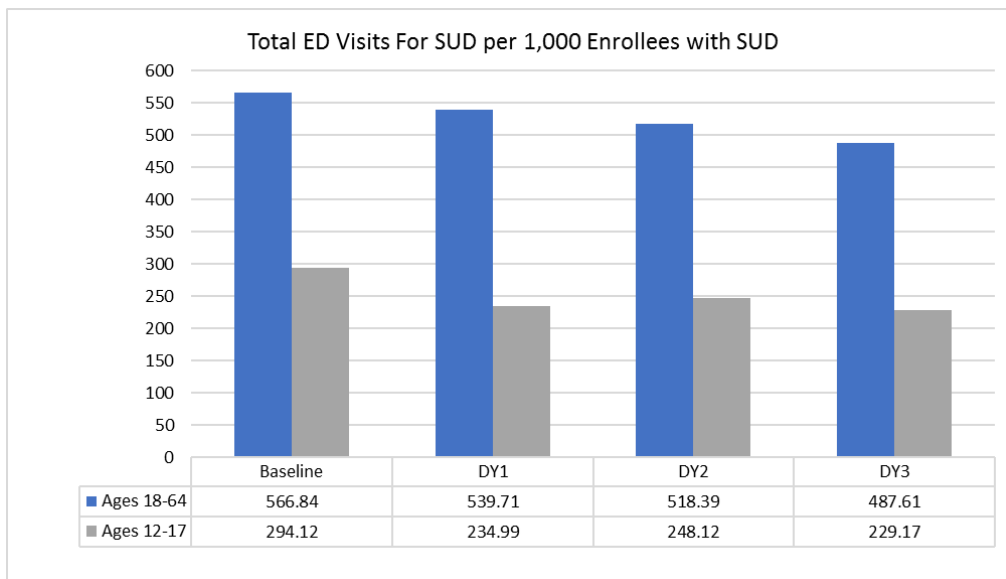
**Measure Description:** This measure follows the SUD Monitoring Protocol methodology for Metric #23 (ED visits for SUD per 1,000 enrollees). The measure was stratified for the adult and adolescent SUD sub-groups and the adult IMD study group.

**Data Source and Time Period:** PAP and MMIS paid claims, and MCO encounters SFY2017-21.

**Analytical Approach:** Linear Regression for the IMD Study Group

**Findings:** ED visits for SUD have been declining since the baseline level of 566.84 visits per 1,000 adult enrollees with an SUD and 294.12 visits per 1,000 adolescent enrollees with an SUD. ED visits for SUD per 1,000 adult enrollees in DY1 declined to 539.71. During the onset of the PHE, the adult rate of ED visits for SUD declined further to 518.39 in DY2 and 487.61 in DY3. ED visits for SUD among adolescents dropped from 294.12 visits per 1,000 at baseline to 234.99 ED visits for SUD in DY1. During the onset of the PHE, adolescent ED visits for SUD rose to 248.12 in DY2 before declining to 229.17 in DY3.

**Exhibit IV-5: Emergency Department (ED) Utilization for Enrollees with SUD**



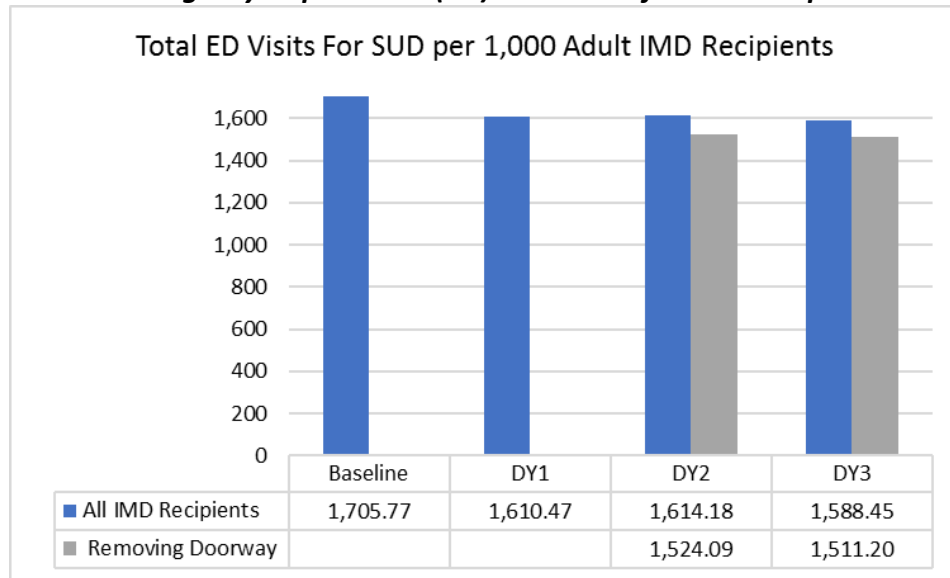
ED visits for the adult IMD study group were also examined. This group represents individuals requiring the most intensive level of SUD treatment, including medically managed and medically monitored detoxification services, intensive residential treatment, and inpatient care.

ED visits for SUD among adult IMD service recipients declined from a baseline of 1,705.77 per 1,000 IMD enrollees to 1,610.47 ED visits for SUD per 1,000 IMD enrollees during DY1. During the onset of the PHE, the IMD enrollee rate of ED visits for SUD rose slightly to 1,614.88 ED visits for SUD before declining to 1,588.45 during DY3. When Doorway program recipients were



removed from the IMD study group, the positive trend in change over baseline was maintained for DY2 and DY3.

**Exhibit IV-6: Emergency Department (ED) Utilization for IMD Recipients**



A linear regression controlling for age and gender for the IMD study group was performed. Statistical significance suggests the likelihood of the variable having an impact, while the coefficient estimate measures the size and direction of the potential effect. The intercept represents the baseline (mean values) before accounting for differences due to member demographics or measurement year.

Age and gender accounted for the some of the variation seen across years with ED use increasing with age and females being less likely than males to use ED services. The Demonstration Year did not have statistically significant explanatory power for the variation in the data. Regression coefficients for the IMD study group are summarized in Exhibit IV-7.

**Exhibit IV-7: Regression Coefficients - ED visits for SUD, IMD Study Group**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	1.753e-03	2.590e-04	6.767	1.48e-11***	Yes
Age	4.129e-05	5.912e-06	6.983	3.30e-12***	Yes
Gender (Female)	-2.887e-04	1.197e-04	-2.412	0.0159*	Yes
Year (DY1)	-6.546e-05	1.707e-04	-0.383	0.7015	No
Year (DY2)	-3.651e-05	1.710e-04	-0.214	0.8309	No
Year (DY3)	-2.095e-04	1.737e-04	-1.206	0.2279	No

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

In addition, a linear regression controlling for age, gender and Doorway participation was performed. Results show that age and Doorway participation accounted for some of the variation seen in DY2 and DY3 (the first full years of Doorway overlap with the Demonstration).

ED use increased with age and with Doorway program services. Demonstration Year did not have statistically significant explanatory power for the variation in the data.

Regression coefficients for DY3 and Doorway services are summarized in Exhibit IV-8.

**Exhibit IV-8: Regression Coefficients ED visits for SUD, Controlling for Doorway Service Recipients DY2-DY3**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	1.528e-03	3.522e-04	4.339	1.49e-05***	Yes
Age	4.420e-05	8.748e-06	5.052	4.70e-07***	Yes
Gender (Female)	-3.194e-04	1.760e-04	-1.815	0.06969 †	No
Year (DY3)	-2.116e-04	1.688e-04	-1.253	0.21023	No
Doorway Service	5.715e-04	2.133e-04	2.680	0.00741**	Yes

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

### 2.B.1. The total number of ED visits for any reason per 1,000 SUD Demonstration enrollees.

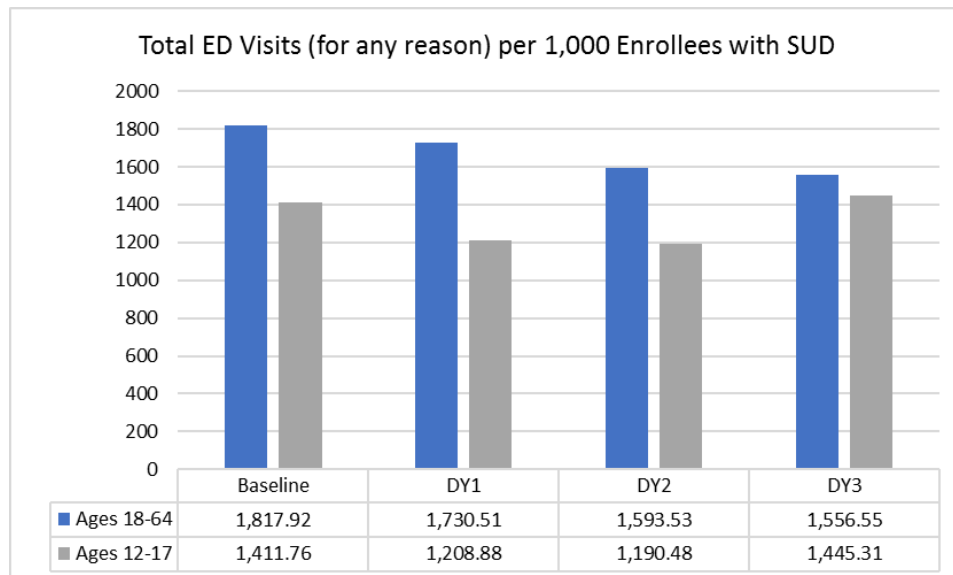
**Measure Description:** This measure is an adaptation of the CMS measure Ambulatory Care: Emergency Department (ED) Visits from the Medicaid Health Home Core Set. The metric was adapted to include those only enrollees identified with an SUD under the Demonstration. The measure was stratified for the adult and adolescent SUD sub-groups and the adult IMD study group.

**Data Source and Time Period:** PAP and MMIS paid claims, and MCO encounters SFY2017-21.

**Analytical Approach:** Linear Regression for the IMD Study Group

**Findings:** ED visits for any reason have been declining since the baseline level of 1,817.92 visits per 1,000 adult enrollees with an SUD. ED visits per 1,000 adult enrollees in DY1 declined to 1,730.51. During the onset of the PHE, the adult rate of ED visits declined further to 1,593.53 in DY2 and 1,556.55 in DY3. ED visits for any reason among adolescents dropped from 1,411.76 visits per 1,000 at baseline to 1,208.88 in DY1. During the onset of the PHE, adolescent ED visits declined to 1,190.48 before increasing in DY3 to 1,445.31.

**Exhibit IV-9: Emergency Department (ED) Utilization for Enrollees with SUD**



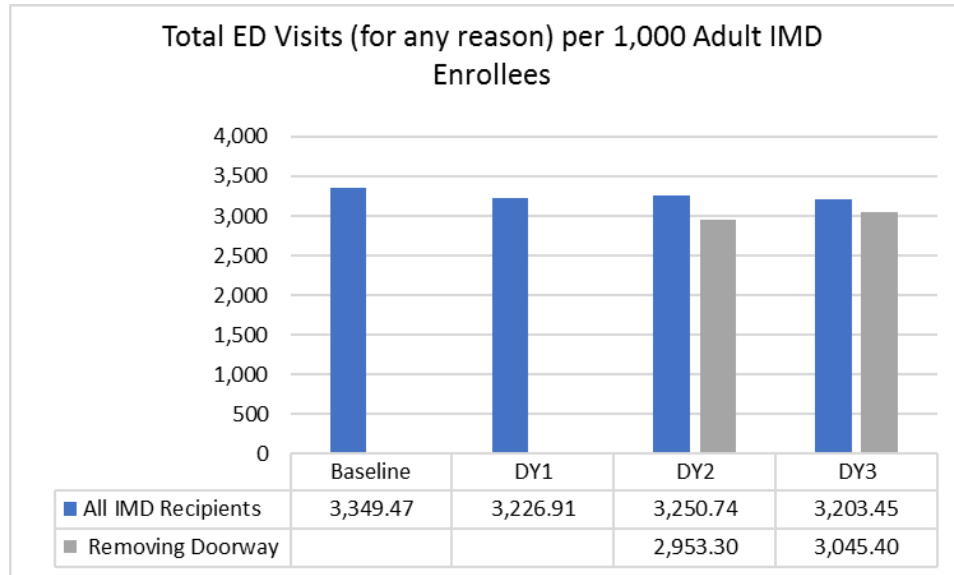
ED visits for the adult IMD study group were also examined. This group represents individuals requiring the most intensive level of SUD treatment including medically managed and medically monitored detoxification services, intensive residential treatment, and inpatient care.

ED visits for any reason among adult IMD service recipients declined from a baseline of 3,349.97 per 1,000 IMD enrollees to 3,226.91 ED visits per 1,000 IMD enrollees during DY1.

During the onset of the PHE, the IMD enrollee rate of ED visits was 3,250.74 in DY2 and 3,203.45 during DY3.

When Doorway program recipients were removed from the IMD study group, the positive trend in change over baseline was maintained for DY2-DY3.

**Exhibit IV-10: Emergency Department (ED) Utilization, All Reasons**



A linear regression controlling for age, gender for the IMD study group was performed. Statistical significance suggests the likelihood of the variable having an impact, while the coefficient estimate measures the size and direction of the potential effect. The intercept represents the baseline (mean values) before accounting for differences due to member demographics or measurement year.

Age accounted for some of the variation seen across years with ED use increasing in older enrollees. Gender and year did not have significant explanatory power to account for the variation seen across years. Regression coefficients for the IMD study group are summarized in Exhibit IV-11.

**Exhibit IV-11: Regression Coefficients ED visits, IMD Study Group**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	3.002852	0.302903	9.914	< 2e-16***	Yes
Age	0.039975	0.007025	5.690	1.33e-08 ***	Yes
Gender (Female)	-0.096879	0.137489	-0.705	0.481	No
Year (DY1)	-0.096291	0.197780	-0.487	0.626	No
Year (DY2)	-0.031689	0.197989	-0.160	0.873	No
Year (DY3)	-0.229070	0.201118	-1.139	0.255	No

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

In addition, a linear regression controlling for age, gender and Doorway participation was performed. Results show that age and Doorway recipients accounted for some of the variation seen in DY2 and DY3 (the first full years of Doorway overlap with the Demonstration). ED use increased with age and with Doorway program services. No other variables had statistically significant explanatory power for the variation in the data. Regression coefficients for the DY2-DY3 and Doorway services are summarized in Exhibit IV-12.

**Exhibit IV-12: Regression Coefficients ED visits, Controlling for Doorway Service Recipients  
DY2-DY3**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	2.54772	0.41800	6.095	1.22e-09***	Yes
Age	0.04542	0.01053	4.315	1.64e-05 ***	Yes
Gender (Female)	-0.07081	0.20330	-0.348	0.728	No
Year (DY3)	-0.27546	0.19582	-1.407	0.160	No
Doorway Service	1.32574	0.24845	5.336	1.01e-07 ***	Yes

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

**2.C.1. The frequency and rate of ED use, for enrollees receiving SUD IMD services, 90 days prior to their IMD admission and 90 days post their IMD discharge.**

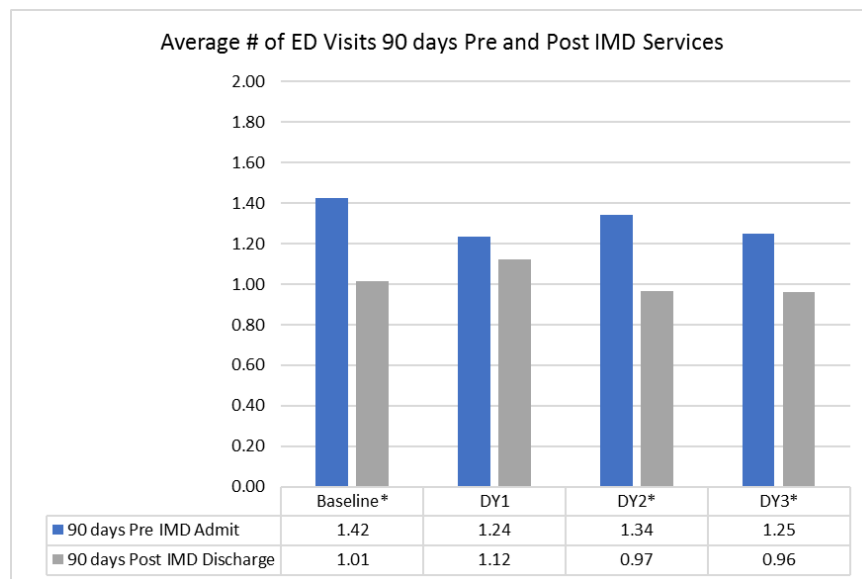
**Measure Description:** IMD service recipients were identified using the DHHS methodology previously described. The frequency and rate of ED use 90 days prior to their IMD admission and 90 days post IMD discharge was calculated. ED visits were defined and counted using the ED visit specifications from measure 2.B.1 above.

**Data Source and Time Period:** PAP and MMIS paid claims, and MCO encounters SFY2017-21.

**Analytical Approach:** Welch Two Sample T-test (unequal variance), individual year and pooled years.

**Findings:** The average number of ED visits in the 90 days prior to an IMD admission was 1.42 during the baseline period, 1.24 in DY1, 1.34 in DY2 and 1.25 in DY3. For each year of the interim evaluation period, IMD enrollees showed fewer visits in the 90 days following discharge. During the baseline period, the average number of visits in the 90 days following discharge was 1.01, in DY1 the average was 1.12 and during the onset of the PHE the average in DY2 was 0.97, and 0.96 in DY3. A pooled t-test for all years yielded a statistically significant difference in the rate of ED visits pre/post IMD services, with a reduction seen post IMD services. In assessing each year individually, the reduction in the average number of ED visits post IMD stay were statistically significant during the baseline period, DY2 and DY3.

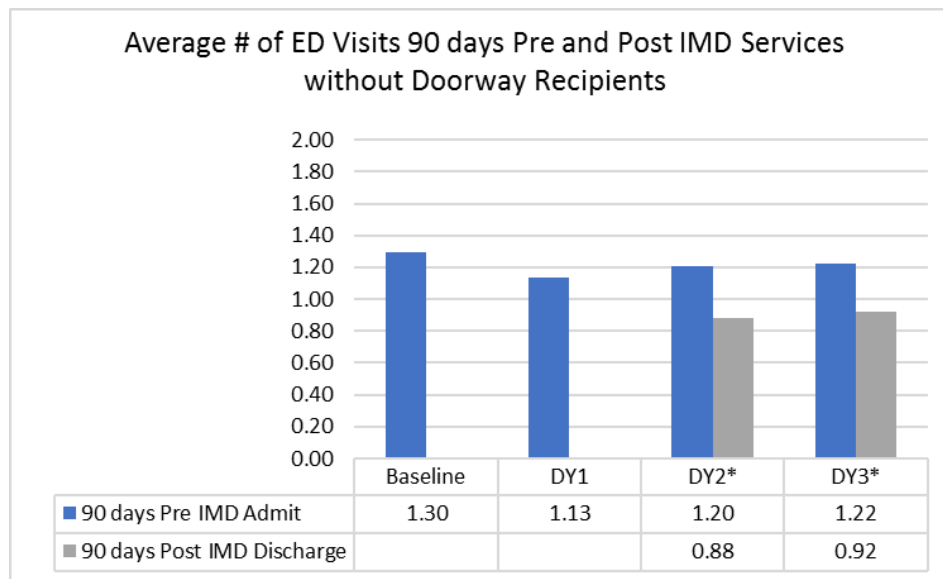
**Exhibit IV-13: Average Number of Emergency Department (ED) Visits Before and After IMD Stay**



*\*Statistically significant change in the ED visit rate post IMD services*

When Doorway program recipients were removed from the IMD study group, the reduction in ED visits post IMD discharge was maintained for DY2-DY3. A pooled t-test for all years yielded a statistically significant difference in the rate of ED visits pre/post IMD services, with an overall reduction in ED use seen post IMD services in each year. In assessing each year individually, the reduction in the average number of ED visits post IMD stay remained statistically significant during DY2 and DY3.

**Exhibit IV-14: Average Number of Emergency Department (ED) Visits Before and After IMD Stay, without Doorway Recipients**



*\*Statistically significant change in the ED visit rate post IMD services*

### 2.D.1. The percentage of enrollees who initiated treatment within 14 days of diagnosis.

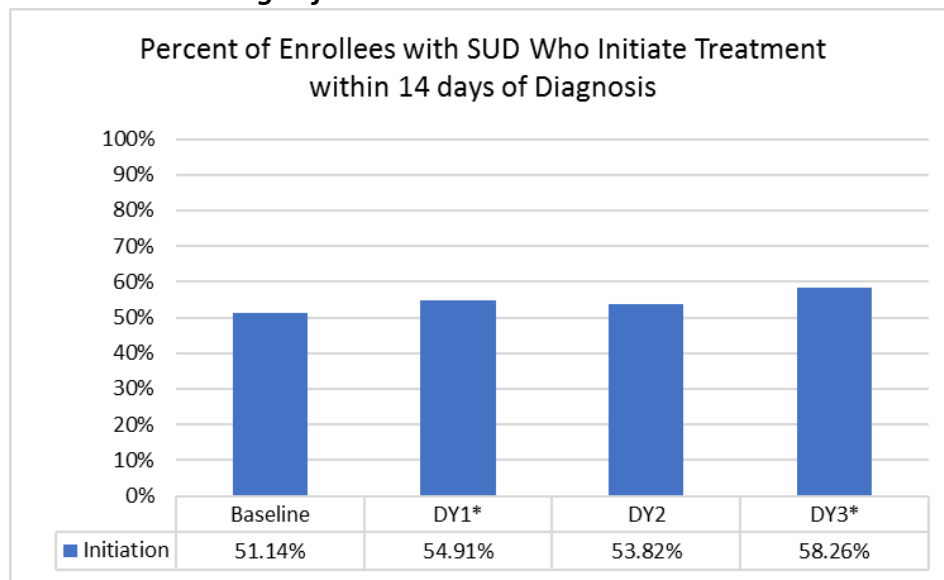
**Measure Description:** This measure follows the HEDIS methodology for Initiation and Engagement in Treatment. The results represent members with an SUD who initiated treatment within fourteen days of their diagnosis.

**Data Source and Time Period:** PAP and MMIS paid claims, and MCO encounters SFY2017-21.

**Analytical Approach:** Logistic Regression.

**Findings:** The percent of enrollees with an SUD has been increasing over the baseline of 51.14 percent. In DY1, 54.91 percent initiated treatment; in DY2, 53.82 percent initiated treatment, and in DY3 58.26 percent initiated treatment. Results in the most recent evaluation period (DY3) represent a 14 percent increase over baseline. Differences compared to baseline were statistically significant in DY1 and DY3.

**Exhibit IV-15: Percentage of Enrollees with SUD Who Initiate Treatment**



*\*Statistically significant change from baseline period*



**2.D.2. The percentage of enrollees who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.**

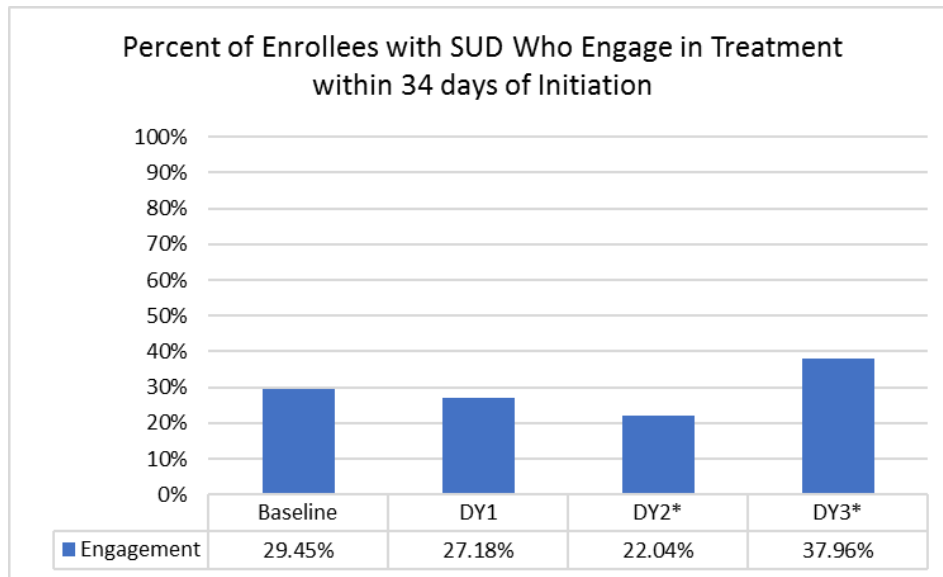
**Measure Description:** This measure follows the HEDIS methodology Initiation and Engagement in Treatment. The results represent the percentage of enrollees who engage in treatment within 34 days of their initiation visit (identified in measure 2.D.1 above).

**Data Source and Time Period:** PAP and MMIS paid claims, and MCO encounters SFY2017-21.

**Analytical Approach:** Logistic Regression.

**Findings:** The percent of enrollees who engaged in treatment following the initiation visit declined from 29.45 percent at baseline to 27.18 percent in DY1 and 22.04 percent in DY2 before increasing above baseline levels to 37.96 percent in DY3. Results in the most recent evaluation period (DY3) represent a 28.90 percent increase over baseline. Differences compared to baseline were statistically significant in DY2 and DY3.

**Exhibit IV-16: Percentage of Enrollees with SUD Who Engage in Treatment within 34 Days**



*\*Statistically significant change from baseline period*

**2.E.1. The percent of SUD IMD stays during the measurement period followed by an SUD IMD readmission for SUD within 30 days.**

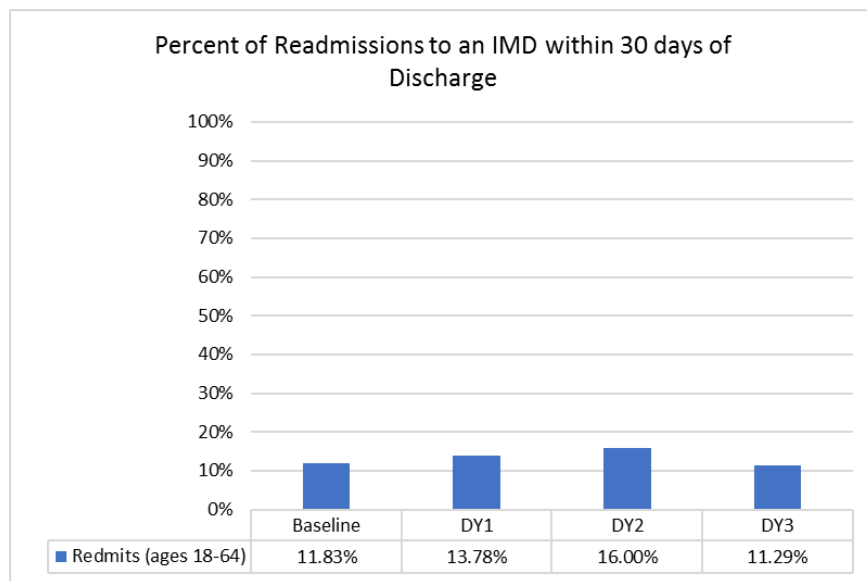
**Measure Description:** The denominator represents the total number of IMD discharges during the measurement period. The numerator represents the number of readmissions to an IMD that occurred within 30 days of the discharge date.

**Data Source and Time Period:** PAP and MMIS paid claims, and MCO encounters SFY2017-21.

**Analytical Approach:** Linear Regression.

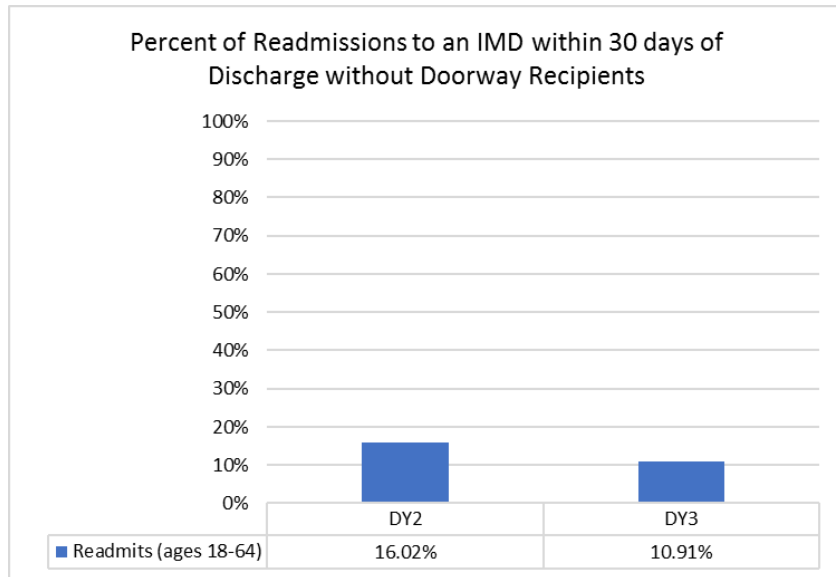
**Findings:** The percent of readmissions to an IMD rose from a baseline of 11.83 percent to 13.78 percent in DY1 and 16 percent in DY2 before declining to 11.29 percent in DY3. The percent of readmission for the most recent year of the evaluation is 4.57 percent lower than the baseline year.

