

New Hampshire
Department of Health and Human Services

Building Capacity for Transformation
Section 1115 Demonstration Waiver

Application

May 30, 2014



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Executive Summary

The New Hampshire Department of Health and Human Services (DHHS) is applying for a Section 1115 Demonstration Waiver (Waiver) from the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) to support the continuing reform of its Medicaid program and of New Hampshire's health care delivery system as a whole. The Waiver, titled *Building Capacity for Transformation*, proposes to address:

- The fragility of the current behavioral health delivery system;
- The challenges facing the behavioral health delivery system in meeting the needs of individuals; and
- The fragmented delivery system for individuals with complex health needs.

The Waiver addresses these needs by:

- Enhancing and expanding existing programs;
- Creating new programs that support New Hampshire's overall health care reform goals; and
- Coordinating new and existing programs in order to focus holistically on the needs of the individuals we serve.

Each Designated State Health Program (DSHP) included in the Waiver will demonstrate that by spending Medicaid dollars differently, DHHS can improve access to needed services, provide better health outcomes, and lower the cost of health care for New Hampshire citizens. The DSHPs complement New Hampshire's overall health reform strategy, including the implementation of its Medicaid Care Management (MCM) program and the expansion of health coverage under the New Hampshire Health Protection Program (NHHPP), and are designed to reinforce other key New Hampshire initiatives including the State's *Ten Year Mental Health Plan* and the *State Health Improvement Plan (SHIP)*.

The Waiver proposes six (6) specific DSHPs that:

1. Establish a community reform pool that stabilizes the current behavioral health delivery system and supports providers' active participation in delivery system reform initiatives.
2. Implement components of its *Ten Year Mental Health Plan* and its December 2013 settlement agreement with the United States Department of Justice (U.S. DOJ) for the State's non-Medicaid population.
3. Enhance and sustain components of its System of Care/Family and Systems Together (F.A.S.T. Forward) program that supports children and youth with serious emotional disturbances (SED).
4. Administer a grant program that would fund workforce development initiatives focused on substance use disorder (SUD) and other behavioral health treatments and services.
5. Extend the current InSHAPE health promotion program to new providers and participants and include a tobacco cessation component.
6. Establish an oral health pilot program for pregnant women and mothers of young children until their child reaches his/her fifth birthday.

DHHS also requests authority to recognize Costs Not Otherwise Matchable (CNOM) to help fund the implementation of the proposed DSHPs. This action will not result in a loss of revenue or an increase in



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Building Capacity for Transformation Section 1115 Demonstration Waiver Application

State funds associated with the Medicaid program. New Hampshire will maintain budget neutrality over the five-year lifecycle of the Waiver, with total spending under the Waiver not exceeding what the federal government would have spent without the Waiver.



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Building Capacity for Transformation Section 1115 Demonstration Waiver Application

Overview

The New Hampshire Department of Health and Human Services (DHHS) is applying for a Section 1115 Demonstration Waiver (Waiver) from the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) to support the continuing reform of its Medicaid program and of New Hampshire's health care delivery system as a whole. The Waiver, titled *Building Capacity for Transformation*, proposes to address:

- The fragility of the current behavioral health delivery system;
- The challenges facing the behavioral health delivery system in meeting the needs of individuals; and
- The fragmented delivery system for individuals with complex health needs.

The Waiver addresses these needs by:

- Enhancing and expanding existing programs;
- Creating new programs that support New Hampshire's overall health care reform goals; and
- Coordinating new and existing programs in order to focus holistically on the needs of the individuals we serve.

New Hampshire is requesting through this Waiver that CMS recognize Costs Not Otherwise Matchable (CNOM) and provide matching funds that will be used to finance six (6) Designated State Health Programs (DSHPs). The DSHPs complement New Hampshire's overall health reform strategy, including the implementation of its Medicaid Care Management (MCM) program and the expansion of health coverage under the New Hampshire Health Protection Program (NHHPP), and are designed to reinforce other key New Hampshire initiatives, including the State's *Ten Year Mental Health Plan* and the *State Health Improvement Plan (SHIP)*. New Hampshire's overall reform strategy is based on achieving the Triple Aim of improving the quality of health care, improving health outcomes of all New Hampshire residents, and lowering health care costs. Each DSHP reflects New Hampshire's commitment to the goals of the Triple Aim.

Introduction

This Waiver application presents the rationale and data supporting the urgent need for New Hampshire to enact health care system reforms. It also documents how the proposed DSHPs complement New Hampshire's overall health reform strategy, which includes the implementation of a MCM program and the expansion of health coverage under the NHHPP. The application revises and builds upon the Concept Paper submitted to CMS the week of April 14, 2014 and distributed for public comment on April 21, 2014. A draft of this application was also posted for public comment.



Section I - Program Description and Historical Context

Background and Current State

New Hampshire's approach to health care reform has four key cornerstones, as illustrated in Figure 1. Each cornerstone strategy focuses on the Triple Aim of improving the quality of care, improving the health of New Hampshire's residents, and reducing the cost of health care.

New Hampshire is currently engaged in the comprehensive reform of its Medicaid program and health care delivery system through its MCM program. In December of 2013, the State began the implementation of comprehensive state-wide managed care through its MCM program. The MCM program is being implemented by DHHS in three phases that recognize the need to carefully design specialty services for vulnerable populations.

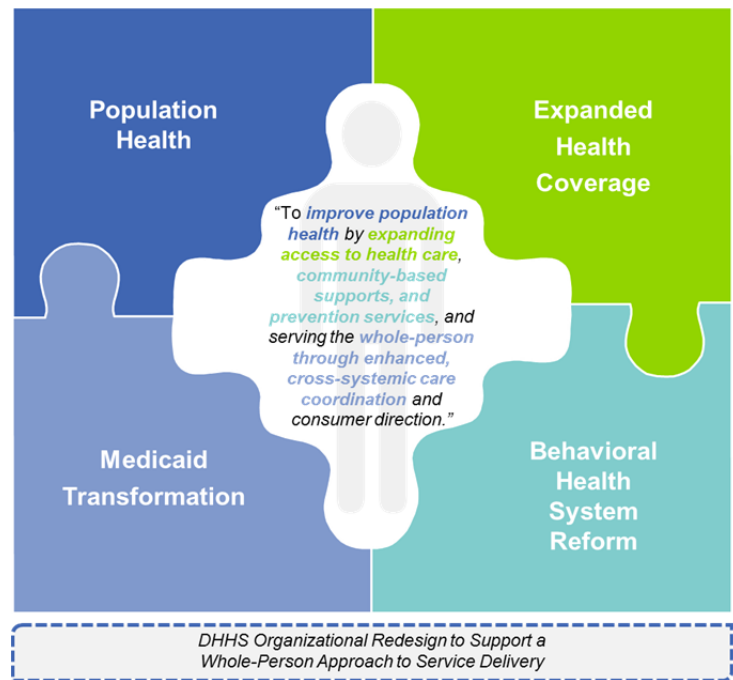


Figure 1. Cornerstones of New Hampshire Health Care Reform.

The first phase of the program included the enrollment of most of the Medicaid population. Individuals who are dually eligible for Medicare and Medicaid (dual-eligibles) and those requiring long term services and supports (LTSS), including nursing homes services, were permitted to opt out of MCM in this phase. Currently, there are over 119,000 beneficiaries receiving health care coverage through three managed care organizations (MCOs) in the MCM program.

The second phase of MCM implementation will be the enrollment of the new adult group under the NHHP, which is described in more detail below.

The final implementation phase will require MCM enrollment for the dual-eligibles, those receiving Medicaid community-based waiver services, and the inclusion of LTSS and nursing home services. Within MCM, the MCOs are seen as change agents encouraging innovative payment and delivery reform within the health care system. New Hampshire requires each MCO to submit a payment reform plan describing how the MCO will engage providers in new and innovative payment and delivery strategies. Beginning in July 2015, the MCOs will have one percent of their capitation withheld, pending successful implementation of their payment reform plans.

The DSHPs described in the Waiver are designed to support DHHS' broader MCM strategy that is focused



on addressing the needs of MCM enrollees holistically and improving the coordination of care for enrollees who are served by multiple systems of care. The first phase of the MCM program began the integration of behavioral health care in the State. Phased implementation of MCM will continue to improve the integration and access to needed services, with an emphasis on both mental health and substance use disorder (SUD) treatment services.

In February 2013, CMS's Center for Medicare and Medicaid Innovation (CMMI) awarded New Hampshire a State Innovation Model (SIM) Model Design grant to develop a State Health Care Innovation Plan and associated delivery system reform and payment reform models. New Hampshire focused its SIM design on models that would reform the provision of LTSS in the State. New Hampshire included community mental health services in its definition of LTSS and actively engaged mental health providers in the development of the SIM plan. The reform goals developed through the SIM process include improving access to care, promoting consumer directed care, and strengthening linkages to acute medical care services for persons receiving LTSS across the continuum of care. New Hampshire is currently utilizing its State Health Care Innovation Plan in the development of its approach to including individuals receiving LTSS and those services in MCM.



New Hampshire estimates that nearly 50,000 newly eligible adults will receive health benefits under the NHHPP. The NHHPP will be expanding health coverage in three different ways:

- Through a Mandatory Health Insurance Premium Program (HIPP) that will help eligible workers pay for employer-sponsored insurance through calendar year 2016;
- Through a Voluntary Bridge to Marketplace plan that will offer coverage to eligible individuals through either MCOs or Qualified Health Plans (QHPs) on the Federal Marketplace in calendar year 2014; and
- Through a Mandatory Premium Assistance Program that will provide coverage for eligible adults through QHPs on the exchange beginning in 2016.

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



The third cornerstone of New Hampshire's comprehensive reform focuses on the behavioral health system. Efforts to reform this system at the agency, community, and cross-agency levels are documented in three publications:

- *Addressing the Critical Mental Health Needs of New Hampshire's Citizens – A Strategy for Restoration (Ten Year Mental Health Plan);*



- *Transforming Children's Behavioral Health Care: A Plan for Improving the Behavioral Health of New Hampshire's Children (Children's Behavioral Health Plan)*; and
- *Collective Action – Collective Impact: New Hampshire's Strategy for Reducing the Misuse of Alcohol and Other Drugs and Promoting Recovery over the next 5 years (Collective Action – Collective Impact)*.

On September 22, 2008, DHHS released the *Ten Year Mental Health Plan*, the plan for the State's public mental health system in the coming decade. The primary finding of the Taskforce that issued the *Ten Year Mental Health Plan* is that "many individuals are admitted to New Hampshire Hospital because they have not been able to access sufficient services in a timely manner (a "front door problem") and remain there, unable to be discharged, because of a lack of viable community-based alternatives (a "back-door" problem)."¹ In order to implement the community-based programs prescribed by this plan, the State is making new investments in its mental health system for the first time in nearly a decade. The State's current Biennial Budget provides over \$26 million in new funding for mental health programs and the State will be investing an additional \$65 million in new community resources over the next four fiscal years.

The recommendations in the *Ten Year Mental Health Plan* focus primarily on adults. To address the children's behavioral health system, the New Hampshire Children's Behavioral Health Collaborative convened to develop a plan to strategically address structural barriers and improve outcomes for children, youth, and their families. In 2013, the Collaborative released the *Children's Behavioral Health Plan* to transform the behavioral health system.² In 2011, DHHS was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) System of Care planning grant, which was followed in 2012 with an implementation grant for the System of Care program titled Family and Systems Together Forward (F.A.S.T. Forward) in New Hampshire. New Hampshire is now joining other states across the U.S. who are implementing Systems of Care and improving the services offered to children and youth with serious emotional disturbances (SED) to keep kids at home.

The third publication supporting behavioral health system reforms describes the State's strategy for reducing the misuse of alcohol and other drugs and promoting recovery. The New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention, and Treatment, established in 2000, initiated a new strategic planning process to identify key priorities, strategy areas, and activities to increase the efforts to address alcohol and other drug misuse, resulting in its March 2013 strategic plan, *Collective Action – Collective Impact*.³

¹ New Hampshire Department of Health and Human Services. "Addressing the Critical Mental Health Needs of New Hampshire's Citizens - A Strategy for Restoration: *Ten Year Mental Health Plan*." 17 September 2008. 10 April 2014 <<http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>>.

² New Hampshire Children's Behavioral Health Collaborative. "Transforming Children's Behavioral Health Care: A Plan for Improving the Behavioral Health of New Hampshire's Children" 19 March 2013. 12 May 2014. <<http://www.nh4youth.org/docs/default-source/default-document-library/executive-summary-transf-child-beh-health-care.pdf?sfvrsn=0>>

³ New Hampshire Department of Health and Human Services. "*Collective Action – Collective Impact: New Hampshire's Strategy for Reducing the Misuse of Alcohol and Other Drugs and Promoting Recovery over the next 5 years (2013-2017)*." 6 March 2013. 15 May 2014.



As the fourth cornerstone to reform, DHHS recently released its *SHIP* that is the State's public health roadmap to guide health improvement work throughout New Hampshire.

The *SHIP* defines measurable objectives, recommended strategies for improvement, and performance measures with time-framed targets for ten population health focus areas,

including tobacco use, obesity/diabetes, healthy mothers and babies, and the misuse of alcohol and drugs. The *SHIP* aims to assist state and community leaders in focusing their work to improve the public's health and to promote coordination and collaboration among public health partners, which has been reflected in the development of this Waiver.

Current Health Care Challenges

Despite each of the efforts toward overall health care reform discussed above, New Hampshire recognizes challenges remain - especially in the behavioral health delivery system, namely:

- The current behavioral health delivery system is financially fragile;
- The ability of the behavioral health delivery system to expand to meet the growing needs of the current Medicaid population and the needs of the NHHPP population is challenged by its fragility; and
- The delivery system for individuals with complex health needs is fragmented and behavioral health and physical health providers have limited resources to make investments to develop new less fragmented systems of care.

Behavioral health services play a critical role in New Hampshire's health care delivery system. As depicted in Figure 2, over 58 percent of adult Medicaid beneficiaries who received a Medicaid paid service in State Fiscal Years (SFY) 2011 and 2012 had a mental health and/or SUD diagnosis. In comparison to adults, roughly 20 percent of children and youth Medicaid beneficiaries who received a Medicaid paid service had a mental health and/or SUD diagnosis. In total, 33 percent of Medicaid beneficiaries who received a Medicaid paid service had had a mental health and/or SUD diagnosis; increasing by almost 1,000 beneficiaries from the previous year .

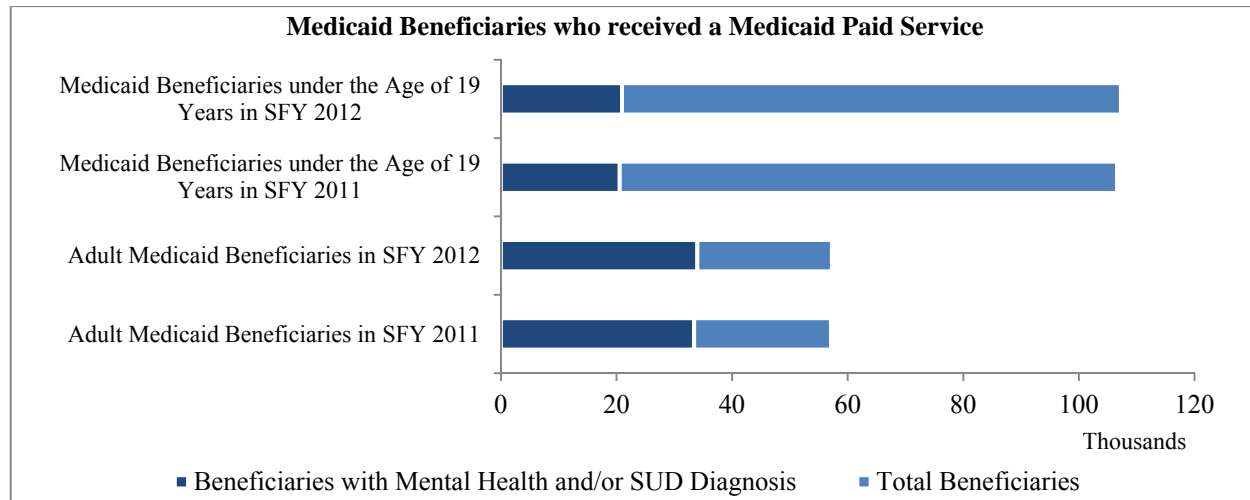


Figure 2. Medicaid Beneficiaries who received a Medicaid Paid Service.

A recent review commissioned by Governor Maggie Hassan of mental health provider issues in the State's largest city, Manchester, emphasizes a variety of contributing factors to a stressed mental health system: "[lack of public and private resources,] the economic downturn, increased substance abuse, reductions in state hospital beds, reductions in psychiatric beds at New Hampshire hospitals, and reductions in community based services". While the review was focused on Manchester, the same contributing factors exist across the State.⁴

As depicted in Figure 3, many children and adults are waiting far too long for mental health treatment, creating an ongoing crisis for both patients and providers. During SFY 2014, on average 11 to 31 adults and 2 to 8 children were awaiting admission into one of New Hampshire Hospital's 158 beds (the State's only psychiatric hospital), primarily from emergency departments across the State.

Inpatient and residential alternatives to New Hampshire Hospital have diminished since the 1990s. There were 236 voluntary inpatient beds in 1990 across the State, 186 beds in 2008, and 177 beds in 2014.⁵ A Designated Receiving Facility (DRF) is a hospital-based psychiatric inpatient unit or a non-hospital-based residential treatment program designated by the Commissioner of DHHS to provide care, custody, and treatment to persons involuntarily admitted to the state mental health services system. The number of community DRF beds has decreased dramatically in the 2000s from 101 to 18 in 2014, as have the number of Acute Psychiatric Residential Treatment Program (APRTP) beds (from 52 to 16). Currently, the State lacks regional capacity for inpatient voluntary and involuntary care. DRF or APRTP care is currently only

⁴ Nadeau, Joseph P, Alexander P. de Nesnera and Michael K. Brown. "New Hampshire Mental Health Sentinel Event Review Report." January 2014. 2014 April 10 <<http://www.governor.nh.gov/media/news/2014/documents/pr-2014-01-28-mental-health.pdf>>.

⁵ New Hampshire Department of Health and Human Services. "Addressing the Critical Mental Health Needs of New Hampshire's Citizens - A Strategy for Restoration: *Ten Year Mental Health Plan*." 17 September 2008. 10 April 2014 <<http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>>.

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



available at four locations. DHHS has been forced to add capacity to New Hampshire Hospital, which is costly and only addresses the issue of involuntary bed capacity.

With few exceptions, acute care hospitals in the State have drastically reduced inpatient mental health care services, many citing cost concerns. These trends have occurred in New Hampshire and nationally due to a combination of factors, including changes in Medicare and Medicaid funding, and a growing uninsured segment of the population. "The Medicaid reimbursements are so low, and the costs so high, that it just became cost-prohibitive," said John Clayton, spokesman for the New Hampshire Hospital Association.⁶

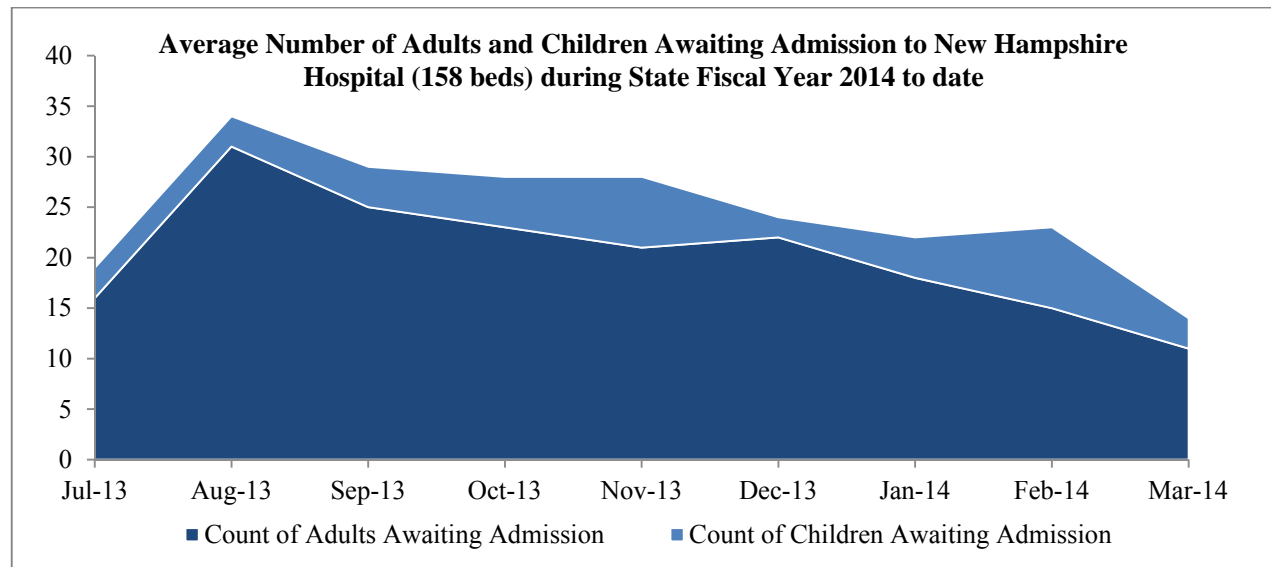


Figure 3. Average Number of Adults and Children Awaiting Admission to New Hampshire Hospital.

This data, in addition to the aforementioned report publications, suggests that there is an inherent need to increase the number of behavioral health providers in the State, and to train and educate emergency department staff on handling complex behavioral health needs of patients. With the addition of a SUD benefit into the State's Medicaid program and the addition of as many 50,000 NHHPP enrollees who will need access to behavioral health services, the need for a stronger behavioral health system will only intensify.

Similarly there is a need to improve how SUD treatments are delivered, and to increase the capacity of hospitals, health systems, and/or community providers (e.g., community mental health centers (CMHCs), federally qualified health centers (FQHCs), and rural health clinics (RHCs) to evaluate and treat patients in need of SUD services.

New Hampshire has also recognized the need to promote the improvement of the overall health of individuals with a persistent and/or severe mental illness (SMI). According to Dr. Stephen Bartels, the

⁶ Solomon, Dave. "NH mental health report: More beds needed." New Hampshire Union Leader 26 February 2014: <<http://www.unionleader.com/article/20130227/NEWS12/130229277/0/SEARCH>>.



director of Dartmouth's Centers for Health and Aging and professor of health policy at the Dartmouth Institute for Health Policy and Clinical Practice, a person with SMI has a life span that is, on average, 25 to 30 years shorter than a person in the general population.⁷ For persons with a persistent and/or severe mental illness staying physically healthy and fit is a special challenge; yet regular exercise and proper diet can be key elements in recovering from a major mental or emotional illness.