**Exhibit IV-17: IMD Readmissions within Thirty Days of Discharge**



When Doorway program recipients were removed from the IMD study group, the group showed the same trend with an increase over baseline in DY2 followed by a decrease over baseline for DY3.

**Exhibit IV-18: IMD Readmissions within Thirty Days of Discharge, without Doorway Recipients**



A linear regression controlling for age, gender for the IMD study group was performed. Statistical significance suggests the likelihood of the variable having an impact, while the coefficient estimate measures the size and direction of the potential effect. The intercept represents the baseline (mean values) before accounting for differences due to member demographics or measurement year.

Neither age nor gender had significant explanatory power to account for the variation seen across years in the percent of members with an IMD readmission. Regression coefficients for the IMD study group are summarized in Exhibit IV-19.

**Exhibit IV-19: Regression Coefficients IMD Readmissions**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	0.4538263	0.0176754	25.676	< 2e-16***	Yes
Age	0.0006387	0.0004158	1.536	0.1248	No
Gender (Female)	0.0052412	0.0078977	0.664	0.5071	No
Year (DY1)	0.0048362	0.0116955	0.414	0.6793	No
Year (DY2)	-0.0003420	0.0114051	-0.030	0.9761	No
Year (DY3)	-0.0237865	0.0122033	-1.949	0.0515	No

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

In addition, a linear regression controlling for age, gender and Doorway participation was performed. Results show that age, year, and Doorway services accounted for some of the variation seen in readmissions for DY2 and DY3 (the first full years of Doorway overlap with the Demonstration). Readmissions increased with age and decreased for members who had Doorway program services. Regression coefficients for DY2-DY3 Doorway analysis are summarized in Exhibit IV-20.

**Exhibit IV-20: Regression Coefficients IMD Readmissions, Controlling for Doorway Service Recipients DY2-DY3**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	0.4192523	0.0217321	19.292	< 2e-16***	Yes
Age	0.0017667	0.0005859	3.015	0.00267 **	Yes
Gender (Female)	0.0088076	0.0107971	0.816	0.41494	No
Year (DY3)	-0.0220716	0.0104660	-2.109	0.03533 *	Yes
Doorway Service	-0.0332684	0.0125926	-2.642	0.00844 **	Yes

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

**2.F.1. The percent of enrollees who had SUD treatment visits at 45, 90, 135 and 180 days following IMD discharge.**

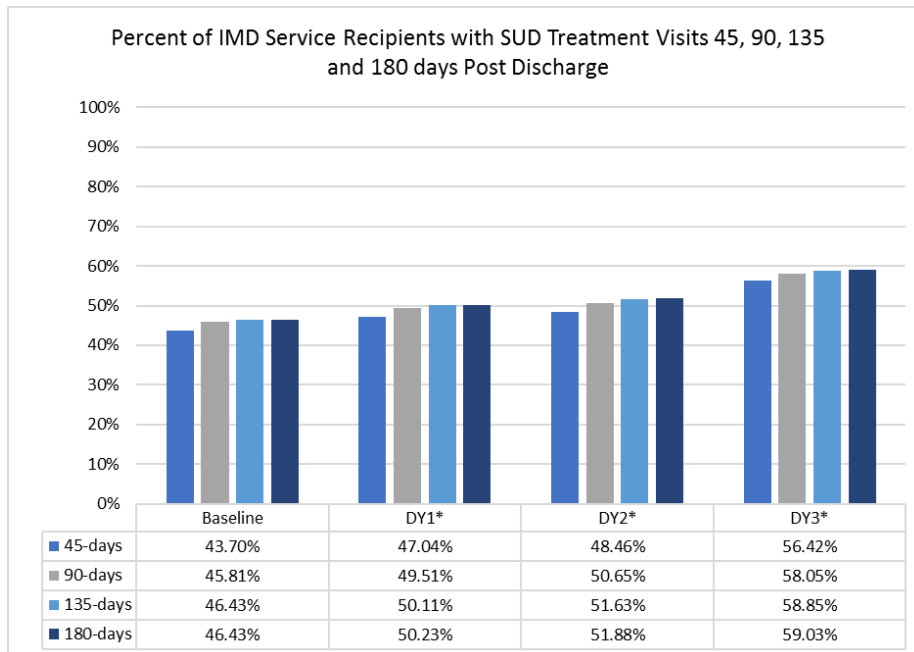
**Measure Description:** The denominator represents the total number of enrollees who were discharged from an IMD during the measurement period. The numerator represents those enrollees who had SUD treatment visits in the 45, 90, 135 and 180 days following the IMD discharge. All claims and encounters with a primary diagnosis of SUD were included in the numerator regardless of treatment setting (e.g., Intensive Outpatient, IMD, and hospital services). Results are cumulative (i.e., the 90-day period includes the 45-day period).

**Data Source and Time Period:** PAP and MMIS paid claims, and MCO encounters SFY2017-21.

**Analytical Approach:** Logistic Regression.

**Findings:** During the baseline period, the percent of recipients receiving a treatment service within 45 days was 43.70 percent, within 90 days was 45.81, within 135 days was 46.43 percent and within 180 days was 46.43. During DY1, the percent rose to 47.04 within 45 days, 49.51 within 90 days, 50.11 within 135 days and 50.23 within 180 days. In DY2, the percentage increased to 48.46 within 45 days, 50.65 within 90 days, 51.63 within 135 days and 51.88 within 180 days. In DY3, the percentages continued to increase over baseline with 56.42 of enrollees receiving SUD treatment services within 45 days, 58.05 within 90 days, 58.85 within 135 days and 59.03 within 180 days. Change over baseline was statistically significant in each year of the evaluation period.

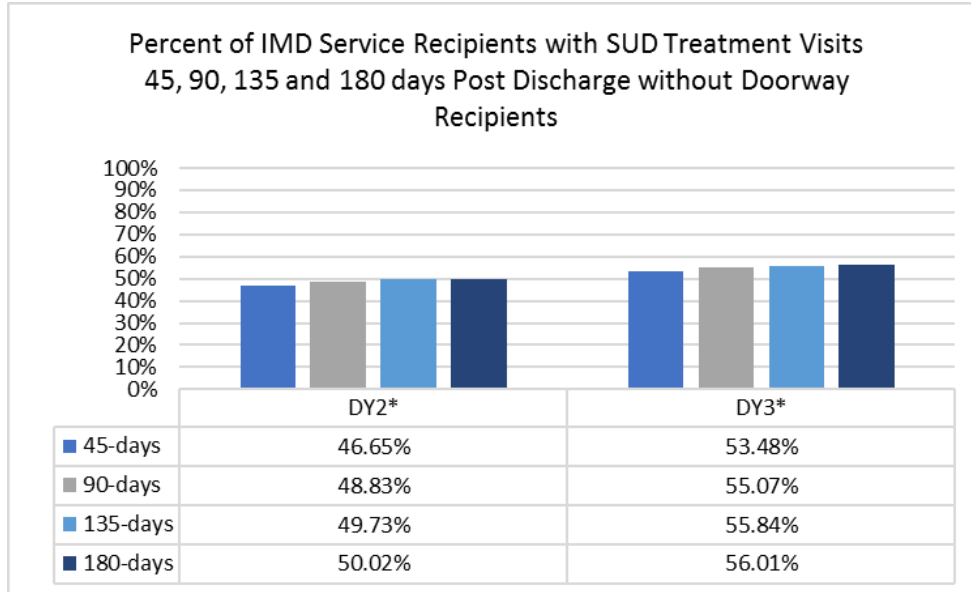
**Exhibit IV-21: Percentage of IMD Service Recipients with Follow-Up SUD Treatment**



*\*Statistically significant change from baseline period*

When Doorway program recipients were removed from the IMD study group, the group showed the same trend in DY2-DY3 with improvements in the percent of IMD recipients who received treatment services at 45-, 90-, 135- and 180-days post discharge.

**Exhibit IV-22: Percentage of IMD Service Recipients with Follow-Up SUD Treatment, without Doorway Recipients**



*\*Statistically significant change from baseline period*

EVALUATION QUESTION 3 (COST)

Evaluation Question 3 asks: “Will the Demonstration maintain or reduce spending in comparison to what would have been spent absent the Demonstration?”

Exhibit IV-23 provides an overview of the hypothesis and measure associated with Evaluation Question 3.

***Exhibit IV-23: Evaluation Question 3 Hypotheses and Measures***

Hypotheses	Measures
A. The Demonstration will be cost neutral	The PMPM trend rates and per capita cost estimates for each eligibility group defined in STC 60 for each year of the demonstration.

**3.A.1. The PMPM trend rates and per capita cost estimates for each eligibility group defined in STC 60 for each year of the Demonstration.**

**Measure Description:** This measure examines the actual PMPM rates against the CMS approved PMPM limits for each of the approved Medicaid Eligibility Groups under the Demonstration. CMS considers these PMPM limits as part of a hypothetical spending cap, representing what may have been spent absent the Demonstration. In alignment with the DHHS budget neutrality reporting methodology, the adolescent group for this measure includes Demonstration participants who are ages 18-21.

**Data Source and Time Period:** DHHS budget neutrality workbook as submitted to CMS annually through the first quarter of DY4.

**Analytical Approach:** Descriptive

**Findings:** New Hampshire’s Budget Neutrality cap was adjusted at the end of DY2 as the result of the Demonstration amendment. The hypothetical PMPM limits (i.e., the estimate of what may have been spent absent the Demonstration) were readjusted by CMS and are no longer considered for DY1 and DY2 as part of the hypothetical spending cap. At the end of DY3, DHHS was meeting the budget neutrality requirements. Actual expenditures through Demonstration in DY3 were \$2,551,780 below the hypothetical cap set by CMS. After the first three quarters of DY4, the Demonstration is maintaining this trend with actual expenditures \$4,767,259 below the cap set by CMS (cumulatively).

**Exhibit IV-24: Summary of Budget Neutrality Status**

Medicaid Eligibility Group	DY3	DY4 Through Q3
<b>Without Waiver Limit</b>		
Medicaid Adults	\$1,003,300	\$797,046
Expansion Adults	\$6,056,909	\$4,400,698
Adolescents	\$27,638	\$17,904
<b>Total</b>	<b>\$7,087,846</b>	<b>\$5,215,648</b>
<b>Actual Expenditures</b>		
	<b>DY 3</b>	<b>DY4 Through Q3</b>
Medicaid Adults	\$1,304,468	\$971,327
Expansion Adults	\$3,211,248	\$2,009,887
Adolescents	\$20,350	\$18,955
<b>Total</b>	<b>\$4,536,066</b>	<b>\$3,000,169</b>
<b>Hypothetical Savings</b>		
Annual Surplus (Deficit)	<b>\$2,551,780</b>	<b>\$2,215,479</b>
Cumulative Surplus (Deficit)	<b>\$2,551,780</b>	<b>\$4,767,259</b>



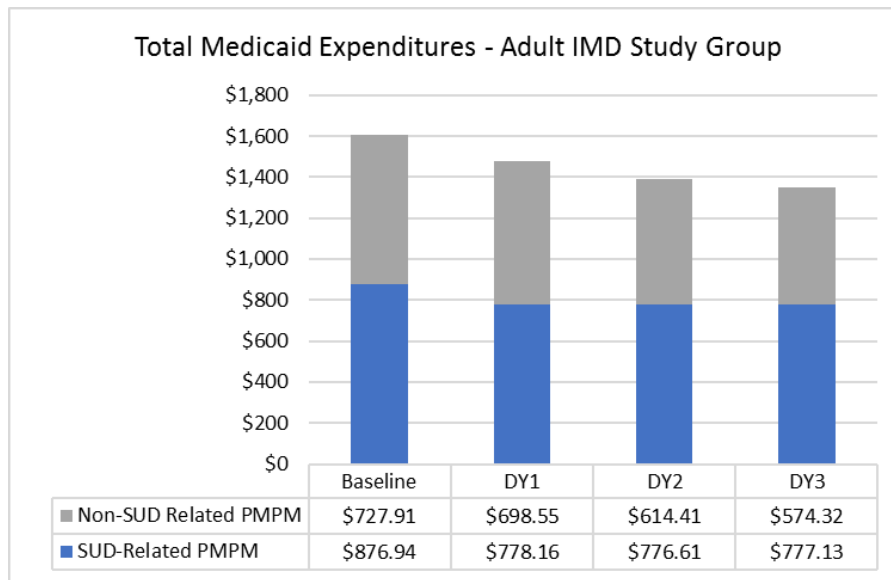
An exploratory analysis of expenditures for the adult IMD study group was performed; these measures capture all costs for the measurement year and are not associated with a hypothesis or with budget neutrality reporting.

Total Cost of Care

The total cost of care was calculated for all adult enrollees who received IMD services during the measurement period. Expenditures were stratified into SUD-related and non-SUD health care services. SUD-related services were defined as claims with a primary diagnosis of SUD. Total costs are expressed as per member per month, with breakouts for cost drivers such as SUD-IMD, SUD-non IMD residential, ED, inpatient, pharmacy, and long-term care (LTC) services.

Total Medicaid expenditures show a steady decline during the Demonstration period, with the PMPM for SUD-related treatment services being slightly higher than the non-SUD related services. Total PMPM during the baseline period was \$1,604.85; DY1 resulted in nearly an eight percent decline to \$1,476.71; DY2 showed a decline of over 13 percent below baseline with a total PMPM of \$1,391.02; DY3 continued the decline with nearly a 16 percent drop over baseline to a PMPM of \$1,351.44.

**Exhibit IV-25: Total Medicaid Expenditures**



A linear regression of costs was performed. Statistical significance suggests the likelihood of the variable having an impact, while the coefficient estimate measures the size and direction of the potential effect. The intercept represents the baseline (mean values) before accounting for differences due to member demographics or measurement year.

Age accounted for some of the variation seen with SUD-related PMPM costs increasing with age. DY3 was also statistically significant in explaining some of the variation. DY1, DY2 and gender did not have statistically significant explanatory power for the variation in SUD-related cost when the total PMPM was examined. Regression coefficients are summarized in Exhibit IV-26, on the following page.

**Exhibit IV-26: Regression Coefficients SUD-Related PMPM, IMD Study Group**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	909.576	44.315	20.525	< 2e-16***	Yes
Age	2.254	1.046	2.155	0.0312 *	Yes
Gender (Female)	-7.002	20.346	-0.344	0.7307	No
Year (DY1)	-15.811	29.063	-0.544	0.5864	No
Year (DY2)	29.810	29.022	1.027	0.3044	No
Year (DY3)	89.004	29.659	3.001	0.0027 **	Yes

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

In examining non-SUD related expenditures, age and gender accounted for the some of the variation in the total non-SUD related PMPM. Costs increased with age and women were associated with more non-SUD related costs. DY2, which aligned with the onset of the PHE, showed some statistical power in explanatory lower costs. DY1 and DY3 did not have statistically significant explanatory power for the variation in the non-SUD related PMPM. Regression coefficients are summarized in Exhibit IV-27.

**Exhibit IV-27: Regression Coefficients Non-SUD PMPM, IMD Study Group**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	335.994	56.216	5.977	2.37e-09***	Yes
Age	12.322	1.322	9.323	< 2e-16 ***	Yes
Gender (Female)	108.279	25.731	4.208	2.60e-05 ***	Yes
Year (DY1)	10.506	36.901	0.285	0.7759	No
Year (DY2)	-72.993	36.847	-1.981	0.0476 *	Yes
Year (DY3)	-69.496	37.621	-1.847	0.0647 †	No

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

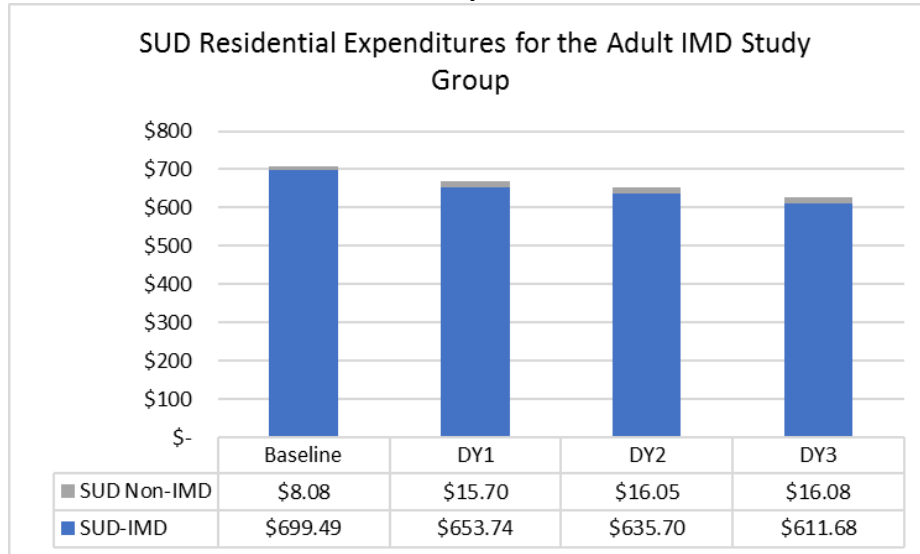
### SUD Residential Treatment Services

Expenditures were examined as they related to SUD-residential services (IMD and non-IMD). Increases were seen in spending for non-IMD residential services; however, they remain a small portion of the residential treatment spending. SUD-IMD service spending declined over baseline, despite an uptick in service utilization in each year of the Demonstration and Medicaid rate increases.

During the baseline year the SUD-IMD PMPM was \$699.49. The PMPM declined from baseline by 6.5 percent to \$653.74 in DY1; DY2 PMPM declined from baseline by over nine percent to a

PMPM of \$635.70; DY3 declined from baseline by over 12.5 percent to \$611.68. Non-IMD residential spending increased from a baseline PMPM of \$8.09 to \$15.70 in DY1 and \$16.05 in DY2 and \$16.08 in DY3.

**Exhibit IV-28: SUD Residential Expenditures**



In a linear regression examining SUD IMD residential costs, neither age, gender nor DY provided statistically significant power in explaining the variation in the SUD-IMD residential treatment PMPM. Regression coefficients are summarized in Exhibit IV-29.

**Exhibit IV-29: Regression Coefficients SUD-IMD Residential PMPM, IMD Study Group**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	829.3158	40.1769	20.642	< 2e-16***	Yes
Age	-0.1515	0.9476	-0.160	0.8730	No
Gender (Female)	-30.9104	18.4507	-1.675	0.0939 +	No
Year (DY1)	3.1785	26.3758	0.121	0.9041	No
Year (DY2)	27.4165	26.3314	1.041	0.2978	No
Year (DY3)	24.4795	26.9000	0.910	0.3628	No

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

In examining the non-IMD residential PMPM, women were less likely to be associated with non-IMD residential costs. No other variable had statistically significant explanatory power for the variation.

Regression coefficients are summarized in Exhibit IV-30, on the following page.

**Exhibit IV-30: Regression Coefficients SUD-Residential PMPM (Non-IMD), IMD Study Group**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	640.763	196.013	3.269	0.00121**	Yes
Age	-1.628	4.167	-0.391	0.69639	No
Gender (Female)	-181.886	77.617	-2.343	0.01980 *	Yes
Year (DY1)	116.216	133.827	0.868	0.38591	No
Year (DY2)	50.314	131.123	0.384	0.70148	No
Year (DY3)	-80.329	128.297	-0.626	0.53175	No

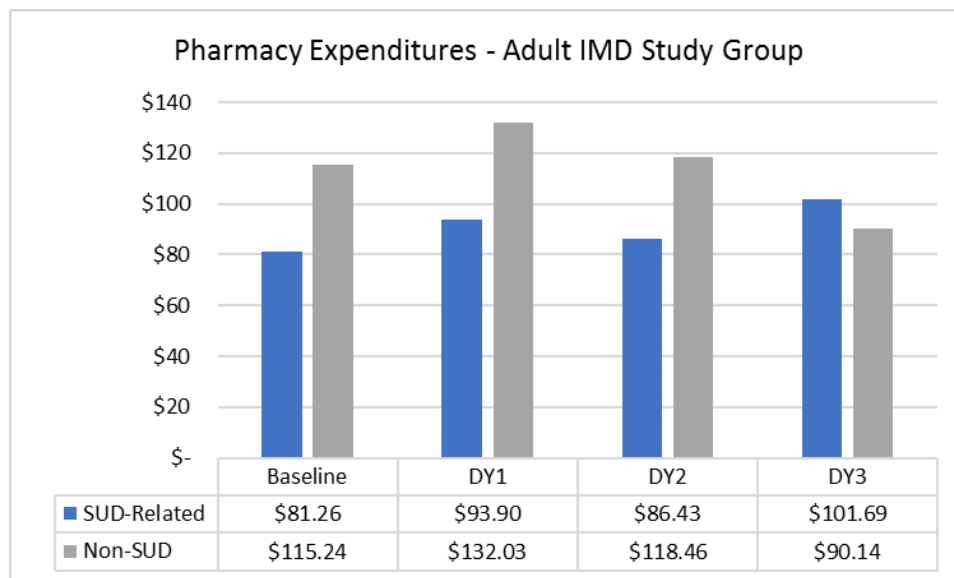
Significance codes: “\*\*\*” = 0.001; “\*\*” = .01; “\*” = 0.05; “+” = 0.1

### Pharmacy

SUD-related pharmacy costs were classified using the HEDIS (measurement year 2020) AOD Medication Treatment Value Set, Alcohol Use Disorder Treatment Medication Lists, and Opioid Use Disorder Treatment Medication Lists, in alignment with the methodology identified in CMS SUD Monitoring Protocol Metric 28 (Medicaid SUD Spending).

Total pharmacy expenditures rose nearly 15 percent over the baseline PMPM of \$196.50 to a DY1 PMPM of \$225.93. DY2 pharmacy costs declined slightly to \$204.89 PMPM (just over four percent above baseline) before declining in DY3 to \$191.83 PMPM (2 percent under baseline levels). SUD-related pharmacy rose from a baseline of \$81.26 PMPM to \$93.90 in DY1; \$86.43 in DY2; and \$101.69 in DY3. SUD-related pharmacy costs remained lower than non-SUD related pharmacy costs apart from DY3.

**Exhibit IV-31: Pharmacy Expenditures**



In a linear regression examining non-SUD-related pharmacy costs, age was the only variable with statistically significant explanatory power. Older recipients were associated with more non-SUD pharmacy costs. Regression coefficients are summarized in Exhibit IV-32.

**Exhibit IV-32: Regression Coefficients Non-SUD Related Pharmacy PMPM, IMD Study Group**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	30.3994	28.8863	1.052	0.2927	No
Age	2.7669	0.6723	4.115	3.91e-05 ***	Yes
Gender (Female)	21.5867	13.0935	1.649	0.0993 †	No
Year (DY1)	20.0650	19.0405	1.054	0.2920	No
Year (DY2)	-1.9438	18.9290	-0.103	0.9182	No
Year (DY3)	-8.4436	19.3136	-0.437	0.6620	No

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

In a linear regression examining SUD-related pharmacy costs, DY3 was the only variable with statistically significant explanatory power. DY3 was associated with more SUD-related pharmacy costs. Regression coefficients are summarized in Exhibit IV-33.

**Exhibit IV-33: Regression Coefficients SUD-related Pharmacy PMPM, IMD Study Group**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	151.40941	15.37529	9.848	< 2e-16***	Yes
Age	0.08946	0.37789	0.237	0.812865	No
Gender (Female)	-5.62694	6.54848	-0.859	0.390227	No
Year (DY1)	7.79098	9.84316	0.792	0.428679	No
Year (DY2)	-4.49749	9.77472	-0.460	0.645452	No
Year (DY3)	35.67182	9.98567	3.572	0.000357 ***	Yes

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

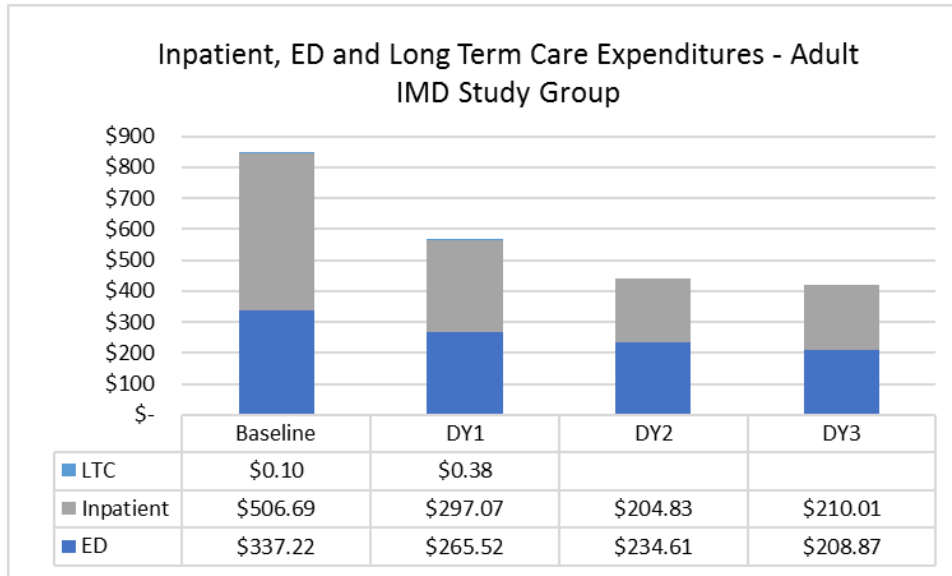
### ED, Inpatient, and Long-Term Care

PMPM trends for ED and inpatient use also declined over the baseline year for the adult IMD study group. At baseline, the PMPM for inpatient treatment was \$506.69. During DY1 the inpatient PMPM dropped to \$297.07, in DY2 the PMPM dropped to \$204.83, followed by a slight increase to \$210.01 in DY3.

The PMPM for ED showed a similar trend, decreasing from a baseline of \$337.22 PMPM to \$265.52 in DY1, \$234.61 in DY2 and \$208.87 in DY3.

Long-Term Care spending was minimal with a PMPM of \$0.10 at baseline and \$0.38 in DY1. No LTC spending was seen in DY2 and 3.

**Exhibit IV-34: Long-Term Care, Inpatient Hospital and Emergency Department Expenditures**



In a linear regression of ED expenditures, age was associated with increased ED cost. Each year of the Demonstration also was associated statistically significant explanatory power for lower ED cost. DY2 and 3 align with the onset of the PHE. Regression coefficients are summarized in Exhibit IV-35.

**Exhibit IV-35. Regression Coefficients ED PMPM, IMD Study Group**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	219.064	41.802	5.240	1.65e-07***	Yes
Age	7.940	0.969	8.194	3.04e-16 ***	Yes
Gender (Female)	-28.601	19.273	-1.484	0.137861	No
Year (DY1)	-72.220	27.588	-2.618	0.008871 **	Yes
Year (DY2)	-105.975	27.578	-3.843	0.000123 ***	Yes
Year (DY3)	-141.936	28.030	-5.064	4.23e-07 ***	Yes

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

In a linear regression of the inpatient expenditures, age was associated with increased cost. Each year of the Demonstration was associated statistically significant explanatory power for lower inpatient cost. Women were also associated with lower inpatient costs. DY2 and 3 align with the onset of the PHE.

Regression coefficients are summarized in Exhibit IV-36.

**Exhibit IV-36: Regression Coefficients Inpatient PMPM, IMD Study Group**

Variable	Coefficient Estimate	Standard Error	t-value	Pr(> t )	Statistical Significance
Intercept	836.653	82.698	10.117	< 2e-16***	Yes
Age	5.539	1.985	2.790	0.00529 **	Yes
Gender (Female)	-114.347	39.783	-2.874	0.00407 **	Yes
Year (DY1)	-114.384	52.942	-2.161	0.03080 *	Yes
Year (DY2)	-215.086	55.544	-3.872	0.00011 ***	Yes
Year (DY3)	-268.485	54.667	-4.911	9.48e-07 ***	Yes

Significance codes: "\*\*\*\*" = 0.001; "\*\*\*" = .01; "\*\*" = 0.05; "+" = 0.1

The long-term care PMPM included fewer than ten observations. Due to the small number a linear regression was not performed.

## V. CONCLUSION

The interim evaluation examined three research questions and eight hypotheses. In general, the Demonstration is achieving its intended goals. A discussion of each evaluation question and interim findings is presented below.

### ***Evaluation Question 1. What are the impacts of the Demonstration on access to SUD residential treatment services for Demonstration enrollees?***

It is hypothesized that access to residential SUD services will increase under the Demonstration. The percent of enrollees with an SUD diagnosis who received IMD services increased in each year of the Demonstration. Enrollees with an IMD service rose from a baseline of 6.5 percent to 8.5 percent in DY 2. In DY 3, as the pandemic moved into an endemic phase, 7.7 percent of enrollees with an SUD received an IMD service. Utilization increased from baseline by just over 30 percent for DY1 and 2 and just under 20 percent in DY3. Differences over baseline were statistically significant in each year of the Demonstration.

The SUD Demonstration also is expected to maintain and encourage growth in adult capacity. In examining the number of Medicaid enrolled SUD residential providers, the evaluation tracked the number of licensed SUD residential treatment beds as of July 1 of each year, regardless of IMD status.

At the onset of the Demonstration there were sixteen licensed residential treatment facilities for individuals with an SUD, fourteen of which were Medicaid enrolled. By DY3, there were nineteen SUD treatment facilities licensed in the State, sixteen of which were Medicaid enrolled. Of the remaining facilities, two were not Medicaid enrolled and one was in the process of becoming enrolled. The licensed bed count for the Medicaid enrolled residential SUD treatment facilities was 554 in the year before the Demonstration; by DY3 that number rose to 697.

The Demonstration is associated with better access to residential SUD treatment services.

### ***Evaluation Question 2. What are the impacts of the Demonstration on quality of care for Medicaid enrollees with an SUD diagnosis?***

The evaluation examined the impact of the Demonstration on ED utilization, IMD readmissions and initiation, engagement, and retention in treatment. It was hypothesized

- A. Enrollees with SUD will have fewer ED visits for SUD
- B. Enrollees with SUD will have fewer total ED visits
- C. Enrollees with SUD will have fewer ED visits post discharge from an SUD IMD
- D. Enrollees with SUD will have improved rates of initiation and engagement in alcohol and other drug treatment



- E. Enrollees with SUD will have lower IMD readmission rates
- F. Enrollees with SUD will have improved rates of treatment retention

Conclusions related to each hypothesis are summarized below.

- A. Enrollees with SUD will have fewer ED visits for SUD
- B. Enrollees with SUD will have fewer total ED visits

The results showed that number of ED visits for SUD declined over baseline in each year of Demonstration. For the overall population of enrollees with an SUD, there was a 20 percent decline in DY1, nearly a 16 percent decline in DY2 and a 22 percent decline in DY3.

The adult IMD study group showed a decline in ED use for SUD over baseline of 5.6 percent in DY1, 5.4 percent in DY2 and nearly 7 percent in DY3. A linear regression showed that age was associated with more ED visits as was having a Doorway service. Being female was associated with fewer ED visits for SUD.

A similar trend was seen when examining ED visits for any reason for DY1 and DY2. ED visits for enrollees with an SUD declined from baseline by just over 14 percent in DY1 and by just over 15 percent in DY2. In DY3, visits were up from baseline by just over 2 percent.

For the adult IMD study group the decline in ED use for any reason over baseline was 3.7 percent in DY1, nearly 3 percent in DY2 and 4.4 percent in DY3. A linear regression showed that age was associated with more ED visits as was having a Doorway service.

In all the regressions, the coefficient estimates were small. Statistical significance suggests the likelihood of the variable having an impact, while the coefficient estimate measures the size of the potential effect. A small coefficient estimate indicates small effect size meaning that while the variables studied (e.g., age, gender, or the 12-month Demonstration period) may be statistically significant (as indicated by p-values) they only play a small part in explaining the results. When the Demonstration period (e.g., DY1, DY2, DY3) and Doorway variable show no significance or show a statistically significant yet a small regression coefficient, we cannot attribute the changes year over year to activities that may have occurred under the Doorway program or Demonstration.

Results show that ED use had declined over baseline in the first year of the Demonstration (pre-pandemic). However, with the onset of the PHE part way through DY2, it is possible that the reductions seen in DY2 and DY3 are impacted the State's PHE response and enrollee concerns with potential exposure to the novel coronavirus in an ED setting. Having a Doorway service was associated with higher ED use. While available to anyone with an SUD, the Doorway is particularly focused on individuals with an opiate addiction, a population with historically high risk of overdose and other health incidents requiring ED services. In some cases, Doorway providers also offer MAT induction in the ED, as they serve as a gateway to other community-

based OUD and SUD treatment and recovery services. In addition, hospital-based providers host Doorway programs, in some cases services are housed on the hospital campus.

C. Enrollees with SUD will have fewer ED visits post discharge from an SUD IMD

In each year of the Demonstration, including baseline, enrollees had fewer ED visits in the 90 days following an IMD discharge as compared to the 90 days prior to admission. In DY1 ED use was over 9 percent lower following an IMD stay, in DY2 ED use was 28 percent lower and DY3 ED use was 23.36 percent lower. While the evaluation findings suggest that ED use post IMD discharge is traditionally lower when compared to use pre-admission, it is likely that the statistically significant drop in ED use post IMD discharge in DY2 and DY3 is also influenced by the State's PHE response.

D. Enrollees with SUD will have improved rates of initiation and engagement in alcohol and other drug treatment

In examining the percent of enrollees who initiated in treatment within 14 days of their diagnosis, DY1 showed a 7.3 percent increase over baseline, DY2 showed a 5.2 percent increase over baseline and DY3 showed a 13.9 percent. The difference from baseline was statistically significant in DY1 and DY3. The percent of enrollees who engaged in additional treatment visits in 34 days after the initiation visits declined in DY1 by nearly 8 percent and in DY2 by over 25 percent before increasing nearly 29 percent over the baseline period. The difference from baseline was statistically significant in DY2 and DY3. It is possible that the decline in engagement after the initial visit was negatively impacted by the onset the PHE and providers suspending operations as quarantine and other emergency actions were implemented. The uptick in engagement in DY3 may be in response to improved access to telehealth, the reinstatement of in-person program operations, and pent-up demand for SUD treatment services.

E. Enrollees with SUD will have lower IMD readmission rates

Readmissions to IMD facilities rose above baseline levels by over 16 percent in DY1 and 35 percent in DY2 before dropping below baseline levels by 4.6 percent in DY3. Unstable living conditions can contribute to SUD relapse and potentially higher readmission rates. DHHS noted that a 1915(i) Supportive Housing waiver was requested from CMS June 21, 2021, for a July 1, 2022, effective date. If approved, hard to reach populations, including Medicaid members with an SUD may be eligible for housing supports. Should the State receive CMS approval, the evaluation will consider its impact in the final year of the SUD Demonstration.

Having a Doorway service was associated with lower rates in DY2 and DY3; older recipients were associated with more readmissions. DY3 showed statistically significant explanatory power for the variation in readmissions. However, in all comparisons the coefficient estimates were small. The coefficient estimates in a regression can be thought of as effect sizes. A small coefficient estimate indicates that while participating in Doorway programs and being older had

a statistically significant impact it played a small part in explaining the differences in results year over year. This makes it difficult to attribute the changes year over year to activities that may have occurred under the Doorway program.

F. Enrollees with SUD will have improved rates of treatment retention

The percent of enrollees who had SUD treatment visits in the six months following IMD discharge was examined at 45-, 90-, 135- and 180-days post discharge. The percent of enrollees with and SUD treatment visit, of any type, in the six months following IMD discharge is consistently increasing year over year. In the first year of the Demonstration, enrollees who had services at each interval increased from 7.6 percent to 8.0 percent over the baseline period. In DY2 the increase in enrollees who had services at each interval ranged from 10.0 percent to 11.7 percent. In DY3 the increase in enrollees who had services at each interval ranged from 26.7 percent to just over 29.0 percent.

Service utilization in DY2 and DY3 was influenced by the onset the PHE. The uptick in members who accessed services post discharge may be related to improvements in discharge planning across all service providers, improved access to telehealth, the reinstatement of in-person program operations, and pent-up demand for SUD treatment services.

***Evaluation Question 3. Will the Demonstration maintain or reduce spending in comparison to what would have been spent absent the demonstration?***

It was hypothesized that the Demonstration will be cost neutral. To track performance CMS and the State agree to a hypothetical cap (i.e., a PMPM limit) on spending. Performance at the end of DY3 showed that the Demonstration expenditures were \$2,931,666 below the hypothetical spending cap. After the first quarter of DY4, the Demonstration continues to show positive results with actual expenditures \$3,016,609 below the hypothetical cap.

In an exploration of total cost of care and cost drivers, the PMPM trends for the adult IMD study group appear to be declining across all categories of service. However, it is likely that expenditures were impacted by the PHE. Additional years of data are needed to assess the trends more fully.

Overall, the SUD Demonstration is associated with meeting its goals including:

1. To improve access to OUD and other SUD services;
2. To improve the quality of the SUD treatment delivery system to provide high-quality coordinated and comprehensive OUD/SUD treatment for Medicaid enrollees; and
3. To maintain budget neutrality.

Exhibit V-1, on the following page, provides an overall summary of the interim evaluation findings for Evaluation Question One.

**Exhibit V-1: Question One Findings**

Evaluation Question 1: What are the impacts of the Demonstration on access to SUD residential treatment services for Demonstration enrollees?		
Hypotheses	Measures	Interim Findings
A. Adult enrollees will have better access to residential SUD treatment services.	1. Percent of enrollees ages 12-64 with an SUD claim for treatment in an IMD with a discharge date during the year	Statistically significant increases in access to IMD services were seen in each year of the Demonstration.
	2. The total number of licensed beds for Medicaid enrolled SUD residential treatment providers each year	Licensed bed capacity for Medicaid enrolled residential treatment facilities increased from 554 beds at baseline to 697 beds in DY3.

Exhibit V-2 provides an overall summary of the interim evaluation findings for Evaluation Question Two.

**Exhibit V-2: Question Two Findings**

Evaluation Question 2: What are the impacts of the Demonstration on quality of care for Medicaid enrollees with an SUD diagnosis?		
Hypotheses	Measures	Interim Findings
A. Enrollees will have fewer ED visits for SUD	1. The total number of ED visits for SUD per 1,000 Demonstration enrollees	<ul style="list-style-type: none"> <li>ED use declined over baseline (both for total ED visits and SUD-related ED).</li> <li>There was a slight increase in total ED use for adolescents with an SUD in DY3.</li> </ul>
B. Enrollees will have fewer total ED visits	1. The total number of ED visits for any reason per 1,000 Demonstration enrollees	
C. Enrollees will have fewer ED visits post discharge from an SUD IMD	1. ED use 90 days prior to IMD admission and 90 days post discharge	<ul style="list-style-type: none"> <li>DY2 and DY3 showed a statistically significant decline in ED visits in the 90 days following IMD discharge as compared to the 90 days prior to admission.</li> <li>ED use may have been influenced by the PHE.</li> </ul>
D. Enrollees will have improved rates of initiation and engagement in treatment	1. Percentage of enrollees who initiated treatment within 14 days of diagnosis	<ul style="list-style-type: none"> <li>There was a statistically significant increase in DY1 and DY3.</li> </ul>
	2. Percentage of enrollees who engage in treatment within 34 days of initiation	<ul style="list-style-type: none"> <li>There was a statistically significant increase in DY2 and DY3.</li> </ul>
E. Enrollees will have lower IMD readmission rates	1. The percent of IMD stays followed by a readmission within 30 days	<ul style="list-style-type: none"> <li>Readmissions increased in DY1 and DY2 before declining in DY3.</li> </ul>

Evaluation Question 2: What are the impacts of the Demonstration on quality of care for Medicaid enrollees with an SUD diagnosis?		
Hypotheses	Measures	Interim Findings
F. Enrollees will have improved rates of treatment retention	1. The percent of enrollees who had SUD treatment visits 45, 90, 135, and 180 days following IMD discharge	<ul style="list-style-type: none"> <li>There was a statistically significant increase over baseline in each year of the Demonstration.</li> </ul>

Exhibit V-3 provides an overall summary of the interim evaluation findings for Evaluation Question Three.

**Exhibit V-3: Evaluation Question Three Findings**

Evaluation Question 3: Will the Demonstration maintain or reduce spending in comparison to what would have been spent absent the demonstration?		
A. The Demonstration will be cost neutral	1. PMPM trends and per capita costs by Medicaid Eligibility Groups identified in the STCs.	<ul style="list-style-type: none"> <li>At the end of DY3 the Demonstration is showing a cumulative surplus.</li> </ul>

Overall, the New Hampshire SUD Treatment and Recovery Access Demonstration is associated with improved access to care for those beneficiaries with intensive SUD treatment needs. In all years, ED use declined in the 90 days following IMD discharge as compared to the 90 days period prior to admissions. IMD services for those meeting criteria may contribute to stabilization and continuity of care post discharge. This is further evidenced by the percent of members who have a claim for SUD treatment in the 45, 90, 135 and 180 days following IMD discharge.

Results from the first year of the Demonstration indicate that SUD treatment utilization had increased, and overall use of ED had declined. However, the onset of the PHE in the second year of the Demonstration makes it difficult to draw strong associations between the Demonstration and continued reductions in ED use.

An exploratory analysis of expenditures for adults who received IMD services shows a similar pattern with lower per member per month costs during the Demonstration period. However, the influence of the PHE on service use may be suppressing utilization and masking the true need for SUD treatment services in the coming years.

## INTERPRETATIONS, POLICY IMPLICATIONS AND INTERACTIONS WITH OTHER STATE INITIATIVES

Prior to the beginning of the Demonstration, New Hampshire began developing a full continuum of care for individuals with SUD. This included maintaining existing prevention, treatment, and recovery capacity while also expanding access to medication assisted treatment (MAT), peer recovery support services, harm reduction initiatives and the coordination of care through a statewide crisis hotline. The SUD system of care also included the development of nine regional treatment Hubs (the Doorways) to serve as 24/7 access points to addiction treatment. The Doorways began operation six months after the start of the Demonstration.

In linear regression models of ED use, SUD Demonstration participants who also had claims from Doorway providers accounted for some of the variation seen in utilization during DY2 and DY3. Individuals with Doorway claims also account for some reduction in IMD readmission rates in DY2 and DY3. However, it is difficult to draw strong conclusions regarding the Doorway's impact on the Demonstration for the following reasons:

- Regression coefficients were small which indicates that the magnitude of impact was also small.
- Individuals may have received a Doorway service that was not reimbursed by Medicaid, making a claims-based method imprecise.
- A priority population for Doorway programs are individuals with OUD. Members with an OUD are more likely to suffer from overdoses and other complications from their addiction that require emergency care.
- Doorway providers offer MAT induction in the ED.
- DY2 and DY3 represent the onset of the PHE, making it difficult to draw strong conclusions regarding service utilization.

A more precise study of the pandemic's impact will require more years of study and larger data sets to better understand how the PHE changed member behavior and their use of health care services.

As noted earlier, DHHS requested a 1915(i) Supportive Housing waiver from CMS June 21, 2021, for a July 1, 2022, effective date. If approved by CMS, the evaluation will consider its impact in the final year of the SUD Demonstration.

## LESSONS LEARNED AND RECOMMENDATIONS

The New Hampshire Substance Use Disorder Treatment and Recovery Access Demonstration was necessary to address critical unmet needs for residential SUD treatment. Prior to the start of the Demonstration, New Hampshire's statutes and rules required that treatment decisions and delivery system innovations be based on the use of the American Society of Addiction Medicine criteria and other nationally recognized assessment and placement tools that reflect

evidence-based clinical treatment guidelines, making the CMS SUD IMD Demonstration requirements a good fit for the State.

Best practice in SUD treatment for children and adolescents supports the delivery of highly integrated mental health and SUD treatment services and family supports. After further evaluation of the child and adolescent service system, the State of New Hampshire concluded that creating a separate SUD treatment facility was not warranted. Instead, the State is transforming its residential care and treatment system for children and adolescents to support a full continuum of integrated, co-occurring mental and physical health and SUD treatment.

#### 4. Public Notice

A – Public Comment Website & Social Media Posts



**ALERT** For the latest on COVID-19 in New Hampshire, go to [www.covid19.nh.gov](http://www.covid19.nh.gov)



**OPEN MENU**

[Home](#) > [Programs & Services](#) > [Medicaid](#) > Medicaid Waivers and Demonstrations

## Medicaid Waivers and Demonstrations

There are several waiver and demonstration programs in NH Medicaid. Below are the links and a

### 1115 Demonstration

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority demonstration projects that are found by the Secretary to be likely to assist in promoting the object of these demonstrations, which give the Department additional flexibility to design and improve our state-specific policy approaches to better serving Medicaid populations. Section 1115 demonstration period and can be extended for up to an additional three to five years, depending on the population

The Department has three 1115 Demonstrations:



#### 1. Substance Use Disorder Serious Mental Illness and Serious Emotional Disturbance Treatment and Recovery Access (SUD SMI SED TRA) demonstration, formerly known as the Substance Use Disorder Treatment and Recovery Access (SUD TRA) demonstration

NH Department of Health and Human Services (DHHS) is applying for an extension to its Section 1115(a) Research and Demonstration Waiver from the Centers for Medicare and Medicaid Services (CMS) for a period of an additional five years. This extension would enable DHHS to claim federal reimbursement for payment of services provided to Medicaid beneficiaries as described below:

- Beneficiaries under age 65 who are otherwise eligible and primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD);
- Beneficiaries ages 21-64 who are otherwise eligible and primarily receiving short-term inpatient psychiatric treatment or short-term residential mental health treatment for serious mental illness (SMI) in an IMD; and
- Beneficiaries who are otherwise eligible and receiving SUD, SMI or Serious Emotional Disturbance (SED) treatment while an inmate of a public institution within NHDOC's system of state prisons, for a tailored package of care coordination services to be provided during the period 45 days prior to release (Tailored Medicaid Services to Support Successful Community Reentry or "Community Reentry").

For more information on the public hearings, read the [public notice](#) .




#### Related Documents

- [Extension Request](#) 
- [Attachment 1 – Budget Neutrality-IMD](#) 
- [Attachment 2-Budget Neutrality-Community Reentry](#) 
- [Attachment 3 – Draft Interim Evaluation Report](#) 

This demonstration provides the Department with authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD). It also builds on the state's existing efforts to improve models of care focused on supporting individuals in the community and home, outside of institutions and strengthen a continuum of SUD services based on the American Society of Addiction Medicine (ASAM) criteria or other national assessment and placement tools that reflect evidence based clinical treatment guidelines.

On June 2, 2022, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) to amend the Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver. The approved amendment increases access to treatment for Medicaid beneficiaries with serious mental illness (SMI) and helps reduce the number of people waiting in hospital emergency departments (EDs) for a mental health bed. The amended waiver allows the New Hampshire Medicaid Program to pay for short-

term stays in IMDs provided to Medicaid beneficiaries between ages 21-64 with SMI and approved for full Medicaid benefits.

- [CMS Approval Letter for NH SUD SMI SED TRA Amendment - Dated June 2, 2022](#) 
- [NH SUD SMI SED TRA Special Terms and Conditions - amended June 2, 2022](#) 
- [Amendment to the Substance Use Disorder Treatment and Recovery Access \(SUD-TRA\) Section 1115\(a\) Research and Demonstration Waiver - dated September 3, 2021](#) 
- [Substance Use Disorder Treatment and Recovery Access \(SUD-TRA\) Monitoring Report](#)  - Quarter ending June 30, 2019
- [Substance Use Disorder Treatment and Recovery Access \(SUD-TRA\) Section 1115\(a\) Research and Demonstration - CMS Approval](#) 

## 2. [Building Capacity for Transformation](#)

On January 5, 2016, the Centers for Medicare and Medicaid Services (CMS) approved New Hampshire's application for a five-year Medicaid Building Capacity for Transformation demonstration project which concluded on December 31, 2020. This demonstration represented an opportunity for New Hampshire to strengthen community-based mental health services, combat the opioid crisis, and drive health care delivery system reform. Through this demonstration, the state pursued improved access to and quality of, both the behavioral health services and physical health services of those with behavioral health diagnoses including both mental health and substance abuse disorders. The demonstration enabled the establishment of regionally-based Integrated Delivery Networks (IDNs) that consisted of behavioral health and other health care and community providers. These providers worked collaboratively to develop a sustainable, integrated behavioral and physical health care delivery system in New Hampshire.


## 3. New Hampshire Granite Advantage Health Care Program

This demonstration provided the Department with the authority to test an approach to promoting community engagement and work by instituting community engagement requirements as a condition of Granite Advantage eligibility. Granite Advantage beneficiaries in the new adult group must work or engage in other specified activities, including vocational educational training, job training, or job search activities, for at least 100 hours per month to maintain eligibility for coverage in the new adult group, unless they meet exemption criteria established by the Department or demonstrate good cause for failing to meet the community engagement requirements. If Granite Advantage beneficiaries failed to meet these requirements for two consecutive months, their Medicaid eligibility would have been suspended. The Granite Advantage Health Care Program demonstration is not enforceable at this time.

- [New Hampshire Granite Advantage Health Care Program 1115 Demonstration](#) 
- [New Hampshire Granite Advantage Health Care Program 1115 Demonstration - CMS Approval](#) 

## 1915(b) Waiver





Section 1915(b) of the Social Security Act provides the Department with the flexibility to modify its delivery systems by allowing CMS to waive statutory requirements for comparability, statewideness, and freedom of choice. The 1915(b) application requires the Department to show that the Section 1915(b) waiver will be cost effective, meaning that its use will not cause expenditures to be higher than they would have been without the waiver. Section 1915(b) waivers are initially approved for two years, with renewals of up to two years. In the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), Congress authorized the Secretary to approve Section 1915(b) for five years if they enroll individuals dually eligible for Medicare and Medicaid. The Department has one 1915(b) waiver.

[Mandatory Managed Care for State Plan Services for Currently Voluntary Populations](#) . The Department's 1915(b) waiver mandates enrollment in the managed care delivery system for Medicaid beneficiaries who could previously elect to receive their state plan services through the fee-for-service delivery system, pursuant to 42 CFR 438.50(d)(1-3).

## 1915(c) Home and Community Based Waivers

Section 1915(c) of the Social Security Act permits the Department to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. To be eligible, individuals must meet level-of-care requirements—that they would require institutionalization in the absence of Home and Community Based Care Services. Coverable HCBS are the services needed to avoid institutionalization; these include services such as, case management, personal care, adult day health, habilitation, and respite care. 1915(c) HCBS waiver services complement and/or supplement the services that the Department offers under its State plan. Waiver participants must have full access to State plan services, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services when children participate in a waiver. Because a separate Section 1915(c) waiver is generally required for each eligible population, the Department operates four HCBS 1915(c) waivers, which are managed by the Division of Long-Term Supports and Services (DLTSS).

Escape Site

1. [In Home Support \(IHS\) Waiver for Children with Developmental Disabilities](#) 
2. [Developmental Disabilities \(DD\) Waiver](#) 
3. [Acquired Brain Disorder \(ABD\) Waiver](#) 
4. [Choices for Independence \(CFI\) Waiver](#) 

 Portable Document Format (.pdf) . Visit [nh.gov](https://www.nh.gov) for a [list of free .pdf readers](#) for a variety of operating systems.



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### NH Department of Health and Human Services

August 5 ·

NH DHHS is seeking public comment on its requested extension for the Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver (SUD-SMI-SED-TRA). The extension will enable New Hampshire to continue enhancing substance use disorder and mental health treatment supports and reinforcing the comprehensive, integrated continuum of behavioral health treatments and care for residents of New Hampshire.

The 30-day public comment period for the Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Extension Request is from Monday, August 8, 2022, at 9:00 am (Eastern) until Tuesday, September 6, 2022, at 5:00 pm (Eastern). All comments must be received by 5:00 pm (Eastern) on Tuesday, September 6, 2022.

There are several ways to give your comments to DHHS:

- Attend either of the two public hearings, where you can give verbal or written comments to DHHS. Please visit <https://bit.ly/3zVXsLv> for more information about the time, location, and venue of each public hearing.
- Attend the Monday, August 8, 2022 Medical Care Advisory Committee (MCAC) meeting, from 10 a.m. - 12 p.m. All MCAC meetings are open to the public. Please visit <https://bit.ly/3zZw8vO> for more information about the times, locations, and venues for MCAC meetings.
- Email comments to [SUD-SMI.1115.Extension@dhhs.nh.gov](mailto:SUD-SMI.1115.Extension@dhhs.nh.gov).
- Mail written comments to:

Carolyn Richards

NH Department of Health and Human Services

Attn: SUD-SMI-SED-TRA Demonstration Extension

129 Pleasant Street

Concord, NH 03301

When mailing or emailing please specify "SUD-SMI-SED-TRA Demonstration Extension" as the subject.



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#### Medical Care Advisory Committee

The New Hampshire Medical Care Advisory Committee (MCAC) is a public advisory group established i...

3

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**NH Department of Health and Human Services**

August 10 ·

TODAY: The Department will hold a Public Hearing on the Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver. Hearing will be held today, August 10, at 5:30 p.m. in the Manchester Public Library auditorium. For more information and a Zoom link for remote access, visit <https://bit.ly/3JBC3KU>.



2

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**NH Department of Health and Human Services**

August 18 ·

TODAY: The Department will hold a Public Hearing on the Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver. Join us today, August 18, at 5:00 p.m. at Littleton Regional Health Care, 600 St. Johnsbury Rd, Littleton. Because the event will be held at a medical facility, masks will be required.

For more information and a Zoom link for remote access, visit <https://bit.ly/3JBC3KU>.



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DHHS is seeking public comment at bit.ly/3zVXsLv for its Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Extension Request.

dhhs.nh.gov  
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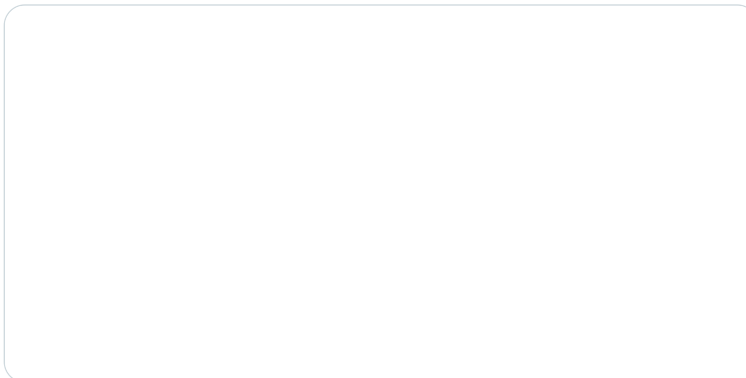
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Public Hearing on the Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver today, 5:30 p.m. at Manchester Public Library. More information at bit.ly/3JBC3KU.



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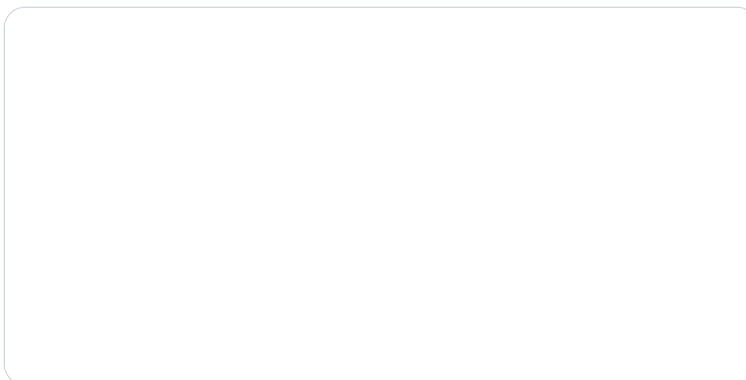
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NH Department of Health and Human Services @NHDHHSPIO

TODAY: Public Hearing on the SUD/SMI/SED Treatment & Recovery Access Section 1115(a) Research & Demonstration Waiver. Today, 8/18 at 5:00 p.m. at Littleton Regional Health Care. Note: Healthcare facility - masks required.

More at [bit.ly/3JBC3KU](https://bit.ly/3JBC3KU).