The Department's recent *SHIP* documents that tobacco use and dependence "remains the single most preventable cause of death and disability in New Hampshire. Helping those who are tobacco dependent and preventing kids from starting tobacco use can save many lives and health care dollars".⁹ This finding and its implications for population health and health costs in New Hampshire is why DHHS has included proposals to cover and enhance tobacco cessation services to vulnerable populations. For example, the rate of tobacco use among people with mental illness and/or SUD is 94 percent higher than among adults without these disorders. Approximately 50 percent of people with mental illnesses and addictions use tobacco, compared to 23 percent of the general population.¹⁰

According to 2011 New Hampshire birth data published in the *SHIP*, 31.9 percent of pregnant women receiving Medicaid benefits smoke tobacco.¹¹ In comparison with the overall New Hampshire population, 13.6 percent report smoking during

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

Women in New Hampshire Who Report Smoking Cigarettes During pregnancy⁸

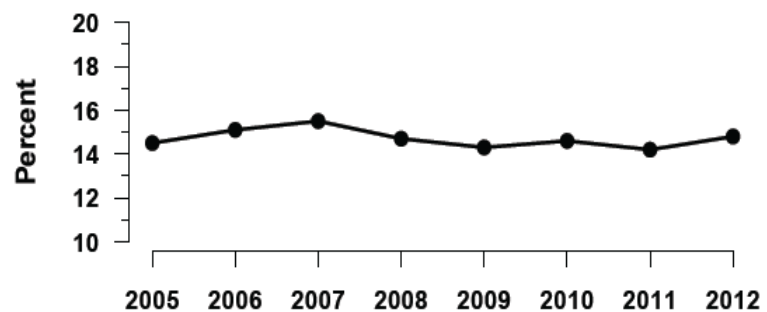


Figure 4. Women in New Hampshire Who Report Smoking Cigarettes During Pregnancy.

⁷ Dartmouth College, Office of Public Affairs. Dartmouth Now: Fitness Program for Mentally Ill Expands in New Hampshire (Associated Press). 23 February 2012. 23 April 2014 <<http://now.dartmouth.edu/2012/02/fitness-program-for-mentally-ill-expands-in-new-hampshire-associated-press/>>.

⁸ New Hampshire Department of Health and Human Services, Division of Public Health Services. "State Health Improvement Plan 2013-2020: Charting a Course to Improve the Health of New Hampshire." December 2013. <<http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf>>.

⁹ Ibid.

¹⁰ National Council for Behavioral Health. National Behavioral Health Network for Tobacco & Cancer Control. n.d. 1 April 2014 <<http://www.thenationalcouncil.org/consulting-best-practices/national-behavioral-health-network-tobacco-cancer-control/>>.

¹¹ New Hampshire Department of Health and Human Services, Division of Public Health Services. "State Health Improvement Plan 2013-2020: Charting a Course to Improve the Health of New Hampshire." December 2013. <<http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf>>.



estimated to be \$585,000.¹²

Population-based studies also demonstrate an association between periodontal diseases and adverse pregnancy outcomes, diabetes, cardiovascular disease, and stroke. There is a known correlation between maternal periodontal disease and preterm birth and/or low birth weight.¹³ Further research is needed to determine the extent to which these associations are causal or coincidental. Smoking is a risk factor common to many diseases; it may be a confounding factor that is complicating apparent associations between periodontal disease and poor pregnancy outcome. A reduction in adverse birth outcomes and associated costs, and a decrease of perinatal morbidity and mortality would likely result from improving oral health during pregnancy.¹⁴

The March of Dimes estimated that the average costs during the first year of life for a premature and/or low birth weight baby (less than 37 weeks gestation and/or less than 2,500 grams) were more than ten times higher than medical costs for a baby born at full term (\$55,393 versus \$5,085).¹⁵ In SFY 2012, New Hampshire Medicaid covered and paid \$7.9 million for all services provided in the first month of life for 780 low birth weight and/or preterm babies.¹⁶ See Figure 5 to the right for the past two SFYs.

In addition to reducing costs associated with poor birth outcomes, improving perinatal oral health also has potential to improve the oral health of children. According to the *Oral Health care During Pregnancy: A National Consensus Statement. Summary of an Expert Workgroup Meeting* issued in collaboration with the U.S. DHHS Maternal and Child Health Bureau, evidence suggests most young children acquire bacteria causing dental

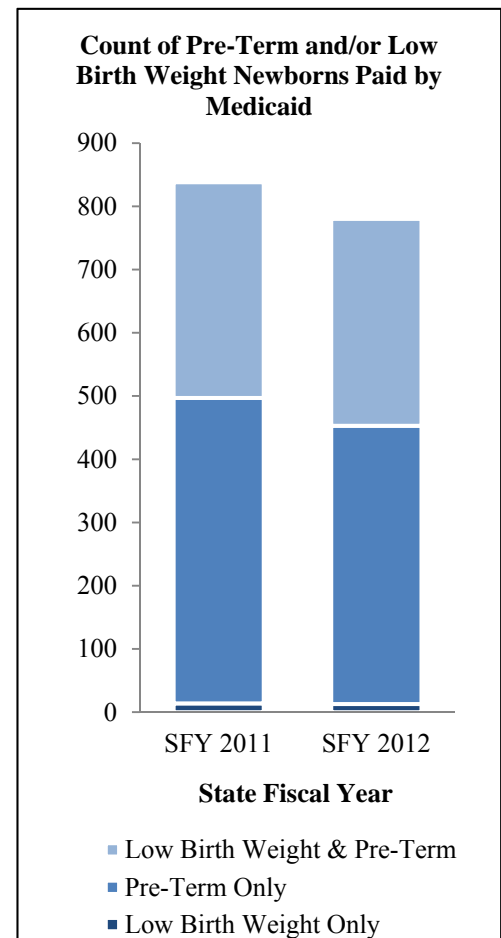


Figure 5. Count of Pre-Term and/or Low Birth Weight Newborns Covered and Paid by Medicaid.

¹² These amounts do not include health costs caused by exposure to secondhand smoke, smoking-caused fires, smokeless tobacco use, or cigar and pipe smoking.

¹³ American College of Obstetricians and Gynecologists. "Committee Opinion No. 569: Oral Health care During Pregnancy and Through the Lifespan." *Obstetrics & Gynecology* 122 (2013): 417-22. <http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Oral_Health_Care_During_Pregnancy_and_Through_the_Lifespan#19>.

¹⁴ Xiong, X, et al. "Periodontal disease and pregnancy outcomes: state-of-the-science." *Obstetrical & Gynecological Survey* 62.9 (2007): 605-15.

¹⁵ March of Dimes. "Premature Babies Cost Employers \$12.7 Billion Annually." 7 February 2014. *March of Dimes Releases New Report about the High Cost of Preterm Birth*. 12 April 2014 <<http://www.marchofdimes.com/news/premature-babies-cost-employers-127-billion-annually.aspx>>.

¹⁶ Total cost of Medicaid services provided by DHHS to low birth weight and/or preterm babies in SFY2012 calculated and provided by Milliman on April 13, 2014.



decay or cavities from their mothers, such as when sharing a spoon or food.¹⁷ There is a correlation between improved oral health and reduced costs for dental treatment in children whose mothers receive routine dental care.¹⁸ The healthier the mother's mouth, then the longer the initial transmission of tooth decay-causing bacteria is delayed and the more likely children are to establish and maintain good oral health.

In the past two SFYs, the annual Medicaid cost for young children who are hospitalized and receive dental services exceeds \$600,000 as seen in Table 1. In New Hampshire, visits related to non-traumatic dental conditions increased significantly in emergency departments from 2001 to 2007, from 11,067 in 2001 to 16,238 in 2007.¹⁹ Improving women's oral health during pregnancy and throughout her child's early childhood may decrease hospital and emergency department utilization and the costs associated with treatment for early childhood tooth decay and cavities.

New Hampshire Department of Health and Human Services						
Facility Costs for Children Under Age Six Years Receiving Dental Services on the Same Day ²⁰						
State Fiscal Year	Unique Beneficiaries	Total Visits	Total Paid	Total Services	Average Paid per Visit	Maximum Paid per Visit
SFY 2011	666	678	\$609,555	20,653	\$899.05	\$11,978.21
SFY 2012	620	629	\$673,512	26,736	\$1,070.77	\$8,581.56

Table 1. Medicaid Paid Claim Summary of Facility Costs for Children Under Age Six Years Receiving Dental Services on the Same Day.

Demonstration Objectives, Hypotheses and Evaluation

Based upon the delivery system challenges outlined above, DHHS developed six DSHPs that it is seeking CMS funding through this Waiver. These DSHPs also focus on encouraging collaborative partnerships among a wide range of providers to improve the coordination and delivery of care for the many individuals who have complex co-occurring conditions.

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

- Encouraging providers to build an integrated health care delivery system at the local level by

¹⁷ Oral Health care During Pregnancy Expert Workgroup. 2012. "Oral Health care During Pregnancy: A National Consensus Statement." Washington, DC: National Maternal and Child Oral Health Resource Center. April 2014 <<http://www.mchoralhealth.org/PDFs/OralHealthPregnancyConsensus.pdf>>.

¹⁸ Children's Dental Health Project and National Institute for Health care Management Research and Educational Foundation. "Improving Access to Perinatal Oral Health: Strategies and Considerations for Health Plans." July 2010. Issue Brief. April 2014 <<http://www.nihcm.org/pdf/NIHCM-OralHealth-Final.pdf>>.

American Academy of Pediatric Dentistry. *Guideline on Perinatal Oral Health care*. Chicago, IL: American Academy of Pediatric Dentistry, 2009.

¹⁹ New Hampshire Department of Health and Human Services, Division of Public Health Services. "State Health Improvement Plan 2013-2020: Charting a Course to Improve the Health of New Hampshire." December 2013. <<http://www.dhhs.nh.gov/dphs/documents/nhship2013-2020.pdf>>.

²⁰ Facility Costs for Children Under Age 6 Receiving Dental Services on the Same Day Paid by New Hampshire Medicaid in State Fiscal Years 2011 and 2012 provided by Milliman on April 30, 2014.



establishing a community reform pool that would support providers' active participation in system reform initiatives.

- Expanding community-based mental health services for the State's non-Medicaid population in accordance with the *Ten Year Mental Health Plan* and its settlement with the U.S. DOJ, now referred to as the *Community Mental Health Agreement (CMHA)*.
- Enhancing community-based mental health services and process under the System of Care/ F.A.S.T. Forward program for children and youth who are considered having SED and are at-risk for multi-agency involvement.
- Improving the service delivery of behavioral health services, especially in emergency departments, by offering financial resources for workforce development.
- Expanding and strengthening the SUD provider network at a time when a new benefit is being implemented and SUD treatment and services become accessible to over 50,000 newly eligible individuals.
- Promoting healthy behaviors and improved health outcomes by expanding the InSHAPE program to new providers and participants and including tobacco cessation as a component for participants who smoke.
- Increasing access to dental services, tobacco cessation, and oral health education by establishing a pilot program for pregnant women and mothers of young children.

The State will submit to CMS for approval an evaluation design for the Waiver no later than 120 days after CMS approval of the Waiver. The overarching hypothesis behind the Waiver is that implementation of the six DSHPs will result in better care and better health for the Medicaid population, and will dramatically reduce both physical health and behavioral health inpatient expenditures. More specifically, the State will test the following research hypotheses through this Waiver:

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

These outcomes will be defined and measured throughout the length of this Waiver. The State's evaluation design for the Waiver will:

- Test the hypotheses described above;
- Describe specific outcome measures that will be used in evaluating the impact of each demonstration-related program during the period of approval;



- Detail the data sources and sampling methodologies for assessing these outcomes;
- Describe how the effects of all demonstration-related programs will be isolated from other initiatives occurring in the State; and
- Discuss the State’s plan for reporting to CMS on the identified outcome measures and the content of those reports.

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

Section II – Designated State Health Programs

New Hampshire’s DSHPs are vehicles for stabilizing a fragile delivery system and investing in new models of supporting coordinated systemic care and quality improvements among the wide variety of providers. DSHPs will be directly responsive to the needs and characteristics of the populations and communities served by each provider or health system. In order to align with the State’s health care reform approach and *SHIP*, New Hampshire is seeking to move the cost and quality curve in four focus areas. The descriptions for each DSHP proposed within this Waiver are on the following pages.



Figure 6. DSHP Activities by Focus Area.

Establish a Community Reform Pool

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



Five Components of Community Reform Pool	
Reform Pool	Description
1. Capacity-Retention Payments	<ul style="list-style-type: none"> A hospital or CMHC would receive this payment if it pledges to maintain access to the mental health and/or SUD related services at current levels. This payment would be 10 percent of the hospital or CMHC's existing Medicaid claim payments for mental health and/or SUD related services. The payment would be calculated based on the previous year's paid claims. This payment would be in place each year of the five year waiver program.
2. Capacity-Expansion Payments	<ul style="list-style-type: none"> If a hospital, health system, community provider, or SUD service provider expands its physical capacity to provide mental health and/or SUD related services, DHHS would increase reimbursement for those services provided through the new "unit" by 25 percent for three years.
3. New Service Payments	<ul style="list-style-type: none"> If a hospital, health system, community provider, or SUD service provider adds inpatient or outpatient mental health and/or SUD related services, DHHS would increase reimbursement for those services by 10 percent for three years.
4. Pilot Program Pool	<ul style="list-style-type: none"> Establish a pool for DHHS to fund grant applications from hospitals, health systems, or community providers to form pilots related to improving the delivery and coordination of physical health, mental health, and/or SUD treatments and services. Grant applications would be evaluated by DHHS based upon a defined set of criteria.
5. Provider Incentive Pool	<ul style="list-style-type: none"> Establish a pool that would begin to provide financial incentives in Year 3 of the demonstration, based upon a hospital, health system, community provider, and/or SUD service provider's achievement of defined outcome measurements. This incentive pool would be funded by a 20 percent holdback in all four components of this broader community reform pool. These hold backs would begin to accrue in Year 2 of the demonstration.

Please note community providers includes CMHCs, FQHCs and RHCs.

Table 2. Five Components of Community Reform Pool.

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

Implementing these reform pool components together enables them to reinforce each other and create more momentum for strengthening New Hampshire's health care delivery system while bending the cost curve. The proposed changes to funding for hospitals, health systems, community providers, and/or SUD service providers under the Waiver will impact over 271 providers that receive payments for mental health and/or SUD services under the Medicaid State Plan. Enhanced payment rates promote marketplace sustainability and incentivize adding capacity into the behavioral health delivery system, thereby sustaining the expanding individual insurance market as a result of the Affordable Care Act (ACA) and New Hampshire's partnership



with the Federal Marketplace.

The fourth component of the reform pool establishes a pilot program pool to fund grant applications submitted by providers to form pilots related to improving health care delivery and care coordination, especially for individuals with physical and behavioral health co-occurring disorders. It presents an opportunity for health systems and providers to address pressing issues in their communities and propose their own tailored solutions. DHHS would solicit and approve a wide variety of pilot program proposals across the State. Suggested pilot programs may focus on, but are not limited to, delivery of physical health and behavioral health services at the local level. Based upon input from stakeholders obtained in the development of this Waiver application, New Hampshire will consider the following projects and interventions for pilot programs proposed from providers. Please note the list of pilot programs is not exhaustive.

Community Reform Pool Pilot Program Pool
Pilot Program Examples
<ul style="list-style-type: none">• Alternative Delivery Models to increase access to services with emphasis on meeting the behavioral health and physical health needs of the NHHPP population
<ul style="list-style-type: none">• Telehealth Delivery Models to increase access to services and improve coordination of behavioral and physical health services
<ul style="list-style-type: none">• Care Models to support MCM Step 1 Initiatives, for example:<ul style="list-style-type: none">– Patient Center Medical Homes– Disease-specific programs
<ul style="list-style-type: none">• Care Models to support integration of behavioral health, physical health, and long-term care, for example:<ul style="list-style-type: none">– Health Homes– Co-occurring Disorders/Comorbidity Specific Programs– Coordination of behavioral health/physical health/LTSS– In-Home technology
<ul style="list-style-type: none">• Quality Improvement projects related to behavioral health
<ul style="list-style-type: none">• Initiatives to support <i>SHIP</i><ul style="list-style-type: none">– Preference to mental health focused proposals– Preference to newly insured focused proposals– May include proposals focused on reducing suicide deaths, improving access to oral health services, the homeless population, or poison control

Table 3. Community Reform Pool Pilot Program Pool.

For each grant application put forth for the pilot program pool, providers would be required to describe their pilot program, discuss intended outcomes and populations served, and present outcome measures. This component is also directly linked to New Hampshire's overarching interest in encouraging payment and delivery reform within the health care system. Within the design of its MCM program, New Hampshire has created an innovative payment reform incentive pool where each of the MCOs is required to submit a



payment reform plan detailing how it will engage providers in new and innovative payment and delivery strategies to improve the delivery and coordination of care. Beginning in July 2015, the MCOs will have one percent of their capitation withheld and then paid back if the MCO successfully implements its plan. It is anticipated that a number of providers will use this pilot pool to support the implementation of payment and delivery reform strategies developed in conjunction with the MCOs.

The fifth and last component is a provider incentive pool that would begin to provide financial incentives in Demonstration Year (DY) 3, based upon the provider's ability to meet defined outcome measurements. This pool would be funded by withholding 20 percent of community reform pool payments in the previous demonstration year. Payments would be at-risk if providers do not achieve outcomes. Improvements will drive whether or not the provider benefits from the incentive pool. New Hampshire recognizes that providers will need to prepare and adapt to new outcome-based payment structures proposed under the Waiver. In DY 1, providers would receive all payment amounts from the abovementioned components of the community reform pool. Beginning in DY 2, 20 percent of payments from the broader community reform pool will be withheld from each provider, and each provider will have the opportunity to earn back their 20 percent in the following year if outcome measures are achieved.

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

All of the abovementioned payments will be in the form of supplemental payments. The expenditure plan showing the allocation between reform pool components over the five-year waiver period is included in *Appendix G* and *Appendix H*.

Enhance Community-Based Mental Health Services

In 2008, a collaborative taskforce between DHHS, New Hampshire Hospital, Bureau of Behavioral Health, and the Community Behavioral Health Association convened to identify the critical mental health needs of New Hampshire's citizens and to assess the current status of publicly funded mental health services and to make recommendations regarding additional services and supports that are critical to meeting the needs of New Hampshire's citizens. Among the areas identified as needing attention were housing and residential supports, more community supports to prevent hospitalization, mental health workforce retention and development, capacity for community based inpatient psychiatric care, services for special populations, and an increase in Assertive Community Treatment (ACT) teams.²¹

²¹ New Hampshire Department of Health and Human Services, Bureau of Behavioral Health Services. "Community Mental Health Services Block Grant Monitoring Report." 4 August 2009. 10 April 2014



The taskforce recommended that group homes, which provide consumers with a safe, supportive living environment, be developed and used as an alternative to state mental health facilities, including New Hampshire Hospital and the Glencliff Home (a State-owned and -operated nursing facility for people with mental illness). However, since the report publication, the number of group home beds has diminished by 13 percent. In 2008, the New Hampshire Bureau of Behavioral Health identified 203 residential group home beds available to serve the approximately 7,000 adults with serious and persistent mental illness in New Hampshire.²² In 2014, the number of residential group home beds available dropped to 177.

The following are the components of the *Ten Year Mental Health Plan* approved in the SFY 2015 budget for which the State is seeking Federal Financial Participation (FFP).

- *ACT* - Multi-disciplinary teams of professionals are available around the clock and provide a wide range of flexible services, including case management, medication management, psychiatric services, assistance with employment and housing, substance use disorder services, crisis services, and other services and supports to allow individuals to live independently in the community. DHHS contracts with CMHCs to expand ACT teams for adults and children.
- *Crisis Respite Beds* - DHHS contracts to provide two peer-run crisis respite beds in Nashua.
- *APRTP Cypress-like DRF model* - DHHS recently released a Request for Proposals (RFP) seeking vendors to provide short-term crisis stabilization services, as an alternative to hospitalization, in a secure, safe, community setting by developing a 16 bed APRTP. This new APRTP will provide services on a statewide basis to individuals in psychiatric crisis but who require a level of care different than that offered by New Hampshire Hospital. An APRTP is also a DRF and provides a critical resource in accepting individuals who require a voluntary or involuntary admission. New Hampshire currently has one APRTP in the Manchester area. This will enhance the ability of the statewide system to improve the quality of life for adults with mental health needs, as well as reduce the need for long-term inpatient care.
- *Expand the Referral Education Assistance & Prevention (REAP) Program* – The New Hampshire Bureau of Elderly and Adult Services, in conjunction with the Seacoast Mental Health Center, CMHCs statewide, and other DHHS partners, administers a statewide REAP program offering free and confidential counseling and educational services to help older adults who are experiencing or are at risk of SUD or mental health issues. The REAP Program is recognized as a national model using evidence-based practices.²³

In December 2013, the New Hampshire Department of Justice entered into a comprehensive settlement agreement, currently referred to as the *CMHA*, of the class action lawsuit, *Amanda D, et al. v. Margaret W.*

<<http://www.dhhs.state.nh.us/dcbcs/bbh/documents/monitoring09.pdf>>.

²² New Hampshire Department of Health and Human Services. "Addressing the Critical Mental Health Needs of New Hampshire's Citizens - A Strategy for Restoration: *Ten Year Mental Health Plan*." 17 September 2008. 10 April 2014 <<http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>>.

²³ New Hampshire Department of Health and Human Services, Bureau of Elderly and Adult Services. "New Hampshire State Plan on Aging —2012-2015." 26 August 2011. 14 May 2014 <<http://www.dhhs.state.nh.us/dcbcs/beas/documents/stateplan.pdf>>.



Hassan.²⁴ Plaintiffs were represented by counsel including the Disability Rights Center and the U.S. DOJ against the State of New Hampshire on behalf of a class of New Hampshire residents with SMI who alleged were unnecessarily institutionalized in New Hampshire Hospital or Glencliff Nursing Home, or were at serious risk of unnecessary institutionalization in hospitals, emergency departments, or prisons. The intention of the *CMHA* is to expand and enhance mental health service capacity in integrated community settings within New Hampshire's mental health system.