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B – Public Notice

NH Department of Health and Human Services

**Public Notice for Proposed**  
Substance Use Disorder Serious Mental Illness and Serious Emotional Disturbance  
Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver  
Extension Request  
**August 8<sup>th</sup>, 2022**

Notice is hereby given that, as part of its ongoing efforts to maintain and improve access to behavioral health services in the State, the NH Department of Health and Human Services (DHHS) is applying for an extension to its Section 1115(a) Research and Demonstration Waiver from the Centers for Medicare and Medicaid Services (CMS) for a period of an additional five years. This extension would enable DHHS to claim federal reimbursement for payment of services provided to Medicaid beneficiaries as follows:

- Beneficiaries under age 65 who are otherwise eligible and primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD);
- Beneficiaries ages 21-64 who are otherwise eligible and primarily receiving short-term inpatient psychiatric treatment or short-term residential mental health treatment for serious mental illness (SMI) in an IMD; and
- Beneficiaries who are otherwise eligible and receiving SUD, SMI or Serious Emotional Disturbance (SED) treatment while an inmate of a public institution within NHDOC's system of state prisons, for a tailored package of care coordination services to be provided during the period 45 days prior to release (Tailored Medicaid Services to Support Successful Community Reentry or "Community Reentry").

There are no proposed changes to the delivery system; the demonstration will continue to apply across managed care and fee for service systems.

### Overview of New Community Reentry Program

As part of this extension submission, the State is requesting approval from CMS for a change to the demonstration to authorize federal Medicaid matching funds for the provision of a tailored set of benefits targeting those incarcerated in NH Department of Corrections (NHDOC) custody in state prisons with behavioral health (BH) disorders (SUD, OUD, SMI, or SED) transitioning to community release. The targeted services primarily involve care coordination: (i) MCO enrollment, (2) peer recovery supports or counseling and (iii) new prescribing provider appointments with identified community BH providers (i.e. one telehealth or in-person intake appointment and one or two peer support or counseling sessions). These connection points are critical to building stronger transitional bridges to the community in the 45-day period prior to release from incarceration.

### Demonstration Hypotheses and Evaluation Approach

The approved goals of the SUD component of the demonstration are:

- Increased rates of identification, initiation, and engagement in treatment;
- Increased adherence to, and retention in, treatment;
- Reduced overdose deaths, particularly those due to opioids;
- Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services;
- Reduced readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate; and
- Improved access to care for physical health conditions among beneficiaries.

The approved goals of the SMI component of the demonstration are:

- Reduce utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings;
- Reduce preventable readmissions to acute care hospitals and residential settings;
- 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;
- Improve access to community-based services to address the chronic mental health care needs of

beneficiaries with SMI/SED, including through increased integration of primary and behavioral health care; and

- Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

The proposed Community Reentry portion of the demonstration is designed to test the following hypothesis: by providing a tailored Medicaid benefit 45 days prior to release, re-integration rates will increase and recidivism will be reduced among Medicaid beneficiaries who receive the pre-release transitional services. The demonstration is focused on the NHDOC system of state prisons and represents a preliminary opportunity to trial this intervention within the relatively standardized system of NHDOC to evaluate the opportunity for future statewide deployment in more varied settings. The proposed goals for Community Reentry are:

- Increase time in community following release from incarceration by enhancing care coordination pre-release;
- Reduce parole violations related to SUD and SMI/SED by effectively connecting formerly incarcerated members with community-based providers;
- Reduce recidivism, especially for SUD-related offenses;
- Reduce utilization of IMD services by formerly incarcerated members; and
- Reduce utilization of emergency department and inpatient hospital settings for SUD and SMI/SED treatment where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services.

New Hampshire's request to extend the demonstration period will allow the State to continue pursuing all of the above goals, and will allow the State to continue testing all associated hypotheses.

## Waiver and Expenditure Authorities

Specifically, New Hampshire is requesting that:

- CMS waive §1905(a)(31)(A) and §1905(a)(31)(B) of the *Social Security Act* as amended, 42 CFR §438.6(e), 42 CFR §435.1010, and 42 CFR §441.11(c)(2) and (5).and any other related federal regulations; 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 extension 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 substance use disorder and mental health treatment supports and by reinforcing the comprehensive, integrated continuum of behavioral health treatments and care for residents of New Hampshire.

Aside from Community Reentry, the state is not requesting any changes to the demonstration scope as approved in the [Special Terms and Conditions](#) dated June 2, 2022. The complete version of the *Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Extension Request* is available for public review at:

<https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-waivers-and-demonstrations>.

CMS guidance regarding opportunities to design innovative service delivery systems to support adults and children with substance use disorder can be found at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>. Similar guidance regarding opportunities to support adults and children with serious mental illness and serious emotional disturbance can be found at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.

## Enrollment and Expenditure Projections

Below are the projected enrollment and expenditures for each year of the demonstration extension by component of the demonstration.

### Substance Use Disorder IMD Component

	SFY24	SFY25	SFY26	SFY27	SFY28
Member Months	5,772	5,888	6,005	6,125	6,248
Average Monthly Members	481	491	500	511	521

Expenditures	\$6,379,106	\$6,823,042	\$7,297,872	\$7,805,747	\$8,348,966
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Serious Mental Illness / Serious Emotional Disturbance IMD Component

	SFY24	SFY25	SFY26	SFY27	SFY28
Member Months	990	1,010	1,030	1,051	1,072
Average Annual Members	523	533	544	554	566
Expenditures	\$9,041,187	\$9,670,334	\$10,343,261	\$11,063,016	\$11,832,856

Community Reentry Component

	SFY24	SFY25	SFY26	SFY27	SFY28
Member Months	869	887	904	923	941
Individual Members	588	599	611	624	636
Expenditures	\$212,557	\$227,432	\$243,347	\$260,378	\$278,598

Cost sharing will not be part of this demonstration. There will be no changes other than those described above.

### Opportunities to Provide Feedback

The 30-day public comment period for the *Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Extension Request* is from Monday, August 8, 2022 until Tuesday, September 6, 2022 at 5:00 pm (Eastern). All comments must be received by 5:00 pm (Eastern) on Tuesday, September 6, 2022.

#### Public Hearings

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

#### Wednesday, August 10, 2022 – Manchester

5:30 - 7:00 pm

Manchester Public Library Auditorium  
405 Pine Street  
Manchester, NH 03104

#### Join Zoom Meeting

<https://nh-dhhs.zoom.us/j/88652187407?pwd=NGdGejFVMXlQd243WWw3NUtNZXISdz09>

Meeting ID: 886 5218 7407

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#### Thursday, August 18, 2022 – Littleton

5:00 - 6:30 pm

Littleton Regional Healthcare  
600 St. Johnsbury Road  
Littleton, NH 03561

Note: Attendee best entrance will be at the Medical Office Building. [See map for more details.](#)

**Masks are required** upon entrance and for the duration of stay inside the facility.

#### Join Zoom Meeting

<https://nh-dhhs.zoom.us/j/84904266940?pwd=Sk9tYjVVRT29KdE5RRitxOE9qVXh6dz09>

Meeting ID: 849 0426 6940

Passcode: 704376

#### One tap mobile

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If accommodations are needed for communication access such as interpreters, CART (captioning), assistive listening devices, or other auxiliary aids and/or services, please contact Carolyn Richards at [Carolyn.S.Richards@dhhs.nh.gov](mailto:Carolyn.S.Richards@dhhs.nh.gov) or (603) 271-9439 no later than three business days before the hearing. 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 8, 2022 Medical Care Advisory Committee (MCAC) meeting, from 10:00 a.m. – 12:00 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

### **Join Zoom Meeting**

<https://nh-dhhs.zoom.us/j/6960029379?pwd=aCtXbGZUZGgyUHVRWE9RQVc2UEtUZz09>

Meeting ID: 696 002 9379

Passcode: 454733

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### **Ways to Submit Comments**

DHHS would like to hear your comments about the extension request. 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 Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Extension Request* and then submit to CMS for final approval. The summary of comments will be posted for public viewing at <https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-waivers-and-demonstrations> along with the extension request when it is submitted to CMS.

There are several ways to give your comments to DHHS:

- Attend either 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 representatives. Additional information about providing comments is noted below.
- Email comments to [SUD-SMI.1115.Extension@dhhs.nh.gov](mailto:SUD-SMI.1115.Extension@dhhs.nh.gov).
- Mail written comments to:  
Carolyn Richards  
NH Department of Health and Human Services  
Attn: SUD-SMI-SED-TRA Demonstration Extension  
129 Pleasant Street  
Concord, NH 03301

When mailing or emailing please specify "SUD-SMI-SED-TRA Demonstration Extension" as the subject.

### **Additional Information**

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

Carolyn Richards  
NH Department of Health and Human Services  
Attn: SUD-SMI-SED-TRA Demonstration Extension  
129 Pleasant Street  
Concord, NH 03301

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

NH Department of Health and Human Services  
Fred H. Brown Building Reception

129 Pleasant Street  
Concord, NH 03301

All information regarding the proposed extension request can be found on the DHHS web site at <https://www.dhhs.nh.gov/programs-services/medicaid> under "Helpful Resources". 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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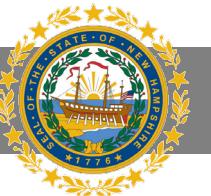
**PUBLIC HEARING FOR:  
SUBSTANCE USE DISORDER SERIOUS MENTAL ILLNESS AND SERIOUS EMOTIONAL  
DISTURBANCE TREATMENT AND RECOVERY ACCESS SECTION 1115(a)  
RESEARCH AND DEMONSTRATION WAIVER**

**EXTENSION REQUEST**

Public Forums:	August 8, 2022	Concord
	August 10, 2022	Manchester
	August 18, 2022	Littleton

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# Demonstration History

## Initial Substance Use Disorder Treatment and Recovery Access (SUD-TRA) 1115 Demonstration

- This section 1115(a) demonstration waives the IMD exclusion rule for Medicaid beneficiaries under 65 with SUD who need residential or hospital level treatment in exchange for NH accepting certain special terms and conditions
- This Demonstration was intended to enhance substance use disorder treatment supports in New Hampshire
- The SUD-TRA was approved on July 10, 2018, for a five-year term ending June 30, 2023
- Licensed bed capacity for Medicaid-enrolled residential treatment facilities increased from 554 beds at baseline (July 1, 2017 – June 30, 2018) to 697 beds in DY3 (July 1, 2020 – June 30, 2021), an increase in SUD treatment capacity of 25.8%

## Serious Mental Illness (SMI) Amendment to the existing SUD-TRA Demonstration 1115 Demonstration

- This amendment expanded the existing SUD-TRA demonstration to include a waiver of the IMD exclusion rule for Medicaid beneficiaries 21-64 with SMI who need residential or hospital level treatment
- This was intended as part of New Hampshire's 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 SMI amendment was approved on June 2, 2022, to coincide with the term of the SUD-TRA ending on June 30, 2023
- Initially New Hampshire Hospital and Hampstead Hospital will be the only providers participating in the SMI component of the demonstration



# Overview of Demonstration Authorities

The current Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver (SUD-SMI-SED-TRA Demonstration) allows New Hampshire to:

- Utilize federal matching funds for Medicaid State Plan services that have historically been carved out of the Medicaid program;
- Expand access to and capacity for behavioral health services; and
- Improve the full continuum of behavioral health care.

## Substance Use Disorder



Beneficiaries under age 65 who are otherwise eligible and primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD)

## Serious Mental Illness

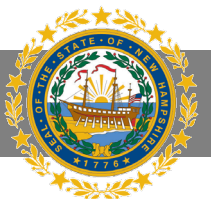


Beneficiaries over age 21 and under age 65 who are otherwise eligible and primarily receiving short-term inpatient psychiatric treatment or short-term residential mental health treatment for serious mental illness (SMI) in an IMD

## Community Reentry (Proposed)



Beneficiaries who are otherwise eligible and receiving SUD, SMI or Serious Emotional Disturbance (SED) treatment while an inmate of a public institution within NHDOC's system of state prisons, for a tailored package of care coordination services to be provided during the period 45 days prior to release

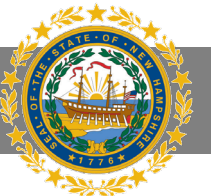


## Accomplishments

Since the initial SUD-TRA Demonstration approval in July 2018, NH has made numerous strides in improving behavioral health care. Positive findings from the independent evaluation include:

- ✓ Increased licensed bed capacity for Medicaid-enrolled residential treatment facilities by 25.8% through the end of DY3 (June 30, 2021)
- ✓ Improved access to care for those beneficiaries with intensive SUD treatment needs
- ✓ Decline in Emergency Department use in the 90 days following IMD discharge as compared to the 90 days period prior to admissions
- ✓ Enhanced stabilization and continuity of care post discharge as demonstrated by percent of members who have a claim for SUD treatment in the 45, 90, 135 and 180 days following IMD discharge
- ✓ Actual expenditures through Demonstration in DY3 were \$2,551,780 below the hypothetical cap set by CMS and the state is expected to maintain or reduce spending in comparison to what would have been spent absent the Demonstration

\*These accomplishments, and others, are described in greater detail in the Interim Evaluation Report. This report is included as an attachment in the extension request posted online.



# Extension Request

## Extension of the SUD-SMI Demonstration

- The Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver is scheduled to expire on June 30, 2023
- Under 42 CFR § 431.412 (c) Demonstration extension request, the state can request that CMS extend the waiver authority granted for an additional 5-year period
- If CMS approves New Hampshire's extension request, the Demonstration will be active through June 2028



## Proposed Changes: Community Reentry

In addition to extending the existing Demonstration authorities, NH DHHS is proposing a new community reentry component:

- Community Reentry aims to create an enhanced care coordination program for Medicaid-eligible individuals with SUD or SMI in the 45 days prior to release from state prisons operated by the Department of Corrections (DOC)
- The key goal of the program would be to connect formerly incarcerated beneficiaries with resources in the community to support a stable reintegration and reduce recidivism
- DHHS has developed Community Reentry in close collaboration with DOC and is including this addition as a requested change to the existing SUD-SMI Demonstration
- The proposed demonstration will be limited to state prisons initially; providing a proof of concept without having to adjust for differences in county jail operating models across NH's 10 counties
- Details are subject to discussion with CMS and may include telehealth consults and / or counseling for incarcerated members with SUD (introductory appointment with community-based MAT provider, peer support) or SMI (introductory appointment with community-based psychiatrist, licensed counselor)- none of which replaces health care provided by the state under its legal obligations
- CMS has not yet approved such a waiver of the “inmate exclusion rule” – a close cousin of the “IMD exclusion rule” – but they plan to issue guidance and consider such requests beginning in 2023
- CMS has indicated that they will consider this change request separately to expedite the rest of the extension pertaining to IMDs



# Extension Goals

NH DHHS has outlined the following goals for the Demonstration:

## SUD Goals

- Increase rates of identification, initiation, and engagement in treatment for SUD;
- Increase adherence to and retention in treatment;
- Reduce overdose deaths;
- Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate;
- Reduce readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
- Improve access to care for physical health conditions

## SMI Goals

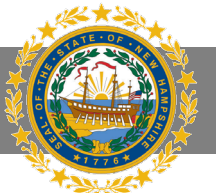
- Reduce utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI/SED;
- Reduce preventable readmissions to acute care hospitals and residential settings;
- Improve availability of crisis stabilization services;
- Improve access to community-based services to address the chronic mental health care needs, including through increased integration of primary and behavioral health care; and
- Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

## Community Reentry Goals

- Increase time in community following release from incarceration by enhancing care coordination pre-release;
- Reduce parole violations related to SUD and SMI/SED by connecting with community-based providers pre-release
- Reduce recidivism, especially for SUD-related offenses;
- Reduce utilization of IMD services by formerly incarcerated members; and
- Reduce utilization of emergency department and inpatient hospital settings for SUD and SMI/SED through improved access to other continuum of care services.

Existing Demonstration Components

Newly Proposed Component





# Budget Neutrality

NH DHHS worked with its actuarial partners at Milliman to project budget neutrality limits for this extension, including both the core demonstration and the newly proposed Community Reentry component. Detailed projections and methodologies are available in the extension request posted online.

### Projected Annual Budget Neutrality Expenditures for IMD Demonstration

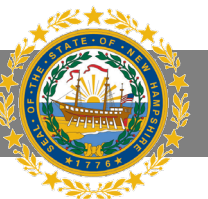
- \$15,420,293 in SFY24 (first year of demonstration extension)
- Achievable based on NH DHHS assessment

### Projected Annual Budget Neutrality Expenditures for Community Reentry

- \$212,557 in SFY24
- Figures are subject to change based on final technical specifications as determined in partnership with CMS

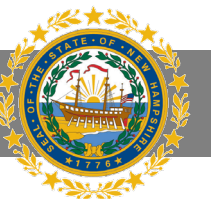
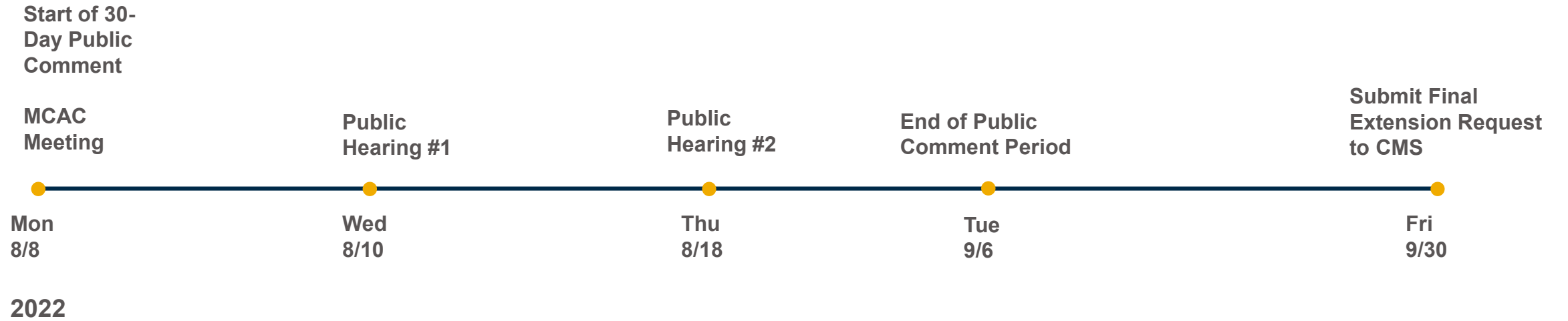
### Projected Enrollment and Expenditures by Demonstration Component (SFY24)

	Member Months	Individual Members	Expenditures
SUD IMD Component	5,772	481 (Monthly Avg)	\$6,379,106
SMI IMD Component	990	523 (Annual Avg)	\$9,041,187
Community Reentry Component	869	588	\$212,557



# Timeline

The timeline for this extension application is outlined below.



# Opportunities for Public Input | Public Hearings

DHHS will offer two opportunities for public hearings and will also include the extension on the upcoming MCAC meeting agenda.

## **MCAC Meeting**

**Monday, August 8, 2022 – Concord**

10:00 a.m. – 12:00 p.m.

Fred H. Brown Building Auditorium

129 Pleasant Street

Concord, NH 03301

**Zoom option:** [https://nh-](https://nh-dhhs.zoom.us/j/6960029379?pwd=aCtXbGZUZGgyUHVRWE9RQVc2UEtUZz09)

[dhhs.zoom.us/j/6960029379?pwd=aCtXbGZUZGgyUHVRWE9RQVc2UEtUZz09](https://nh-dhhs.zoom.us/j/6960029379?pwd=aCtXbGZUZGgyUHVRWE9RQVc2UEtUZz09)

Meeting ID: 696 002 9379

Passcode: 454733

Mobile: +13017158592,,6960029379#,,,,\*454733#

## **Public Hearing #1**

**Wednesday, August 10, 2022 – Manchester**

5:30 - 7:00 pm

Manchester Public Library Auditorium

405 Pine Street

Manchester, NH 03104

**Zoom option:** [https://nh-](https://nh-dhhs.zoom.us/j/88652187407?pwd=NGdGejFVMXIQd243WWw3NUtNZXISdz09)

[dhhs.zoom.us/j/88652187407?pwd=NGdGejFVMXIQd243WWw3NUtNZXISdz09](https://nh-dhhs.zoom.us/j/88652187407?pwd=NGdGejFVMXIQd243WWw3NUtNZXISdz09)

Meeting ID: 886 5218 7407

Passcode: 704376

Mobile: +16465588656,,88652187407#,,,,\*704376#

## **Public Hearing #2**

**Thursday, August 18, 2022 – Littleton**

5:00 - 6:30 pm

Littleton Regional Healthcare

600 St. Johnsbury Road

Littleton, NH 03561

*Note: Attendee best entrance will be at the H Taylor Caswell Center / Cafeteria Entrance (next to Urgent Care Unit). Masks are required upon entrance and for the duration of stay inside the facility.*

**Zoom option:** [https://nh-](https://nh-dhhs.zoom.us/j/84904266940?pwd=Sk9tbjVRT29KdE5RRitxOE9qVXh6dz09)

[dhhs.zoom.us/j/84904266940?pwd=Sk9tbjVRT29KdE5RRitxOE9qVXh6dz09](https://nh-dhhs.zoom.us/j/84904266940?pwd=Sk9tbjVRT29KdE5RRitxOE9qVXh6dz09)

Meeting ID: 849 0426 6940

Passcode: 704376

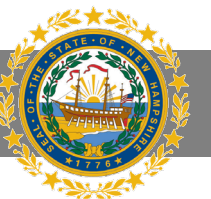
Mobile: +13017158592,,84904266940#,,,,\*704376#



## Opportunities for Public Input | Email or Mail

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

- Email: [SUD-SMI.1115.Extension@dhhs.nh.gov](mailto:SUD-SMI.1115.Extension@dhhs.nh.gov)
- Mail: Carolyn Richards  
NH Department of Health and Human Services  
Attn: SUD-SMI-SED-TRA Demonstration Extension  
129 Pleasant Street  
Concord NH 03301



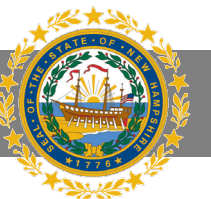
## Contact Information

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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 Carolyn Richards at (603) 271-9439.

**Public Comment may be submitted until 5:00 p.m. (Eastern) on Tuesday, September 6, 2022.**



## Draft Extension Application

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

- The complete version of the *Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Extension Request* is available for public review at: <http://www.dhhs.nh.gov/programs-services/medicaid/medicaid-waivers-and-demonstrations>.
- CMS guidance regarding opportunities to design innovative service delivery systems to support adults and children with substance use disorder can be found at: <http://www.medicare.gov/federal-policy-guidance/downloads/smd17003.pdf>.
- Similar guidance regarding opportunities to support adults and children with serious mental illness and serious emotional disturbance can be found at: <http://www.medicare.gov/federal-policy-guidance/downloads/smd18011.pdf>.
- Subtitle D (*Medicaid Reentry Act / §5032*) of *SUPPORT for Patients and Communities Act* promotes "innovations to ease transitions and integration to the community for [inmates of a public institution]" at <http://www.congress.gov/bill/115th-congress/house-bill/6/text>.
- Other notices, demonstration documents, and information about the demonstration are available on the DHHS website at: <http://www.dhhs.nh.gov>.



## D – MCAC Meeting Agenda

**Medical Care Advisory Committee (MCAC)**  
**Brown Building Auditorium, 129 Pleasant Street, Concord**  
**Zoom (page 2 for details)**

**Monday, August 8, 2022, 10:00am – 12:00pm**

**AGENDA**

10:00-10:05

**Introductions/Announcements**

Holly Stevens, Chair

10:05-10:10

**Review/Approval: July 11, 2022 Minutes**

Holly Stevens, Chair

10:10-10:15

**Agenda Items – September 12, 2022**

Members

10:15-10:20

**Membership Subcommittee**

Carolyn Virtue, Subcommittee Chair

10:20-10:50

**SUD/SMI Public Hearing**

Henry Lipman, Medicaid Director

10:50-11:00

**Annual External Quality Review Organization (EQRO)  
Technical Report Q&A (continued from 7/11/22)**

Jill Fournier, Quality Assurance and Improvement Nurse

11:00-11:25

**Medicaid Quality Information System (MQIS) Tutorial**

Andrea Stewart, MQIS Administrator

Jill Fournier, Quality Assurance and Improvement Nurse

11:25-11:45

**MCOs**

AmeriHealth, NH Healthy Families, Wellsense

- MCO process to change coverage of services and notification to members
- MCO process to approve or deny claims as secondary payer

11:45-11:50

**Public Health Emergency**

Medicaid Continuous Enrollment

Lucy Hodder, Deb Fournier, UNH Health Law & Policy

11:50-12:00

**Department Updates**

- Dental Benefit
- Disability Determinations
- [American Rescue Plan Act HCBS Spending Plan](#)

Sarah Finne, DMD, Medicaid Dental Director

Deb Sorli, Bureau of Family Assistance

Henry Lipman, Medicaid Director

**Rule: Consent**

He-W 854.15, Adult Category Earned Income Disregard



**Join Zoom Meeting**

<https://nh-dhhs.zoom.us/j/6960029379?pwd=aCtXbGZUZGgyUHVRWE9RQVc2UEtUZz09>

Meeting ID: 696 002 9379

Passcode: 454733

One tap mobile

+13017158592,,6960029379#,,,,\*454733# US (Washington DC)

+13126266799,,6960029379#,,,,\*454733# US (Chicago)

Dial by your location

+1 301 715 8592 US (Washington DC)

+1 312 626 6799 US (Chicago)

+1 646 558 8656 US (New York)

+1 253 215 8782 US (Tacoma)

+1 346 248 7799 US (Houston)

+1 669 900 9128 US (San Jose)

Meeting ID: 696 002 9379

Passcode: 454733

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

**Note: Medicaid Public Notices**

The Department of Health & Services (DHHS) is meeting CMS' public notice requirement by publishing State Plan Amendment (SPA) Public Notices on a dedicated [DHHS Webpage](#) in accordance with [CMS' Informational Bulletin](#), which outlines procedures states must follow when making changes to provider payments under the Medicaid State Plan. Therefore, the Division of Medicaid Services is no longer publishing SPA public notices in the Union Leader and Nashua Telegraph, at a significant savings to the Department.

E – MCAC Draft Meeting Minutes

**Medical Care Advisory Committee (MCAC)**  
**Monday, August 8, 2022**

**Minutes**

**Members:** Michael Auerbach, Kathy Bates, Kelley Capuchino, Tamme Dustin, Joan Fitzgerald, Ellen Keith, Ellen McMahon, Paula Minnehan, Kara Nickulas, Karen Rosenberg, Holly Stevens, Lisabritt Solsky Stevens, Carolyn Virtue, Elinor Wozniakowski

**Excused:** Kristine Stoddard

**Alternates:** Gina Balkus, Deodonne Bhattarai, Amy Girouard, Emily Johnson, Cheryl Steinberg, Nichole VonDette

**DHHS:** Henry Lipman, Alyssa Cohen, Katja Fox, Joe Caristi, Melissa Hardy, Morissa Henn, Sarah Finne DMD, Dawn Tierney, Laura Ringelberg, Olivia May, Carolyn Richards, Jill Fournier, Andrea Stewart, Susan Drown, Leslie Melby, Jordan McCormick, Diana Lacey, Julianne Carbin, Janine Corbett, Jody Farwell, Leslie Bartlett, Catrina Rantala, Sara Cleveland

**Guests:** DOC Commissioner Helen Hanks, Deb Fournier, Lucy Hodder, Deb Chotkevys, Jay Nagy, Jillian Salmon, Susan Paschell, Leann Wirth, Erica Oberman, Trina Loughery, Lakeesha Dickerson, Jane Kapoian, Leeann Wirth, Jessica Rubinstein, Debra Jacobs, Julie Wolter, Jeffrey Atwood, Josh Krintzman, Nicole Burke, Erin Hall, Alex Katroubas, Rachel Chumbly, Loren Wilson, Stephanie Myers, Tracy Gillick, Rich Sigel, Thomas Grinley, Jesse Fennelly

**July 11, 2022 Minutes**

M/S/A

**Agenda Items – September 12, 2022**

- Case management funding for housing
- Supportive housing 1915i waiver

**Membership Subcommittee**

**Carolyn Virtue, Subcommittee Chair**

Motion: Having provided the MCAC 30 days' notice, affirm the appointment of Elinor Wozniakowski of Dartmouth-Hitchcock/Conifer Solutions as Member. M/S/A

The membership subcommittee will review a revised Member application and a new Alternate application.

**Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver. (SUD-SMI-SED-TRA)**

**Henry Lipman, Medicaid Director; Commissioner Helen Hanks, DOC; Katja Fox, Director, Division for Behavioral Health, Joe Caristi, CFO, New Hampshire Hospital, Alyssa Cohen, Deputy Medicaid Director**

In 2018 DHHS applied for and received approval for the Substance Use Disorder Treatment and Recovery Access (SUD-TRA) 1115 Demonstration waiver for a 5-year term ending June 30, 2023. Under the waiver, CMS provides federal match for otherwise excluded services administered in IMDs to improve inpatient capacity. The proposed 5-year extension will enable DHHS to claim federal reimbursement, continue to expand the continuum of care, and increase access to SUD and mental health treatment supports for Medicaid beneficiaries.

The original SUD-TRA waiver was recently amended and approved to provide federal funding for Serious Mental Illness (SMI) services otherwise carved out from federal financial participation; expand access to and capacity for behavioral health services; and improve the continuum of behavioral health care. As of July 1,

2022, the SMI amendment waives the IMD exclusion rule<sup>1</sup> for beneficiaries ages 21-64 with SMI who need residential or inpatient hospital treatment at an IMD. The amendment is predicated on NH's investment in community-based services.

The waiver renewal proposes a new Community Reentry component of the demonstration for individuals who are otherwise Medicaid eligible and receiving SUD or SMI treatment in a "public institution" within NH's state prison system. The program would use federal funds to provide enhanced care coordination during the period 45 days prior to release from prison through the Medicaid program. The goal is to connect formerly incarcerated individuals with resources, including peer support services, to support stable reintegration and reduce recidivism. The proposed Community Reentry program will be limited to the state prison system. If proven successful, the state would consider expanding to include county jails at a later date. Waiver renewal is not contingent on approval of the Community Reentry program.

The independent evaluator's findings are key to moving forward with SUD and SMI and to ensure that the waiver's goals are met. Goals are consistent with those of the state opioid response and NH's 10-year mental health plan:

SUD: Increase rates of engagement and retention in treatment, reduce overdose deaths, reduce use of EDs and inpatient settings, reduce readmissions, and improve access to care for physical health.

SMI: Reduce ED utilization and ED lengths of stay, reduce preventable readmissions, and improve access to community services, care coordination and continuity of care, including CTI<sup>2</sup>. All CMHCs have staff to assist with the transition from the inpatient to community settings and with mental health and basic living needs.

Community Reentry: Reduce parole violations, recidivism, use of IMD services, and reduce use of ED and inpatient hospital settings through improved access to community services.

Since implementation of the initial SUD-TRA waiver, behavioral health care improvements include: 25.8% increase in SUD residential treatment facilities' licensed bed capacity through 7/30/21; improved access to care for beneficiaries with intensive SUD treatment needs; decline in ED use in the 90 days post-discharge from IMDs as compared to the 90 days period prior to admissions; enhanced stabilization and continuity of care post-discharge; and savings of \$2.5 million below the hypothetical cap set by CMS. The SMI component of the demonstration was only recently approved (June 2, 2022) and implemented after the date of the interim evaluation report.

DHHS worked with its actuarial partners to project budget neutrality limits for the waiver to ensure the state does not spend more for waiver-supported services than it would in the absence of the waiver.

DHHS is seeking public comment over a 30-day public comment period (8/8/22-9/6/22) prior to submitting the extension request to CMS. All comments must be received by 5pm on Sept 6, 2022. DHHS will host two public hearings – Manchester, Aug 10, 5:30pm and Littleton, Aug 18, 5:00pm. Comments may be submitted by mail and email. The [extension request](#) is available online.

#### Comment #1

Speaker Name: Holly Stevens

Speaker Organization: MCAC Chair, NAMI NH

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<sup>1</sup> Medicaid payments to states are prohibited for adults 21-64 receiving psychiatric care in an institution for mental diseases (IMD) with more than 16 beds.

<sup>2</sup> Critical time intervention is a 9-month, intensive care transition program that connects people to services and supports in their home communities upon discharge from a psychiatric inpatient setting.

Summary Remarks: What will be the impact of this demonstration on DRFs [Designated Receiving Facilities]?  
(Henry Lipman: Since DRFs are components of a larger hospital and would not typically represent 50% or more of the total beds of the facility, the demonstration does not have an impact on DRFs.)

#### Comment #2

Speaker Name: Carolyn Virtue  
Speaker Organization: MCAC Member  
Summary Remarks: How does this impact mental health supports for the aging and elderly whose needs can't always be met through the CFI waiver?  
(Henry Lipman: Beneficiaries directly impacted by the waiver are those under 65 years of age. Ongoing investments in community-based care that are indirectly associated with the waiver have more of a role to play in supporting the aging and elderly.)

#### Comment #3

Speaker Name: Susan Stearns and Holly Stevens  
Speaker Organization: [NAMI NH](#) and MCAC Chair, respectively  
Summary Remarks: We are interested in the Community Reentry program. What is the likelihood that this program would be expanded to the county jails in the future?  
(Commissioner Hanks: Uptake may be mixed among counties; some may be ready to join immediately while others need more time.)  
(Henry Lipman: The important part is demonstrating success first in the more controlled environment that is the State prisons).

#### Comment #4

Speaker Name: Karen Rosenberg  
Speaker Organization: MCAC Member, [Disability Rights Center](#)  
Summary Remarks: Would this Demonstration provide FMAP only for SMI stays? What authorities would this Demonstration grant?  
(Henry Lipman: The Demonstration extension would continue all of the original authorities (SUD & SMI IMD stays), while adding the corrections piece. It would also continue to emphasize community benefits.)  
  
What is the relationship between FFP and community-based services in this demonstration? How are they being incentivized?  
(Henry Lipman: We want to increase community-based services as these services cost less money. We are trying to avoid more costly institutionalization where possible. Sometimes institutionalization is necessary, but we want to avoid it where possible and use the savings to invest in community-based care.)  
(Katja Fox: Community-based services are a big part of our DNA).

#### Comment #5

Speaker Name: Kelley Capuchino  
Speaker Organization: MCAC Member [NH Community Behavioral Health Association](#)  
Summary Remarks: Would this Demonstration include settings outside New Hampshire Hospital and Hampstead Hospital? We noted the Demonstration application only named these two facilities. Any thoughts about including new settings? We understand residential settings may need time to prepare before they are fully ready.  
(Joe Caristi: All IMDs would be eligible. New Hampshire Hospital and Hampstead Hospital are the only two currently in existence.)

## **Annual External Quality Review Organization (EQRO) Technical Report Q&A**

**Jill Fournier, Quality Assurance and Improvement Nurse; Debbie Chotkevys, Health Services Advisory Group**

The next EQRO report will be published Feb/March, 2023 and is due to CMS in April.

Next year's topics to be evaluated include contract compliance review, performance improvement projects, performance measure validation, network adequacy validation; comparisons of HEDIS and CAHPS data, encounter data validation, semi-structured interview reports, and at least one quality study.

## **Medicaid Quality Information System (MQIS) Tutorial**

**Andrea Stewart, MQIS Administrator; Jill Fournier, Quality Assurance and Improvement Nurse**

DHHS developed MQIS to allow for the submission, validation and public access to quality data submitted by the MCOs. DHHS maintains metadata for each measure within MQIS to include descriptive data for reports and specifications for data submitters. DHHS receives and validates data for 280 measures required by the MCM contracts.

The [MQIS website](#) was demonstrated to view the types of quality data available. Information can be found using quality measures listed by A-Z and by topic. The search bar is used to search broadly for data and reports. Measures were demonstrated, e.g. timeliness of prenatal care, to highlight comparator data (New England, National, and NH commercial). Charts may be customized and converted, and data can be downloaded and exported. Subgroup populations can be accessed for each MCO. There is no identifiable data, as data is suppressed when numbers are too low. See slides 11-17 of the presentation to view MQIS screens.

Questions were raised about publication of specific types of data. Available information is limited to measures required by the state's managed care contract. However, it's possible to drill down by types of services used by a subgroup. Although HEDIS measures have some limitations, it is the standard used nationally to compare commercial and Medicaid health plan performance. Questions may be directed to Andrea Stewart at [Andrea.L.Stewart@dhhs.nh.gov](mailto:Andrea.L.Stewart@dhhs.nh.gov) /603-271-9437 and Jill Fournier at [Jill.Fournier@dhhs.nh.gov](mailto:Jill.Fournier@dhhs.nh.gov) /603-271-9582.

## **MCOs: Prior Authorization (PA) and Secondary Payer Issues:**

**AmeriHealth (ACNH): Lakeesha Dickerson, Manager, Utilization Management, Trina Loughery, Director, Operations and Administration**

ACNH performs standard and expedited PA reviews and concurrent reviews of select services to determine medical necessity. PA is performed by utilization management (UM) clinical staff supported by physicians. Decisions are based on nationally accepted UM medical necessity guidelines. When a reviewer cannot approve the request, the case is referred to the medical director, BH medical director, or physician designee.

Coordination of benefits: The MCO is the payer of last resort. When a hospital claim is billed secondary to Medicare, ACNH pays the full patient responsibility. If the claim is a medical claim or a commercial insurer is primary, ACNH pays the lesser of member responsibility or the difference between the amount paid by the primary carrier and the ACNH allowed amount.

## **NHHF: Erica Oberman, Director of UM: Jane Kapoian, Director Claims Ops, Leeann Wirth, TPL/COB SME**

Medical necessity review is based on InterQual criteria, Centene clinical policy, and state policy guidelines. PA nurses review cases and refer to medical director if the case does not meet criteria. Denials are sent to provider and member. When an adverse determination occurs, providers can provide additional information to the NHHF medical director. This option, as well as appeals information, is provided to members and providers. 100% concurrent reviews are performed for all inpatient admissions using InterQual. Cases that do not meet the criteria are referred to the medical director and follow the same process as PA.

Coordination of Benefits: Same as ACNH above. If a member is billed for a portion of services paid by the primary insurer and NHHF as secondary, with a portion that remains unpaid, the member should contact NHHF member services. If the primary payer rejects a pharmacy claim, NHHF as secondary follows the primary decision. If the member has Medicare and NHHF for pharmacy coverage, medications are processed through Medicare Part D unless excluded by Part D, and NHHF processes using formulary edits.

**WSHP: Jessica Rubinstein, Senior Medical Director, Debra Jacobs, VP of Utilization Management**

Medical: As secondary payer, WellSense covers patient responsibility but does not exceed the allowed amount for the service. When the primary payer does not cover a service, Well Sense PA rules must be followed.

DME: If the primary payer paid, no authorization is needed. If WellSense is secondary and the primary payer denied the claim, the DME provider must obtain an authorization.

WellSense follows the COB claims processing rules for pharmacy for primary commercial coverage or primary Medicare coverage.

Discussion: When a generic is substituted for brand name, the MCO is not obligated to notify the member because it's the same drug.

Questions for follow-up:

- Once the generic is filled but the brand must be substituted, the member should inform the pharmacist that a PA is required to get the brand name drug.
- Does the 72-hour emergency supply rule apply to substituting the brand name drug so the member does not go without medication? The member must ask, and pharmacy will comply.
- To avoid delays, the prescriber should order the medication as brand name only.

**Medicaid Continuous Enrollment**

**Deb Fournier, UNH Health Law & Policy**

- Medicaid enrollment increased by 34% since February 2019.
- In June 10% of overdue redeterminations completed; In July, 15% completed for a total of 15,616.
- Updated data on number of enrollees in the protected population will be available next month.
- The federal PHE will expire October 13 unless further extended. States should hear within the next few weeks whether or not the PHE will expire Oct 13.
- The Affordable Connectivity Program helps low-income households pay for internet service and connected devices. Households with incomes below 200% FPL or those receiving a government benefit (e.g. Medicaid, SNAP) qualify for discounts on devices and internet.
- Clients with online accounts have PIN numbers. Clients receive PINs by notices and can request them by mail and by phone. If a PIN is lost, clients can access their account information by providing their social security number or Medicaid ID number, and date of birth.

**Department Updates, Henry Lipman, Medicaid Director**

**Dental Benefit:** RFI responses due August 8. RFP will be issued in August.

**Disability Determinations (DDU report):** As of July 29, 2022:

- 21 children pending, of which 4 are on Medicaid. 15 cases 0-45 days; 6 cases 46-90 days. Zero over 90 days.
- 223 adults pending, of which 175 are on Medicaid. 97 cases 0-45 days; 82 cases 46-90 days; 44 cases 90+ days, of which 34 have Medicaid; 15 ready for nurse write-up or sign-off; 2 pending medical records after two requests; 26 scheduled for consultative exams.

[American Rescue Plan Act HCBS Spending Plan](#): DHHS will be issuing payments to case management providers soon.

**Rules - Consent:** He-W 854.15, Adult Category Earned Income Disregard

Meeting adjourned.

DRAFT



F – Newspaper Tear Sheets

## Legal Notice

### MORTGAGEE'S NOTICE OF SALE OF REAL PROPERTY

By virtue of a Power of Sale contained in a certain mortgage given by **Jeff Lemay** ("the Mortgagor(s)") to Mortgage Electronic Registration Systems, Inc., as nominee for CMG Mortgage, Inc. dba CMG Financial, dated May 23, 2019 and recorded in the Rockingham County Registry of Deeds in Book 6003, Page 1975 (the "Mortgage"), which mortgage is held by CMG Mortgage, Inc., 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 September 9, 2022 at 1:00 PM**

Said sale being located on the mortgaged premises and having a present address of 9 Mayhew Drive, Candia, 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 6003, Page 1974.

### 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 425 Phillips Blvd, Ewing, NJ 08618 and the name of the mortgagee's agent for service of process is Cenlar FSB Attn: Legal Department.

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 Five Thousand (\$5,000.00) 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 14, 2022.  
CMG Mortgage, Inc.  
By its Attorney,  
Lori Bolduc  
Harmon Law Offices, P.C.  
PO Box 610389  
Newton Highlands, MA 02461  
603-669-7963  
21764  
(UL - July 22, 29; Aug. 5)

### Public Notices

They're how you know!  
Public Notices help citizens to stay alert to what is happening in the community.

## Legal Notice

### MORTGAGEE'S NOTICE OF SALE OF REAL PROPERTY

By virtue of a Power of Sale contained in a certain mortgage given by **Rita M. Murphy, Patrick J. Murphy** ("the Mortgagor(s)") to Mortgage Electronic Registration Systems, Inc., as nominee for Quicken Loans Inc., dated September 7, 2011 and recorded in the Strafford County Registry of Deeds in Book 3962, Page 175 (the "Mortgage"), which mortgage is held by Federal National Mortgage Association, 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 September 2, 2022 at 3:00 PM**

Said sale being located on the mortgaged premises and having a present address of 5 Williams Way, Durham, Strafford County, New Hampshire. The premises are more particularly described in the Mortgage.

Being more accurately described as Lot #3 on plans recorded as Plans 8C and 8D in Pocket 12, Folder 1 of the Strafford County Registry of Deeds; previously inadvertently referred to as Plan No. 80 and Plan No. 60.

For mortgagor's(s) title see deed recorded with the Strafford County Registry of Deeds in Book 3962, Page 172.

### 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 Federal National Mortgage Association (Fannie Mae), Legal Department, Granite Park VII, 5600 Granite Parkway, Plano, TX 75024 and the name of the mortgagee's agent for service of process is Todd Barton.

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 Five Thousand (\$5,000.00) 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 18, 2022.  
Federal National Mortgage Association  
By its Attorney,  
Autumn Sarzana  
Harmon Law Offices, P.C.  
PO Box 610389  
Newton Highlands, MA 02461  
603-669-7963  
21737  
(UL - July 22, 29; Aug. 5)

## Legal Notice

### MORTGAGEE'S NOTICE OF SALE OF REAL PROPERTY

By virtue of a Power of Sale contained in a certain mortgage given by **Kelly A. Labrie, Noriyuki Kasahara** ("the Mortgagor(s)") to Mortgage Electronic Registration Systems, Inc. as nominee for Guaranteed Rate, Inc., dated February 25, 2019 and recorded in the Hillsborough County Registry of Deeds in Book 9148, Page 1273 (the "Mortgage"), which mortgage is held by Guaranteed Rate, Inc., 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 September 7, 2022 at 3:00 PM**

Said sale being located on the mortgaged premises and having a present address of 99 Brimstone Corner Road, Hancock, Hillsborough County, New Hampshire. The premises are more particularly described in the Mortgage.

For mortgagor's(s) title see deed recorded with the Hillsborough County Registry of Deeds in Book 9148, Page 1271.

### 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 2 1/2 Beacon Street, Concord, NH 03301 and the name of the mortgagee's agent for service of process is CT Corporation System.

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 Five Thousand (\$5,000.00) 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 19, 2022.

Guaranteed Rate, Inc.  
By its Attorney,  
Autumn Sarzana  
Harmon Law Offices, P.C.  
PO Box 610389  
Newton Highlands, MA 02461  
603-669-7963  
20875  
(UL - July 29; Aug. 5, 12)

## Legal Notice

### MORTGAGEE'S NOTICE OF SALE OF REAL ESTATE

By virtue of a Power of Sale contained in a certain Mortgage given by **William Mahoney** (the "Mortgagor") to Mortgage Electronic Registration Systems, Inc., as nominee for Freedom Mortgage Corporation, its successors and assigns, dated April 11, 2016 and recorded in the Hillsborough County Registry of Deeds in Book 8846, Page 2504 (the "Mortgage"), as affected by an Affidavit recorded June 6, 2022 in said Registry of Deeds in Book 9622, Page 2314, of which mortgage the undersigned is present holder by assignment, pursuant to and in execution of said power and for breach of conditions of said Mortgage and for the purpose of foreclosing same will be sold at:

**Public Auction on August 12, 2022 at 11:00 AM**

Said sale being located on the mortgaged premises and having a present address of **603 Turnpike Road, Greenville, NH 03048, and Parcel ID: 00000J 000007 000000, Old Turnpike Road, Mason, Hillsborough County, NH.** The premises are more particularly described in the Mortgage.

Upon information and belief, the metes and bounds and acreage are omitted from the legal description attached to the mortgage, thereby providing an ambiguous description of the subject premises. The metes and bounds of the subject premises should read:

Beginning at the northwesterly corner of the premises herein described at a corner of walls on the northeasterly side of Route #124, which corner is in the Town of Greenville and is 130 feet, more or less, northerly of the Greenville-Mason town line; thence 1) N 42 degrees E by stone wall and land now or formerly of John W. Laine 126 feet, more or less, to a slight bend in said stone wall; thence 2) N 39 degrees E by stone wall and land of said Laine 160 feet, more or less, to a corner in said stone wall; thence 3) turning and running southeasterly, southerly and southwesterly by a wire fence, as the same now runs, and by land formerly of Bingham Lumber Company, now or formerly of A. Oliver and Vivian E. Ilomaki, crossing over the Greenville-Mason town line and running into the Town of Mason, all for a distance of 580 feet, more or less, to a point at the end of a stone wall on the northeasterly side of said Route #124; thence 4) N 23 degrees E by stone wall and the northeasterly side of said Route #124, 200 feet, more or less, to a point at said Greenville-Mason town line; thence 5) continuing into the Town of Greenville, N 23 degrees E, by stone wall and the northerly side of said Route #124, 130 feet, more or less, to the bound of beginning. Containing 2.0 acres, be the same more or less.

### 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 mortgagee's name and address for service of process is Freedom Mortgage Corporation at 10500 Kincaid Drive, Fishers, IN, 46037. The name and address of the mortgagee's agent for service of process is CT Corporation System at 2 1/2 Beacon Street, Concord, NH 03301. 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".

The foreclosure sale will be made for the purpose of foreclosure of all rights of redemption of the said mortgagor(s) therein possessed by them and any and all persons, firms, corporations, or agencies claiming by, from or under them.

### TERMS OF SALE:

A deposit of FIVE THOUSAND DOLLARS AND 00 CENTS (\$5,000.00) in the form of a certified check, bank treasurer's check, or money order will be required to be delivered at or

before the time the bid is offered. The description of the premises contained in said mortgage shall control in the event of an error in this publication.

Freedom Mortgage Corporation  
Present Holder of said Mortgage,  
By Its Attorneys,  
Orlans PC  
PO Box 540540  
Waltham, Massachusetts 02454  
Phone: (781) 790-7800  
(UL - July 22, 29; Aug. 5)

## Legal Notice

### MORTGAGEE'S NOTICE OF SALE OF REAL PROPERTY

By virtue of a Power of Sale contained in a certain mortgage given by **Paul R. Antcliff, Kimberly L. Caron** ("the Mortgagor(s)") to Mortgage Electronic Registration Systems, Inc., as nominee for CitiMortgage, Inc., dated March 2, 2010 and recorded in the Hillsborough County Registry of Deeds in Book 8236, Page 2175 (the "Mortgage"), which mortgage is held by Federal Home Loan Mortgage Corporation, 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 September 21, 2022 at 11:00 AM**

Said sale being located on the mortgaged premises and having a present address of 15 Albury Stone Circle, Unit 219, The Villages at Kessler Farm Condominium, Nashua, Hillsborough County, New Hampshire. The premises are more particularly described in the Mortgage.

Being more particularly described as Unit 219 in The Villages at Kessler Farm Condominium; reference to Unit 215 is erroneous.

For mortgagor's(s) title see deed recorded with the Hillsborough County Registry of Deeds in Book 5956, Page 375.

### 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 425 Phillips Blvd, Ewing, NJ 08618 and the name of the mortgagee's agent for service of process is Cenlar FSB Attn: Legal Department.

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 Five Thousand (\$5,000.00) 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 27, 2022.

Federal Home Loan Mortgage Corporation  
By its Attorney,  
Autumn Sarzana  
Harmon Law Offices, P.C.  
PO Box 610389  
Newton Highlands, MA 02461  
603-669-7963  
21532  
(UL - Aug. 5, 12, 19)

## Legal Notice

### MORTGAGEE'S NOTICE OF SALE OF REAL PROPERTY

By virtue of a Power of Sale contained in a certain mortgage given by **Brian Baker**, (the "Mortgagor") to RBS Citizens, N.A. and now held by **Federal National Mortgage Association** (the "Mortgagee"), said mortgage dated April 24, 2009, and recorded with the Grafton County Registry of Deeds in Book 3603 at Page 0625 (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 20, 2022 at 12:00 PM**

Said sale to be held directly on the mortgaged premises described in said mortgage and having a present address of 330 Eastside Road, Woodstock, Grafton 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:

Federal National Mortgage Association (Fannie Mae)  
Legal Department  
Granite Park VII  
5600 Granite Parkway  
Plano, TX 75024  
THE NAME OF THE MORTGAGEE'S AGENT FOR SERVICE OF PROCESS IS:  
Todd Barton  
Federal National Mortgage Association (Fannie Mae)  
Legal Department  
Granite Park VII  
5600 Granite Parkway  
Plano, TX 75024

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 26, 2022.

Federal National Mortgage Association  
By its Attorney,  
/s/ Christopher I. Henry, Esq.  
Christopher I. Henry, Esq.  
Bendett & McHugh, P.C.  
270 Farmington Avenue, Ste. 151  
Farmington, CT 06032  
(860) 677-2868  
(UL - July 29; Aug. 5, 12)

## Legal Notice

### NH Department of Health and Human Services Substance Use Disorder Serious Mental Illness and Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Extension Request

Notice is hereby given that, as part of its ongoing efforts to maintain and improve access to behavioral health services in the State, the NH Department of Health and Human Services (DHHS) is applying for an extension to its Section 1115(a) Research and Demonstration Waiver from the Centers for Medicare and Medicaid Services (CMS) for a period of an additional five years. This extension will enable DHHS to claim federal reimbursement for payment of services provided to Medicaid beneficiaries as follows:

- Beneficiaries under age 65 who are otherwise eligible and primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD);
- Beneficiaries ages 21-64 who are otherwise eligible and primarily receiving short-term inpatient psychiatric treatment or short-term residential mental health treatment for serious mental illness (SMI) in an IMD; and
- Beneficiaries who are otherwise eligible and receiving SUD, SMI or Serious Emotional Disturbance (SED) treatment while an inmate of a public institution within NHDOS's system of state prisons, for a focused package of care coordination and services to be provided during the period 45 days prior to release (tailored Medicaid State Plan services to support community reentry or "Community Reentry").

DHHS is interested in public input on the extension request for the Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access (SUD-SMI-SED-TRA) Section 1115(a) Research and Demonstration Waiver. DHHS is convening two public hearings to seek public input on this extension request. Comments will also be considered at the Medical Care Advisory Committee (MCAC) meetings in August. All MCAC meetings are open to the public.

The hearings will be held:  
• Wednesday, August 10, 2022, from 5:30 - 7:00 pm at Manchester Public Library Auditorium, 405 Pine Street, Manchester, NH 03104

• Thursday, August 18, 2022, from 5:00 - 6:30 pm at Littleton Regional Healthcare, 600 St. Johnsbury Road, Littleton, NH 03561 (Masks required)

The MCAC meeting will be held:

• Monday, August 8, 2022, from 10 a.m. - 12 p.m. at Fred H.

Brown Building Auditorium, 129 Pleasant Street, Concord, NH 03301

The complete version of the Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Extension Request is available for public review at: <https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-waivers-and-demonstrations>. Aside from Community Reentry, the State is not requesting any changes to the demonstration scope as approved in the **Special Terms and Conditions** dated June 2, 2022. All public comments must be received by 5:00 pm (Eastern) on Tuesday, September 6, 2022.

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 [SUD-SMI-1115-Extension@dhhs.nh.gov](mailto:SUD-SMI-1115-Extension@dhhs.nh.gov); or (4) mailed to Carolyn Richards, NH Department of Health and Human Services, Attn: SUD-SMI-SED-TRA Demonstration Extension, 129 Pleasant Street, Concord, NH 03301 (UL - Aug. 5)

## Legal Notice

### MORTGAGEE'S NOTICE OF SALE OF REAL PROPERTY

By virtue of a Power of Sale contained in a certain mortgage given by **Matthew J. Nolan, Tania L. Kendrick** ("the Mortgagor(s)") to Mortgage Electronic Registration Systems, Inc., as nominee for Freedom Mortgage Corporation, dated July 14, 2021 and recorded in the Hillsborough County Registry of Deeds in Book 9508, Page 92 (the "Mortgage"), which mortgage is held by Freedom Mortgage Corporation, 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 September 14, 2022 at 11:00 AM**

Said sale being located on the mortgaged premises and having a present address of 10 Upton Road, Mont Vernon, Hillsborough County, New Hampshire. The premises are more particularly described in the Mortgage.

For mortgagor's(s) title see deed recorded with the Hillsborough County Registry of Deeds in Book 8796, Page 868.

### 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 9 Capitol Street, Concord, NH 03301 and the name of the mortgagee's agent for service of process is C T Corporation.

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 Five Thousand (\$5,000.00) 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 18, 2022.

Freedom Mortgage Corporation  
By its Attorney,  
Autumn Sarzana  
Harmon Law Offices, P.C.  
PO Box 610389  
Newton Highlands, MA 02461  
603-669-7963  
21895  
(UL - Aug. 5, 12, 19)

## Legal Notice

The Planning Board for the Town of Derry will hold a public hearing on **Wednesday, August 17, 2022, at 7:00 p.m.** at the **Derry Municipal Center**, 14 Manning Street,

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12 p.m. Thursday for Sunday insertion

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3 p.m. Wednesday for Sunday insertion

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**45**  
**Garage/Yard Sales**

**Yard Sales**  
 Nashua Multifamily Yard Sale. Sunday 8/7 8 am to 3pm. 1 Dawn St. Tools, very nice furniture, bird cages, boat and utility trailer, & knick knacks. Deals galore!

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**60**  
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**603.594.1218 msavoie@nashuatelegraph.com**

**LEGAL NOTICE - MILFORD SCHOOL DISTRICT HEARING TO ACCEPT PRIVATE GRANT FUNDS**  
 The Milford School Board will hold a hearing pursuant to RSA 198:20b to accept federal grant funds.  
 Date: Monday, August 15, 2022  
 Location: Milford High School Lecture Hall & Virtual Zoom  
 Time: 7:00 PM

**Let it be known to all those interested:**  
 • Fay Bulcock was the Settlor of The Fay Bulcock Living Trust and died on December 6, 2021. Fay Bulcock was domiciled in Manchester, New Hampshire on the date of death. The Trustee of the decedent's trust is Maureen Nisi, with a mailing address c/o Sowerby and Moustakis Law, PLLC, 282 Route 101, Unit 15, Amherst, NH 03031; and  
 • Any claim against the settlor will be barred unless a proceeding to enforce the claim is commenced within one year after the publication date of the notice.