According to the U.S. DOJ Civil Rights Division, "The Agreement will enable a class of adults with serious mental illness to receive needed services in the community, which will foster their independence and enable them to participate more fully in community life. The expanded and enhanced community services will significantly reduce visits to hospital emergency departments and will avoid unnecessary institutionalization at State mental health facilities, including New Hampshire Hospital (the State's only psychiatric hospital) and the Glencliff Home (a State-owned and -operated nursing facility for people with mental illness).²⁵"

New Hampshire seeks federal funds to enable New Hampshire to implement components of its *Ten Year Mental Health Plan* and the *CMHA*. Specifically, DHHS is proposing to use DSHP funding to help implement activities and services for the State's non-Medicaid population that are not currently matched for FFP. In addition to adding ACT teams and supportive housing similar to those described in the *Ten Year Mental Health Plan*, the following are central components of the *CMHA* summarized by the Disabilities Rights Center and the U.S. DOJ Civil Rights Division for which the State is seeking federal financial assistance.^{26, 27}

- *Mobile Crisis Teams* – These teams are able to respond to individuals in their homes and communities 24 hours a day and include access to new crisis apartments, where individuals experiencing a mental health crisis can stay for up to seven days, as an alternative to hospitalization. Under the *CMHA*, New Hampshire will create three mobile crisis teams, with accompanying crisis apartments, to help divert people experiencing mental health crises from emergency departments and New Hampshire Hospital.
- *Quality Assurance and Performance Improvement* – New Hampshire will develop and implement a quality assurance and performance improvement system that emphasizes the use of client-level outcome tools and measures to ensure that individuals are provided with sufficient services and supports of good quality. The goal is to help individuals achieve increased independence and greater

²⁴ *Amanda D, et al. v. Margaret W. Hassan*; United States v. New Hampshire. Civ. No. 1:12-cv-53-SM. United States District Court for the District of New Hampshire. . Class Action Settlement Agreement filed 12 February 2014. <<http://www.dhhs.state.nh.us/dcbcs/bbh/documents/approved-agreement.pdf>>.

²⁵ U.S. Department of Justice, Civil Rights Division. . "New Hampshire ADA Mental Health Settlement Fact Sheet." 8 January 2014. *Amanda D, et al. v. Margaret W. Hassan*; United States v. New Hampshire. Civ. No. 1:12-cv-53-SM. 10 April 2014 <<http://www.ada.gov/olmstead/documents/nh-fact-sheet.pdf>>.

²⁶ Disabilities Rights Center, Inc. "Press Release: Federal Judge Approves Class Action Settlement Expanding Mental Health Services." 12 February 2014. 10 April 2014 <<http://www.drcnh.org/pressrelease21214judgeissuesfinalorder.pdf>>.

²⁷ U.S. Department of Justice, Civil Rights Division. "New Hampshire ADA Mental Health Settlement Fact Sheet." 8 January 2014. *Amanda D., et al. v. Hassan, et al.; United States v. New Hampshire, No. 1:12-CV-53 (SM)*. 10 April 2014 <<http://www.ada.gov/olmstead/documents/nh-fact-sheet.pdf>>.



integration in the community, obtain and maintain stable housing, avoid harms, and decrease the incidence of hospital contacts and institutionalization.

- *Independent Monitor* – For the *CMHA*, an expert reviewer will assess the State’s implementation of and compliance, provide technical assistance, and mediate disputes.

Below is a table of the activities for the State’s non-Medicaid population in SFY 2015 that are not currently matched for FFP.



Expand and Enhance Mental Health Services: Unmatched Funding Amount in State Fiscal Year (SFY) 2015 As of December 31, 2013			
Mental Health Program Name	Included as Part of	Funding Amount in SFY 2015 (Total Funds)	Unmatched Amount in SFY 2015 (Federal Funds Requested)
ACT - 4 adult teams	<i>Ten Year Mental Health Plan</i>	\$456,000	\$228,000
ACT - 6 child teams	<i>Ten Year Mental Health Plan</i>	\$840,000	\$420,000
Housing Bridge Subsidy Program	<i>Ten Year Mental Health Plan</i>	\$1,090,000	\$545,000
DRF - Community (Cypress like model)	<i>Ten Year Mental Health Plan</i>	\$675,000	\$337,500
2 Peer-run Crisis Respite Beds	<i>Ten Year Mental Health Plan</i>	\$150,000	\$75,000
Residential - 62 beds	<i>Ten Year Mental Health Plan</i>	\$310,000	\$155,000
Expand REAP Program	<i>Ten Year Mental Health Plan</i>	\$100,000	\$50,000
ACT - Bring 11 current Adult ACT teams to fidelity	<i>CMHA</i>	\$1,280,000	\$640,000
ACT - Add 12th and 13th Adult ACT teams	<i>CMHA</i>	\$113,000	\$56,500
Mobile Crisis Teams	<i>CMHA</i>	\$88,500	\$44,250
Community Crisis Apartments	<i>CMHA</i>	\$256,950	\$128,475
Housing Bridge Subsidy Program	<i>CMHA</i>	\$817,500	\$408,750
Quality Assurance	<i>CMHA</i>	\$101,816	\$50,908
Expert Reviewer	<i>CMHA</i>	\$175,000	\$87,500
Total		\$6,453,766	\$3,226,883

Table 4. Unmatched Funding Amount in State Fiscal Year 2015.

The *CMHA* will provide people with SMI in New Hampshire, both Medicaid and non-Medicaid, with robust community alternatives that will reduce or eliminate the need for hospitalization. The *CMHA* requires the State to create and expand services over the next six years.²⁸ An independent expert reviewer will evaluate the State's compliance with the agreement and will issue public reports on the state's ongoing implementation efforts. The services included in the settlement agreement are proven, cost-effective measures that lead to recovery and the ability of people with SMI to live successful and fulfilling lives in the community.

²⁸ U.S. Department of Justice, Office of Public Affairs. News Release: Justice Department Reaches Settlement with State of New Hampshire to Expand Community Mental Health Services and Prevent Unnecessary Institutionalization. 19 December 2013. 12 April 2014 <<http://www.justice.gov/opa/pr/2013/December/13-crt-1347.html>>.



Sustain Community-Based Services for Children and Youth under the System of Care/F.A.S.T. Forward Program

For the past two years, DHHS has been implementing a System of Care program called F.A.S.T. Forward for children and youth with SED. A System of Care is “a spectrum of effective, community based services and supports for children and youth with or at risk for mental health challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.” Services include:

- Coordination and connection to natural community supports;
- In-home supports;
- Respite;
- Mobile crisis intervention and support; and
- Short-term residential treatment/therapeutic-level foster care.

Development of the System of Care/F.A.S.T. Forward program was made possible by planning and implementation grants from the U.S. Department of Health and Human Services SAMSHA. This work started as an initiative of the New Hampshire Children’s Behavioral Health Collaborative.²⁹

The latest SAMSHA grant is being used to develop a System of Care/F.A.S.T. Forward infrastructure for children and youth with serious emotional and behavioral health challenges and their families. The infrastructure development will expand the array of supports for children and youth who are involved in two or more systems and who are at risk of out of home placement. Most services included in New Hampshire’s System of Care Service Array are covered currently by Medicaid, but not all. In order to ensure successful and sustainable implementation of Systems of Care Service Array, DHHS proposes a new Medicaid benefit to cover those services required for the Service Array that not currently covered by Medicaid, specifically wraparound team meeting participation, respite care, flexible spending, mobile crisis response and eventually wrap around facilitation and care coordination.

System of Care/F.A.S.T. Forward in New Hampshire will use a high fidelity wraparound approach, which supports the System of Care guiding principles. The New Hampshire Division for Children, Youth and Families (DCYF) is responsible for developing and implementing an enhanced service array, braiding together traditional services offered by CMHCs and DCYF to create a more efficient and cost-effective system, and managing WRAP Facilitators who will act as care coordinators with children, youth, and families statewide.

²⁹ New Hampshire Children’s Behavioral Health Collaborative. "Transforming Children’s Behavioral Health care: A Plan for Improving the Behavioral Health of New Hampshire’s Children" 19 March 2013. 12 May 2014. <<http://www.nh4youth.org/docs/default-source/default-document-library/executive-summary-transf-child-beh-health-care.pdf?sfvrsn=0>>.



DCYF anticipates beginning to serve children and youth in 2014 under System of Care/F.A.S.T. Forward. Services in the Service Array covered currently by Medicaid, either through CMHCs or DCYF include:

- Assessment and diagnostic evaluation
- Outpatient Therapy: Office based, individual, group and family therapies
- Medication management
- Psychiatric/medication consultation
- Community Youth Mentor/Behavioral Aide Service
- School-based behavioral health services
- Substance abuse intensive outpatient treatment
- Substance use disorder support services
- Therapeutic Day Treatment: after school programs
- DCYF ISO In Home supports
- DCYF Home Based Therapeutic Support
- DCYF Child Health Support/Parent Aide
- Crisis Stabilization: out of home
- Therapeutic Foster Care: ISO foster care
- Residential Treatment
- Family Support and Education
- Youth Peer Support

There are several critical services for System of Care/F.A.S.T. Forward not covered currently by SAMSHA grant funding or by New Hampshire Medicaid. Within this Waiver, DHHS proposes a new Medicaid benefit to cover these services for those enrolled in System of Care/F.A.S.T. Forward.

- Wraparound team meeting participation: Billing for participation in a child/youth's wraparound team meetings for both clinical providers and family and peer support providers.
- Respite care: Short-term planned respite care out of home in either a licensed foster home, ISO level foster home or a residential group home, depending on the need of the child.
- Flexible spending: Flexible funds are available for enrolled System of Care/F.A.S.T. Forward families. Flexible funds are to be used as one-time payments for things that create barriers to accessing services and supports in the community or may cause a need for a higher level service if not addressed early.
- Mobile Crisis Response: Mobile Crisis Response services are available for child/youth and families enrolled in System of Care/F.A.S.T. Forward 24 hours per day. This mobile crisis response is intended to be delivered face-to-face at the family's home or community.

Currently, the SAMSHA grant provides funding for wrap around facilitation and care coordination, which is standard for every child/youth and family participating in System of Care/F.A.S.T. Forward. However, the grant is scheduled to expire in October 2016. Therefore, DHHS proposes to include wrap around facilitation/care coordination as a covered service under this new System of Care/F.A.S.T. Forward Medicaid benefit once the implementation grant from SAMSHA expires. The care coordinator assists the child and family to access mental health services, social services, educational information, and other services and supports that may be available in their community, and support the child/youth/family needs in meeting the needs and objectives of the Plan of Care.

By providing financial resources to fund and sustain all services included in the System of Care Service Array, New Hampshire will be able to achieve the following key outcomes for the child/youth and family involved and at the system level:



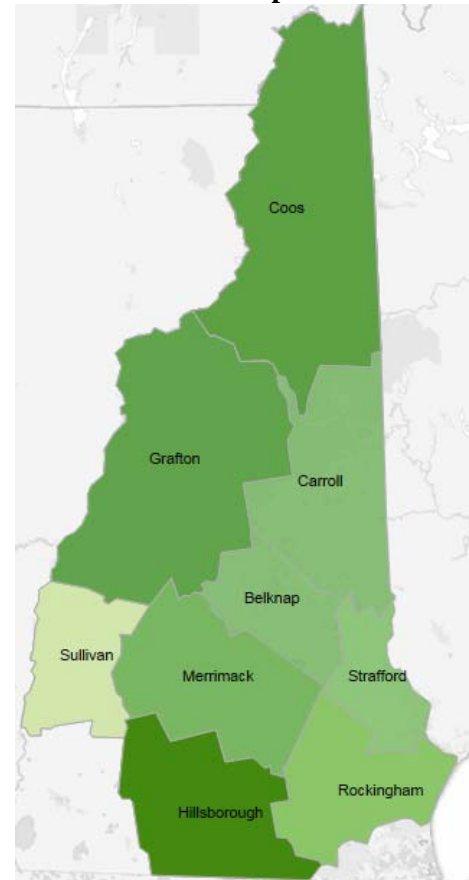
- Increased family involvement in planning and service delivery;
- Access to an enhanced service array;
- Reduced rates of psychiatric hospitalizations;
- Improved clinical outcomes;
- Reduced need for child protection and juvenile justice; and
- Increased empowerment and self-advocacy.

Invest in Behavioral Health Workforce Development

One of the State's population health focus areas, as outlined in the *SHIP* and *Collective Action – Collective Impact*, is to address substance misuse by reducing the non-medical use of pain relievers and drug-related overdose deaths in the State. Meeting these goals will require a stronger workforce capable of providing enhanced behavioral health treatments and services and addressing behavioral health co-occurring disorders. To address this need, DHHS proposes a grant program that would fund training education and workforce development programs focused on behavioral health treatments and services. New Hampshire is experiencing shortages of psychiatrists and other treatment staff. Over one-third of New Hampshire is designated a "mental health professional shortage area" by the Health Resources Services Administration.³¹ Figure 7 shows the degree of mental health professional shortage area across New Hampshire. According to the *Ten Year Mental Health Plan*, the availability of adequately trained staff is a significant challenge that directly affects service quality in both inpatient and outpatient settings, in addition to staff wages and staff turnover. This challenge will increase with the advent of a SUD treatment benefit in July 2014 for NHHPP enrollees.

To access this funding pool, hospitals, health systems, community providers and/or professional associations will submit proposals and funding requests to DHHS for review and approval.

Average Score of Mental Health Professional Shortage by County in New Hampshire³⁰



Color Scale of Average Scores
0 19

The higher the score, the greater the priority for assignment of clinicians.

□ No Mental Health Professional Shortage

Figure 7. Average Score for Mental Health Professional Shortage Area by County.

³⁰ Health Resources and Services Administration. [Health Professional Shortage Area Data Download](http://datawarehouse.hrsa.gov/data/datadownload/hpsaDownload.aspx). 12 April 2014. <<http://datawarehouse.hrsa.gov/data/datadownload/hpsaDownload.aspx>>.

³¹ New Hampshire Department of Health and Human Services. "Addressing the Critical Mental Health Needs of New Hampshire's Citizens - A Strategy for Restoration: *Ten Year Mental Health Plan*." 17 September 2008. 10 April 2014 <<http://www.dhhs.nh.gov/dcbcs/bbh/documents/restoration.pdf>>.



Curriculum components may include, but are not limited to:

- Crisis intervention;
- Crisis stabilization;
- Emergency Departments and related continuum of care;
- Related mental health co-occurring disorders;
- Neonatal abstinence syndrome (NAS);
- Screening, Brief Intervention and Referral to Treatment (SBIRT);
- Substances misuse and abuse trends;
- Navigating the SUD provider network.
- Alcohol abuse;
- Adolescent use of marijuana; and
- Prescription drug abuse.

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

This training grant would be administered by DHHS, and payments would be specific to each award. Funding for activities related to this behavioral workforce development initiative will be distributed directly by DHHS.

Expand the InSHAPE program

For persons with a persistent and/or severe mental illness staying physically healthy and fit is a special challenge; yet regular exercise and proper diet can be key elements in recovering from a major mental or emotional illness. To address this challenge, New Hampshire launched an InSHAPE health promotion program in 2004 that brings the benefits of exercise and a healthful way of living to individuals facing these concerns.³² In order to scale this program further, DHHS proposes expanding the InSHAPE program to additional populations and additional provider settings. In addition to the focus on improving cardiovascular health by reducing obesity, DHHS proposes adding a tobacco cessation component to InSHAPE. This DSHP would establish a funding pool to award grant applications from hospitals, health systems, and/or community providers to implement an InSHAPE program that (1) includes children with SED as participants, (2) includes individuals enrolled in New Hampshire's 1915(c) Home and Community Based Services Waiver for Developmentally Disabled (HCBS-DD) as participants, and (3) offers tobacco cessation as a program component to all InSHAPE participants who smoke.

InSHAPE is a health promotion intervention consisting of a gym membership, basic education in healthy

³² Monadnock Family Services. InShape. n.d. 2 April 2014 <<http://www.mfs.org/services/inshape/inshape>>.



eating and nutrition, and weekly sessions with a “health mentor” (i.e., fitness trainer) who has received training in goal setting, motivational interviewing, and healthy eating behaviors as well as training around the needs of persons with SMI. Health mentors also receive instruction from registered dietitians in setting dietary goals. The program is based on principles of social inclusion and community integration.³³ InSHAPE is a treatment approach in the same way that cognitive behavior therapy and motivational interviewing are treatment approaches. Those treatment approaches are employed by the clinician when providing specific services prescribed in a treatment plan. Therapeutic Behavioral Services are the Medicaid covered community mental health service that would most often be provided for an individual who needed the provider to employ the InSHAPE treatment approach.

In September 2011, the New Hampshire DHHS Bureau of Behavioral Health Services received a grant from CMS to implement a Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) program to measure the impact of providing incentives for healthy behavior to the Medicaid population. With the MIPCD grant funding, DHHS proposed the New Hampshire Medicaid Wellness Incentive Program (WIP) also known as “Healthy Choices, Healthy Changes” to address both the health disparity and increased costs by providing incentivized health promotion programs to overweight or obese and/or tobacco-smoking Medicaid beneficiaries receiving services at New Hampshire’s ten regional CMHCs.³⁴ One of WIP’s fitness and weight management components is InSHAPE, a motivational health-promotion program for persons with mental illness. Currently, 736 people currently participate in InSHAPE through WIP.

The five year MIPCD grant is scheduled to end in September 2016. Under this Waiver, DHHS will expand the InSHAPE program by extending the funding after MIPCD grant funding expires in September 2016.

DHHS will further expand the InSHAPE program by accepting grant applications from hospitals, health systems and other community providers to implement an InSHAPE health promotion program with the new tobacco cessation element and for additional populations.

DHHS will expand participation in the InSHAPE program to include children with SED and 1915(c) HCBS-DD waiver enrollees in the State. There are 9,763 children with SED in the State served by the CMHCs in SFY 2013 who could be eligible for an expanded InSHAPE program. Approximately 5,000 individuals enrolled with 1915(c) HCBS-DD waiver could also be eligible for an expanded InSHAPE program.

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

³³ Van Citters, Aricca et al. “A Pilot Evaluation of the In SHAPE Individualized Health Promotion Intervention for Adults with Mental Illness.” *Community Ment Health J.* 46(6) (2010): 540-552.

<<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3163497/pdf/nihms-175473.pdf>>.

³⁴ New Hampshire Medicaid Wellness Incentive Program Application and Project Narrative



Launch Oral Health Pilot Program for Pregnant Women

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

- Establishes an education program for all mothers to increase the understanding and value of oral health for themselves and their children;
- Enhances the existing tobacco cessation benefit for pregnant women and encourages participation by all mothers who smoke in an approved tobacco cessation program;
- Establishes a benefit that provides coverage for dental services to all pregnant women during pregnancy *until their child's fifth birthday*,
 - Including mothers under 21 years of age who are currently eligible for Medicaid dental services through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and
 - Including pregnant women over 21 years of age who are not currently eligible for any comprehensive Medicaid dental services;

The scope of dental benefits will include comprehensive and periodic dental examinations, periodontal services as indicated, restorative and limited prosthetic dental treatment, and extractions if medically necessary.

Program rewards and incentives would be provided to women and children who meet certain performance criteria developed by DHHS that include but are not limited to:

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

All women who participate in the oral health pilot program will be required to participate in a related evaluation study. Experience of participants will be compared with non-participants and historical Medicaid claims' data to evaluate the differences between those who fully participate in a comprehensive oral health program and those who are offered paid dental benefits, but do not participate in obtaining routine oral health care, including smoking cessation. The outcomes to be compared will include such variables of experience as: positive birth outcomes, use of dental services to treat urgent and emergent dental conditions of the parent, use of Emergency Department services for dental complaints, use of early dental services by the children, severity of dental disease, and decay experience as reflected by the children's dental claims. Assignment to status of "Participant" or "Non-Participant" will be based on retrospective review of performance relative to criteria to be established: i.e., whether an individual followed through with making/attending regular and treatment appointments, attended smoking cessation treatment, and sought dental care for children prior to age one.



Dental services provided through the Waiver's dental benefit to clients will be paid on a fee-for-service basis.

Section III – Impact of Demonstration on State's Current Medicaid and CHIP Programs

Impact of Demonstration on Eligibility

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

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

Impact of Demonstration on Benefits and Cost Sharing Requirements

Through its Waiver, New Hampshire proposes to offer two new demonstration-only benefits.

- New Hampshire proposes to offer Medicaid dental benefits to women who are pregnant until their child's fifth birthday as long as Medicaid eligibility is maintained. Pregnant women under 21 years of age will continue to be eligible for EPSDT dental services. Dental services for pregnant women through the benefit will differ from those provided under the Medicaid and/or CHIP State Plan. Scope of dental services within the benefit will include comprehensive and periodic dental examinations, periodontal services as indicated, restorative and limited prosthetic dental treatment, and extractions if medically necessary. In addition, DHHS proposes to offer screening and referral and home visiting services as described below in this document.
- New Hampshire proposes to offer certain Medicaid benefits to children and youth who are considered having SED, are at risk for multi-agency involvement and out of home placement, and are enrolled in System of Care. Wraparound team meeting participation, respite care, flexible spending, mobile crisis response, and wraparound facilitation/care coordination services for children and youth enrolled in System of Care will differ from those provided under the Medicaid and/or CHIP State Plan.

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

Since two new benefits will apply to different eligibility groups affected by the Waiver, the table below



specifies the benefit package that each eligibility group will receive under the Waiver.

New Hampshire Department of Health and Human Services	
Benefit Package	
Eligibility Group	Benefit Package
Pregnant women and mothers of young children <i>who are currently not eligible for EPSDT dental benefits</i>	Demonstration-only Dental Benefit
Children and youth who are considered having SED, are at risk for multi-agency involvement and out of home placement, and are enrolled in System of Care	Demonstration-only System of Care/F.A.S.T Forward Benefit

Table 5. Benefit Package.

The Benefit Charts are included in *Appendix B*, and related Benefit Specifications and Qualifications forms are included in *Appendix C*.

Section IV – Delivery System of Demonstration

The delivery system used to provide benefits to demonstration participants will not differ from the Medicaid and/or CHIP State Plan. New Hampshire enrolls the majority of its Medicaid beneficiaries on a mandatory basis into MCOs for State Plan Services under its Section 1932 State Plan Amendment (12-006) effective September 2012 and will eventually include almost all Medicaid beneficiaries. However, dental services are reimbursed on a fee-for-service basis.