**LEGAL NOTICE FOR AUCTION BEING HELD Saturday, August 13, 2022**, 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 13, 2022 at **10:00AM** all and singular contents of lockers of Richard Diogiovanni, Brandon Gilcreast, and Donald Miner. Starting at **10:45 a.m** same day Saturday, August 13, 2022 at 248 Mont Vernon Rd., Milford, New Hampshire all and singular contents of lockers of Andrew Knowlton, Sarah McEwen, and Jason Poirier 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. 603-673-9538

**NOTICE OF PUBLIC HEARING**  
 RSA 149-M:9, RSA 149-M:11, Env-Sw 304.08  
**PERMIT APPLICATION FOR A SOLID WASTE LANDFILL EXPANSION**  
**Four Hills Secure Landfill Expansion - 840 West Hollis Street, Nashua, NH**  
**Permit No. DES-SW-SP-95-002**

The New Hampshire Department of Environmental Services (NHDES) is seeking public comments on an application for expansion of the Four Hills Secure Landfill Expansion located in Nashua, NH. A public hearing is scheduled for **6:00 pm on Wednesday, September 7, 2022**, for receipt of oral testimony. The public comment period is open and continues until 4:00 pm on Friday, September 23, 2022, for receipt of written comments to be included in the public hearing record.

**Application Summary:** The City of Nashua submitted to NHDES a Type I-A Permit Modification Application to expand the existing landfill vertically and horizontally above the closed, unlined MSW landfill; the active, lined MSW landfill; and in the area between the two existing landfills. The proposed expansion, called Phase IV, covers approximately 32.4 acres. Phase IV would add about 3.9 million cubic yards of capacity and extend the facility's operating life by about 30 years into 2060. The applicant has also submitted an application for waiver of Env-Sw 805.05(j) relative to expanding over existing leachate collection system pipe penetrations in the lined landfill.

The permit application documents are available for public review during regular business hours at City Hall, 229 Main Street, Nashua, NH, and at the NHDES' office, 29 Hazen Drive, Concord, NH. The application is also available electronically on the NHDES' OneStop website (<https://www.des.nh.gov/onestop-navigation>).

**Public Hearing:** A hearing to receive testimony on the application will be held in-person at the Nashua City Hall Auditorium, 229 Main Street, Nashua, NH on Wednesday, September 7, 2022 at 6:00 pm. Remote access is also available by registering at <https://attendee.gotowebinar.com/register/8126966953918581261>. After registering, you will receive confirmation by email with information on how to join the hearing through the internet. Advance registration is not required but is encouraged. In the event of inclement weather, please call (603) 271-2925 for further information.

**Written Comments:** Instead of or in addition to providing oral testimony at the public hearing, written testimony may be submitted to NHDES at any time before close of the public comment period on September 23, 2022, at 4:00 pm. To be included in the public record, written testimony must be submitted using one of three methods: by email to [swpublic.comment@des.nh.gov](mailto:swpublic.comment@des.nh.gov); by post to NHDES-SWMB Attn: Mary Daun, PO Box 95, Concord, NH 03302; or by hand delivery to NHDES' office at 29 Hazen Drive, Concord, NH.

**Assistance:** Individuals may request special assistance to attend the hearing under the provisions of the Americans with Disabilities Act by contacting Nelson Ordway, NHDES, 29 Hazen Dr., PO Box 95, Concord, NH 03302-0095; TDD Access: Relay NH 1-800-735-2964; or by email at [solidwasteinfo@des.nh.gov](mailto:solidwasteinfo@des.nh.gov). Requests for assistance must be received no later than 6:00 pm on August 24, 2022.

**Additional Information:** For additional information, please contact Mary Daun, P.E., Solid Waste Permit Engineer, at (603) 271-8573, email [mary.f.daun@des.nh.gov](mailto:mary.f.daun@des.nh.gov), or mail to NHDES-SWMB, PO Box 95, Concord, NH 03302-0095.

**NOTICE OF PUBLIC SALE: LAKE COUNTY TOW NORTHEAST INC** gives Notice of Foreclosure of Lien and intent to sell these vehicles on **August 22, 2022, at 9:00 AM at 32 Cross Street, Hudson NH 03051**. Pursuant to RSA 262:32 of New Hampshire state law, Lake County Tow Northeast Inc, reserves the right to reject or accept any/or all bids.

**VEHICLE 1:** 2F94H540459 **1972 Mercury Cougar**  
**VEHICLE 2:** 4MZAX14J153000812 **2005 Buell Firebolt XB12R**  
**VEHICLE 3:** 1G2NW12T6TC763620 **1996 Pontiac Grand Am**  
**VEHICLE 4:** 1NXBU40E09Z009671 **2009 Toyota Corolla Silver**

**Announcement to Former Serenity Place Patients:**  
 In 2018, all patient records in the custody of Serenity Place were transferred to the State of New Hampshire, DHHS, BDAS. The Serenity Place records transferred to BDAS are being held at BDAS's office located at 105 Pleasant Street, Concord, NH 03301. If you are a former patient and you want to obtain a copy of your own records, you can do so by completing a Request for Access to Client's Own Confidential Information. If you are a person requesting a former patient's records with the patient's permission, you can do so by completing an Authorization Form. To obtain a Request for Access to Client's Own Confidential Information or Authorization Form visit the DHHS website at <https://www.dhhs.nh.gov/news-and-media/announcement-former-serenity-place-patients> or call (p) 603-271-6113 and one will be mailed to you. Executed Requests/Authorizations must be returned to: Nicole Robbins, BDAS, 105 Pleasant Street, 3rd Floor North, Concord, NH 03301. Once BDAS receives an executed Request or Authorization, a representative will contact you to schedule an appointment for you to pick up the records. **Please be advised that BDAS anticipates destroying Serenity Place patient files and records in its custody on October 1, 2022. You should, therefore, take prompt action to request a copy of your records.**

**NH Department of Health and Human Services Substance Use Disorder Serious Mental Illness and Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Extension Request**

Notice is hereby given that, as part of its ongoing efforts to maintain and improve access to behavioral health services in the State, the NH Department of Health and Human Services (DHHS) is applying for an extension to its Section 1115(a) Research and Demonstration Waiver from the Centers for Medicare and Medicaid Services (CMS) for a period of an additional five years. This extension will enable DHHS to claim federal reimbursement for payment of services provided to Medicaid beneficiaries as follows:

- Beneficiaries under age 65 who are otherwise eligible and primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD);
- Beneficiaries ages 21-64 who are otherwise eligible and primarily receiving short-term inpatient psychiatric treatment or short-term residential mental health treatment for serious mental illness (SMI) in an IMD; and
- Beneficiaries who are otherwise eligible and receiving SUD, SMI or Serious Emotional Disturbance (SED) treatment while an inmate of a public institution within NHDOC's system of state prisons, for a focused package of care coordination and services to be provided during the period 45 days prior to release (tailored Medicaid State Plan services to support community reentry or "Community Reentry").

DHHS is interested in public input on the extension request for the Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access (SUD-SMI-SED-TRA) Section 1115(a) Research and Demonstration Waiver. DHHS is convening two public hearings to seek public input on this extension request. 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:  
 • Wednesday, August 10, 2022, from 5:30 - 7:00 pm at Manchester Public Library Auditorium, 405 Pine Street, Manchester, NH 03104  
 • Thursday, August 18, 2022, from 5:00 - 6:30 pm at Littleton Regional Healthcare, 600 St. Johnsbury Road, Littleton, NH 03561 (Masks required)

The MCAC meeting will be held:  
 • Monday, August 8, 2022, from 10 a.m. - 12 p.m. at Fred H. Brown Building Auditorium, 129 Pleasant Street, Concord, NH 03301

The complete version of the Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver Extension Request is available for public review at: <https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-waivers-and-demonstrations>. Aside from Community Reentry, the State is not requesting any changes to the demonstration scope as approved in the Special Terms and Conditions dated June 2, 2022. All public comments must be received by 5:00 pm (Eastern) on Tuesday, September 6, 2022.

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 [SUD-SMI.1115.Extension@dhhs.nh.gov](mailto:SUD-SMI.1115.Extension@dhhs.nh.gov); or (4) mailed to Carolyn Richards, NH Department of Health and Human Services, Attn: SUD-SMI-SED-TRA Demonstration Extension, 129 Pleasant Street, Concord, NH 03301

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## G – Letters of Comment Received

## Nagy, Jay

---

**From:** DHHS: SUD-SMI 1115 Extension <SUD-SMI.1115.Extension@dhhs.nh.gov>  
**Sent:** Friday, September 09, 2022 12:00 PM  
**To:** Nagy, Jay; Salmon, Jillian  
**Subject:** FW: SUD-SMI Demonstration Extension

**Follow Up Flag:** Follow up  
**Flag Status:** Completed

 [EXTERNAL EMAIL]: Use Caution

---

**From:** Martins, Germano <Germano.M.Martins@dhhs.nh.gov>  
**Sent:** Friday, August 5, 2022 12:47 PM  
**To:** DHHS: SUD-SMI 1115 Extension <SUD-SMI.1115.Extension@dhhs.nh.gov>  
**Subject:** Re: SUD-SMI Demonstration Extension

Thank you for sending this email.

I do not believe most staff understand what “SUD-SMI-SED-TRA” is, so I think perhaps at another time we could please list what these acronym mean.

Respectfully submitted,  
Germano Martins

Germano Martins, MBA  
Community Relations Manager  
Department of Health and Human Services  
[germano.martins@dhhs.nh.gov](mailto:germano.martins@dhhs.nh.gov)  
cell: 1 (603) 545 1635

---

**From:** DHHS: SUD-SMI 1115 Extension <[SUD-SMI.1115.Extension@dhhs.nh.gov](mailto:SUD-SMI.1115.Extension@dhhs.nh.gov)>  
**Sent:** Friday, August 5, 2022 10:33:57 AM  
**To:** DHHS: SUD-SMI 1115 Extension <[SUD-SMI.1115.Extension@dhhs.nh.gov](mailto:SUD-SMI.1115.Extension@dhhs.nh.gov)>  
**Subject:** SUD-SMI Demonstration Extension

Good morning,

NH DHHS is excited to share with you our draft extension request for the SUD-SMI-SED-TRA Demonstration. On the [DHHS website](#) you will find a downloadable copy of the demonstration extension request, information on the public hearings, and details on how to submit comments (which include replying to this email during the public comment period). Public comment period begins on Monday, August 8, 2022 until Tuesday, September 6, 2022 at 5:00 pm (Eastern). All comments must be received by 5:00 pm (Eastern) on Tuesday, September 6, 2022

Below are the Public Hearing locations, dates and times:

The hearings will be held:

- Wednesday, August 10, 2022, from 5:30 - 7:00 pm at Manchester Public Library Auditorium, 405 Pine Street, Manchester, NH 03104

- Thursday, August 18, 2022, from 5:00 - 6:30 pm at Littleton Regional Healthcare, 600 St. Johnsbury Road, Littleton, NH 03561 (Masks required)

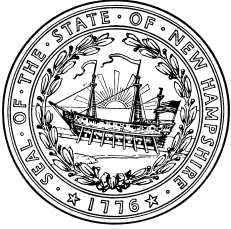
The Medical Care Advisory Committee (MCAC) meeting will be held:

- Monday, August 8, 2022, from 10 a.m. - 12 p.m. at Fred H. Brown Building Auditorium, 129 Pleasant Street, Concord, NH 03301

Thank you in advance for your feedback.

Carolyn Richards  
Federal Waivers Administrator  
Division of Medicaid  
State of NH-DHHS  
129 Pleasant Street  
Concord, NH 03301  
603.271.9439

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## GOVERNOR'S COMMISSION ON ALCOHOL & OTHER DRUGS

### BUREAU OF DRUG AND ALCOHOL SERVICES

105 Pleasant Street, Concord NH 03301  
603-271-5818 TDD ACCESS: 1-800-804-0909

August 31, 2022

Governor Chris Sununu  
Patrick Tufts, Chairman

Carolyn Richards  
Federal Waivers Manager  
New Hampshire Department of Health and Human Services  
129 Pleasant Street  
Concord, New Hampshire 03301

Steve Ahnen

Mark Armaganian

Senator Kevin Avar

Russ Conte

Commissioner Frank Edelblut

Representative Jess Edwards

Commissioner Helen Hanks

Representative William Hatch

Keith Howard

Timothy Lena

Chancellor Chuck Lloyd

Attorney General John Formella

Traci Fowler

Joseph Johnsick

Matt McKenney

Major General David Mikolaities

Honorable Tina Nadeau

Commissioner Chris Nicolopoulos

Commissioner Robert L. Quinn

Director Joseph Ribsam

Kathie Saari

Seddon Savage, MD

Stephanie A. Savard

Kate Thomson

Senator David Watters

Dear Ms. Richards:

On behalf of the Governor's Commission on Alcohol and Other Drugs ("Governor's Commission"), I write to express our support for New Hampshire's request for a five-year extension of the Substance Use Disorder (SUD) Serious Mental Illness (SMI) Serious Emotional Disturbance (SED) Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver. The proposed extension will strengthen SUD and mental health treatment supports for NH residents.

The Governor's Commission's mission is to significantly reduce alcohol and other drug problems and their behavioral, health and social consequences for the citizens of New Hampshire by advising the Governor and Legislature regarding the delivery of effective and coordinated substance misuse prevention, treatment, and recovery services throughout the state. The initial SUD-TRA Demonstration, approved in July 2018, has already contributed to our collective goals. As reported in the Interim Evaluation Report,<sup>1</sup> the Demonstration has increased access to care for those beneficiaries with intensive SUD treatment needs, as well as enhanced stabilization and continuity of care post-discharge.

Extending the existing authorities represents a major step forward for New Hampshire's multi-sector efforts to expand access to and engagement in SUD treatment in appropriate settings, reduce overdose deaths, and improve population health. The newly proposed Community Reentry Initiative for incarcerated individuals would build upon this foundation by targeting one of our most high-risk and high-need groups. By enhancing care coordination for Medicaid-individuals with SUD and SMI/SED prior to release from state prisons, the program would support stable re-integration and reduce recidivism; it would also reduce utilization of emergency department and inpatient hospital settings through improved access to the other continuum of care services.

The Governor's Commission strongly supports the Department's renewal request of the existing SUD-SMI demonstration, which would allow the demonstration to be in effect until June 30, 2028, and encourage CMS to approve the request as soon as possible.

Thank you,

Patrick M. Tufts  
Chair, Governor's Commission on Alcohol and Other Drugs

<sup>1</sup> Draft Interim Evaluation Report -

<https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/sed-extention-request-app3.pdf>

Carolyn Richards NH Department of Health and Human Services  
Attn: SUD-SMI-SED-TRA Demonstration Extension  
129 Pleasant Street Concord NH 03301

August 29, 2022

Dear Ms. Richards,

As the former Executive Director of NAMI NH, The National Alliance on Mental Illness, and as a family member of an individual who has experienced homelessness, and incarceration as a result of co-occurring mental illness and substance use disorders, I am offering my enthusiastic support for the New Hampshire Department of Health and Human Services waiver application to the Center for Medicare and Medicaid for extending the Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver.

Despite challenges posed by the COVID pandemic, during the past several years New Hampshire's has made significant progress in reducing continuity of care gaps for individuals with mental illness and/or substance use disorders. The transformation which resulted from the Medicaid Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver approved in June of 2018 has played a significant role in reducing these gaps. One notable improvement has been the creation of over 100 additional short term treatment beds since approval of the waiver. The additional waiver for people with serious mental illness approved in June 2022 is also another significant step forward and I anticipate there will be similar positive outcomes.

The Department of Health and Human Services Ten Year Mental Health Plan issued in January of 2019, and the New Hampshire Legislature's support of key recommendations of the plan have also been effective at providing improved access to care for individuals with substance use disorders, people with severe mental illness and those who have co-occurring disorders. These improvements in the service delivery system have been especially timely given the dramatic increase in people seeking services during the pandemic. There is no indication that current demand for services will decrease in the months and years to come. Extension of New Hampshire's waiver is essential to continue to address emergency department boarding, and other challenges in accessing mental health and/or substance use disorder treatment which have been exacerbated by the pandemic.

The additional waiver provision for incarcerated individuals in this extension request is an important step toward increasing community tenure for a very vulnerable population. For individuals who have been incarcerated, the transition back to the community, is especially problematic for identifying and engaging treatment providers and insuring continuity of care. As a family member, I have personally witnessed the cycle of homelessness, probation violations, and repeated incarceration which occurs when there is inadequate planning and follow up with treatment providers when transitioning back to the community. As such, I strongly support this component of the waiver.

Transition to the community for individuals who have been incarcerated is also a time of high risk for suicide and drug overdose. The addition of this provision is reflective of close collaboration between the Department of Health and Human Services and the New Hampshire Department of Corrections. My only suggestion to the proposed waiver is to include a statement about higher risk for suicide in the waiver application.



Please feel free to contact me at [kencnorton1@gmail.com](mailto:kencnorton1@gmail.com) or 603.496.5748 if you have any questions concerning my support of the proposed waiver extension.

Respectfully,

A handwritten signature in black ink, appearing to read 'Kenneth Norton', written in a cursive style.

Kenneth Norton LICSW



September 5, 2022

Carolyn Richards  
NH Department of Health and Human Services  
Attn: SUD-SMI-SED-TRA Demonstration Extension  
129 Pleasant Street  
Concord, NH 03301

Dear Ms. Richards,

I am pleased to provide this letter of support for the NH Department of Health and Human Services' (DHHS) request to extend the SUD-SMI Demonstration and expand its scope to include a community reentry component. I commend you and your department for seeking the initial demonstration waiver in 2018 and applaud the successes of your efforts.

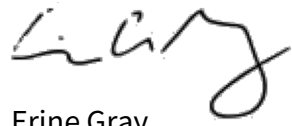
New Hampshire is not immune to the impacts of the national behavioral health and substance use disorder crises, and unfortunately has experienced one of the highest rates of opioid addiction in the country. Many institutionalized individuals are released from treatment or incarceration without adequate support to successfully reenter their communities. Our organizations share a fundamental belief that removing barriers to care is critical to reducing rates of recidivism and improving the lives of the people and communities we serve.

Findhelp's mission is to be part of the solution by connecting all people in need and the programs that serve them, with dignity and ease. We are the largest social care network in the United States and our interoperable technology supporting closed-loop referrals is used by over 430 customers, including 295 health systems, health plans, community health centers, and health departments. Our New Hampshire network includes two of the three managed care organizations, Centurion, BeneLynk, American Red Cross, and AARP, and approximately 350 community-based organizations offering services to residents of the state, resulting in nearly 200,000 searches for help state-wide.

We commend you on the critical work New Hampshire is doing to alter the trajectory of the behavioral health and substance use disorder epidemics. It is unprecedented and should be an example for other states to follow.

Please let me know how I and my team can assist you and NH DHHS in the great work you are doing for the citizens of New Hampshire.

Sincerely,

A handwritten signature in black ink, appearing to read "Erine Gray". The signature is fluid and cursive, with the first name "Erine" and the last name "Gray" clearly distinguishable.

Erine Gray  
Founder and CEO  
findhelp

CC: Henry Lipman, Medicaid Director

September 6, 2022

Carolyn Richards  
NH Department of Health and Human Services  
Attn: SUD-SMI-SED-TRA Demonstration Extension  
129 Pleasant Street  
Concord, NH 03301

Re: NAMI NH Comments on SUD-SMI-SED-TRA Demonstration Waiver Extension Request

Dear Ms. Richards:

Thank you for the opportunity to provide comments on the State's SUD-SMI-SED-TRA Demonstration Waiver Extension Request. NAMI New Hampshire is a non-profit, grassroots organization whose mission is to improve the lives of all people impacted by mental illness and suicide through support, education, and advocacy. We write today in full support of the demonstration waiver because it will improve access to, and coordination of, mental health and substance use disorder services in the state.

The institutions of mental disease (IMD) exclusion under the federal Medicaid law is discriminatory in nature, and NAMI NH applauds the Department in its efforts to apply for a waiver of this exclusion. On any given day in New Hampshire, there are dozens of individuals waiting in emergency rooms for involuntary admission to a psychiatric hospital. The state currently has two hospitals that are considered IMD, both of which are owned by the State of New Hampshire. Because the IMD exclusion prevents billing for inpatient services, private hospitals in the state are disincentivized from providing inpatient psychiatric services except on a very small scale. Having the waiver in place would encourage private hospitals to increase their capacity, thus increasing overall access. Additionally, because the northernmost IMD is in Franklin, there is limited access to inpatient care in the northern part of New Hampshire. The approval of this waiver extension could encourage private hospitals north of Concord to increase capacity. An increased capacity in northern New Hampshire would improve access for the folks living there. New Hampshire has three private facilities with 16 beds each and one with 10 beds. The 16-bed maximum at these facilities is likely related to the IMD exclusion, since anything over 16 beds would make them an IMD, and therefore, unable to bill Medicaid for services rendered.

In addition to the extension of the SUD/IMD waiver, NAMI NH is in strong support of broadening the waiver to include tailored Medicaid services to support the successful community

*Reflecting on 40 Years: Continuing Our Journey to Hope, Help, and Health*

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re-entry for individuals within the state prison. As of July 1, 2020, twenty-nine percent of males and sixty-six percent of females residing within the NH prison system were being prescribed psychiatric medications. Additionally, other data around our state indicated that in Sullivan County, there was a seventy-six percent overlap between people in the county jail and people served by the community mental health center; in Cheshire County, of those who received a mental health assessment, eighty-four percent met the criteria for a substance use disorder and sixty-four percent had a co-occurring mental health disorder; and in Coos County it was estimated in 2019 that about one-quarter of the people incarcerated had an opioid use problem. Lastly, both in NH and nationwide, rates of mental illness and substance use disorders among jail populations are significantly higher when compared to the general population.

It is essential that NH establish comprehensive re-entry programs for people with mental illness and substance use disorders. Nationally, lack of timely access to critical services and supports for health or mental health conditions places individuals at a higher risk of repeated incarceration. In addition, the risk of death by suicide or overdose dramatically increases in the first days and weeks after an individual is released from jail or prison. According to one study, the risk of a fatal drug overdose is 129 times higher for individuals returning to the community than for the general population.

This waiver, allowing for Medicaid reimbursement for community-based mental health and substance use disorder services within 45 days of release, is a strong start for the state in developing a comprehensive re-entry program. Individuals who have an established relationship with a provider prior to release are more likely to continue with treatment after release. This, in turn, will likely result in lower recidivism rates, and decreased incidences of suicide and overdose shortly after release.

NAMI New Hampshire recognizes the significant pressures which the state's continuum of mental health care is currently experiencing. We look forward to learning more about how the state will expand community-based mental health care, as well as efforts to engage private providers and reduce barriers to care, such as transportation and waitlists. As advocates we stand ready to work with our partners in supporting initiatives that will help expand access to care at all levels.

As an organization, NAMI New Hampshire wholeheartedly supports the State of New Hampshire's SUD-SMI-SED-TRA Demonstration Extension waiver. We are grateful for the opportunity to provide these comments.

Sincerely,



Susan L. Stearns  
Executive Director

# DISABILITY RIGHTS CENTER - NH

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64 North Main Street, Suite 2, Concord, NH 03301-4913 • mail@drcnh.org • drcnh.org  
(603) 228-0432 • (800) 834-1721 voice or TTY • FAX: (603) 225-2077

September 6, 2022

**Via Electronic Mail Only (SUD-SMI.1115.Extension@dhs.nh.gov)**

Carolyn Richards  
NH Department of Health and Human Services  
Attn: SUD-SMI-SED-TRA Demonstration Extension  
129 Pleasant Street  
Concord, NH 03301

**RE:** SUD-SMI-SED-TRA Demonstration Extension

Dear Ms. Richards:

We are writing on behalf of the Disability Rights Center – NH (DRC-NH) to voice our opposition to the New Hampshire Department of Health and Human Services’ (the “Department”) request for an extension of its Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver (Demonstration Project No. 11-W-00321/1) Please note these comments are limited to the portions of the extension request pertaining to individuals with Serious Mental Illness and Serious Emotional Disturbance (“SMI/SED”).<sup>1</sup>

As New Hampshire’s federally designated protection and advocacy system for individuals with mental illness, DRC-NH advocates for the rights of people with mental illness through providing legal representation to ensure such individuals are afforded their rights under state and federal law and through investigating incidents involving abuse and neglect of treatment facility residents with mental illness.<sup>2</sup> Among DRC-NH’s highest priorities for our work on behalf of individuals who experience mental illness is to advocate for access to community based mental health services and to prevent unnecessary institutionalization.

As expressed in our August 2021 and October 2021 letters to your office and the Centers for Medicare and Medicaid Services (“CMS”) in response to New Hampshire Section 1115(a) Demonstration, Amendment #2 Request, allowing federal financial participation (“FFP”) for institutional psychiatric treatment, particularly when New Hampshire has an inadequate

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<sup>1</sup> DRC-NH submits these comments without prejudice to the right of our law firm and our clients to make additional claims or to take different positions including, but not limited to, in the following federal lawsuits: Amanda D., et al. v. Sununu, et al., No. 1:12-cv-53-SM (DNH) and G.K., et al., v. Sununu, et al., No.1:21-cv-00004-PB (DNH). The absence of comments regarding any particular provisions of the Department’s 1115(a) Demonstration Waiver Extension Request does not reflect support for those provisions or DRC-NH’s agreement that they are satisfactory or lawful.

<sup>2</sup> 42 U.S.C. §10801(b)

community-based mental health service system, is detrimental to the people of our State who experience serious mental illness and is inconsistent with the State's existing obligations to provide an integrated mental health system under federal and state laws, including the Americans with Disabilities Act and R.S.A. 135-C. See DRC-NH letters to John Poirier dated August 31, 2021, and The Honorable Xavier Becerra dated October 21, 2021, incorporated herein and enclosed with this letter.

Institutions for mental disease ("IMDs") are --by definition --segregated settings. Providing additional funding for services in IMDs will inevitably have an impact on where people with disabilities receive services. Continuing to provide federal funding for these institutional settings risks both re-enforcing discriminatory presumptions about the ability of individuals with disabilities to live in the community and diverting scarce resources to congregate facilities, undermining the integration mandate articulated by the Supreme Court in *Olmstead v. L.C. ex rel. Zimring*.<sup>3</sup>

We are acutely aware that significant numbers of adults and children experiencing mental health crises in our State have been transported to, and remained for prolonged periods of time in, hospital emergency rooms. However, contrary to the Department's assertions, the cause of New Hampshire's emergency room boarding problem is not an inadequate number of inpatient acute care psychiatric beds. Rather, the cause of this problem is the lack of an adequate array of community-based treatment and supports for individuals who experience mental illness.

Inpatient psychiatric treatment should be reserved for individuals who are experiencing acute psychiatric crises. People admitted to hospitals or other IMDs should be discharged to their homes or other community-based programs when they no longer require the intensive oversight that can only be provided in such institutions. However, because New Hampshire lacks sufficient community-based treatment options, significant numbers of adults and children who occupy the State's inpatient acute care beds languish in these facilities instead of being discharged.

Extending a demonstration waiver which incentivizes the development and placement of individuals with mental illness in IMDs will not solve the fundamental deficiencies in New Hampshire's behavioral health system for individuals who are enrolled in Medicaid. Rather than create additional beds and entrench the State's reliance on institutional care, the Department should pursue more permanent solutions to expanding and enhancing the State's array of community-based treatment options and supports for people who experience mental illness, including individuals who experience crises, which could be managed in their homes and communities rather than through hospitalization.

**New Hampshire has an adequate supply of psychiatric hospital beds. Yet it continues to add beds rather than expend the necessary resources to ensure New Hampshire has an**

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<sup>3</sup> 527 U.S. 581(1999)

**adequate array of community-based treatment options and supports for individuals with serious mental illness.**

Publicly available data does not support expansion of New Hampshire's IMD beds.

The Department's request to extend its 1115(a) Demonstration waiver of the IMD exclusion for individuals with SMI/SED is based in large part on the faulty assertion that despite what it characterizes as "significant investments in the community-based continuum of care to support Medicaid beneficiaries experiencing mental health crises . . . the persistence of ED boarding . . . indicates that demand for acute care capacity exceeds supply . . ." <sup>4</sup> However, as was the case when the Department initially requested authority for a waiver of the IMD exclusion in 2021, there is significant evidence that New Hampshire's inpatient service capacity is adequate for the existing, and future, demand.

As has been the case in New Hampshire for years, due to the lack of a sufficient array of community programs to meet treatment and service needs, many of New Hampshire's residents who experience severe mental illness are unnecessarily institutionalized rather than receiving medically-necessary mental health treatment and supports in their homes and communities. <sup>5</sup> The Department has recognized that the lack of community-based resources has resulted in overuse of the State's publicly funded psychiatric beds. For example, during her March 2, 2021 presentation to the New Hampshire House of Representatives, Finance Committee – Division III, Heather Moquin, Chief Executive Officer of New Hampshire Hospital, stated, "at least half the patients at New Hampshire Hospital could be better served in a less restrictive environment," <sup>6</sup> With an average daily census of approximately 175 patients, this means that at least 87 of the patients occupying beds at New Hampshire Hospital could have been served in the community if adequate resources were available. The Department's 10-year mental health plan notes, "the limited array of community supports in some areas means that too much of our current inpatient capacity is occupied by patients who might be able to be effectively treated in less restrictive and more economical environments." <sup>7</sup>

A review of the Department's quarterly Community Mental Health Agreement progress reports also indicates erosion of, or at the very least inadequacies in, the state's community-based services system. The Department's quarterly report for January to March of 2020 indicates that there were 218 admissions to New Hampshire Hospital, a mean daily census of 159 patients and that the median length of stay was 17 days. By comparison, during the same time period this calendar year, there were significantly fewer admissions (only 172),

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<sup>4</sup> See Extension Request, p. 6.

<sup>5</sup> See *Amanda D., et al v. Sununu, et al.*, No. 1:12-cv-53 SM (D.N.H.), Complaint Filed February 9, 2012.

<sup>6</sup> March 1, 2021 statement to a panel of the New Hampshire House of Representatives Finance Committee by Heather Moquin, Chief Executive Officer of New Hampshire Hospital, recording available at <https://www.youtube.com/watch?v=TRNx6gZTk20&list=PLfTxvjbRjCjUJ24GUPGxJvlh3FsDHMIAY6&index=48>

<sup>7</sup> 10-Year Mental Health Plan, 2019, p. 9.



yet a higher mean daily census (168) and a significantly longer median length of stay – 27 days.<sup>8</sup>

In his January 2022 report regarding the State’s efforts towards compliance with the Community Mental Health Agreement that resulted from the *Amanda D.* case, the Expert Reviewer noted that 29 people housed at Glencliff Home for the Elderly “could be transitioned to integrated community settings once appropriate living settings and community services become available.”<sup>9</sup> While this report does not indicate that the State had any specific plan to facilitate transfers to community settings for these individuals in the near term, the Expert Reviewer’s Report reveals that during 2021, the State dedicated significant financial resources (payments of \$45,000 per person to nursing facilities plus an enhanced per diem rate) to encourage private nursing facilities to admit people transferred from Glencliff to such facilities.<sup>10</sup>

Over the last two years New Hampshire’s reliance on institutionalization of individuals with mental illness has continued to increase.

The Department has been steadily increasing the number of psychiatric beds for individuals who require psychiatric hospitalization since at least State FY 2018. Between FY 2018 and FY 2022 the Department increased the number of beds at New Hampshire Hospital from 168 beds to 184 beds. In addition, in April of 2022, the Department entered into a contract with Wellpath Recovery Solutions, LLC to maintain a minimum of 55 hospital beds at Hampstead Hospital for children and young adults up to age 25, and to increase the number of beds at this institution to “at least 65,” including 12 PRTF beds, within the next year.<sup>11</sup> In his January 2022 report on the State’s compliance with the Community Mental Health Agreement reached in the settlement of *Amanda D.*, the Expert Reviewer found that admissions to New Hampshire Hospital increased 11.2% (from 867 to 964) over the most recent two-year reporting periods.<sup>12</sup>

The Emergency Room Boarding Problem should be addressed through further development of New Hampshire’s Community-Based Treatment and Support options; not by increasing the State’s reliance on institutional psychiatric beds.

As the State has increased its institutional capacity, so has utilization of that resource. Further extending Medicaid funding to IMDs only encourages overreliance on institutional

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<sup>8</sup> Sources: NH DHHS CMHA quarterly progress reports for January to March 2020 and January to March 2022, available at <https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/cmha-quarterly-report-Jan-March2020.pdf>; <https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/cmha-quarterly-report-jan-mar-2022.pdf>.

<sup>9</sup> Fifteenth Expert Reviewer Report, p. 33, available at <https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/cmha-review-report-012022.pdf>.

<sup>10</sup> *Id.*

<sup>11</sup> NH DHHS contract with Wellpath Recovery Solutions dated April 14, 2022, available at <https://sos.nh.gov/media/vy4clfec/011a-gc-agenda-04202022.pdf>.

<sup>12</sup> New Hampshire Community Mental Health Agreement, Expert Reviewer Report Number 15, p. 7, available at <https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/cmha-review-report-012022.pdf>.

settings and diverts resources and attention from the continued expansion of community-based services people need to avoid unnecessary admissions and prolonged institutionalization. Although one of the goals stated in the extension request is to improve access to community-based services, there is no evidence that extension of the IMD waiver will achieve this goal.

According to the Department's publicly reported data, as of September 2, 2022, there were 22 adults in emergency rooms waiting for a designated receiving facility (DRF) bed and 10 minors awaiting voluntary admission to Hampstead Hospital's Children's Unit.<sup>13</sup> If, rather than focusing its efforts on solidifying its dependency on inpatient psychiatric treatment, the Department redoubled its efforts to expand New Hampshire's community-based treatment and support options, the Department could free up inpatient psychiatric beds for use by individuals who meet the clinical criteria for admission and cannot be appropriately treated in their communities.

The Department has taken some, though not all, of the actions required under the *Amanda D. Settlement Agreement*, approved by the U.S. District Court in 2014 ("the CMHA"), to address deficiencies in New Hampshire's community-based service array for adults. In 2019, the Department published a 10-year mental health plan that addresses the need to expand community-based services and supports for both adults and children who experience mental illness. In addition, as the Department indicates in its 1115(a) extension request, on July 16, 2022, it launched a Rapid Response system with a centralized access point and, for the first time, New Hampshire will provide statewide access to mobile crisis teams for children and adults. These are the types of steps the Department must take, and expand upon, to ensure that individuals with mental illness receive necessary treatment and supports in the most integrated settings; not building more institutional beds or creating financial incentives to further entrench New Hampshire's over-reliance on acute care psychiatric hospitals or other IMDs to house people with serious mental illness.

However, while there has been progress towards addressing the State's shortage of community-based treatment options that will enable people with mental illness to avoid hospitalization and/or to successfully transition to their communities after an acute psychiatric episode requiring inpatient treatment, there is more to be done. First and foremost, before adding yet more inpatient beds or directing additional federal and state funds towards psychiatric hospitalization or inpatient services at IMDs, the Department must take all actions necessary to achieve compliance with the CMHA. In his most recent report, issued in January 2022, the Expert Reviewer who monitors the Department's compliance with the CMHA, found that New Hampshire continues to be noncompliant with the agreement in key respects including:

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<sup>13</sup> See <https://www.dhhs.nh.gov/about-dhhs/locations-facilities/new-hampshire-hospital/designated-receiving-facility-drf-data>, last accessed September 6, 2022. Note, this data does not indicate where the children awaiting admission to Hampstead are being housed pending their admission to the Hospital.

- Assertive Community Treatment (ACT): failure to meet the CMHA’s patient capacity requirements and failure to ensure that each of the State’s ACT teams meet staffing and team composition requirements.
- Failure to provide effective transition planning and in-reach activities for residents of Glencliff, 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.<sup>14</sup>

In addition, although the Expert Reviewer found the State in “technical” compliance with the Agreement’s standards for supported employment penetration, the Expert Reviewer noted that seven of New Hampshire’s 10 community mental health regions have penetration rates lower than the standard, evidencing that New Hampshire’s adults with serious mental illness do not have equal access to this service statewide.<sup>15</sup>

**New Hampshire’s community-based behavioral health providers are facing unprecedented workforce challenges. Increasing the State’s investment in inpatient psychiatric services will further strain the ability of community-based providers to recruit and retain staff and exacerbate challenges to the development of an adequate array of community-based treatment and support services.**

The development of an adequate array of community-based treatment options and supports for beneficiaries of Medicaid depends, in large part, on the ability of New Hampshire’s community mental health centers to hire and retain sufficient numbers of qualified clinical staff members. Since at least 2018, the NH Community Behavioral Health Association has regularly reported 200 or more clinical vacancies in New Hampshire’s Community Mental Health Centers (CMHCs). However, in January of 2022, that number skyrocketed to 400 vacancies.<sup>16</sup> CMHCs are offering sign on and retention bonuses but are still experiencing high turnover and staff vacancies. Adding additional resources to support psychiatric hospitalization and inpatient services at IMDs with no meaningful concrete plans to support urgently needed workforce growth for community based providers will only make it more difficult for our community mental health system to attract and maintain the staff required to provide the array of community-based treatment required to address the needs of individuals in crisis in their homes and communities and to provide the sustained treatment and support services such individuals require to remain in their homes and communities.

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<sup>14</sup> Fifteenth Expert Reviewer Report, pp 19-20, 38, available at <https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/cmha-review-report-012022.pdf>

<sup>15</sup> *Id.* at 56.

<sup>16</sup> See Couture, Jay, Commentary: The workforce problem is a mental health problem, NH Bulletin, February 28, 2022, available at <https://newhampshirebulletin.com/2022/02/28/commentary-the-workforce-problem-is-a-mental-health-problem/>

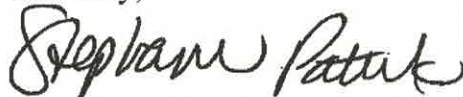
## Conclusion.

For all the above reasons, the Department should not pursue an extension of the 1115(a) Demonstration waiver for individuals with SMI/SED. Instead, the Department should focus on developing a robust array of community-based behavioral health services, including crisis intervention services, that will afford individuals who experience mental illness, the ability to retain their homes, employment, and lives in their communities, while, at the same time receiving the mental health treatment they require to meet their mental health needs. Doing so requires increased, and sustained, investments in community-based services; not pursuing FFP for institutionalization – which will only increase New Hampshire’s reliance on psychiatric hospitalization or other IMDs.

At the very least, and prior to seeking an extension of this portion of the 1115(a) waiver, the Department must demonstrate that it is meeting the expectations outlined by CMS in its June 2, 2022 1115(a) Demonstration Amendment approval letter. These expectations include, but are not limited to, the following: all providers are using an evidence-based tool to determine the appropriate level of care, people with mental illness are being placed in the level of care that is indicated in the assessment, and the average length of stay for individuals receiving services in IMDs does not exceed 30 days. This data must be made publicly available as part of the extension request. In addition, the Department’s application for renewal should include the monitoring protocol and evaluation design required in CMS’s Demonstration Amendment approval letter together with an independent review and assessment of data collected in accordance with these protocol and evaluation design to date, including findings pertaining to the State’s goals related to improving access to community based mental health services. The Department’s monitoring protocol, evaluation design and results of the independent review should be made publicly available as soon as possible. Should the Department’s extension request be approved, the Department should ensure that an independent review of the State’s progress towards each of the goals in its renewal application is conducted, and publicly reported, quarterly.

Please do not hesitate to contact either of us if you have questions, or would like to discuss, our concerns. Thank you for your consideration.

Sincerely,



Stephanie Patrick  
Executive Director



Karen L. Rosenberg  
Policy Director

Enclosure

## H – Prior Letters of Comment Referenced

In response to NH DHHS' request to extend the SUD-SMI-SED-TRA Demonstration, DRC-NH submitted feedback during the public comment period that took place from August 8, 2022, through September 6, 2022. DRC-NH's comment letter included references to previous letters submitted during the August 2021 public comment period for the Amendment #2 Request to the SUD-TRA Demonstration. In the interest of transparency, NH DHHS has attached these prior letters to this demonstration extension request, along with the NH DHHS response to all feedback from the August 2021 comment period (see below).

The text below is copied from the Amendment #2 Request to the SUD-TRA Demonstration submitted on September 3, 2021. Text marked with a strikethrough indicates references to prior attachments that are not relevant in the context of the current extension request.

### 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 include justice-involved persons, DHHS acknowledges the

Comment Theme	Interested Parties	State Response
		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 care for individuals with SMI who experience homelessness or housing	NAMI NH	Goals and evaluation measures align with CMS technical guidance on this type of demonstration. DHHS



<b>Comment Theme</b>	<b>Interested Parties</b>	<b>State Response</b>
<p>insecurity or are incarcerated as a specific measure of Goal 5.</p>		<p>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 additional demands on an inadequate labor pool.</p>	<p>DRC NH</p>	<p>More completely building out the continuum of care will make NH a more attractive practice environment. One tool utilized by DHHS in this</p>

Comment Theme	Interested Parties	State Response
		<p>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>

# DISABILITY RIGHTS CENTER - NH

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(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 Shibinette 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 Shibinette'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.

# DISABILITY RIGHTS CENTER - NH

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64 North Main Street, Suite 2, Concord, NH 03301-4913 • mail@drcnh.org • drcnh.org

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

October 21, 2021

The Honorable Xavier Becerra, Secretary  
U.S. Department of Health and Human Services Hubert H. Humphrey Building  
200 Independence Ave., S.W.  
Washington, D.C. 20201

## **By Electronic Submission Only**

### **RE: New Hampshire Section 1115 Demonstration, Amendment #2 Request**

Dear Secretary Becerra:

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

The Disability Rights Center is New Hampshire'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 class action litigation that resulted in the current Community Mental Health Agreement, a settlement in which New Hampshire committed to expanding community mental health services.<sup>2</sup> We also regularly investigate incidents involving the abuse and neglect of treatment facility residents with mental illness.

The Disability Rights Center has serious concerns about the waiver request. It is our view that increasing federal financial participation for institutional psychiatric treatment, particularly when New Hampshire has an inadequate community-based service system, will be detrimental to the people of the state with serious mental illness and inconsistent

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<sup>1</sup> 42 U.S. Code § 10801 (b)

<sup>2</sup> Amanda D., et al v. Sununu, et al, No. 1:12-cv-53 SM, (D. N.H.)

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**

New Hampshire's waiver amendment request is clearly aimed at increasing the state's publicly funded institutional treatment capacity. 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>3</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 New Hampshire, and the state's consultants have relied in part on such an expectation in making the recommendation that the waiver be requested.<sup>4</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>5</sup> The existing financial incentive promotes the development of services which are consistent with the ADA.

#### **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 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 public involuntary treatment beds.<sup>6</sup> However, there is significant evidence that the state's inpatient service capacity is adequate for the existing demand.

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<sup>3</sup> See Amendment Request at 11.

<sup>4</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>5</sup> The only mention of actual expansion of community based care is at page 11 of the Amendment Request: "The State will request that any parties seeking to add to IMD capacity also consider enhancing community-based care. . . ." (emphasis added).

<sup>6</sup> See Amendment 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.").

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>7</sup>

The report further found that “[b]ased purely on population size, New Hampshire currently has an adequate number of inpatient beds available,”<sup>8</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>9</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 inpatient services by expanding community interventions for those ready to leave New Hampshire Hospital.” The report’s findings prompted the Department of Health and Human Services [the department] and the Governor to “redirect[ ] funds set aside for designated receiving facility beds for involuntary admissions to housing services.”<sup>10</sup>

Representatives of the department have also repeatedly made it clear in their presentations to the New Hampshire 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

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<sup>7</sup> See HSRI report at 21. Accessible at <https://www.dhhs.nh.gov/dcbcs/bbh/documents/nh-final-report-12222017.pdf>.

<sup>8</sup> See HSRI report at 22. The total number of inpatient beds in the state has increased since the HSRI determination.

<sup>9</sup> See HSRI report at 23.

<sup>10</sup> See December 22, 2017 press release at <https://www.dhhs.nh.gov/media/pr/2017/12222017-mental-health-report.htm>.

out that “at least half of the patients at New Hampshire Hospital could be better served in a less restrictive environment.”<sup>11</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.<sup>12</sup> 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.<sup>13</sup>

There are also strong indications that the emergency department waitlist is composed in significant part of persons who are inappropriate for involuntary admission, as they either have been certified for involuntary admission 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 transferred to an involuntary treatment facility. At a June 8, 2021 hearing before the Health and Human Services Committee of the New Hampshire Senate, Health and Human Services Commissioner Lori Shibinette 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,

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<sup>11</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).

<sup>12</sup> New Hampshire’s 10-Year Mental Health Plan [the 10-Year Plan], issued in early 2019, noted the importance of such resources in preventing readmission to the hospital as well, stating that “about one-third of discharged patients are readmitted to [New Hampshire Hospital] within six months, a statistic that highlights the need to do a better job supporting transitions back into the community.” New Hampshire 10-Year Mental Health Plan at page 27. Accessible at <https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan.pdf>.

<sup>13</sup> This problem was recognized in the 10-Year Plan, which noted that “the limited array of community supports in some areas means that too much of our current inpatient capacity is occupied by patients who might be able to be effectively treated in less restrictive and more economical environments.” See page 9 of the 10-Year Plan.

and dementia. During the same period, 19 persons were taken off the wait list and either released or referred to community services through the state's rescission process. That is a total of 44 persons in 21 days who were held in emergency rooms to await involuntary admission but that were not actually candidates for a hospital-level of psychiatric treatment.<sup>14</sup> This is a problem that has been recognized for years but has not been adequately addressed by New Hampshire. In its January 2019 10-Year Plan, the department stated that more resources needed to be devoted to training and education to "ensure that only those persons who need treatment through an involuntary inpatient admission are certified for that treatment."<sup>15</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.

In its Amendment Request, New Hampshire responds to the Disability Rights Center's state-level comment about the lack of justification for increased bed capacity by stating that "[t]he 10-Year Mental Health Plan called for an increase in inpatient psychiatric beds." and that "the ongoing persistence of a waitlist for inpatient admission . . . is evidence of the need for additional capacity."<sup>16</sup>

However, the 10-Year Plan's proposed increase in bed capacity has already been fulfilled. The Plan called for exploration of 2 options for "ensuring adequate inpatient bed capacity for the state." The larger of the alternatives was to transfer all children from the New Hampshire Hospital to another public facility to provide for the "addition of up to 48 new adult beds."<sup>17</sup> In the department's report on progress toward implementation of the 10-Year Plan, issued after submission of its Amendment Request, it stated that since the 10-Year Plan had been issued, capacity for 48 adults had been added at New Hampshire Hospital by transferring children to a contracted private facility,<sup>18</sup> and that it had further added an 8-bed private unit to accept involuntary admissions.<sup>19</sup>

The 10-Year Plan's recommendations for inpatient capacity expansion, if they are evidence of anything, are not evidence of a continuing need after the recommendations were followed. In fact, New Hampshire's experience with the significant recent expansion of its public inpatient capacity, including the rising fraction of beds occupied

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<sup>14</sup> Commissioner Shubinette's testimony can be accessed at <https://www.youtube.com/watch?v=0sBAhHg950Y&t=4632s>.

<sup>15</sup> See 10-Year Plan at page 4.

<sup>16</sup> See Amendment Request at page 18.

<sup>17</sup> See 10-Year Plan at page 4.

<sup>18</sup> See Report on Priorities for Implementation of New Hampshire's 10-year Mental Health Plan of 2019 [Implementation Report], accessible at <https://www.dhhs.nh.gov/dcbcs/bbh/documents/10-year-mh-plan-progress.pdf>, at page 8.

<sup>19</sup> See Implementation Report at page 6.

by persons not in need of that level of treatment, reinforces that its actual capacity shortcomings are not with inpatient services, but rather with those services which allow people with mental illness to live successfully in the community.

Further, the persistence of a waitlist itself is not evidence of a need for more inpatient capacity. As previously discussed, the New Hampshire Hospital CEO has described the demand for inpatient treatment as “steady,” and the waitlist is composed in significant part of persons who are not actually eligible for involuntary inpatient treatment.

### **C. The Waiver Request is Inconsistent with New Hampshire’s Obligation to Improve the Community-Based Treatment System Rather Than Expand Unneeded Inpatient Treatment Capacity**

New Hampshire 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 New Hampshire 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>20</sup> the Expert Reviewer monitoring performance of the agreement found that New Hampshire continues to be non-compliant with the agreement in several respects. His findings included the following:

- In the area of Assertive Community Treatment, an evidence-based intervention associated with reduced hospital admissions, the state did not have the patient capacity it had promised nor was its existing capacity adequately staffed.
- The availability of mobile crisis services, an intervention that according to providers results in hundreds of diversions from hospitals every year, had actually become less available than it was a year ago.
- The state’s practices were inadequate to transition facility residents into integrated community settings, or to develop a supply of such settings to receive residents now living in institutions.

In addition to the Mental Health Agreement, New Hampshire is required by 2019 state legislation<sup>21</sup> to provide mobile crisis services to all persons under age 21. New Hampshire has not yet established those services, although procurement was recently

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<sup>20</sup> The report is accessible at [https://drcnh.org/wp-content/uploads/2021/10/Fourteenth\\_Expert\\_Reviewer\\_Report\\_9.30.21.pdf](https://drcnh.org/wp-content/uploads/2021/10/Fourteenth_Expert_Reviewer_Report_9.30.21.pdf); the summary of findings begins on page 59.

<sup>21</sup> See N.H. Rev. Stat. Ann. § 167:3-I III.

completed and implementation of combined adult and child services is planned for the beginning of 2022. 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 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.

#### **D. Conclusion**

New Hampshire's waiver request 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 and the state's commitments under the Community Mental Health Agreement.

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)



## I – Summary of Testimony from Public Hearing

## SUD-SMI-SED-TRA Demonstration Extension Request – Public Hearing Record

**Date & Time:** Thursday, August 18, 2022

**Location:** Littleton Regional Healthcare (Littleton, NH)

**Present in Person:** Henry Lipman (Medicaid Director), Alyssa Cohen (Deputy Medicaid Director), Carolyn Richards (Federal Waivers Manager), Diana Lacey (Behavioral Health Senior Policy Analyst), Jodi Nelson (Candidate for State Representative from Keene, NH), Jarrett Stern (Vice President at Littleton Regional Healthcare), Jay Nagy (Alvarez & Marsal)

**Present on Zoom:** Katja Fox (Director of Division for Behavioral Health), Amy Pidhurney (The Stephen Group), Nicholas Germana (Candidate for State Representative from Keene, NH), Jillian Salmon (Alvarez & Marsal)

Henry Lipman, Diana Lacey, and Alyssa Cohen presented an overview of the public notice for the extension request to the Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver. The presenters utilized a set of PowerPoint slides, which were publicly available for [download](#) prior to the meeting and in hard copy onsite, to describe the outcomes achieved in the demonstration as of the draft interim evaluation, objectives for the extension, and anticipated expenditures under the demonstration.

The following topics were discussed by those present in person and participating by phone / Zoom.

### Topic #1

**Theme:** **Awareness of State Efforts Related to SUD/SMI**

**Jodi:** This is something that is very important to me as I lost someone from an overdose. How can we make sure to stay plugged in and get updates on this topic? I want to be as knowledgeable as possible. This is amazing work, and we want to support it. We support this work and encourage more outreach and awareness.

**Henry:** NH has really stepped up on this work, we were one of two states not to see overdose deaths increase during the pandemic and attribute that to all our efforts over the past five years. The State is facing a number of new challenges including fentanyl. The State is using general funds to support options including recovery centers, Critical Time Intervention (CTI), peer support, and transition support. Workforce does continue to be a challenge.

**Diana:** Transparency around these efforts is very important. The CMS Demonstration process is designed to help build awareness, knowledge, and ongoing support. The public sends comments, and DHHS sharing information on our website and through the hearings helps build ongoing knowledge and support.

## Topic #2

### **Theme: Provider Stability and Consistency of Funding**

- Diana: This Demonstration allows us to unlock the door to funding that will create more stable providers who are less likely to fail. There are economies of scale.
- Jodi: I have heard about challenges based on grant funding and how this can create more transitory, unstable services. It sounds good that we can provide five years of stable funding here.
- Henry: The extension would allow us to extend funding almost ten years in total and provide consistency. It would also allow us to free up state block grant funding for other services such as community-based programs.
- Jarrett: This is distinct from Doorways funding, correct?
- Henry: Doorways funding is primarily provided at the federal level through SAMHSA, although some other funds have also been provided to support Doorways.
- Diana: We utilize block grants for other things, such as CTI, and coaches to help mentor people and teach them how to navigate their care needs.
- Henry: Some funding must come from grants, but this gives us a stronger base.
- Nicholas: I like the idea of planning for five years out. This is great for the consistency of funds and services and the ability to plan ahead.
- Henry: We were also able to use enhanced federal funding to purchase Hampstead Hospital, for example, and provide consistent children's services in New Hampshire. This will be a key resource.

## Topic #3

### **Theme: Need for Behavioral Health Services in NH / Growing Challenge of Fentanyl**

- Diana: The demand for behavioral health services is growing significantly. We need more resources to meet the need, especially for the youth.
- Henry: The 10-Year Mental Health Plan also identified a critical growing need to build out our children's system of care. I would encourage all stakeholders to read it as well as the updates available on the DHHS website.
- Jodi: I also heard about an issue where a hospital had gallons of fentanyl go missing. Is there a correlation between what went missing and what we're seeing in terms of fentanyl in the community?
- Henry: This is not my area of expertise, and I don't have any specific information about that incident, but in general NH State Police briefings highlight that fentanyl is coming in locally and globally, including across international borders. We need to get the message out about how dangerous it is, how even vapes can be laced with it. Reports are that it is taking more doses of naloxone to reverse an

overdose with the added fentanyl. One thing the State has been able to do with freeing up funding is distributing more Naloxone.

Jodi: Are they doing anything around fentanyl test strips?

Henry: This is something the State Lab is evaluating at this point.

Alyssa: The State must also report on what they're doing in the community, and one of the areas CMS asks about is Naloxone distribution. This is an area we track.

Diana: The Demonstration is ultimately a partnership. There is funding from CMS, and the State is obligated to maintain/expand community services. We will continue to expand community-based services in exchange for leveraging these funds to support the most acute cases.

#### Topic #4

##### **Theme: Budget Neutrality**

Nicholas: I am looking at the projection for 2028. Can you explain what member months mean and how you arrived at the projection?

Henry: The Waiver measures the number of individuals on a monthly basis who are spending time in the inpatient setting. Member months is during the course of a month how many individuals who have Medicaid coverage are spending time in an IMD (member = beneficiary), and what is the length of time they are spending. On average, CMS wants the stay to be less than 30 days, with a limit of 60 days to have federal participation. This measures the number of days and people in the institutionalized setting. Then they look at the cost of funding them actual vs projected. If it's less than projected, it's budget neutral. If the State does not achieve budget neutrality, there is a risk they would be obligated to pay some of that money back to the federal government. DHHS negotiated a cap for expenditures with input from its actuaries with CMS.

Nicholas: Ok, so average monthly members are the number of people using the services? And then the member months is that number times the days they spend?

Henry: Yes. To the first question. The second part: the member months are the number of collective months in which members are in an IMD, counted as a full month regardless of the stay duration. For example, an individual who stayed in the IMD for 1.5 months would count for 2 member months since that person was in an IMD during two separate months. Member months are then aggregated together for all individuals.

Diana: There is also an important programmatic piece of this emphasized by the financial cap of CMS 30-day average length of stay requirement. This is to ensure we are not relying on institutionalizing people, rather instead meeting the need with community services; or if acute care is needed then transitioning individuals back into the community.

## Topic #5

### **Theme: Transitioning Between Settings**

- Jodi: Transitioning out of intensive services can be very difficult. Rehab care is like a manufactured environment, whereas the real world has more challenges. It's refreshing to hear more focus being put on all the steps holistically.
- Diana: We've already shifted from a 30-day SUD program to basing it on clinical appropriateness. Some may only need the program for two weeks, before transitioning to something in the community.
- Henry: I also want to point out that we are looking for a new authority to fund care coordination for otherwise eligible individuals with SUD or SMI 45 days prior to release from incarceration in the state prison system. The State is meeting its constitutional obligation to provide health care to incarcerated persons; this proposal is a step above that. NH is hoping to receive the first approval for such a demonstration in the nation.
- Nicholas: That speaks to the point Jodi was making about the transition being so difficult. I can imagine reentry from incarceration itself is a shock and could be a trigger. I know a number of people who enter into incarceration may be undiagnosed in the community and the treatment they receive in correctional facilities may be their first. They have no experience trying to manage their situation in the community. Preparing them better for that transition will hopefully be positive for the individual and help with recidivism rates.
- Henry: Yes, the number one reason people end up back in the prison system is relapse. Hopefully someone has enough success in the community to get exchange- or employer-based coverage and need only a minimal safety net.