Section V – Implementation of Demonstration

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

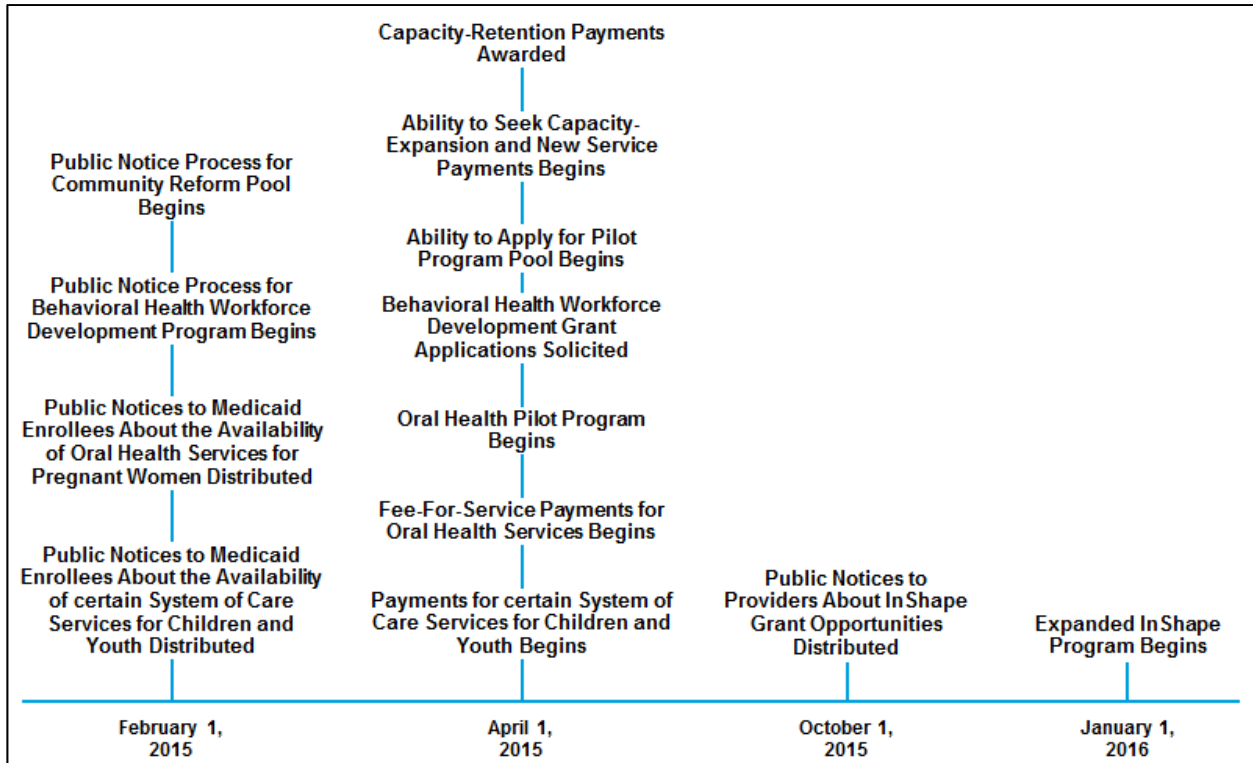


Figure 8. Implementation Timeline.

Oral health benefits will continue to be paid on a fee-for-service basis. MCOs will provide InSHAPE services as described in this Waiver. For System of Care/F.A.S.T. Forward services, capitation payment changes will be made through a future MCO contract amendment. All other payments will be made outside of MCM.

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

Section VI – Demonstration Financing and Budget Neutrality

New Hampshire will maintain budget neutrality over the five-year lifecycle of the Waiver, with total spending under the Waiver not exceeding what the federal government would have spent without the Waiver. New Hampshire's budget neutrality methodology includes the following components with a net savings of \$46.9 million over the five year demonstration period:

- Managed care savings related to the implementation of the MCM program. With-Waiver cost projections include savings related to Step 1 of the MCM program (i.e., acute care and mental health services) and Step 2 of the MCM program (i.e., expanding the MCM program to include long term services and supports and mandatory enrollment for all eligible beneficiaries). MCM implementation is expected to save \$265.4 million over the five year demonstration period.
- Net expenditures related to the six DSHPs included in the Waiver. In developing the net expenditures, DHHS considered estimated expenditures for the DSHPs as well as related savings in other Medicaid services that are expected to result from the DSHPs. The net expenditures for DSHPs



are expected to be a cost of \$18.5 million over the five year demonstration period.

- New Hampshire is requesting \$200 million of expenditures over the five year demonstration period for CNOM related to programs that provide vital services that today are not reimbursed by Medicaid or any other federal source.

Note that Medicaid expansion populations are not part of the budget neutrality projections for the Waiver at this time.

Appendix F includes the information requested in the Budget Neutrality Forms available at <http://www.medicaid.gov> regarding historical expenditure data and projected expenditures. The budget neutrality projections using the CMS template are included as *Appendix I*.

Section VII – List of Proposed Waivers and Expenditure Authorities

Federal Waivers, Expenditure, and Cost Not Otherwise Matchable Authorities Requested

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

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

The potential sources for match are included in *Appendix A*. CMS and the State will identify any other waivers and expenditure authorities needed to implement this waiver.

Legislative Authority

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



Section VIII – Stakeholder Engagement and Public Notice

As part of the stakeholder engagement process required within the development of this Waiver, the State sought consultation with stakeholders including state, county, and local officials, health care providers, advocacy organizations, and professional associations.

DHHS gathered stakeholder input through a required public notice process that included two public hearings and a dedicated website. The website for public information on this Waiver is

<http://www.dhhs.nh.gov/section-1115-waiver/index.htm> . The web page include a copy of the waiver concept paper, waiver application draft, materials from public hearings, and instructions (with links) on how to submit comments on the waiver application draft.

The full public notice was also posted on the State’s website and is in *Appendix D*. An abbreviated public notice was published in two newspapers, *The Telegraph* and *New Hampshire Union Leader*, on Monday, April 21, 2014. In addition, the abbreviated public notice was e-mailed on Monday, April 21, 2014 to DHHS stakeholders, MCO account managers, advocacy groups and county representatives.

The public comment period for New Hampshire’s proposed Demonstration Waiver was from Monday, April 21, 2014 until Tuesday, May 20, 2014 at 5 p.m. (Eastern Time). Comments received within 30 days of the posting of this notice were reviewed and considered for revisions to the Waiver application. Two public hearings on the proposed Waiver were held prior to submitting the application to CMS to discuss waiver concepts and solicit comments from stakeholders. The dates for the public hearings were May 8, 2014 and May 12, 2014. Both hearings included teleconferencing and web capability to maximize accessibility. Written and verbal comments received from the public are included in *Appendix E*.

In addition to the public hearings, state staff met individually with stakeholder groups and advocates, including, but not limited to the following groups:

- New Hampshire Association of Counties
- New Hampshire Hospital Association
- Behavioral Health Association (the governing body and trade association for CMHCs)
- New Hampshire Dental Society
- Medicaid Care Management Commission (MCAC)
- SUD Stakeholder Representatives

There are no recognized tribes in New Hampshire to conduct tribal consultation.

As part of the State’s oversight of its MCM program, Governor Maggie Hassan established a commission that brings together members of the public representing a broad range of experience in health care issues to review and advise on the implementation of an efficient, fair, and high-quality Medicaid care management



system.³⁵ The Governor's Commission on Medicaid Care Management was actively engaged in the development of this Demonstration Waiver application. Specifically, the second public hearing was held in conjunction with a meeting of the Governor's MCAC.

The state legislature was also significantly involved in the development of this Waiver. This process formally began on March 27, 2014 when SB413 was signed into law requiring DHHS to submit a statewide Section 1115 Demonstration Waiver by June 1, 2014. DHHS meets regularly with legislative leadership in both informal and formal venues, including the legislature's Fiscal Committee. This Waiver application was approved by the legislature's Fiscal Committee on May 28, 2014 before its submission to CMS.

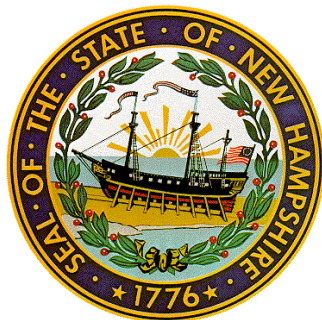
During and after approval from CMS, the State will continue to seek stakeholder input in standing up each DSHP program and conduct a robust engagement process to spread awareness about these system improvements.

Section IX – Demonstration Administration

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

Name and Title: Jeffrey A. Meyers, Director, Intergovernmental Affairs
New Hampshire Department of Health and Human Services
Telephone Number: (603) 271-9210
Email Address: jeffrey.meyers@dhhs.state.nh.us

³⁵ State of New Hampshire. "Press Release: Governor Hassan Issues Executive Order Creating Commission on Medicaid Care Management." 10 April 2013. 2 April 2014 <<http://www.governor.nh.gov/media/news/2013/pr-2013-04-10-medicare-care.htm>>.



New Hampshire
Department of Health and Human Services

Building Capacity for Transformation
Section 1115 Demonstration Waiver

Section X – Appendices

May 30, 2014



Section X – Appendices

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Appendix A: Resources for Costs Not Otherwise Matchable

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

State of New Hampshire Health Care Funding Summary of Potential Designated State Health Program (DSHP) Resources*	
Funding Sources	Funding Amount
State Funding Sources	
<i>Department of Health and Human Services SFY 2015 Biennial Budget:</i>	
Glenclyff Home General Funds	\$7,544,949
New Hampshire Hospital General Funds	\$24,650,441
Sununu Youth Services Center General Funds	\$14,683,277
<i>Department of Health and Human Services Ten Year Mental Health Plan/DOJ Settlement</i>	\$3,227,000
<i>Department of Health and Human Services SFY 2015 Biennial Budget for Laconia DRF</i>	\$1,235,043
<i>Department of Corrections SFY 2015 Biennial Budget for Medical and Dental Services</i>	\$10,760,687
State Funding Sources Total	\$62,101,397
Municipality Funding Sources	
<i>2013 Report of Appropriations Actually Voted (M-2 Form) reported to the Department of Revenue Administration</i>	
Health Administration	\$4,320,521
Health Agencies & Hosp. & Other	\$7,367,123
Municipality Funding Sources Total	\$11,687,644
County Funding Sources	
Correctional Medical/Health Spending	\$6,093,757
County Funding Sources Total	\$6,093,757
Grand Total	\$79,882,798



Appendix B: Benefit Charts

This Demonstration will provide two new benefits that differ from the Medicaid or CHIP State plan.

- Below are charts describing the dental service benefit offered to pregnant women who are not currently eligible for EPSDT benefits and therefore, may be eligible for this Demonstration-only dental benefit. An individual would stay eligible for the demonstration-only dental benefit through their child's fifth birthday as long as she remains eligible for Medicaid post 60 days post-partum. The dental benefit for pregnant women up to age 21 years old will be the EPSDT benefit, which includes medically necessary dental services described and limited in He-W 566.

A provider of dental services shall:

- (1) Be license to practice dentistry in the state where they practice,
- (2) Be enrolled as a NH Medicaid (dental) provider; and
- (3) Provide dental services in accordance with the NH Dental Practice Act (RSA 317-A) and related administrative rules (Den 100-500)

Other providers for the smoking cessation activities could include providers such as PCPs and others who are qualified to provide smoking cessation counseling.

- The charts also describes the System of Care/F.A.S.T. Forward benefit offered to children and youth (to transition age) who are SED and are at risk for multi-agency involvement, who require access to an enhanced services array and process, and who may be eligible for this Demonstration-only benefit.



New Hampshire Department of Health and Human Services		
Benefit Provided through <i>Building Capacity for Transformation</i> Section 1115 Demonstration Waiver		
Benefit	Description of Amount, Duration and Scope	Reference
Dental Services	<p>The dental benefit shall comprise of the following broad categories of services:</p> <ul style="list-style-type: none">• <u>Diagnostic Services</u> including clinical oral evaluations, pre-diagnostic services, Diagnostic imaging, and laboratory testing.• <u>Restorative Services</u> including amalgam and composite "fillings".• <u>Periodontic Services</u> including scaling and root planning, and periodontal surgery.• <u>Prosthodontics (removable)</u> including full and partial dentures.• <u>Oral and Maxillofacial Surgery</u> including extractions and surgery required for prosthetics.• <u>Adjunctive General Services</u> including palliative treatment and anesthesia. <p>Prior authorization requirements and service limitations for the above benefits are further described in the New Hampshire Administrative Rules He-W 566 (Dental Services), and the dental "Procedure Code Listing" found at https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms.</p> <p>This would also include health promotion initiative for pregnant women and all mothers with kids through age 5.</p>	Optional 1905(a)(10)
Tobacco Cessation for Pregnant Women	Please see the existing mandatory tobacco cessation benefit currently available at http://www.dhhs.nh.gov/ombp/medicaid	Mandatory 1905(a)(4)



New Hampshire Department of Health and Human Services		
Benefit Provided through <i>Building Capacity for Transformation</i> Section 1115 Demonstration Waiver		
Benefit	Description of Amount, Duration and Scope	Reference
Other: System of Care / F.A.S.T. Forward	<p>The System of Care/F.A.S.T. Forward benefit shall comprise of the following services:</p> <ul style="list-style-type: none">• Wraparound team meeting participation• Respite care• Flexible spending• Mobile Crisis Response• Wrap around facilitation/care coordination (<i>Once the System of Care implementation grant from SAMHSA expires</i>) <p>Prior authorization requirements and service limitations for the above benefits are further described in below in the Benefit Specifications and Qualifications Form for F.A.S.T. Forward: System of Care.</p>	Optional 1905(a)(29)

New Hampshire Department of Health and Human Services		
Benefits Not Provided through <i>Building Capacity for Transformation</i> Section 1115 Demonstration Waiver		
Benefit	Description of Amount, Duration and Scope	Reference
Dental Services	<p>Services that will not be provided to pregnant women over the age of 21 include:</p> <ul style="list-style-type: none">• Space maintainers.• Orthodontics including limited, interceptive and comprehensive treatments.• Endodontics including root canal treatment.• Implant Services.• Fixed crowns.• Fixed partial dentures, also known as “bridges”.• Services that are otherwise not coverable because:<ul style="list-style-type: none">○ The service is cosmetic in nature;○ The service is provided for the convenience of the patient;○ The service is not the least expensive method to achieve the therapeutic result; or○ The service is experimental.	Optional 1905(a)(10)



Appendix C: Benefit Specifications and Qualifications Forms

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State provides a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service in accordance with the Benefit Specifications and Provider Qualifications form. Responses from the State are italicized.

Name of Benefit or Service: **Dental Services for Pregnant Woman (21 years and older)**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Pregnant women over the age of 21 are not entitled to services provided to children in accordance with EPSDT requirements Dental benefits offered to pregnant women over the age of 21 shall be more comprehensive than those offered to other adult recipients, and will be similar to those offered to children, with some exceptions. For example, sealants and orthodontia will not be covered for pregnant women. Pregnant women over the age of 21 are not entitled to the services provided to children in accordance with EPSDT requirements.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

The dental benefit shall comprise of the following broad categories of services:

- *Diagnostic Services including clinical oral evaluations, pre-diagnostic services, Diagnostic imaging, and laboratory testing.*
- *Restorative Services including amalgam and composite “fillings”.*
- *Periodontic Services including scaling and root planning, and periodontal surgery.*
- *Prosthodontics (removable) including full and partial dentures.*
- *Oral and Maxillofacial Surgery including extractions and surgery required for prosthetics.*
- *Adjunctive General Services including palliative treatment and anesthesia.*

Not all codes within a category may be covered. For details on which codes are coverable, please refer to the “Procedure Code Listing” found at <https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms>.

Benefit Amount: Other, Describe:

Service limits for all dental services are further described in the New Hampshire Administrative Rules He-W 566 (Dental Services), and in the dental “Procedure Code Listing” found at <https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms>.

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:



New Hampshire Department of Health and Human Services

Building Capacity for Transformation Section 1115 Demonstration Waiver Application

The dental benefit will continue until either the pregnant woman's child reaches 5 years of age or the woman loses Medicaid eligibility.

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization (PA) requirements are further described in New Hampshire Administrative Rules He-W 566 (Dental Services). The dental "Procedure Code Listing", found at <https://nhmmis.nh.gov/portals/wps/portal/DocumentsandForms>, indicates by code which services require a PA.

Provider Specifications and Qualifications:

Provider Category(s):

☒ Individual (list types)

☒ Agency (list types of agencies)

The service may be provided by a:

☐ Legally Responsible Person

☐ Relative/Legal Guardian

Description of allowable providers:

A provider of dental services must be:

- Licensed to practice dentistry in the state where they practice; and*
- Enrolled as a NH Medicaid (dental) provider.*



Benefit Specifications and Qualifications form, continued

Name of Benefit or Service: **System of Care/F.A.S.T. Forward**

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

System of Care (SOC) services are provided for children and youth (to transition age) who are considered having serious emotional disturbances (SED) and are at risk for multi-agency involvement and require access to an enhanced services array and process. The following services are not currently covered by the State Plan and are proposed under the Building Capacity for Transformation Section 1115 Demonstration Waiver.

Wraparound team meeting participation:

Billing for participation in a child/youth's wraparound team meetings for both clinical providers and family and peer support provider, and other team members that may require resources to be able to participate.

Respite care:

Short- term, planned respite care out of home in either a licensed foster home, ISO level foster home or a residential group home, depending on the need of the child.

Flexible spending:

Flexible funds are available for enrolled SOC families. Flex funds are to be used as one-time payment for things that create barriers to accessing services and supports in the community or may cause a need for a higher level service if not addressed early.

Mobile Crisis Response:

Mobile Crisis Response is available for child/youth and families enrolled in the SOC. This service is a crisis response designed to be available to the child/youth and family 24 hours per day, 7 days a week. This mobile crisis response is intended to be delivered face to face at the family's home or other community location, where the crisis is occurring.

Crisis stabilization service as part of a mobile crisis response, is a short-term intervention provided in or outside the Youth's home and is designed to evaluate, manage, monitor, stabilize and support the youth's wellbeing and appropriate behavior consistent with the Youth's individual crisis/safety plan. The crisis stabilizer helps to insure the adherence of the youth and caregiver to the crisis/safety plan including helping the family recognize high risk behaviors, modeling and teaching effective interventions to deescalate the crisis, identifying and assisting the youth with accessing community resources that will aide in crisis intervention and/or stabilization. Group home child care worker experience preferred.

Mobile Crisis Response is initiated by a phone call from the family to the response team. The staff responding to the call should assess the immediate situation over the phone and determine if there



needs to be an emergency response by local police or an emergency evaluation done at the local emergency room for personal and community safety.

If an emergency response is not necessary, the staff person will need to assess the crisis over the phone and determine which part of the mobile crisis team is necessary to deescalate given situation. Some situations may be resolved over the phone, but this should not be the default response. The family should dictate if they need someone on site to help reduce the crisis.

Providers of Mobile Crisis Response must have a phone number that is staffed all hours, by Mobile Crisis Team. Mobile Crisis Teams can consist of the following types of staff;

- *Crisis stabilizer /behavioral aide service*
- *Licensed Clinician*
- *Psychologist*
- *Psychiatrist*

Wrap around facilitation/care coordination services will be covered by Medicaid when the System of Care implementation grant from SAMHSA expires in 2016:

This service will be standard for every child/youth and family participating in the System of Care. A care coordinator will be assigned to each child/ youth enrolled in the SOC.

A care coordinator must be in place for every child/youth/family that is open and receiving services through the system of care.

The Care coordinator assists the SOC child and family to access mental health, social services, educational information, and other services and supports that may be available in their community, and support the child/youth/family needs in meeting the needs and objectives of the Plan of Care.

Care coordination services include;

- *Assessment/evaluation of service needs*
- *Identifying team members involved with the child/youth*
- *Planning meetings*
- *Facilitate Wraparound meetings in accordance with the Model and Curriculum*
- *Support the child/youth and his/her family in meeting the needs and objectives in the Plan of Care.*
- *Developing a Plan of Care based on strengths and needs and that have a solution based focus, with the team*
- *Obtain and arranging for formal services from agencies in the SOC provider network or within the family's insurance network, and informal services in the community;*
- *Monitoring the Plan of Care and revising as needed;*
- *Ensuring that services from providers are being provided as called for in the Plan of Care by agencies that have agreed to participate in the Plan of Care;*
- *Providing educational materials to families;*
- *Collecting and reviewing wraparound team meeting participation stipend invoices;*
- *Advocating for the child/youth and family's needs; and*
- *Providing emergency interventions.*



Care coordination services are provided through face to face and telephone contact with the wrap around child/youth and family as well as significant family supports, and SOC providers involved with the Plan of Care and can be conducted anywhere in the community.

Care Coordinators/wrap facilitators should not be assigned more than 7 SOC families at a time.

Amount of Benefit/Service – Describe any limitations on the amount of service provided under the Demonstration:

Benefit Amount: Other, describe:

The amount or duration for each service listed is based on the needs of the youth and family served under the System of Care in order to avoid higher cost service systems such as psychiatric hospitalization and residential treatment. The SOC is intended to be a short term service system and on average should effectively serve children and youth for a period of 2 years. Within the service period access to the purchased services described here will not be limited and would be approved for each child or youth based on their current needs.

Each child/youth's wrap around team will be responsible for identifying the needs and then the purchased services that will meet those needs throughout the SOC service period.

Each purchased service described here will be prior authorized by System of Care administration. A prior authorization will be entered into the Medicaid billing system and the provider would then bill on a fee for service basis.

Respite care would be limited in use by families in planned way to provide periodic respite care during their service provision in the SOC. Respite care is a planned event and would be limited to 9 consecutive days per respite event.

Duration of Benefit/Service: Describe any limitations on the duration of the service under the demonstration:

Respite care will be approved for periodic use, throughout the family's SOC participation.

Flexible funding would be used for one-time payment for identified barriers and can be used more than once as different barriers are identified.

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

All services described for this benefit will be prior authorized by Administration and will be



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reviewed periodically. These services will also be part of the System of Care evaluation process. These services will fall under Managed Care once Step 2 of Medicaid Care Management is implemented in NH. Once part of Managed Care responsibility, services will still be prior authorized by SOC administration. An SOC Case rate based on full SOC service array should be established.