J – Notice of Post-award Public Forum Posted to DHHS Website

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

October 18, 2021

### Substance Use Disorder Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver: Annual Post Award Forum

The Centers for Medicare & Medicaid Services (CMS) Special Terms and Conditions requires that the Department provide the public information annually regarding the NH Section 1115(a) Medicaid demonstration, [Substance Use Disorder Treatment and Recovery Access](#) (SUD-TRA) (Project Number 11-W-08321.1). The Department provided information on this waiver at the Annual Post Award Forum on Monday, October 18, 2021 at the Medical Care Advisory Committee (MCAC) meeting. The New Hampshire Medical Care Advisory Committee (MCAC) is a public advisory group established in accordance with 42 CFR § 431.12 to advise the State Medicaid Director regarding New Hampshire Medicaid policy and planning.

September 3, 2021

The State of New Hampshire Department of Health and Human Services (DHHS), submitted to Center for Medicare and Medicaid Services today an amendment to its 1115(a) Substance Use Disorder Treatment and Recovery Access Research 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").

- [Governor Christopher Sununu cover letter](#)
- [Amendment](#)
- [Amendment Completeness Letter](#)
- [View Comments/Submit Comments](#)

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

search this site

**DHHS Events Calendar**

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- Program Information**
- > SMI IMD Amendment to SUD-TRA Section 1115(a) Research and Demonstration Waiver Comment Period
  - > 2019 Annual Post Award Forum Presentation
  - > 2018 Post Award Forum Information
  - > CMS Approval Letter With Waiver
  - > Waiver Comment Period
  - > Waiver
  - > Public Hearing Presentation
  - > Public Comment and DHHS Responses
  - > Comments: NAMI NH

- Related Resources**
- > 513 Rule
  - > Sununu Center RFP
  - > DSRIP Waiver Program

K – Minutes from October 2021 Post-award Public Forum



**Medical Care Advisory Committee (MCAC)**  
**October 18, 2021**  
**Minutes**

**Members Present:** Kathy Bates, Sai Cherala, Lisa DiMartino, Tamme Dustin, Paula Minnehan, Sarah Morrison, Ken Norton, Ronnieann Rakoski, Bill Rider, Karen Rosenberg, Jonathan Routhier, Holly Stevens, Kristine Stoddard, Carolyn Virtue, Michelle Winchester

**Alternates:** Jake Berry, Cheryl Steinberg, Nichole VonDette

**DHHS:** Henry Lipman, Alyssa Cohen, Brooke Belanger, Nancy Rollins, Dr. Sarah Finne, Dawn Landry, Leslie Melby, Janine Corbett, Nancy Plourde, Laura Ringelberg, Leslie Bartlett, Shirley Iacopino, Deb Sorli, Patrick McGowan

**Guests:** Lucy Hodder, Deb Fournier, Kelley Capuchino, Nick Toumpas, Susan Paschell, Lisa Pettengill, Nicole St. Hillaire, Rich Sigel, Tina McKernan, Heidi Kroll, Jasmine Harris, Deb Ritcey, Josh Kintzman, Karen Blake, Jesse Fennelly, Rachel Chumbley, Tommy Whalen

**Announcement:**

Carolyn Virtue announced the passing of General Colin Powell and read the following into the record:

*This morning we lost a great American, General Colin Powell.*

*Immediately after hearing this news report on TV, that he had succumbed to COVID-19, the discussion turned to his vaccination status.*

*In August my husband was on a ventilator for 23 days. I can count on one hand the number of people who reached out and did not ask "Was he vaccinated?" I should mention, Director Lipman was one of them, thank you.*

*Within the first few minutes after his death, the media frenzy about Powell's vaccination status raged. Aside from being what he was to this country, General Powell was a husband and father. At their moment of loss this family felt it important to let the world know he was fully vaccinated at Walter Reed.*

*Powell had accolades few others ever attain. I am glad the conversation can now move on to the story of his life of public service. I'd ask you to consider, had he not been vaccinated, would the story have turned to his achievements as quickly?*

*While I fully support a concerted effort to vaccinate, I do not think we will get there by shaming people who have made individual decisions in regard to their medical care. We need to reframe the vaccination discussion away from shaming. We need to be kinder.*

*Thank you for your consideration.*

**Review/Approval: September 13, 2021 minutes**

M/S/A

**Agenda Items - November 8, 2021**

- Update on FMAP proposal

Members may send agenda requests to Henry Lipman or Carolyn Virtue.

**Public Health Emergency**

**Unwind Planning - Next Steps, Lucy Hodder, Deb Fournier, UNH Health Law & Policy**

UNH continues to work with the DHHS team to prepare for the end of the PHE. DHHS is updating and streamlining the beneficiary pink letters. Support provided to beneficiaries during the Public Health Emergency (PHE) now to complete their redeterminations will reduce backlog at the end of the PHE and minimize potential coverage gaps. The Department can give providers lists of their clients at risk of losing their coverage at the end of the PHE so that the providers can do direct outreach. Providers can obtain a

list of their clients at risk of losing coverage by using the email at [ContinuedCoverage@dhhs.nh.gov](mailto:ContinuedCoverage@dhhs.nh.gov).

Open enrollment for marketplace health insurance plans begins Nov 1. DHHS is reaching out to the New Hampshire Navigators and the Insurance Department to ensure clear communication about and assistance with transition to the marketplace plans to those who will no longer be eligible for Medicaid at the end of the PHE. DHHS is scheduled to meet with the MCOs this week to discuss their plans to support redetermination efforts. DHHS call center coverage for redeterminations will transition to Maximus to assist with managing the redetermination process and beneficiary questions.

### **SUD 1115 Waiver Award Forum, Alyssa Cohen, Deputy Medicaid Director**

The annual post award forum provides an update of waiver activity over the past year.

The waiver allows the State to draw down Medicaid matching funds for residential SUD treatment to Medicaid-eligible individuals aged 21-64 in an IMD (Institute of Mental Disease). States need an 1115 waiver to use Medicaid funding for this population. CMS approved (1) the waiver July 2018, (2) the evaluation plan March 2019, and (3) the budget neutrality amendment June 2021. The Serious Mental Illness (SMI) amendment to the SUD waiver was submitted Sept 2021.

Future waiver deliverables include:

2021: mid-point assessment; quarterly and annual reports; annual post-award forum.

2022: SMI amendment implementation 7/1/22; quarterly and annual reports; evaluation report; renewal request

2023: SUD and SMI waiver end 6/30/23; quarterly and annual reports until then

2024: draft evaluation report due December

2025: final evaluation report due March

Next steps: respond to mid-point assessment; prepare for SMI implementation; ongoing data collection, and analysis of Prescription Drug Monitoring Program. The federal comment period ends Oct 21, 2021.

### **Department Updates, Henry Lipman, Medicaid Director**

#### **Disability Determinations, Deb Sorli, Bureau Chief, Bureau of Family Assistance**

As of Sept 24, 2021:

- Pending applications: 227 adults (180 have Medicaid coverage); 29 children (14 have Medicaid)
- Over 90 days: 37 adults; (31 have Medicaid); 1 child (no Medicaid).

#### **Enrollment**

As of October 11, 2021, 229,400 individuals were on Medicaid (29.3 increase) of which 81,652 are on Granite Advantage (59% increase), and 147,748 are on standard Medicaid (17.2% increase).

#### **DHHS Budget/HB2 Implementation Updates**

The genetic testing rate increase is on track for November; Nursing home rate update is on track for 10/1/21 update; a second rate update is scheduled for January.

The Medicaid home visiting rules are currently with the Department's Administrative Rules Unit and on schedule for the February 2022 JLCAR meeting.

HCBS spending plan for enhanced federal percentage: At the end of September, DHHS received partial approval from CMS for the spending plan. Most states received partial approval on their plans.

DHHS had a technical assistance call with CMS on Oct 15. The CMS 64 reporting just became available last week, so, states have just been able to begin drawing the enhanced federal match. CMS shared with NH, that the state is no further behind any other state in being able to claim or spend funds. An update will be provided at the Nov. meeting.

**Bureau of Developmental Services Direct Billing & Rate Subcommittee Cancellation, Nancy Rollins, Interim Director, DLTSS**

BDS has engaged stakeholders on the corrective action plan (CAP) required by CMS due to conflicted case management practices. This work has positioned the state well to set the base approach to remove conflict and come into compliance with federal regulations that govern 1915(c) waiver services. The CAP stakeholder group was emailed on 7/1/21 to inform them that work was being placed on hold as BDS identified how it would address previously developed stakeholder groups under the context of accepting the recommendations put forth in the A&M report.

Given the relationship of the CAP with the work being undertaken related to the waiver, rates and IT development, BDS decided to not restart the CAP and Rates stakeholder groups due to duplication. The stakeholders' previous work was significant and serves as building block for the work of A&M. The work was therefore subsumed under A&M's work.

There are three new targeted workgroups to advise BDS that met in October: Waiver, Rates, and Steering. Updates are posted on the [BDS System Work website](#). *Web address was emailed to MCAC 10/18/21.*

**Closed Loop Referral System(s) (CLR)**

DHHS met with the Legislative HHS Oversight Committee 9/24/21 on specific areas related to PFI analysis. On Oct 22, Rep. Edwards and Sen. Rosenwald will speak to the Committee as to how NH should move on CLR. The HHS Oversight Committee will submit its report by November, which will serve as the basis for potential legislation.

**MCAC Subcommittees, Carolyn Virtue, Chair**

**Membership Committee, Jonathan Routhier, Vice Chair**

There are two open seats on the MCAC. MacKenzie Nicholson of the Alzheimer's Association has applied for membership. The Committee approved the application and sent to Henry Lipman for approval. For the other vacancy, applications should be submitted to Leslie Melby.

**He-E 801, CFI, Michelle Winchester**

There is no new information on the rule.

Nancy Rollins informed the members that the policy group has responded to 100 pages of stakeholder feedback; the rule is currently under review.

**Dental**

The committee working on HB 103 will meet today. The committee is working to develop legislation with the correct funding. An update will be provided at the November meeting.

**Closed Loop Referral and Blanket Consent Subcommittee(s)**

The legislative HHS Oversight Committee will meet October 22<sup>nd</sup>. Subcommittee members will be updated.

**Motion to adjourn. M/S/A**

L – Presentation from Post-award Public Forum



**New Hampshire Department of Health and Human Services**

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

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**Annual Post Award Forum - MCAC**

**October 18, 2021**

# Agenda

- **Overview**
- **Timeline of Significant Actions**
- **Serious Mental Illness (SMI) Amendment Overview**
- **Timeline of Future Deliverables Next Steps**
- **Next Steps**
- **Questions**

# Overview

The New Hampshire Department of Health and Human Services requested a Substance Use Disorder Treatment and Recovery Access Section 1115(a) Demonstration Waiver to allow New Hampshire to provide Medicaid payments for individuals receiving substance use disorder (SUD) services in an Institution for Mental Disease (IMD). This request will further the objectives of Title XIX by increasing access to residential SUD treatment services for adults and adolescents in New Hampshire.

Specifically, New Hampshire requested that:

- 1) 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 aged 21 to 64 receiving residential substance use disorder (SUD) treatment in an IMD for as long as is medically necessary.
- 2) 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 long as is medically necessary.

# Timeline of Significant Actions

## July 10, 2018

- Demonstration Approved
- FFP for expenditures began
- SUD Implementation Protocol approved

## April 2019

- Initial Evaluation Plan Design submitted to CMS

## May 2019

- Final Evaluation Plan submitted to and approved by CMS

## August 2020

- Budget Neutrality Amendment submitted to prospectively adjust budget neutrality target

## March 2021

- PHPG selected as evaluator for Mid-Point Assessment and Evaluation Plan

## June 2021

- CMS approved Budget Neutrality Amendment and sent revised STC's

## September 2021

- Serious Mental Illness (SMI) Amendment to the demonstration waiver submitted



# SMI Amendment Overview

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, DHHS is applying for an amendment to its Section 1115(a) Demonstration from 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).
- 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.

# Timeline of Future Deliverables

## 2021

- Mid-Point Assessment due by December 31, 2021
- Regular quarterly monitoring reports, annual report, and annual post-award forum

## 2022

- SMI Amendment implementation targeted for July 1, 2022, pending CMS approval
- Regular quarterly monitoring reports, annual report, and annual post-award forum
- Draft Interim Evaluation report in June
- Submit request to renew and extend demonstration including aligning the SMI amendment with overall SUD demonstration

# Timeline of Future Deliverables

## 2023

- Draft Close-out Operational Report in March
- SUD demonstration waiver and the SMI waiver end June 30, 2023
- Regular quarterly monitoring reports, annual report, and annual post-award forum

## 2024

- Draft Summative Evaluation Report due in December

## 2025

- Final Evaluation due in March

# Next Steps

- Respond to Mid-Point Assessment findings
- Prepare for SMI Amendment implementation pending CMS approval
- On going data collection and analysis of the Prescription Drug Monitoring Program (PDMP)

# Questions and Answers

## M – DY4 Q2 Monitoring Report Including Information About Post-award Public Forum

**Medicaid Section 1115 Substance Use Disorder Demonstrations  
Monitoring Report Template**

*Note: PRA Disclosure Statement to be added here*

**1. Title page for the state’s substance use disorder (SUD) demonstration or the SUD component of the broader demonstration**

*The title page is a brief form that the state completed as part of its monitoring protocol. The title page will be populated with the information from the state’s approved monitoring protocol. The state should complete the remaining two rows. Definitions for certain rows are below the table.*

<b>State</b>	New Hampshire
<b>Demonstration name</b>	Substance Use Disorder Treatment and Recovery Access (SUD-TRA)
<b>Approval period for section 1115 demonstration</b>	<i>Automatically populated with the current approval period for the section 1115 demonstration as listed in the current special terms and conditions (STC), including the start date and end date (MM/DD/YYYY – MM/DD/YYYY).</i> Start Date: 07/10/2018 End Date: 06/30/2023
<b>SUD demonstration start date<sup>a</sup></b>	<i>Automatically populated with the start date for the section 1115 SUD demonstration or SUD component if part of a broader demonstration (MM/DD/YYYY).</i> 07/10/2018
<b>Implementation date of SUD demonstration, if different from SUD demonstration start date<sup>b</sup></b>	<i>Automatically populated with the SUD demonstration implementation date (MM/DD/YYYY).</i> 07/10/2018
<b>SUD (or if broader demonstration, then SUD - related) demonstration goals and objectives</b>	<i>Automatically populated with the summary of the SUD (or if broader demonstration, then SUD- related) demonstration goals and objectives.</i> The goal of this demonstration is for NH to maintain critical access to opioid use disorder
<b>SUD demonstration year and quarter</b>	<i>Enter the SUD demonstration year and quarter associated with this monitoring report (e.g., SUD DY1Q3 monitoring report). This should align with the reporting schedule in the state’s approved monitoring protocol.</i> SUD DY 4 Q 2
<b>Reporting period</b>	<i>Enter calendar dates for the current reporting period (i.e., for the quarter or year) (MM/DD/YYYY – MM/DD/YYYY). This should align with the reporting schedule in the state’s approved monitoring protocol.</i> Start Date: 10/01/2021 End Date: 12/31/2021

<sup>a</sup> **SUD demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state’s STCs at time of SUD demonstration approval. For example, if the state’s STCs at the time of SUD demonstration approval note that the SUD demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SUD demonstration. Note that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

<sup>b</sup> **Implementation date of SUD demonstration:** The date the state began claiming or will begin claiming federal financial participation for services provided to individuals in institutions for mental disease.



## **2. Executive summary**

*The executive summary should be reported in the fillable box below. It is intended for summary-level information only. The recommended word count is 500 words or less.*

*Enter the executive summary text here.*

DHHS submitted an SMI Amendment during the last quarter and continues to work with CMS on moving forward in this process. If approved, the seriously mentally ill (SMI) will be part of the target population.

DHHS signed contracts to provide funding to several residential treatment providers, two of whom fall under the IMD category. (Southeastern NH Services and Farnum Center). All providers must be contracted with Medicaid and the MCOs, and must sign eligible individuals up for Medicaid within two weeks of admission to treatment.

Work has started on MMRWM (Medically Monitored Residential Withdrawal Management) funding availability to expand treatment. This funding is through ARPA to expand services to those currently without health insurance coverage, with the goal of assisting these individuals to enroll in Medicaid if they are eligible. Those individuals determined ineligible for Medicaid will continue to have the MMRWM services covered by the ARPA funds if they are not eligible for any other health insurance coverage.

**3. Narrative information on implementation, by milestone and reporting topic**

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
<b>1. Assessment of need and qualification for SUD services</b>			
<b>1.1 Metric trends</b>			
1.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services		3, 4	Measure 3 - Medicaid Beneficiaries with SUD Diagnosis (monthly) - The monthly rolling six month average showed increases greater than 2% in 2021 Quarter 2 when compared to 2021 Quarter 1. The increase in the rate may
<b>1.2 Implementation update</b>			
1.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to: 1.2.1.a The target population(s) of the demonstration			The State submitted an SMI Amendment in the last quarter and continue to work with CMS on moving forward in this process. This amendment is to include SMI inpatient treatment facilities in the IMD exclusion. If approved, the seriously mentally ill will be part of the
1.2.1.b The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration			The State submitted an SMI Amendment in the previous quarter to this waiver to include SMI inpatient treatment facilities in the IMD exclusion. If approved, clinical
1.2.2 The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services			The State is getting ready to launch the NH Rapid Response Access Point in January 2022. It offers over-the-phone support to help individuals navigate their

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
<b>2. Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)</b>			
<b>2.1 Metric trends</b>			
2.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1		6, 7, 9, 10, 11, 12	* Measure 6 - Any SUD Treatment - The monthly rolling six month average showed increases greater than 2% in 2021 Quarter 2 when compared to 2021 Quarter 1. An
<b>2.2 Implementation update</b>			
2.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to: 2.2.1.a Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g., outpatient services, intensive outpatient services, medication-assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)			As noted above, the NH Rapid Response Access Point will begin in January 2022. It offers over-the-phone support to help individuals navigate their mental health, or substance misuse related crisis. The aid could include over-the-phone referrals to outpatient services, or if needed, the mobile crisis unit could be dispatched.  Work has started on MMRWM (Medically Monitored Residential Withdrawal Management) funding availability to expand treatment. This funding is through ARPA to expand services to those currently without health
2.2.1.b SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication-assisted treatment services provided to individual IMDs	X		
2.2.2 The state expects to make other program changes that may affect metrics related to Milestone 1			As noted above, the NH Rapid Response Access Point will begin in January 2022. It offers over-the-phone

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
<b>3. Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)</b>			
<b>3.1 Metric trends</b>			
3.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2		5	Measure 5 - Medicaid Beneficiaries Treated in an IMD for Substance Use - The annual count showed increase greater
<b>3.2. Implementation update</b>			
3.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to: 3.2.1.a Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria			A contract between DHHS and the New Hampshire Alcohol and Drug Abuse Counselors Association, funded trainings on addiction and recovery, included " Understanding ASAM Criteria for Non-clinicians" in October 2021, and "Initial Training on Addiction and Recovery", in December 2021.
3.2.1.b Implementation of a utilization management approach to ensure (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, or (c) use of independent process for reviewing placement in residential treatment settings			DHHS signed contracts to provide funding to several residential treatment providers, two of whom fall under the IMD (Southeastern NH Services and Farnum Center). All providers must be contracted with Medicaid and the MCOs, and must sign eligible individuals up for Medicaid within two weeks of admission to treatment.  Work has started on MMRWM (Medically Monitored
3.2.2 The state expects to make other program changes that may affect metrics related to Milestone 2	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
<b>4. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)</b>			
<b>4.1 Metric trends</b>			
4.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3  Note: There are no CMS-provided metrics related to Milestone 3. If the state did not identify any metrics for reporting this milestone, the state should indicate it has no update to report.	X		
<b>4.2 Implementation update</b>			
4.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to:  4.2.1.a Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards			The State worked closely with providers (all of whom accept Medicaid) in order to address audit deficiencies related to the audit BDAS conducted in the summer of 2021 on BDAS-contracted treatment providers. BDAS assisted these providers with their plans of correction in order to improve ASAM criteria services delivered.
4.2.1.b Review process for residential treatment providers' compliance with qualifications	X		
4.2.1.c Availability of medication-assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site			The Department assisted BDAS-contracted treatment providers (all of whom accept Medicaid) in order to improve their MAT referral process. Work has started on MMRWM (Medically Monitored
4.2.2 The state expects to make other program changes that may affect metrics related to Milestone 3			The Department plans to implement "mini audits " designed to address past areas of need in real time. These

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
<b>5. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)</b>			
<b>5.1 Metric trends</b>			
5.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4	X		
<b>5.2 Implementation update</b>			
5.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to: Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care	X		
5.2.2 The state expects to make other program changes that may affect metrics related to Milestone 4	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s)	State response
<b>6. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)</b>			
<b>6.1 Metric trends</b>			
6.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5		23	Measure 23 – Emergency Department Utilization for SUD - The monthly rolling six month average showed
<b>6.2 Implementation update</b>			
6.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to: 6.2.1.a Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD	X		
6.2.1.b Expansion of coverage for and access to naloxone			The state expects to transfer naloxone from the Department of Safety to the Regional Public Health
6.2.2 The state expects to make other program changes that may affect metrics related to Milestone 5	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
<b>7. Improved Care Coordination and Transitions between Levels of Care (Milestone 6)</b>			
<b>7.1 Metric trends</b>			
7.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6		17(2)	Measure 17(2) – Follow-Up After Emergency Department Visit for Mental Health in 7 and 30 Days-
<b>7.2 Implementation update</b>			
7.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to: Implementation of policies supporting beneficiaries’ transition from residential and inpatient facilities to community-based services and supports			The state is in the process of reviewing and updating He-A 300, which are the Administrative Rules related to substance use disorder treatment in New Hampshire.
7.2.2 The state expects to make other program changes that may affect metrics related to Milestone 6	X		



Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
<b>8. SUD health information technology (health IT)</b>			
<b>8.1 Metric trends</b>			
8.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its health IT metrics	X		
<b>8.2 Implementation update</b>			
8.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to: 8.2.1.a How health IT is being used to slow down the rate of growth of individuals identified with SUD			Telehealth continues to be a valuable resource for patients seeking SUD treatment and support. Specifically, patients who struggle with geographic (living in rural areas) or other barriers and might otherwise be unable to attend treatment.
8.2.1.b How health IT is being used to treat effectively individuals identified with SUD	X		
8.2.1.c How health IT is being used to effectively monitor “recovery” supports and services for individuals identified with SUD	X		
8.2.1.d Other aspects of the state’s plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels			DHHS is in the process of creating a Request for Proposal (RFP) Process to procure a closed loop referral vendor. The goal for the release of the RFP is in the 1st quarter of 2022.
8.2.1.e Other aspects of the state’s health IT implementation milestones	X		
8.2.1.f The timeline for achieving health IT implementation milestones			Ongoing

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
8.2.1.g Planned activities to increase use and functionality of the state’s prescription drug monitoring program			The State is reviewing the PDMP functionality to determine how to best increase utilization.
8.2.2 The state expects to make other program changes that may affect metrics related to health IT	X		
<b>9. Other SUD-related metrics</b>			
<b>9.1 Metric trends</b>			
9.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics		24, 32	*Measure 24 – Inpatient Stays for SUD -The monthly rolling six month average showed decreases greater than 2% in 2021 Quarter 2 when compared to 2021 Quarter 1.
<b>9.2 Implementation update</b>			
9.2.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics	X		

**4. Narrative information on other reporting topics**

Prompts	State has no update to report (place an X)	State response
<b>10. Budget neutrality</b>		
<b>10.1 Current status and analysis</b>		
10.1.1 If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality as a whole. Describe the current status of budget neutrality and an analysis of the budget neutrality to date.		The State is below the Budget Neutrality target for QE 12/31/21 as per the BN workbook submitted with this report.
<b>10.2 Implementation update</b>		
10.2.1 The state expects to make other program changes that may affect budget neutrality		If the SMI Amendment is approved, it will also be subject to budget neutrality.

Prompts	State has no update to report (place an X)	State response
<b>11. SUD-related demonstration operations and policy</b>		
<b>11.1 Considerations</b>		
<p>11.1.1 The state should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration’s approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.</p>		<p>The most significant SUD-related operations during this quarter are the gearing up for the implementation of the Rapid Response Access Point in January 2022. In addition, work has started on MMRWM (Medically Monitored Residential Withdrawal Management) funding availability to expand treatment. This funding is through ARPA to expand services to those currently without health insurance coverage, with the goal of assisting these individuals to enroll in Medicaid if they are eligible. Individuals determined ineligible for Medicaid will continue to have the MMRWM services covered by the ARPA funds if they are not eligible for any other health insurance coverage. Both of these initiatives will have a beneficial impact on the Medicaid population, as well as the</p>
<b>11.2 Implementation update</b>		
<p>11.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to:</p> <p>11.2.1.a How the delivery system operates under the demonstration (e.g., through the managed care system or fee for service)</p>	X	
<p>11.2.1.b Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes)</p>	X	
<p>11.2.1.c Partners involved in service delivery</p>	X	

Prompts	State has no update to report (place an X)	State response
11.2.2 The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities	X	
11.2.3 The state is working on other initiatives related to SUD or OUD	X	
11.2.4 The initiatives described above are related to the SUD or OUD demonstration (The state should note similarities and differences from the SUD demonstration)	X	

Prompts	State has no update to report (place an X)	State response
<b>12. SUD demonstration evaluation update</b>		
<b>12.1 Narrative information</b>		
12.1.1 Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this monitoring report is due to CMS and the timing for the demonstration. There are specific requirements per 42 Code of Federal Regulations (CFR) § 431.428a(10) for annual [monitoring] reports. See Monitoring Report Instructions for more details.		SUD Mid-Point Assessment: a) PHPG completed the Draft SUD Mid-Point Assessment Report and presented the findings to DHHS staff. b) One area, the SUD IT Plan, was identified for follow-up with CMS. While the State's PDMP appears to be meeting most of the CMS requirements, documentation of an approved SUD IT plan was not immediately found. After discussion with CMS, it was determined that
12.1.2 Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs		The SUD Mid-Point Assessment Report was submitted to CMS on 12/29/2021 and is currently under review by CMS. The SUD Interim Evaluation activities are in process and it is anticipated that NH will meet the timeline for submission.
12.1.3 List anticipated evaluation-related deliverables related to this demonstration and their due dates		PHPG and DHHS met bi-weekly to identify implementation activities, address gaps in information, and clarify necessary next steps. The project

Prompts	State has no update to report (place an X)	State response
<b>13. Other SUD demonstration reporting</b>		
<b>13.1 General reporting requirements</b>		
13.1.1 The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol	X	
13.1.2 The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes	X	
13.1.3 Compared to the demonstration design and operational details, the state expects to make the following changes to: 13.1.3.a The schedule for completing and submitting monitoring reports	X	
13.1.3.b The content or completeness of submitted monitoring reports and/or future monitoring reports	X	
13.1.4 The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation	X	
13.1.5 Provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, per 42 CFR § 431.428(a)5	X	

Prompts	State has no update to report (place an X)	State response
<b>13.2 Post-award public forum</b>		
<p>13.2.2 If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual monitoring report.</p>		<p>DHHS held the post award forum on October 18, 2021 at MCAC. The presentation was also posted on the DHHS website. There were no questions or concerns from the public related to the SUD waiver.</p>



Prompts	State has no update to report (place an X)	State response
<b>14. Notable state achievements and/or innovations</b>		
<b>14.1 Narrative information</b>		
<p>14.1.1 Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.</p>		<p>The most significant SUD-related operations during this quarter are the gearing up for the implementation of the Rapid Response Access Point in January 2022. Work has also started on MMRWM (Medically Monitored Residential Withdrawal Management) funding availability to expand treatment. This funding is through ARPA to expand services to those currently without health insurance coverage, with the goal of assisting these individuals to enroll in Medicaid if they are eligible. Those individuals determined ineligible for Medicaid will continue to have the MMRWM services covered by the ARPA funds if they are not eligible for any other health insurance coverage.</p>

\*The state should remove all example text from the table prior to submission.

Note: Licensee and states must prominently display the following notice on any display of Measure rates:

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