Provider Specifications and Qualifications

Provider Category(s):

☒ Individual (list types)

☒ Agency (list types of agencies)

The service may be provided by a:

☒ Legally Responsible Person

☒ Relative/Legal Guardian

Description of allowable providers:

- *Licensed Foster Care Homes-General Level*
- *Licensed and certified Child Placing Agencies- Therapeutic Level*
- *Licensed and certified Residential group homes*
- *Relative caregiver-General Level*

Specify the types of providers of this benefit or service and their required qualifications:

1. Provider Type: **Respite Care**

License Required: ☒ Yes ☐ No

Certificate Required: ☒ Yes ☐ No

Describe:

For providers that are not identified as Relative Caregivers to the child/youth, the providers for this service will be licensed under foster care licensing rules, Child Placing agency rules or residential group home licensing rules and certified for payment under DCYF certification for payment rules.

2. Provider Type: **Flexible funding**



License Required: ☐ Yes ☒ No

Certificate Required: ☐ Yes ☒ No

Describe:

Payments made directly to the family or other entity to alleviate barriers to access to care and community supports.

Other Qualifications required for this Provider Type (please describe): *None*

3. Provider Type: **Mobile Crisis**

License Required: ☒ Yes ☐ No

Certificate Required: ☒ Yes ☐ No

Describe:

Mobile Crisis Response Teams are comprised of the following providers;

- *Licensed Mental Health Practitioner- Master's level*
- *Licensed psychiatrist/and or psychologist, PhD, PsyD or MD.*
- *Behavioral Aide, Crisis Response Supervisor: BA or BS in mental health or social work practice;*
- *Behavioral Aide/Crisis Stabilizer: Paraprofessional with experience in Residential Group home work, meets qualifications for a Residential Group Home Child Care worker or Hospital Mental Health Worker.*

Other Qualifications required for this Provider Type (please describe):

- *Behavioral Aide, Crisis Response Supervisor: BA or BS in mental health or social work practice;*
- *Behavioral Aide/Mentor: Paraprofessional with experience in Residential Group home work, meets qualifications for a Residential Group Home Child Care worker or Hospital Mental Health Worker.*

4. Provider Type: **Wrap around participation/ Professional team members and natural support team members**

License Required: ☐ Yes ☒ No

Certificate Required: ☐ Yes ☒ No

Describe:

Other Qualifications required for this Provider Type (please describe):



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Qualifications for this payment are tied to the service the providers deliver as part of the SOC service array or the service in which they provide in the community. Qualifications are that they attend family team wrap meetings that they have been identified as a team member.

Natural supports do not require any specific qualifications, licensing or certification. This provider type needs to be identified as part of the child/youth's wrap around teams and attend meetings to qualify for this payment.



Appendix D: Public Notice

The State of New Hampshire Department of Health and Human Services (DHHS) as the single state Medicaid agency is seeking Section 1115 Demonstration Waiver authority to support the comprehensive reform of its Medicaid program. The initiatives proposed within this “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver will include improvements to the delivery of mental health, physical health, substance use disorder (SUD), oral health, and population health programs and services.

Overview

New Hampshire is requesting federal financial participation (FFP) for five proposed Designated State Health Programs (DSHPs) focused on improving the payment and delivery of population health programs, including mental health system reforms, oral health coverage for pregnant women and mothers of young children, and SUD workforce development.

To date, New Hampshire has taken several significant steps toward addressing the population’s needs in its overall approach to health care reform. New Hampshire is currently engaged in the comprehensive reform of its Medicaid program and its health care delivery system through its Medicaid Care Management (MCM) program. In addition to MCM, New Hampshire will be implementing an SUD benefit into its Medicaid program. With this addition, the State will be adding up to 60,000 newly eligible persons who will receive SUD treatment services into the system. New Hampshire is also currently implementing the New Hampshire Health Protection Program, which is the State’s program for expanding health coverage to childless adults under the Affordable Care Act (ACA). The final element of New Hampshire’s comprehensive reform of its Medicaid program focuses on mental health and addressing the goals of the State’s 10 Year Mental Health Plan. DHHS is positioning its “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver as an element of this broader health care reform strategy. To begin progressing towards its overall health care reform goals, DHHS is proposing five related Designated State Health Programs (DSHPs) within its “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver, which are described in more detail below.

To the greatest degree possible programs funded under the “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver will build capacity for mental health/SUD treatment and services, oral health related services, wellness programs, and workforce development opportunities. New Hampshire requests authority to recognize costs not otherwise matchable from local and state health expenditures to implement these programs. The freed up state and local funding would provide needed financial assistance to pursue meaningful delivery system reforms that will help improve the New Hampshire health care system in these outlined focus areas.

To implement these Medicaid reforms, DHHS intends to submit its “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application to the federal Centers for Medicare and Medicaid Services (CMS) for waivers under Section 1115 of the Social Security Act (42 U.S.C.A. §1315). New Hampshire



must ask for approval from CMS to “waive,” certain federal rules about the Medicaid program. “Waiving” means asking permission to do certain activities or provide services in a different way. Asking permission is achieved through an “1115 waiver” or “demonstration” application. It’s called an “1115 waiver” because Section 1115 of the Social Security Act allows states to request federal permission to waive certain Medicaid rules. To learn more about 1115 waivers, you can visit the CMS website at this URL:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>

Within its “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver, DHHS is seeking to improve access to quality, affordable health care by:

Encouraging hospitals, health systems, and non-traditional providers to build an integrated system at the local level by establishing a new mental health community reform pool that would reward providers for their active participation in system reform initiatives and their overall agreement to reform

Expanding community based mental health services for the State’s non-Medicaid population in accordance with the *Ten Year Mental Health Plan* and its settlement with the United States Department of Justice

Improving the service delivery of mental health and SUD services, especially in Emergency Departments, by offering financial resources for workforce development

Increasing access to dental services by establishing an pilot program and dental benefit for pregnant women and mothers of young children

Promoting healthy behaviors and improved health outcomes by expanding the InSHAPE program at hospitals, health systems, and non-traditional providers to additional populations – children and 1915(c) Developmentally Disabled Waiver enrollees – and to include smoking cessation classes as a component for adults

New Hampshire’s “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application requests federal approval for five years. DHHS seeks public comment on the proposed application. This notice provides the following:

- A description of the “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver and its associated DSHP programs
- Information on how to view the full “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application either by website or hard copy.
- Information on the public comment process through public hearings, mail and e-mail.

Public Input

DHHS posted its “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application on DHHS’s website so the public can read the waiver application. DHHS would like to hear your comments about the changes it is proposing to enhance the Medicaid program. After hearing the public’s ideas and comments about the proposed changes, DHHS will make final decisions about what changes to make to the “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver and then submit it to CMS. You can find the “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application at this website: <http://www.dhhs.nh.gov/section-1115-waiver/index.htm>. DHHS will update this web site



throughout the public comment and application process.

A hard copy of the “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application may be requested by contacting DHHS at the mailing address or e-mail address provided under the Public Comment section. Individuals should include their full name and mailing address when making a request.

The public comment period for the “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application is from **Monday, April 21, 2014** until **Tuesday, May 20, 2014 at 5 p.m. (Eastern)**. Comments received within **30** days of the posting of this notice will be reviewed and considered for revisions to the application. There are several ways to give your comments to DHHS on the application. One way is to attend public hearings that DHHS will hold to review its “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application. At the public hearing, you can give verbal or written comments to DHHS about the proposed programs. Two public hearings will be held at the dates/locations noted below.

Public Hearings

Two public hearings on the “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application have been scheduled to solicit input on the proposed enhancements to the Medicaid program. DHHS will accept verbal and/or written comments at the public hearings. The dates for the public hearings are Thursday, May 8, 2014 and Monday, May 12, 2014. The detailed information for each public hearing is shown below.

Thursday, May 8, 2014

Public Forum

Time: 4:30 p.m. to 6:30 pm (Eastern)

Location: New Hampshire Department of Health and Human Services

Division of Public Health Services Auditorium

29 Hazen Drive

Concord, NH 03301

If you are unable to attend the public hearing in person, you may participate by teleconference or webinar. To participate via teleconference (on the date and time of the public hearing) call 1-888-972-9247, and enter passcode 8376703. To participate via webinar during this public forum on May 8, 2014, please use the following URL:

<https://deloittemeetings.webex.com/deloittemeetings/j.php?MTID=mb8068a51cd2aa136852823b6273e8aa8>

and follow the instructions posted at this link.

- **Meeting Number:** 733 657 357
- **Meeting Password:** 1115waiver

Monday, May 12, 2014

Medical Care Advisory Committee (MCAC)

Open to the Public



New Hampshire Department of Health and Human Services

Building Capacity for Transformation Section 1115 Demonstration Waiver Application

Time: 1:00 p.m. to 3:00 p.m. (Eastern)

Location: New Hampshire Hospital Association
125 Airport Road
Concord, NH 03301

If you are unable to attend the public hearing in person, you may participate by teleconference or webinar. To participate via teleconference (on the date and time of the public hearing) call 888-972-9247, and enter passcode 8376703. To participate via webinar during this public forum on May 12, 2014, please use the following URL:

<https://deloittemeetings.webex.com/deloittemeetings/j.php?MTID=mdf1589c2686c52c7855233b5f9e3e172>

and follow the instructions posted at this link.

- **Meeting Number:** 736 812 494
- **Meeting Password:** 1115waiver

If you need any assistance with joining the webinar, please use the following URL:

<https://deloittemeetings.webex.com/deloittemeetings/mc> and on the left navigation bar, click "Support". To check whether you have the appropriate players installed for UCF (Universal Communications Format) rich media files, please visit URL: <https://deloittemeetings.webex.com/deloittemeetings/systemdiagnosis.php>.

Public Comment

The public comment period for the “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application is from Monday, April 21, 2014 until Tuesday, May 20, 2014 at 5 p.m. (Eastern). All comments must be received by 5 p.m. on Tuesday, May 20, 2014.

Requests for a hard copy of the “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application should be submitted by mail to:

New Hampshire Department of Health and Human Services
Attn: “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application
129 Pleasant Street
Concord, NH 03301

Another way to provide your comments is by emailing comments to 1115waiver@dhhs.state.nh.us or mailing written comments to the address above. When mailing or emailing please specify the “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application.

A hard copy of the “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver application can also be picked up at DHHS, which is located at:

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



Summary of the “Building Capacity for Transformation” Section 1115

Demonstration Waiver Application

Program Description, Goals and Objectives

This proposal outlines a Demonstration waiver under Section 1115(a) and cost not otherwise matchable authority (CNOM) of the Social Security Act that is designed to build on existing New Hampshire health care reforms and to enhance health care delivery in the State. While ensuring continued coverage for groups of individuals currently under the Medicaid and CHIP State plans, previous waiver programs, and previously state-funded programs, the State seeks to establish and enhance Designated State Health Programs (DSHPs) and improve the Medicaid care delivery system through this Demonstration. This “Building Capacity for Transformation” Section 1115 Demonstration Waiver will promote the improvement of overall health, will integrate and align New Hampshire’s Medicaid Care Management program, and will improve the quality of care and access to care for Medicaid and CHIP beneficiaries accessing mental health, SUD, oral health and/or wellness related services.

The overarching objective of the Demonstration is that implementation of the five DSHPs will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement. The State will test the following research hypotheses through this Demonstration:

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

DHHS will submit to CMS for approval an evaluation design for the Demonstration no later than 120 days after CMS approval of the Demonstration. The design and improvements made by each DSHP program will demonstrate that by spending Medicaid dollars differently, DHHS can provide better health outcomes for its Medicaid clients, and these outcomes will be defined and measured throughout the length of this Demonstration.

Proposed Health Care Delivery System Improvements

Descriptions of the five DSHPs are below.

1. DHHS proposes to establish a new mental health community reform pool that rewards hospitals, health systems, and/or non-traditional providers for their active participation in system reform initiatives and their overall agreement to reform.
 - Capacity-retention Payments



- A hospital would receive this payment if it pledged not to reduce access to mental health/SUD related services in their health system
 - Capacity-expansion Payments
 - If a hospital, health system, and/or non-traditional provider expands its capacity to provide mental health/SUD related services, DHHS would pay an enhanced rate for those services provided through the new “unit” for three years
 - New Service Payments
 - If a hospital, health system, and/or non-traditional provider adds inpatient or outpatient mental health/SUD related services, DHHS would pay an enhanced rate for those services for three years
 - Pilot Program Pool
 - Establish a pool for DHHS to fund grant applications from hospitals, health systems, and/or non-traditional providers to form pilots related to improving the delivery of physical health, mental health, and/or SUD treatments and services
 - Grant applications would be evaluated by DHHS based upon a defined set of criteria and will be aligned with DHHS’ incentive program with its MCOs to encourage payment and delivery reform
 - Hospital Incentive Pool
 - Establish a pool that would begin to provide financial incentives in Year 3 of the demonstration, based upon a hospital, health system, and/or non-traditional provider’s ability to meet defined outcome measurements
2. In addition to the mental health community reform pool outlined above, New Hampshire is requesting DSHP funding to help implement the components of its *Ten Year Mental Health Plan* and its December 2013 settlement agreement with the United States Department of Justice for the State’s non-Medicaid population.
 3. DHHS proposes a grant program that would fund training education and workforce development programs focused on SUD treatments and services in which hospitals, health systems, and/or non-traditional providers would apply and DHHS would administer.
 4. DHHS proposes to establish as a pilot, with a sound evaluation plan to demonstrate the impact on children’s oral health and improved birth outcomes of a program to provide oral health education and Medicaid coverage for dental treatment to women during pregnancy and up to the child’s fifth birthday.
 5. DHHS proposes to expand key components of the InSHAPE program. Specifically, this program would establish a funding pool to award grant applications from hospitals, health systems, and/or non-traditional providers to implement an InSHAPE program that (1) includes children as participants and (2) includes 1915(c) Developmentally Disabled (DD) waiver enrollees as participants, and includes a smoking cessation component for adults.



Impact to Eligibility Requirements, Benefit Coverage and Cost Sharing

New Hampshire is not requesting any changes in Medicaid program eligibility through this “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver. Therefore, there is no anticipated impact on total Medicaid enrollment as a result of these proposed DSHPs.

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

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

1115 Demonstration Financing and Budget Neutrality

Federal policy requires that section 1115 Demonstration applications be budget neutral to the federal government. This means that an 1115 Demonstration should not cost the federal government more than what would have otherwise been spent absent the 1115 Demonstration. Particulars, including methodologies, are subject to negotiation between the State and CMS.

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

- The baseline historical data will include 5 full years of New Hampshire Medicaid expenditures derived from CMS-64 reports and related enrollment data from calendar year (CY) 2008 – CY 2012
- The projected “without waiver” expenditures will reflect the following changes between the baseline and waiver periods:
 - Enrollment trends, reflecting any anticipated trend differences by eligibility category (e.g., low income children and families, Medicaid-only disabled, and dual eligibles)
 - Medical service trends
 - Impact of known program changes (e.g., the impact of the United States Department of Justice settlement on behavioral health services)
 - Excludes the impact of New Hampshire’s Medicaid Care Management program that was implemented on December 1, 2013
- The projected expenditures under the proposed Section 1115 Demonstration Waiver will reflect the following changes to the “without waiver” projections:



- Managed care savings resulting from the December 1, 2013 implementation of the Medicaid Care Management program for acute care services (i.e., “Step 1” services)
- Trend differences due to Medicaid Care Management program implementation
- The new financial impact of the proposed Designated State Health Program services included in the Section 1115 Demonstration Waiver

Fiscal Impact

This action will not result in a loss of revenue or an increase in State funds associated with the Medicaid program.

Federal Waiver and Expenditure Authorities Requested

CMS and the State will identify proposed waivers and expenditure authorities needed to implement this waiver. New Hampshire seeks federal financial participation for costs not otherwise matchable under Medicaid to enable New Hampshire to implement the DSHPs under its “*Building Capacity for Transformation*” Section 1115 Demonstration Waiver. Under the authority of Section 1115(a)(2) of the Social Security Act, expenditures made by the State for the items identified below, which are not otherwise included as expenditures under Section 3, 455, 1003, 1403, 1603, or 1903, shall, for the period of this demonstration, be regarded as expenditures under the Medicaid.

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



Appendix E: Public Comments Received and State Responses

Prior to submission of this Waiver application, New Hampshire had an extensive process for public input. The public notice and input process was consistent with the requirements outlined in 42 CFR Part 431 Subpart G. It should also be noted that many of the provisions included in this application grew out of the ongoing health reform dialogue in the State as outlined in *Section VIII – Stakeholder Engagement and Public Notice*.

Comments were received from the public from Monday, April 21, 2014 until Wednesday, May 21, 2014. The first section documents comments received via email or in writing. The second section documents testimony and comments provided at two public hearings.

Written Public Comments Received on *Building Capacity for Transformation* Section 1115 Demonstration Waiver

Below are comments received from the public by emailing 1115waiver@dhhs.state.nh.us or in writing.

Comment Received via Email from Michael Massiwer – Government Affairs Manager, Simon & Co., LLC

Date Received: 4/23/2014 at 11:58 AM
From: Michael Massiwer, Government Affairs Manager
Simon & Co., LLC
1331 G Street NW, Suite 910
Washington, D.C. 20005
(202) 204-4707
mmassiwer@mjsimonandcompany.com

Is it possible to get a copy of the waiver? I can only find a summary or "concept paper" but would like to review the details.

State's Response:

Thanks for your inquiry. A copy of the full draft waiver application was posted on the website <http://www.dhhs.state.nh.us/section-1115-waiver/index.htm> for public review and comment on Monday April 28th.

Additional Comment Received via Email from Michael Massiwer on 4/28/2014 at 12:24 PM:

Is the premium assistance waiver still expected to come out in October 2014?



State's Response:

The Premium Assistance Waiver is a separate waiver that relates to the implementation of the New Hampshire Health Protection Program and is not the same as this Section 1115 Medicaid Demonstration Waiver. If you have any questions regarding this Building Capacity for Transformation 1115 Waiver, we are happy to consider, but cannot comment on other efforts within DHHS. Thank you.

Comment Received via Email from keefitz@gmail.com

Date Received: 4/28/2014 at 11:21 PM
From: Anonymous at keefitz@gmail.com
Subject: NH needs this

NH needs to pass the 1115 waiver! Adequate services and improved care will decrease our expenditures and improve the mental and physical health of many of our sentences. Thank you!

State's Response:

Thank you for your comment on and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.

Comment Received via Email from Susan Paschell on behalf of Mary Duquette – President, New Hampshire Dental Hygienists' Association

Date Received: 5/06/2014 at 10:47 AM
From: Susan Paschell, Senior Counsel, Policy and Research
The Dupont Group
114 North Main Street
Suite 401
Concord NH 03301
603-228-3322 ext. 107
spaschell@dupontgroup.com

*Good morning -
Please find attached a letter from Mary Duquette, President of the NH Dental Hygienists' Association, in support of the 1115 waiver application. A hard copy of the letter will also be sent to you for the file.*



New Hampshire Department of Health and Human Services

Building Capacity for Transformation Section 1115 Demonstration Waiver Application

*Thank you for your consideration -
Susan Paschell*



Commissioner Nicholas Toumpas
NH Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301

Via email: 1115waiver@dhhs.state.nh.us

May 5, 2014

Dear Commissioner Toumpas:

The NH Dental Hygienists' Association wishes to register strong support for the Oral Health Pilot Program proposed in the Section 1115 Demonstration Waiver application prepared by your Department for submission to CMS. NHDHA was a proponent of the Medicaid expansion legislation (SB 413) that led to the waiver application and associated state plan amendments, and we are extremely pleased and heartened that the proposal includes this critical element.

The intent of the Affordable Care Act is to increase access to care and address the rising costs of health care. Although the federal health care reform law does not recognize oral health care as an essential benefit for adults, it is considered essential for children. Adding this Medicaid benefit for pregnant women and mothers of children under age 5 will help many New Hampshire uninsured citizens who lack access to oral health care and now must resort to hospital emergency rooms for their untreated dental problems.

NHDHA believes that Medicaid expansion, which will increase overall health coverage for uninsured, poor adults, is a solid first step toward improving public health in our state. The proposal for a pilot program for oral health care for pregnant women may mark the beginning of a new movement in New Hampshire to add a dental benefit to Medicaid coverage for all eligible adults. We need to start moving toward a system that finally treats oral health as part of our total health.

Thank you for your work on the Medicaid waiver and your commitment to this effort.

Sincerely,

Mary Duquette, President
NHDHA Board of Trustees
info@nhdha.org



State's Response:

Thank you for the comment and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.



Comment Received via Email from Joan Fitzgerald – Former President of the New Hampshire Dental Hygienists' Association and serves on Board of Trustees of the American Dental Association

Date Received: 5/08/2014 at 11:39 PM

Proposed NH Medicaid Innovations Waiver - Public Hearing - May 8, 2014

Good afternoon,

My name is Joan Fitzgerald and I am a practicing dental hygienist, Past President of the NH Dental Hygienists' Association and currently serve on the Board of Trustees of the American Dental Hygienists' Association. I know from my many years of leadership and health policy advocacy, that we cannot solve tomorrow's problems with yesterday's solutions. I commend the NH Department of Health and Human Services for proposing the initiatives within the "Building Capacity for Transformation" Section 1115 Demonstration Waiver as forward thinking programs that serve the whole person with a focus on wellness and prevention and just makes sense for New Hampshire.

I support the draft Waiver's proposed Oral Health program for pregnant women and mothers of children up to age 5, because oral health care for pregnant women has been shown to reduce adverse pregnancy outcomes, including pre-term (premature) and low birth-weight babies as well as reduce the transmission of dental disease from mothers to children. Oral health coverage for mothers up to the age of 5 also provides Moms and kids with a meaningful opportunity for access to essential dental care to stay healthy.

I'm pleased to see a component of the Oral Health program include smoking cessation. According to the Surgeon General's Report on The Health Consequences of Smoking, smoking remains the leading cause of preventable death and has negative health impacts on people of all stages of life. It harms unborn babies, infants, children, adolescents, adults and seniors. There may be no better time to intervene and have a successful quit attempt than when a mother is carrying her unborn child. My experience working in collaboration with oral health stakeholders and community health professionals on developing and implementing a professional workshop for Oral Health Providers, "Motivating Patients to Quit Tobacco", taught me that oral health providers can play a key role in identifying and enrolling their patients in smoking cessation.

I'm confident that this oral health program will demonstrate a positive measurable outcome for pregnant women and their young children, the ripple effect of which could last a lifetime, even generations! These initiatives will go a very long way toward reducing the overall burden of disease on the citizens of our state.

Thank you for proposing this important benefit and demonstration program. I also will be conveying the strength of my support for this proposed measure/program to members of the legislature's Joint Fiscal Committee and to CMS.

Sincerely,

Joan

Joan Kenney Fitzgerald, RDH, BS, CPHDHc
69 Lancelot Avenue
Manchester, NH 03104-1419
Mobile: 603-493-4723
Email: joankf@comcast.net



State's Response:

Thank you for the comment and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.

Comment Received via Email from Kenneth Jue – Ken Jue & Associates and creator of the InSHAPE program

Date Received: 5/12/2014 at 9:08 AM

From: Kenneth Jue

23 Ridgewood Avenue

Keene, NH 03431

(603) 903-3323

ken@kenjue.com

To Representatives of the New Hampshire Department of Health and Human Services,

I have attached testimony offered for the May 12, 2014 public hearing on the proposed “Building Capacity for Transformation” Section 1115 Demonstration Waiver Application.



TESTIMONY related to Dental Care for Pregnant Women and their Children Program for Public Hearing, May 12, 2014, on the "Building Capacity for Transformation" Section 1115 Demonstration Waiver Application, submitted by Kenneth Jue, 23 Ridgewood Avenue, Keene, NH 03431

As a member of the Board of Directors of a community-based non-profit (501c3) dental practice named Dental HealthWorks established in 2003 in Keene, NH I would like to present this testimony to support addressing the needs of pregnant women, their newborns and any of their other young children. This attractive and busy practice was established by a collaborative of health and human service community organizations and institutions and a group of local dentists to address a significant need for dental care in Cheshire County for underserved populations. The primary target populations served by this practice are persons who are low-income, have a demonstrated disability (i.e., developmental disability, serious mental illness), Medicaid insured, including children and youth on Medicaid, and the uninsured. The practice is also open to providing dental care to the general public. The staff includes a team of dental professionals led by a full-time dentist/executive director, a part-time dentist, five or six dental hygienists and dental students from Boston University School of Dentistry. The Endowment for Health, Concord, NH provided a substantial grant to help establish this much needed community service.

Each year Dental HealthWorks treats hundreds of people from Cheshire County. The revenues of the practice are diverse coming from a combination of Medicaid insurance, private insurances, a few small periodic donations and modest payments from a cluster of community agencies. It is financially strong and has been so for a number of years. Several years ago the practice purchased its previously leased space and building and then increased its dental service volume. The practice also provides Cheshire Smiles, which is a preventative dental cleaning and education program initiated by Cheshire Medical Center, to a significant number of children in preschools and the public schools in the Monadnock Region. The Board of Directors and the staff believe firmly in preventative care, thus, this function is appropriately staffed to represent this part of our service to the community. Although I cannot speak on behalf of the full Board of Directors of Dental HealthWorks, I wish to whole-heartedly support this 1115 Demonstration Waiver and believe that it is very important to provide dental education and care to pregnant women and their children, especially to those on Medicaid and with inadequate personal financial resources. Practices, such as Dental HealthWorks can be an important and helpful partner, if the waiver is approved.

5/12/2014

Kj

State's Response:

Thank you for the comment and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.



Additional Comment Received via Email from Kenneth Jue – Ken Jue & Associates and creator of the InSHAPE program

Date Received: 5/12/2014 at 2:16 PM

To Representatives of the New Hampshire Department of Health and Human Services,

I am resending this testimony regarding the expansion of the InSHAPE program to children and youth with serious emotional and behavioral disturbances and to persons with a developmental disability. I discovered that I had not included my full address in the testimony and have included it now in this revised version of this testimony.

*Thank you,
Kenneth Jue*



TESTIMONY on the InSHAPE Program for Public Hearing, May 12, 2014, on the "Building Capacity for Transformation" Section 1115 Demonstration Waiver Application, submitted by Kenneth Jue, MSSA, Principal Consultant, Ken Jue Consulting, Keene, NH and creator of the InSHAPE program

I strongly believe that the InSHAPE program is a very effective model in serving special populations and that it can effectively benefit children and youth with serious emotional and behavioral disturbances and persons with developmental disabilities. It is currently helping persons across our State of New Hampshire experiencing the most serious mental illnesses to improve their lifespan which is 25-30 years shorter than the average lifespan of other American citizens. It has been studied here in New Hampshire since 2003 by the Dartmouth Center for Health and Aging. Each completed study adds evidence to the programs efficacy and benefits to these individuals. Presently, a statewide study in our state is further testing the efficacy of the model and how additional components can increase and enhance the health benefits for Medicaid populations experiencing a broad range of mental health issues and problems. In addition to replications of the InSHAPE program here in New Hampshire, InSHAPE has been replicated by community mental health agencies in the states of Michigan and Texas, and in the cities of Pittsburgh, Pennsylvania and Providence, Rhode Island. Each of these agencies is evaluating and studying the health effects and benefits for their clients who are experiencing serious mental illnesses. Thus, far they are seeing significant improvements in the health status of those clients enrolled in InSHAPE. These agencies have expressed their great satisfaction with having implemented the program. I am not aware of any other on-going health improvement program in the country targeted for special populations that is undergoing the extensive study and evaluation as is the InSHAPE program and which is demonstrating such positive results.

Why was the InSHAPE program created? As a former chief executive of Monadnock Family Services in Keene, New Hampshire, I created the InSHAPE program in 2003 for the agency in order to address and attack the lifespan gap crisis that has befallen adults with serious mental illness in our community, our state and our nation. People experiencing a serious mental illness, such as schizophrenia, major clinical depression or serious bi-polar disorder, are disproportionately dying at younger ages than the general population. The lifespan disparity or gap for these individuals is 25-30 years shorter than the normal expected lifespan in the United States. Cardio-vascular disease, diabetes, metabolic syndrome, respiratory or pulmonary issues and high blood pressure are the primary health conditions that are leading to the premature deaths of these persons. However, not only are they living with these co-morbid life threatening conditions, they experience significant disparity in access to essential societal resources. They are generally not welcome patients in primary care clinics or other medical services, at community fitness facilities or recreation centers and in numerous other societal institutions and organizations. To make things worse, their levels of unemployment are 10 times that of the general population, thus most are low income; they live in sub-standard housing and have low levels of education. They have poor access to healthy foods, so that lack of a healthy diet is another major problem that contributes to their overall poor health status. Finally, they suffer from significant social discrimination. These factors all contribute to their shorter lifespan.

What is the InSHAPE program? The InSHAPE program is intended to be a person-centered and individual recovery-focused initiative to address the above problem and needs. Each InSHAPE



participant is urged and supported to take charge and to define their personal health aspirations and goals. InSHAPE participants identify and direct their own health plans and choose their own goals. (Control is a positive health impact factor.) Thus, each participant is encouraged to take responsibility for their own health status and health status improvement. The InSHAPE program firmly advocates that all health creation activities that a participant identifies and selects should take place in mainstream community settings, not in a mental health agency or other mental health institution. This promotes social inclusion, and community social inclusion is another proven and well understood factor that contributes to building positive health status. The InSHAPE program seeks to improve the quality of life of its participants and to help them commit to making significant and lasting behavioral lifestyle changes through engagement in and with their communities. This approach can help to reduce the discrimination that is faced by persons experiencing a mental illness.

The core components of the InSHAPE program include:

1. The Individual InSHAPE Health Plan contains fitness goals, healthy eating goals and, possibly, for those participants who smoke, smoking cessation interventions, and sobriety for those abusing or mis-using substances, such as alcohol and other drugs.
2. Health Mentors are the core staff of the program and are all certified personal trainers, who work closely with each participant and fulfill the roles of health consultant, trainer, educator, facilitator, advocate and cheer leader.
3. Routine and ready access to primary care.
4. Community Partnerships, which may include small or large businesses, fitness facilities, nutrition education and medical providers, are part of the heart of the program.
5. Community Engagement and Social Inclusion strategies.
6. Smoking cessation

Common health issues for program participants include: substantial overweight, obesity, cardio-vascular complaints, chronic pain, poor balance and a history of falling and broken bones, chronic dental issues, diabetes, sleep disorders, respiratory issues and incontinence.

A few of the findings from the on-going studies conducted by the Dartmouth Medical Center's Center for Health and Aging include:

1. The Health Mentor relationship is highly valued by successful program participants and credited by these program participants with their individual progress and success.
2. Improved cardio-vascular status
3. Improved (-) symptoms related to mental illnesses of the participants being studied.



4. A significant number of participants experience significant to moderate weight loss and/or make other changes in their lives, by changing their diets, finding employment or returning to school or college.

What do InSHAPE participants say about the program and their participation in it?

"Today I go to the gym three times a week. I meet wonderful people."

"InSHAPE has literally saved my life. It gave me hope.....I suffer from depression andfeelings of worthlessness. It has given me new life."

"I have been given a gift (InSHAPE). I have several diagnoses (chronic depression, personality disorder, PTSD). I have made changes because of InSHAPE."

"If I can lose this weight, I can do anything. (Dahna just started a new job.) When I'm working and healthy, I feel my best."

Other thoughts shared by participants about their experience with InSHAPE refer to how InSHAPE is changing many of their lives, but that many of the participants reach the recognition that it takes hard work and much effort to turning their poor health status around. Becoming fit and staying fit is very hard work. Eating healthy is a major challenge, given the limited economic resources of the large majority of InSHAPE participants. However, participants report that they are able to do things they did not think they could ever do (i.e., leave their homes and interact with strangers in fitness centers, attend cooking classes, participate in swimming classes, etc.). Participants feel more energetic in the pursuit of their daily goals and activities, report that they sleep better and feel more rested in the mornings.

In conclusion, InSHAPE appears on the surface to be a combination of common sense strategies, but it is really a carefully constructed and woven set of beliefs and processes for building major health improvements, and not only a weight loss initiative, although weight loss is important in combating the co-morbid health conditions of these participants. InSHAPE is a program intended to improve the overall quality of life for persons experiencing a serious mental illness and to help them make major behavioral lifestyle changes. It is a program that underscores and represents the aims of this demonstration waiver, as it promotes consumer direction through the person-centered and recovery-focused philosophy and processes embodied in the program. It promotes and strengthens linkages and access to acute care medicine and to other community resources as described in the waiver application.

The program philosophy can be applied and the core components can be adapted to the needs of children and adolescents with serious emotional disturbances and to the needs of the developmentally disabled population. It can help these children and youth avoid and can prevent a future serious health disparity in adulthood. We have already begun a local community planning process in the Keene area to adapt the program for these children and youth with an interagency group of community organizations led by the local community mental health center, Monadnock Family Services, in Keene, New Hampshire. New and additional community interagency and cross-sector partnerships have already been forged to serve these young people in creative and innovative partnerships. Similar to the



adult InSHAPE program, we will develop a program implementation manual in the coming months. A similar planning process could be initiated to effectively adapt the InSHAPE program to serve persons with a developmental disability following the completion of the planning process for children and youth and the approval of this waiver application. This population of persons also needs a substantial health improvement initiative, as they are similarly subject to the many risks experienced by persons with a serious mental illness. It is my hope that this waiver application will be accepted and approved by the Center for Medical Services, as it will greatly enable and facilitate the adaptation of this program to address the circumstances of these additional populations in our state.

5/12/2014

kj

State's Response:

Thank you for the information on InSHAPE and supporting the Demonstration Waiver.

Comment Received via Email from Sarah Mattson – Policy Director, New Hampshire Legal Assistance

Date Received: 5/13/2014 at 9:36 AM
From: Sarah Mattson, Esq., Policy Director
New Hampshire Legal Assistance
117 North State Street
Concord, NH 03301
(603) 223-9750, ext. 2803
smattson@nhla.org

Dear Jeff,

Thank you for the opportunity to submit questions related to the draft application. I reiterate NHLA's support for the oral health pilot project. I am writing to ask a question about how it would be structured. On page 24 of the draft application, it says that "women who participate by meeting certain compliance goals" will receive dental benefits. I am wondering if women who fail to meet the compliance goals will have their dental benefits terminated. If so, what plans does the Department have to build in good cause exceptions (e.g., one of the compliance goals listed is taking a child to a dental checkup beginning before age one; what



would be the result for a mother who can't find a dentist – or can't get to one – who can see the infant?). Also, would participants have the opportunity to remedy failure to complete a compliance goal prior to having benefits terminated?

I look forward to your response. Thank you for your work on this important program.

State's Response:

The narrative in the waiver application has been revised to emphasize that rewards and incentives would be provided to women and children who meet certain performance criteria developed by DHHS. These performance criteria are not tied to women's eligibility or access to the dental benefit. It is a standalone component of the proposed pilot to offer incentives to motivate participation and compliance with a dental prevention and treatment plan for mothers and their children.

All women who participate in the oral health pilot program will be required to participate in a related evaluation study. Experience of participants will be compared with non-participants and historical Medicaid claims' data to evaluate the differences between those who fully participate in a comprehensive oral health program and those who are offered paid dental benefits, but do not participate in obtaining routine oral health care, including smoking cessation. The outcomes to be compared will include such variables of experience as: positive birth outcomes, use of dental services to treat urgent and emergent dental conditions of the parent, use of Emergency Department services for dental complaints, use of early dental services by the children, severity of dental disease, and decay experience as reflected by the children's dental claims. Assignment to status of "Participant" or "Non-Participant" will be based on retrospective review of performance relative to criteria to be established: i.e., whether an individual followed through with making/attending regular and treatment appointments, attended smoking cessation treatment, and sought dental care for children prior to age one.

Thank you for supporting the Building Capacity for Transformation Section 1115 Demonstration Waiver.

Comment Received via Email from Dianne Pepin – Executive Director, New Hampshire Alcohol & Drug Abuse Counselors Association

Date Received: 5/19/2014 at 12:46 PM

From: Dianne Pepin, MEd., MLADC, Executive Director

New Hampshire Alcohol & Drug Abuse Counselors Association

New Hampshire Training Institute on Addictive Disorders

130 Pembroke Road, Suite 100

Concord, NH 03301

nhtiad@gmail.com



The NH Alcohol & Drug Abuse Counselors Association would like to submit for consideration the following comments in response to the Draft Building Capacity for Transformation Section 1115 Demonstration Waiver. It is attached in both Word and PDF formats.



New Hampshire Alcohol & Drug Abuse Counselors Association
New Hampshire Training Institute on Addictive Disorders

130 Pembroke Road, Suite 100
Concord, NH 03301
www.nhadaca.org

(603) 225-7060 phone
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nhtiad@myfairpoint.net

May 17, 2014

Jeffrey A. Meyers, Director
Intergovernmental Affairs
NH Department of Human Services
Concord, NH 03301
1115waiver@dhhs.state.nh.us

Dear Mr. Meyers,

The NH Alcohol & Drug Abuse Counselors Association would like to submit for consideration the following comments in response to the Draft *Building Capacity for Transformation* Section 1115 Demonstration Waiver.

We would like to applaud the work and significant efforts put forth in the review and writing of the draft section 1115 demonstration waiver. We agree and appreciate the recognition of the need to enhance health care delivered in NH and the focus identified of improving and expanding alcohol and other drug service delivery. We concur with the identified critical need to increase the delivery of substance use disorder (SUD) treatment with community providers in hospitals, health systems, community mental health centers, federally qualified health centers and rural health clinics. With the advent of Medicaid expansion, building the substance use disorders workforce is increasingly imperative. As licensed professionals in the substance abuse profession we have observed these areas of need for a very long time and find the prospect of change and improvement both refreshing and quite hopeful. We strongly support the Designated State Health Program (DSHP) that seeks to *"Establish a grant program that would fund training education and workforce development programs focused on SUD treatment and services."*

The state plan for reforming the mental health system is prominently mentioned in the introduction of the goals of, and background for, the waiver. We encourage the committee to mention as well as examine and incorporate the March 2013 strategic plan, *Collective Action – Collective Impact: New Hampshire's Strategy for Reducing Alcohol and Other Drug Misuse and Promoting Recovery*, a publication of the New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention, and Treatment. This document may provide insight, guidance and support for the DSHPs identified in the Section 1115 Demonstration Waiver. Given that the application is the road map of what will be funded by the waiver process, alignment with the NH substance abuse strategic plan is important.



We also believe it essential to suggest language be added in relation to curriculum components that include those that specifically identify programs such as:

- Screening, Brief Intervention and Referral to Treatment (SBIRT);
- Substances Misuse and Abuse Trends; and
- Navigating the SUD Provider Network.

We have often found that medical providers in primary care settings, hospitals and emergency rooms have not asked the addiction related questions due to a lack of information, an absence of understanding of what to do with the information that is received, and not knowing where to refer their patients for treatment services.

As the profession most experienced, trained and educated in substance use disorders, we stand ready to work with the Department of Health and Human Services, as well as the medical and mental health systems, to ensure that the goals identified in the Draft *Building Capacity for Transformation* Section 1115 Demonstration Waiver will be accomplished.

If you have any questions please feel free to contact us at nhtiad@gmail.com; (603) 225-7060 or (603) 724-7520.

Respectfully,

Dianne Pepin, MEd, MLADC
Executive Director

Peter DalPra, LADC, LCS
President

State's Response:

This Demonstration Waiver aligns with the objectives of the March 2013 strategic plan, Collective Action – Collective Impact: New Hampshire's Strategy for Reducing Alcohol and Other Drug Misuse and Promoting Recovery. The narrative for the Demonstration Waiver has been revised to reference this publication from the New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention, and Treatment.

The narrative for the Demonstration Waiver has been revised to include the following as potential curriculum components for behavioral health workforce development:

- Screening, Brief Intervention and Referral to Treatment (SBIRT);
- Substances Misuse and Abuse Trends; and
- Navigating the SUD Provider Network.

Thank you for the comment and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.



Comment Received via Email from Maggie Pritchard – Executive Director, Genesis Behavioral Health

Date Received: 5/19/2014 at 1:29 PM

From: Maggie Pritchard, Executive Director

Genesis Behavioral Health

111 Church Street

Laconia, NH 03246

603.524.1100 x134

603.528.0760 (fax)

mpritchard@genesishbh.org

www.genesishbh.org

Just wanted to be sure my thoughts on adding a little something to the waiver (my theory being if you are asking the Federal Government to recognize some of the NH specific efforts and challenges and how they can help...why not)

Medicare – says the if a therapist is not independently licensed (as an LICSW or APRN or PHD or MD) they cannot bill for their services unless there is a licensed person in the same “suite of offices” under which they can then bill “incident to” ... it translates to cmhc(s) making the choice to cancel patients appointments or deliver the service and eat the cost... Medicare CMS recognizing telehealth services such that if a psychiatrist sees a patient face to face on video for a covered service they pay for that service ...I would ask that if a center has the ability to have a doc face to face for a patient but not in the suite (say Plymouth doc is out sick Laconia doc is in and can be “beamed in”) the agency should be able to see the patient as planned and be paid as that doctor is clearly fulfilling the need of “incident to” I would further state that NH being such a rural state it is impossible for North Country in particular to have physician in Berlin Littleton Lancaster and Gorham No Conway and Wolfeboro on any given dayit makes no sense to deny patients services nor does it make sense for the centers to not be paid for a service they rendered .

Retention of beds issue again there are far too few 24 hour beds available in cmhc's (previously referred to as group homes) and those that are left should be part of the retention efforts this cmhc system has been decimated over the years and we must try to stop it.

The bricks and mortar reward for new beds ...just want to make sure that if the RFP for the APRTP came out last month but is not scheduled to be on line til July 15 that it could qualify as new...otherwise we should think about the timing.

Finally please verify the State Prison and County Corrections spend included MH / SA spends



...keeping in mind the state has a contract with a for profit entity for psychiatry I am concerned the captured spend was not all inclusive.

Thank you for your thoughtful consideration of these points. Good Luck with the waiver...keeping my fingers crossed.

State's Response:

The narrative for the Demonstration Waiver has been updated to include telehealth as potential pilot programs under the community reform pool. DHHS will consider reviewing "incident to" billing for psychiatrists outside of this Demonstration Waiver process.

The narrative for the Demonstration Waiver has also been revised to include CMHCs as eligible for the capacity-retention payments under the community reform pool if the CMHC pledges not to reduce access to mental health and/or SUD related services.

Funding for capacity expansion payments under the community reform pool will be made available as soon as the Demonstration Waiver and implementation is approved by CMS.

DHHS has verified the Counties Correctional Medical/Health Spending and Department of Corrections SFY 2015 Biennial Budget shown in Appendix A.

Thank you for supporting the Building Capacity for Transformation Section 1115 Demonstration Waiver.

Comment Received via Email from Michele Merritt – Policy Director, New Futures, Inc.

Date Received: 5/19/2014 at 4:49 PM
From: Michele D. Merritt, Esq., Policy Director
New Futures, Inc.
10 Ferry St. – Suite 307
Concord, NH 03301
Tel: (603) 225-9540 Ext. 109
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mmerritt@new-futures.org

Attached please find written comments by New Futures and the NH Providers Association on the 1115 Demonstration Waiver.



newfutures →

advocate • educate • collaborate
to reduce alcohol and other drug problems in New Hampshire



THE
NH PROVIDER
ASSOCIATION

May 19, 2014

Commissioner Toumpas
Office of the Commissioner
NH Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301

Re: 1115 Demonstration Waiver Comment

Dear Commissioner Toumpas:

New Futures and the New Hampshire Alcohol and Other Drug Service Providers Association (NH Providers Association) appreciate the opportunity to comment on the Draft 1115 Demonstration Waiver to be submitted to the Centers for Medicaid Services by the NH Department of Health and Human Services.

New Futures is a nonpartisan, nonprofit organization that advocates, educates and collaborates to prevent and reduce New Hampshire substance abuse problems. New Futures envisions a State and local communities where public policies support prevention, treatments and recovery oriented efforts to reduce alcohol and other drug problems.

The NH Providers Association works specifically for providers in the substance abuse profession. The NH Providers Association works for providers by advocating, facilitating and communicating with funders, policymakers and the public to ensure high quality substance abuse prevention, treatment, intervention and recovery support services are available for the citizens of New Hampshire.



For the past decade, New Futures and the NH Providers Association have worked diligently to ensure the citizens of New Hampshire have access to quality behavioral health services. New Futures and the NH Providers Association were overjoyed by the recent passage of the New Hampshire Health Protection Plan (NHHP), which will expand access to substance use treatment to approximately 7,000 New Hampshire residents.

With the passage of the NHHP, the NH Department of Health and Human Services (the Department) was tasked with creating a service array for the new Substance Use Disorder (SUD) benefit. The Department recommended a comprehensive and robust SUD service array, which, if passed, will ensure the residents of NH have access to high quality SUD care and treatment.

Given the small size of the existing SUD provider network in New Hampshire, the 1115 Demonstration waiver provides a critical opportunity for building and expanding New Hampshire's SUD provider network. With that in mind, we offer the following comments.

Capacity Retention Payments

The draft 1115 Demonstration waiver proposes to provide incentives to hospitals who pledge not to reduce their mental health or substance use disorder related services. This payment would be approximately 10% of the hospital's existing Medicaid claim payments for mental health and/or substance use related services, based on previous years.

Given the pressing need to establish a parity compliant SUD benefit, New Futures and the NH Providers Association urge the Department to consider offering an enhanced payment for SUD providers who also pledge to retain their treatment capacities. Offering an enhanced match would not only help SUD providers remain operational during the period of transition to Medicaid, but it would also encourage SUD providers to accept Medicaid patients. New Futures recognizes that the enhanced match for SUD providers would not be able to be calculated in the same manner as the match for hospitals, as many providers have not previously billed Medicaid. As an alternative, we would suggest setting an enhanced match at 10% of the fair-market value of the services rendered by each SUD provider.

Pilot Program Pool- Integrated Care

The proposed 1115 Demonstration waiver includes the creation of a "pilot program pool," which would allow the Department to fund grant applications from hospitals, health systems and community providers to create pilots related to improving the delivery of physical, mental and behavioral health services. Integrating physical, mental and behavioral health care allows for the coordination of care between providers and reduces healthcare costs. Integrated care models have been recommended to the Department by the Governor's Commission on Managed Care¹ and numerous stakeholder groups. The Federal Government also encourages the use of

¹ See Governor Hassan's Commission on Managed Care, Recommendation 3, April 3, 2014. Available at <http://www.governor.nh.gov/media/news/2014/documents/mm-04-03-2014-recommendations.pdf>



integrated care and offers an enhanced match under the Affordable Care Act (ACA) for states who adopt a “Section 2703 Health Home” service delivery system. New Futures strongly recommends that the Department consider obtaining this federal match by filing a State Plan Amendment, as these federal funds will provide further support of integrated healthcare in New Hampshire.

New Futures understands that, under the ACA, the federal match expires after four quarters and we appreciate the Department’s concerns about funding a health home system after the federal match expires; however, we would argue that the State of New Hampshire is already obligated to provide the minimum requirements for an ACA compliant health home under federal parity law and the NHHPP.² A state plan amendment adopting a health home model would not only capture federal dollars for services New Hampshire is already required to provide, but will ultimately lead to a significant cost-savings for the State.³

Substance Use Disorder Workforce Development

The third priority identified by the Department in the 1115 Demonstration Waiver is the creation of a strong SUD workforce. To promote the creation of a strong workforce, the Department hopes to fund a grant program which will distribute funding to hospitals, health systems and community providers who administer SUD training and educational programs. New Futures and the NH Providers Association strongly support this section of the waiver; however, New Futures and the NH Providers Association strongly recommend that institutes and professional organizations be eligible to apply for grant funding and administer trainings. In fact, the New Hampshire Training Institute on Addictive Disorders (NHTIAD) currently provides training and professional development opportunities for SUD providers; permitting institutes like NHTIAD access to grant funding would allow for further expansion of their curriculums to meet the State’s needs under this waiver.

Integration of the Children’s Behavioral Health Plan

As a final note, New Futures strongly recommends the incorporation of the Children’s Behavioral Health Plan (CBHP) under the mental health reform section of the 1115 Demonstration Waiver. In March 2013, the Children’s Behavioral Health Collaborative released a comprehensive plan for the transformation of children’s behavioral system in New Hampshire. By incorporating the CBHP into the 1115 waiver application, the State of New Hampshire may be able to secure much needed funding which would support the CBHP’s implementation.

² See Takach, Mary et al. *Developing and Implementing Section 2703 Health Home State Option: State Strategies to Address Key Issues*, National Academy for State Health Policy, July 2012. Available at http://nashp.org/sites/default/files/health.home_state_option.strategies.section.2703.pdf

³ See generally *Id.*



Thank you for the opportunity to submit these comments. New Futures and the NH Providers Association look forward to working together with the Department to ensure the successful implementation of the New Hampshire Health Protection Plan and its associated programs.

Sincerely,

Linda Saunders Paquette, Esq.
Executive Director
New Futures

Michele D. Merritt, Esq.
Policy Director
New Futures

Abigail Shockley, MPH
Executive Director
NH Alcohol & Other Drug Service Providers Association

State's Response:

There are numerous initiatives proposed in the Waiver addressing health care challenges faced by SUD providers. For example, SUD providers are eligible to submit proposals and budget requests for workforce development. Also, SUD providers are included as eligible providers for the capacity expansion and new services payment pools within the community reform pool. At this time, DHHS decides to not include SUD providers as eligible providers for the capacity retention payment pool. There is little to no Medicaid claim expenditures or experience with the new SUD benefit for the



NHHP population to calculate or project capacity retention payments for SUD providers.

Health homes are potential pilot programs under the community reform pool. Any State Plan Amendments will be developed outside this Demonstration Waiver process.

The narrative for the Demonstration Waiver has also been revised to include professional associations as eligible to submit grant proposals for behavioral health workforce development. Criteria for interested parties will be drafted and shared when the application process begins

Based upon public comment, the efforts of the Children's Behavioral Health Collaborative and its Children's Behavioral Health Plan, as well as the System of Care/F.A.S.T. Forward service array are now incorporated into the Waiver.

Thank you for the comment and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.

Comment Received via Email from Gail Brown – Director, New Hampshire Oral Health Coalition

Date Received: 5/20/2014 at 12:18 PM
From: Gail T. Brown, J.D., MSW, Director
New Hampshire Oral Health Coalition
#4 Park St., Suite 403
Concord, NH 03301
603-415-5550
gbrown@nhoralhealth.org

Thank you for the opportunity to provide both oral and written comments regarding this proposed waiver. See attached 4 documents.

- *“Building Capacity for Transformation” Section 1115 Waiver Comments from NH Oral Health Coalition*
- *Oral Health care During Pregnancy: A National Consensus Statement. Summary of an Expert Workgroup Meeting*
- *A Costly Dental Destination: Hospital Care Means States Pay Dearly*
- *Improved Health and Lower Medical Costs: Why good dental care is important*



May 20, 2014

"Building Capacity for Transformation" Section 1115 Waiver Comments

Kathleen Dunn, Director, Medicaid Program
Brown Building
NH Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

Dear Ms. Dunn:

The New Hampshire Oral Health Coalition is a diverse group of organizations, agencies, and individuals, concerned about the impact of oral health issues facing New Hampshire. This group is broadly representative of those involved in oral health provision, planning and funding including the dental and medical communities, the legislature, educational programs, advocacy groups, insurance providers, state agency leaders, and private funders.

Established in 2002, this critical public initiative convened by the Endowment for Health and the New Hampshire Department of Health and Human Services as the Coalition for New Hampshire Oral Health Action published the New Hampshire Oral Health Plan: A Framework for Action to provide structure and vision for oral health advancement in New Hampshire. Maintaining the spirit of the plan as a "living document" the Coalition continues to work toward its vision of *optimal oral health for the residents of New Hampshire*.

Key Principles

- Dental decay is the #1 chronic disease in children both in NH and in the nation;
- Decay is caused by bacteria that is easily passed from caregiver to child by the sharing of eating utensils, mother cleaning a pacifier with saliva, and direct contact. Thereby cavities in young children can be prevented in part by reducing bacterial transfer from the caregiver;
- Pregnant women are often unaware of the importance of getting oral health care during pregnancy; in fact, some have been advised that dental care during pregnancy is "risky."
- Many pregnant women are not told by their medical providers that oral health care during pregnancy is important and recommended; and in reality, they may have no resources to receive that care;
- NHOHC provider members report they are seeing women during pregnancy that experience gum disease, tooth decay, broken and missing teeth, poor nutrition, smoking habits and more that affect their oral health, overall health, and function;
- Pregnant women who integrate oral health into their own care during pregnancy are more likely to continue beyond pregnancy and teach/encourage the same in their children; and
- *Most importantly, good oral health is a foundation of good overall health.*

NHOHC Strongly Supports the 1115 Waiver and its Plan to Address

- Oral health education to pregnant women and young mothers;



- Education on the oral health impact of smoking, supported by the current smoking cessation program benefit; and
- A Dental Benefit Pilot Project that provides a near-comprehensive dental benefit for pregnant women entering the program up to their child's age of 5.

We believe the pilot is an opportunity to target a specific and distinct group that is easily accessed and easily measured; and that improved oral health in this population will result in financial savings to the Medicaid and uncompensated care funding for dental care for the mother and her children.

Literature Supporting the Potential for Cost Reductions through the Provision of Preventive Care

In a 2010 white paper, Improved Health and Lower Medical Costs: Why Good Dental Care is Important, Cigna reports the following. Attached.

- Every dollar spent on preventive dental care, can save \$8 to \$50 in restorative and emergency care; and
- Pregnant women with untreated gum disease are up to eight times more likely to give birth prematurely with associated high costs for the birth and first year of life of the child.

Likewise in A Costly Dental Destination: Hospital Care Means States Pay Dearly, February 2012, the PEW Center on the States adds

- Dental care provided in the hospital via emergency room or in-patient service is considered to be up to ten times more expensive than the preventive care that could have been provided in the community.

This supports the expectation that with improved oral health through early preventive care, it is reasonable to expect long-term savings for the Medicaid program. Additionally integration of the learning and behavior change may mean that the mother will begin any subsequent pregnancies from the stand point of better health thereby leveraging the educational and service activities from the pilot program into the health of future children by delaying exposure to the bacteria that causes decay.

Opportunity for cross-disciplinary support and intervention

We encourage NH Medicaid to implement the standards for both the educational and pilot project that are not only supported evidence-based science but that are consistent with best-practice, accepted clinical standards, and recognized in the 2012, National Maternal and Child Oral Health Resource Center published Oral Health Care During Pregnancy: A National Consensus Statement – Summary of an Expert Workgroup Meeting that was written to provide guidance to the many health professionals involved in the care of pregnant women.

The expert workgroup consisted of individuals with expertise in prenatal and dental care including representatives from the American Academy of Pediatrics, American Academy of Pediatric Dentists, American College of Gynecologists, American Dental Association, the American Dental Hygienists' Association, the American Association of State and Territorial Dental Directors, the Medicaid-CHIP State Dental Association, the National Maternal and Child Health Center, and many more committed to improving the oral health of pregnant women and their children. The document is available at:



www.mchoralhealth.org.

The 1115 Waiver oral health education and pilot program, as outlined, address many of the Consensus recommendations including

- Preventive, diagnostic, and restorative dental treatment is safe throughout pregnancy and is effective in improving and maintaining oral health;
- Educating pregnant women about preventing and treating dental caries is important for women's oral health and the future oral health of their child;
- Dental decay, caused by bacteria, is transmittable from mother to child, and education and counseling may reduce incidence.

Thank you for your consideration of these comments. Please contact me if you have any questions.

Sincerely,

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Oral Health Care During Pregnancy: A National Consensus Statement

Summary of an Expert Workgroup Meeting



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Oral Health Care During Pregnancy: A National Consensus Statement—Summary of an Expert Workgroup Meeting
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Oral Health Care During Pregnancy: A National Consensus Statement

Summary of an Expert Workgroup Meeting

October 18, 2011

**Georgetown University Hotel
and Conference Center
Washington, DC 20007**

Sponsored by

**Health Resources and Services Administration
Maternal and Child Health Bureau**

In collaboration with

**American College of Obstetricians and Gynecologists
American Dental Association**

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Introduction

Pregnancy is a unique period during a woman's life and is characterized by complex physiological changes, which may adversely affect oral health. At the same time, oral health is key to overall health and well-being. Preventive, diagnostic, and restorative dental treatment is safe throughout pregnancy and is effective in improving and maintaining oral health.

However, health professionals often do not provide oral health care to pregnant women. At the same time, pregnant women, including some with obvious signs of oral disease, often do not seek or receive care. In many cases, neither pregnant women nor health professionals understand that oral health care is an important component of a healthy pregnancy.

In addition to providing pregnant women with oral health care, educating them about preventing and treating dental caries is critical, both for women's own oral health and for the future oral health of their children. Evidence suggests that most infants and young children acquire caries-causing bacteria from their mothers. Providing pregnant women with counseling to promote healthy oral health behaviors may reduce the transmission of such bacteria from mothers to infants and young children, thereby delaying or preventing the onset of caries.

For these reasons, it is essential for health professionals (e.g., dentists, dental hygienists, physicians, nurses, midwives, nurse practitioners, physician assistants) to provide pregnant women with appropriate and timely oral health care, which includes oral health education.

Several national organizations have undertaken efforts to promote oral health for pregnant women. The American Academy of Pediatric Dentistry (AAPD), the American Academy of Pediatrics (AAP), the American Academy of Periodontology, the American Academy of Physician Assistants, the American College of Nurse-Midwives (ACNM), the American College of Obstetricians and Gynecologists (ACOG), and the American Dental Association (ADA) have issued statements and recommendations for improving oral health care during pregnancy.



To reinforce these recommendations and to provide guidance to health professionals, the New York State Department of Health produced *Oral Health Care During Pregnancy and Early Childhood: Practice Guidelines* in 2006. Following publication of these guidelines, AAPD, the California Dental Association Foundation, the South Carolina Department of Health and Environmental Control, and the University of Washington School of Dentistry also developed guidelines for perinatal oral health care.

In 2008, an expert panel convened by the Health Resources and Services Administration's (HRSA's) Maternal and Child Health Bureau (MCHB) developed strategies for improving oral health care during the perinatal period, which were presented in *Improving Perinatal Oral Health: Moving Forward*. One of these strategies was to "promote the use of guidelines addressing oral health during the perinatal period and disseminate the guidelines to maternal and child health professionals and oral health professionals." This recommended strategy provided the charge for the Oral Health Care During Pregnancy Consensus Development Expert Workgroup Meeting convened by HRSA's MCHB in collaboration with ACOG and ADA and coordinated by the National Maternal and Child Oral Health Resource Center. The meeting was

held on October 18, 2011, at Georgetown University in Washington, DC.

The expert workgroup reviewed policies from federal agencies and national organizations, recent literature, and existing guidelines on oral health care during pregnancy. (See Appendix: Agenda.) This workgroup identified common ground to increase health professionals' awareness of the importance and safety of women's oral health care during pregnancy through the promotion of evidence-based science. The national consensus statement that resulted from the October 2011 meeting comprises this document.

This national consensus statement was developed to help health professionals, program administrators and staff, policymakers, advocates, and other stakeholders respond to the need for improvements in the provision of oral health services to women during pregnancy. Ultimately, the implementation of the guidance within this consensus statement should bring about changes in the health-care-delivery system and improve the overall standard of care.

The expert workgroup consisted of individuals with expertise in oral health and prenatal care with representation from national organizations including AAP, AAPD, ACOG, ACNM, ADA, the American Dental Hygienists' Association, the Association of



State and Territorial Dental Directors, the National Maternal and Child Oral Health Policy Center, and the Medicaid-CHIP State Dental Association; federal agencies; as well as those involved in the development of existing perinatal oral health guidelines. (See Appendix: Participant List.)

National Consensus Statement: Guidance for Health Professionals

Guidance for Prenatal Care Health Professionals

Prenatal care health professionals may be the “first line” in assessing pregnant women’s oral health and can provide referrals to oral health professionals and reinforce preventive messages.

Assess Pregnant Women’s Oral Health Status

During the initial prenatal evaluation

- Take an oral health history. Following are examples of questions that prenatal care health professionals may ask pregnant women. This information may be gathered through a conversation or a questionnaire.
 - Do you have swollen or bleeding gums, a toothache (pain), problems eating or chewing food, or other problems in your mouth?
 - Since becoming pregnant, have you been vomiting? If so, how often?
 - Do you have any questions or concerns about getting oral health care while you are pregnant?
 - When was your last dental visit? Do you need help finding a dentist?
- Check the mouth for problems such as swollen or bleeding gums, untreated dental decay (tooth with a cavity), mucosal lesions, signs of infection (e.g., a draining fistula), or trauma.
- Document your findings in the woman’s medical record.

Advise Pregnant Women About Oral Health Care

- Reassure women that oral health care, including use of radiographs, pain medication, and local anesthesia, is safe throughout pregnancy.



- If the last dental visit took place more than 6 months ago or if any oral health problems were identified during the assessment, advise women to schedule an appointment with a dentist as soon as possible. If urgent care is needed, write and facilitate a formal referral to a dentist who maintains a collaborative relationship with the prenatal care health professional.
- Encourage women to seek oral health care, practice good oral hygiene, eat healthy foods, and attend prenatal classes during pregnancy. (See *Guidance for Health Professionals to Share with Pregnant Women*.)
- Counsel women to follow oral health professionals’ recommendations for achieving and maintaining optimal oral health.



Work in Collaboration with Oral Health Professionals

- Establish relationships with oral health professionals in the community. Develop a formal referral process whereby the oral health professional agrees to see the referred individual in a timely manner (e.g., that day, the following day) and to provide subsequent care.
- Share pertinent information about pregnant women with oral health professionals, and coordinate care with oral health professionals as appropriate.

Provide Support Services (Case Management) to Pregnant Women

- Help pregnant women complete applications for insurance or other sources of coverage, social services (e.g., domestic violence services), or other needs (e.g., transportation, translation).
- If the woman does not have a dental home, explain the importance of optimal oral health during pregnancy. Help her obtain care by facilitating referrals to oral health professionals in the community, including those who serve pregnant women enrolled in Medicaid and other public insurance programs, or by contacting a dental office to schedule care.

Improve Health Services in the Community

- On the patient-intake form, include questions about oral health (e.g., name and contact information of oral health professional, reason for and date of last dental visit, previous dental procedures).
- Establish partnerships with community-based programs (e.g., Special Supplemental Nutrition Program for Women, Infants and Children [WIC], Early Head Start) that serve pregnant women with low incomes.
- Provide a referral to a nutrition professional if counseling (e.g., guidance on food choices or nutrition-related health problems) would be beneficial.
- Integrate oral health topics into prenatal classes.
- Provide culturally and linguistically appropriate care. Take the time to ensure that women understand the information shared with them.



Guidance for Oral Health Professionals

Activities described below are performed by oral health professionals as allowed by state practice acts.

Assess Pregnant Women's Oral Health Status

- Take an oral health history. Following are examples of questions that oral health professionals may ask pregnant women. This information may be gathered through a conversation or a questionnaire.
 - When and where was your last dental visit?
 - Do you have swollen or bleeding gums, a toothache (pain), problems eating or chewing food, or other problems in your mouth?
 - How many weeks pregnant are you? (When is your due date?)
 - Do you have any questions or concerns about getting oral health care while you are pregnant?



- Since becoming pregnant, have you been vomiting? If so, how often?
- Have you received prenatal care? If not, do you need help making an appointment for prenatal care?
- In addition to reviewing the dental history, review medical and dietary histories, including use of tobacco, alcohol, and recreational drugs.
- Perform a comprehensive oral examination, which includes a risk assessment for dental caries and periodontal disease.
- Take radiographs to evaluate and definitively diagnose oral diseases and conditions when clinically indicated.

Advise Pregnant Women About Oral Health Care

- Reassure women that oral health care, including use of radiographs, pain medication, and local anesthesia, is safe throughout pregnancy.
- Encourage women to continue to seek oral health care, practice good oral hygiene, eat healthy foods, and attend prenatal classes during pregnancy. (See *Guidance for Health Professionals to Share with Pregnant Women*.)



Work in Collaboration with Prenatal Care Health Professionals

- Establish relationships with prenatal care health professionals in the community. Develop a formal referral process whereby the prenatal care health professional agrees to see the referred individual in a timely manner (e.g., that day, the following day) and to provide subsequent care.
- Share pertinent information about pregnant women with prenatal care health professionals, and coordinate care with prenatal care health professionals as appropriate.
- Consult with prenatal care health professionals, as necessary—for example, when considering the following:
 - Co-morbid conditions that may affect management of oral problems (e.g., diabetes, hypertension, pulmonary or cardiac disease, bleeding disorders).
 - The use of intravenous sedation or general anesthesia.
 - The use of nitrous oxide as an adjunctive analgesic to local anesthetics.

Provide Oral Disease Management and Treatment to Pregnant Women

- Provide emergency or acute care at any time during the pregnancy, as indicated by the oral condition.
- Develop, discuss with women, and provide a comprehensive care plan that includes prevention, treatment, and maintenance throughout pregnancy. Discuss benefits and risks of treatment and alternatives to treatments.

- Use standard practice when placing restorative materials such as amalgam and composite.
- Use a rubber dam during endodontic procedures and restorative procedures.
- Position pregnant women appropriately during care:
 - Keep the woman's head at a higher level than her feet.
 - Place woman in a semi-reclining position, as tolerated, and allow frequent position changes.
 - Place a small pillow under the right hip, or have the woman turn slightly to the left as needed to avoid dizziness or nausea resulting from hypotension.
- Follow up with pregnant women to determine whether preventive and restorative treatment has been effective.

Provide Support Services (Case Management) to Pregnant Women

- Help pregnant women complete applications for insurance or other sources of coverage, social services (e.g., domestic violence services), or other needs (e.g., transportation, translation).
- If the woman does not have a prenatal care health professional, explain the importance of care. Facilitate referrals to prenatal care health professionals in the community, especially those who accept Medicaid and other public insurance programs.

Improve Health Services in the Community

- On the patient-intake form, record the name and contact information of the prenatal care health professional.
- Accept women enrolled in Medicaid and other public insurance programs.
- Establish partnerships with community-based programs (e.g., WIC, Early Head Start) that serve pregnant women with low incomes.
- Provide a referral to a nutrition professional if counseling (e.g., guidance on food choices or nutrition-related health problems) would be beneficial.
- Provide culturally and linguistically appropriate care. Take the time to ensure that women understand information shared with them.

Pharmacological Considerations for Pregnant Women

The pharmacological agents listed below are to be used only for indicated medical conditions and with appropriate supervision.

Pharmaceutical Agent	Indications, Contraindications, and Special Considerations
Analgesics	
Acetaminophen	May be used during pregnancy.
Acetaminophen with Codeine, Hydrocodone, or Oxycodone	
Codeine	
Meperidine	
Morphine	
Aspirin	May be used in short duration during pregnancy; 48 to 72 hours. Avoid in 1st and 3rd trimesters.
Ibuprofen	
Naproxen	
Antibiotics	
Amoxicillin	May be used during pregnancy.
Cephalosporins	
Clindamycin	
Metronidazole	
Penicillin	
Ciprofloxacin	Avoid during pregnancy.
Clarithromycin	
Levofloxacin	
Moxifloxacin	
Tetracycline	Never use during pregnancy.
Anesthetics	Consult with a prenatal care health professional prior to using intravenous sedation or general anesthesia.
Local anesthetics with epinephrine (e.g., Bupivacaine, Lidocaine, Mepivacaine)	May be used during pregnancy.
Nitrous oxide (30%)	May be used during pregnancy when topical or local anesthetics are inadequate. Pregnant women require lower levels of nitrous oxide to achieve sedation; consult with prenatal care health professional.
Over-the-Counter Antimicrobials	Use alcohol-free products during pregnancy.
Cetylpyridinium chloride mouth rinse	May be used during pregnancy.
Chlorhexidine mouth rinse	
Xylitol	



Guidance for Health Professionals to Share with Pregnant Women

Guidance provided to pregnant women should be modified based on risk assessment. Creating opportunities for thoughtful dialogue between pregnant women and health professionals is one of the most effective ways to establish trust and build a partnership that promotes health and prevents disease.

Share the information on the following two pages with pregnant women. In addition to discussing the information with pregnant women, health professionals may photocopy the pages, or download and print them, to serve as a handout.

Sources

- American Academy of Pediatric Dentistry. 2011. Guideline on perinatal oral health care. *Reference Manual* 33(6):118–123. http://www.aapd.org/media/Policies_Guidelines/G_PerinatalOralHealthCare.pdf.
- CDA Foundation. 2010. *Oral Health During Pregnancy & Early Childhood: Evidence-Based Guidelines for Health Professionals*. Sacramento, CA: CDA Foundation. http://www.cdafoundation.org/Portals/0/pdfs/poh_guidelines.pdf.
- Kumar J, Iida H. 2008. *Oral Health Care During Pregnancy: A Summary of Practice Guidelines*. Washington, DC: National Maternal and Child Oral Health Resource Center. http://www.mchoralhealth.org/PDFs/Summary_PracticeGuidelines.pdf.
- Kumar J, Samelson R, eds. 2006. *Oral Health Care During Pregnancy and Early Childhood: Practice Guidelines*. Albany, NY: New York State Department of Health. <http://www.health.state.ny.us/publications/0824.pdf>.
- Northwest Center to Reduce Oral Health Disparities. 2009. *Guidelines for Oral Health Care in Pregnancy*. Seattle, WA: University of Washington School of Dentistry. http://depts.washington.edu/nacrohd/sites/default/files/oral_health_pregnancy_0.pdf.



Tips for Good Oral Health During Pregnancy

Below are tips for taking care of your oral health while you are pregnant. Getting oral health care, practicing good oral hygiene, eating healthy foods, and practicing other healthy behaviors will help keep you and your baby healthy. Delaying necessary treatment for dental problems could result in significant risk to you and your baby (for example, a bad tooth infection in your mouth could spread throughout your body).

Get Oral Health Care

- Taking care of your mouth while you are pregnant is important for you and your baby. Changes to your body when you are pregnant can make your gums sore or puffy and can make them bleed. This problem is called *gingivitis* (inflammation of the gums). If gingivitis is not treated, it may lead to more serious periodontal (gum) disease. This disease can lead to tooth loss.
- Oral health care, including use of X-rays, pain medication, and local anesthesia, is safe throughout pregnancy.
- Get oral health treatment, as recommended by an oral health professional, before delivery.
- If your last dental visit took place more than 6 months ago or if you have any oral health problems or concerns, schedule a dental appointment as soon as possible.



- Tell the dental office that you are pregnant and your due date. This information will help the dental team provide the best care for you.

Practice Good Oral Hygiene

- Brush your teeth with fluoridated toothpaste twice a day. Replace your toothbrush every 3 or 4 months, or more often if the bristles are frayed. Do not share your toothbrush. Clean between teeth daily with floss or an interdental cleaner.
- Rinse every night with an over-the-counter fluoridated, alcohol-free mouthrinse.
- After eating, chew xylitol-containing gum or use other xylitol-containing products, such as mints, which can help reduce bacteria that can cause tooth decay.
- If you vomit, rinse your mouth with a teaspoon of baking soda in a cup of water to stop acid from attacking your teeth.

Eat Healthy Foods

- Eat a variety of healthy foods, such as fruits; vegetables; whole-grain products like cereals, bread, or crackers; and dairy products like milk, cheese, cottage cheese, or unsweetened yogurt. Meats, fish, chicken, eggs, beans, and nuts are also good choices.
- Eat fewer foods high in sugar like candy, cookies, cake, and dried fruit, and drink fewer beverages high in sugar like juice, fruit-flavored drinks, or pop (soda).
- For snacks, choose foods low in sugar, such as fruits, vegetables, cheese, and unsweetened yogurt.
- To help choose foods low in sugar, read food labels.
- If you have problems with nausea, try eating small amounts of healthy foods throughout the day.
- Drink water or milk instead of juice, fruit-flavored drinks, or pop (soda).

- Drink water throughout the day, especially between meals and snacks. Drink fluoridated water (via a community fluoridated water source) or, if you prefer bottled water, drink water that contains fluoride.
- To reduce the risk of birth defects, get 600 micrograms of folic acid each day throughout your pregnancy. Take a dietary supplement of folic acid and eat foods high in folate and foods fortified with folic acid. Examples of these foods include
 - Asparagus, broccoli, and green leafy vegetables, such as lettuce and spinach
 - Legumes (beans, peas, lentils)
 - Papaya, oranges, strawberries, cantaloupe, and bananas
 - Grain products fortified with folic acid (breads, cereals, cornmeal, flour, pasta, white rice)

Practice Other Healthy Behaviors

- Attend prenatal classes.
- Stop any use of tobacco products and recreational drugs. Avoid secondhand smoke.
- Stop any consumption of alcoholic beverages.

Resources

Cavity Keep Away (brochure and poster in English and Spanish) produced by the California Dental Association Foundation. <http://www.cdafoundation.org/Learn/EducationTraining/PerinatalOralHealthEducation/PatientEducationMaterial.aspx>.

Dental Care Before, During, and After Pregnancy (handout) produced by the South Carolina Department of Health and Environmental Control, Division of Oral Health. <http://www.scdhec.gov/administration/library/CR-009602.pdf>.

For the Dental Patient: Oral Health During Pregnancy—What to Expect When Expecting (handout) produced by the American Dental Association. <http://www.ada.org/993.aspx>.

Good Oral Health for Two (handout) produced by the Northeast Center for Healthy Communities, Greater Lawrence Family Health Center. http://www.mchoralhealth.org/pdfs/goodoralhealthfortwo_eng.pdf (English), http://www.mchoralhealth.org/pdfs/goodoralhealthfortwo_sp.pdf (Spanish).

Healthy Smiles for Two (brochure) produced by the South Dakota Department of Health, Oral Health Program. http://doh.sd.gov/OralHealth/PDF/SmilesforTwo_Brochure.pdf.

Nothing But the Tooth (video) produced by the Texas Department of State Health Services, Nutrition Services Section

and Texas Oral Health Coalition. <http://www.youtube.com/watch?v=4m41tR3s9sE> (English), <http://www.youtube.com/watch?v=vuYTLjXG-do> (Spanish).

Patient Education Tools (articles in Chinese, English, Hmong, Russian, Spanish, and Vietnamese) produced by the California Dental Association. http://www.cda.org/page/patient_education_tools.

Pregnancy and Dental Care (poster and wallet card) produced by the New York State Department of Health. <http://www.health.state.ny.us/prevention/dental/publications.htm>.

text4baby (mobile information service) produced by the National Healthy Mothers, Healthy Babies Coalition. <http://www.text4baby.org>.

Two Healthy Smiles: Tips to Keep You and Your Baby Healthy (brochures) produced by the National Maternal and Child Oral Health Resource Center. <http://www.mchoralhealth.org/PDFs/pregnancybrochure.pdf> (English) and http://www.mchoralhealth.org/PDFs/pregnancybrochure_sp.pdf (Spanish).

Finding a Dentist

- <http://www.ada.org/ada/findadentist/advancedsearch.aspx>
- <http://www.knowyourteeth.com/findadentist>

Finding Low-Cost Dental Care

- <http://www.nidcr.nih.gov/FindingDentalCare/ReducedCost/FLCDC.htm>

Finding Dental Insurance Coverage

- <https://www.healthcare.gov>

After Your Baby Is Born

- Continue taking care of your mouth after your baby is born. Keep getting oral health care, practicing good oral hygiene, eating healthy foods, and practicing other healthy behaviors.
- Take care of your baby's gums and teeth, feed your baby healthy foods (exclusive breastfeeding for at least 4 months, but ideally for 6 months), and take your baby to the dentist by age 1.
- Ask your baby's pediatric health professional to check your baby's mouth (conduct an oral health risk assessment) starting at age 6 months, and to provide a referral to a dentist for urgent oral health care.

Resource

A Healthy Smile for Your Baby: Tips to Keep Your Baby Healthy (brochures in English and Spanish) produced by the National Maternal and Child Oral Health Resource Center. <http://www.mchoralhealth.org/materials/consumerbrochures.html>.

Resources for Health Professionals

Although we have tried to present a thorough overview of available resources, we realize that this list is not complete. For further information, we encourage you to contact the organizations listed in the following section.

Materials

American Academy of Pediatric Dentistry. 2011. Guideline on perinatal oral health care. *Reference Manual* 33(6):118–123. http://www.aapd.org/media/Policies_Guidelines/G_PerinatalOralHealthCare.pdf.

American Academy of Pediatrics; American College of Obstetricians and Gynecologists. 2007. *Guidelines for Perinatal Care* (6th ed.). Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American College of Obstetricians and Gynecologists.

American Dental Association, Council on Dental Benefit Programs, Council on Dental Practice, Council on Scientific Affairs; U.S. Department of Health and Human Services, Public Health Services, Food and Drug Administration. 2004. *The Selection of Patients for Dental Radiograph Examination* (rev.). Chicago, IL: American Dental Association; Washington, DC: Food and Drug Administration. http://www.ada.org/sections/professionalResources/pdfs/topics_radiography_examinations.pdf.

American Dental Association, Council on Scientific Affairs. 2010. *Bisphenol A and Dental Materials*. <http://www.ada.org/1766.aspx>.

American Dental Association, Council on Scientific Affairs. 2009. *Statement on Dental Amalgam*. <http://www.ada.org/1741.aspx>.

Brown A. 2009. *Improving Perinatal Oral Health: Moving Forward—An Expert Meeting, Meeting Summary Report*. Washington, DC: Altarum Institute. http://www.mchoralhealth.org/PDFs/Perinatal_ExpertMeeting_Report.pdf.

Brown A. 2008. *Access to Oral Health Care During the Perinatal Period: A Policy Brief*. Washington, DC: National Maternal and Child Oral Health Resource Center. <http://www.mchoralhealth.org/PDFs/PerinatalBrief.pdf>.

Buerlein J, Isman B, Hanlon C. 2009. *Medicaid Coverage of Dental Care for Pregnant Women*. Washington, DC: National Maternal and Child Oral Health Policy Center. <http://www.cdhp.org/system/files/Medicaid%20Coverage%20of%20Dental%20Care%20for%20Pregnant%20Women%2011.09.pdf>.

Buerlein J, Peabody H, Santoro K. 2010. *Improving Access to Perinatal Oral Health Care: Strategies and Considerations for Health Plans*. Washington, DC: National Institute for Health Care Management Foundation and Children's Dental Health Project. <http://nihcm.org/pdf/NIHCM-OralHealth-Final.pdf>.

Casamassimo P, Holt K, eds. 2004. *Bright Futures in Practice: Oral Health—Pocket Guide*. Washington, DC: National Maternal and Child Oral Health Resource Center. <http://www.mchoralhealth.org/pocketguide>.



CDA Foundation. 2010. *Oral Health During Pregnancy & Early Childhood: Evidence-Based Guidelines for Health Professionals*. Sacramento, CA: CDA Foundation. http://www.cdafoundation.org/Portals/0/pdfs/poh_guidelines.pdf.

Centers for Disease Control and Prevention. 2012. *Folic Acid: Recommendations*. <http://www.cdc.gov/ncbddd/folicacid/recommendations.html>.

Douglass AB, Maier R, Deutchman M, Douglass JM, Gonsalves W, Silk H, Tysinger JW, Wrightson AS. 2010. *Smiles for Life: A National Oral Health Curriculum* (3rd ed.). Leawood, KS: Society of Teachers of Family Medicine, Group on Oral Health. <http://www.smilesforlifeoralhealth.org>.

Grantmakers in Health. 2011. *Making the Connection: Pregnancy and Oral Health*. Washington, DC: Grantmakers in Health. http://www.gih.org/usr_doc/Issue_Focus_Pregnancy_and_Oral_Health_2-21-11.pdf.

Institute of Medicine, Standing Committee on the Scientific Evaluation of Dietary Reference Intakes. 1998. *Dietary Reference Intakes for Thiamin, Riboflavin, Niacin, Vitamin B6, Folate, Vitamin B12, Pantothenic Acid, Biotin, and Choline*. Washington, DC: National Academy Press. http://books.nap.edu/openbook.php?record_id=6015.

Kumar J, Iida H. 2008. *Oral Health Care During Pregnancy: A Summary of Practice Guidelines*. Washington, DC: National Maternal and Child Oral Health Resource Center. http://www.mchoralhealth.org/PDFs/Summary_PracticeGuidelines.pdf.

Kumar J, Samelson R, eds. 2006. *Oral Health Care During Pregnancy and Early Childhood: Practice Guidelines*. Albany, NY: New York State Department of Health. <http://www.health.state.ny.us/publications/0824.pdf>.

Maternal and Child Health Bureau. 2009. *Engaging Providers to Improve Perinatal and Infant Oral Health: Innovative Strategies* [webcast]. Rockville, MD: Maternal and Child Health Bureau. <http://webcast.hrsa.gov/Postevents/archivedWebcastDetail.asp?acid=494>.

National Institutes of Health, Office of Dietary Supplements. 2009. *Dietary Supplement Fact Sheet: Folate*. Bethesda, MD: National Institutes of Health, Office of Dietary Supplements. <http://ods.od.nih.gov/factsheets/folate>.

New Jersey Department of Human Services, Division of Medical Assistance and Health Services. 2007. *Perinatal Screening, Risk Assessment and Referral Form*. Trenton, NJ: New Jersey Department of Human Services, Division of Medical Assistance and Health Services. http://www.chcs.org/usr_doc/PRA_Form.pdf.

New York State Department of Health. 2006. *Oral Health Care During Pregnancy and Early Childhood: Practice Guidelines*. Albany, NY: New York State Department of Health. <http://www.health.ny.gov/publications/0824.pdf>.

Northwest Center to Reduce Oral Health Disparities. 2009. *Guidelines for Oral Health Care in Pregnancy*. Seattle, WA: University of Washington School of Dentistry. http://depts.washington.edu/nacrohd/sites/default/files/oral_health_pregnancy_0.pdf.

South Carolina Department of Health and Environmental Control, Division of Oral Health. 2010. *Dental Care Before, During, and After Pregnancy*. Columbia, SC: South Carolina Department of Health and Environmental Control, Division of Oral Health. <http://www.scdhec.gov/administration/library/CR-009602.pdf>.

U.S. Department of Health and Human Services, Trans-agency Working Group on the Health Effects of Dental Amalgam. 2004. *Review and Analysis of the Literature on the Potential Health Effects of Dental Amalgams*. Bethesda, MD: Life Sciences Research Office. http://www.lsr.org/amalgam/frames_amalgam_report.html.

U.S. Food and Drug Administration. 2009. Medical Devices [website]. *About Dental Amalgam Fillings*. <http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/DentalProducts/DentalAmalgam/ucm171094.htm>.

U.S. Food and Drug Administration. 2009. Medical Devices [website]. *Class II Special Controls Guidance Document: Dental Amalgam, Mercury, and Amalgam Alloy—Guidance for Industry and FDA Staff*. <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm073311.htm>.



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Oral Health Care During Pregnancy: Consensus Development Expert Workgroup Meeting

October 18, 2011

**Georgetown University Hotel and Conference Center
Washington, DC 20007**

Sponsored by

Health Resources and Services Administration
Maternal and Child Health Bureau

In collaboration with

American College of Obstetricians and Gynecologists
American Dental Association

Agenda

8:00–8:30 *Continental Breakfast*

8:30–9:00 **Welcome, Opening Remarks, and
Introductions**

Health Resources and Services Admin-
istration, Maternal and Child Health
Bureau, Pamela Vodicka, M.S., R.D.

Health Resources and Services Admin-
istration, Office of Strategic Priorities,
Wendy Mouradian, M.D., M.S.

American College of Obstetricians and
Gynecologists, Jay Schulkin, Ph.D.

American Dental Association, Rocky
Napier, D.M.D.

Charge for the Meeting

Ann Drum, D.D.S., M.P.H., facilitator

9:00–9:30 **Review of Policies from Federal
Agencies and National Organizations
Addressing the Oral Health Needs of
Pregnant Women**

Steve Geiermann, D.D.S., and
Sheila Strock, D.M.D., M.P.H.

9:30–10:30 **Review of Recent Literature on Oral
Health Care During Pregnancy**

Mona Haleem, D.D.S., M.P.A.,
Hyewon Lee, D.M.D., and Jay Kumar,
D.D.S., M.P.H.

10:30–10:45 *Break*

10:45–11:45 **Overview of the Development of
Existing Oral Health Care During
Pregnancy Guidelines and Lessons
Learned**

Jay Kumar, D.D.S., M.P.H., Lindsey
Robinson, D.D.S., and Ned Savide,
D.D.S.

12:00–12:45 *Lunch*

12:45–4:00 **Crosswalk of Existing Oral Health
Care During Pregnancy Guidelines—
Group Discussion**

Ann Drum, D.D.S., M.P.H., facilitator

- All Health Professionals
- Prenatal Care Health Professionals
- Oral Health Professionals
- Pharmacologic Considerations for
Pregnant Women

4:00–4:30 **Next Steps**

Wendy Mouradian, M.D., M.S.

4:30 **Meeting Adjourned**



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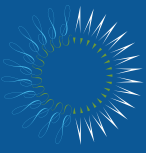
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A Costly Dental Destination

Hospital Care Means States Pay Dearly

Each year, many Americans seek dental care in hospital emergency rooms (ERs). The Pew Center on the States estimates that preventable dental conditions were the primary diagnosis in 830,590 visits to ERs nationwide in 2009—a 16 percent increase from 2006.¹ For many low-income children, emergency rooms are the first and last resort because their families struggle to find a dentist who either practices in their area or accepts Medicaid patients.


Earlier this year, Dr. Alan Sorkey, an emergency-room physician in Louisiana, told a reporter, “It is a very rare event when I do not see one dental complaint during a (12-hour) shift.”² The fact that so many people are turning to hospitals to address oral health needs is another sign that the U.S. dental system is failing to reach many who need care.

These ER trips add to the financial burdens confronting states. A study of decay-related ER visits in 2006 found that treating about 330,000 cases cost nearly \$110 million.³ States are saddled with some of these expenses through Medicaid and other public programs.⁴

Especially large bills result when severe decay-related problems require hospitals to use general anesthesia.⁵ The problem is serious enough that Michigan Governor Rick Snyder (R) told legislators last year that poor oral health is a reason for “inappropriate use of emergency rooms.”⁶

In Arizona, taxpayers have borne a major portion of dental-related ER costs. In 2005, roughly 46 percent of the state’s ER visits for dental reasons were made by Medicaid enrollees.⁷ Roughly one-third of Florida’s hospital emergency-room dental visits in 2010 were paid by taxpayers through the Medicaid program.⁸



 **In New York State, the average charge per emergency visit for young children with dental ailments increased 30 percent during a recent five-year span.⁹**

This problem is not new. In the late 1990s, data from various states revealed that significant numbers of people were showing up at hospital ERs with toothaches or other dental disorders.¹⁰ In 1997, there were about 62,000 emergency dental visits by Medicaid enrollees in North Carolina that could have been avoided if these patients had received preventive care from a dentist.¹¹

By working to increase access to preventive dental care in more cost-effective settings, policy makers can spare many children the pain and lifelong impact of poor oral health while saving taxpayer dollars.

What is the cause?

In 2009, more than 16 million Medicaid-enrolled children (56 percent) received no dental care—not even a routine exam.¹² This has serious consequences. Although oral health generally has improved in recent decades, many kids have untreated decay.¹³ In 2008, nearly one out of seven children ages 6 to 12 in the U.S. had suffered a toothache in the previous six months.¹⁴ A recent

study showed that children with poor oral health were more likely to have pain, miss school, and experience poor academic performance.¹⁵

A major driver of dental-related hospital visits is a failure by states to ensure that disadvantaged people have access to routine preventive care from dentists and other providers.


A dentist shortage exacerbates this access problem. Roughly 47 million Americans live in areas that are federally designated as having a shortage of dentists.¹⁶ This is a key reason why dental care remains the greatest unmet health need of children.¹⁷ One study projects that by 2019, there could be 7,000 fewer dentists practicing in the United States compared with the number working in 2009.¹⁸

Even in states with a less severe shortage, many people live far from the nearest dentist.¹⁹ The Walsh Center for Rural Health Analysis has cited “[p]ersistent and worsening shortages of oral health care providers in rural areas” as one factor driving people to ERs “for problems that might have been prevented.”²⁰

Many families face a different kind of shortage as they struggle to find dentists to care for their Medicaid-enrolled children. In 2008, fewer than half of the dentists in 25 states treated any Medicaid patients.²¹

Many Americans face access challenges because they lack dental insurance and cannot afford care or because they do not live near a community health center offering affordable dental services. A recent national survey showed that 45 percent of Hispanics lack dental insurance.²² A 2011 poll revealed that three out of 10 Maine residents had put off a dental appointment because of the cost.²³

Hospitals, therefore, frequently serve as the provider of first and last resort when an oral health condition develops.²⁴

 **A study in Washington State revealed that a trip to the ER was the first “dental visit” for one in four children overall, and for roughly half the children younger than 3 and a half years.²⁵**

States need to do more to ensure that preventive dental services are available to all children, especially the most vulnerable. Once a child has a decayed tooth, delays in treatment are highly likely to make the experience more painful and costly. An untreated cavity is not like a cold or flu, which go away with time and bed rest. As the August 2010 death of a young Ohio man revealed, a cavity that goes untreated can become a serious and potentially life-threatening problem. Improved access must be coupled with more prevention.

Why does this matter?

Both patients and policy makers face serious consequences when oral health problems are addressed in hospitals.

For states, the costs of emergency-room visits place added pressure on already squeezed budgets. Research shows the average cost of a Medicaid enrollee’s inpatient hospital treatment for dental problems is nearly 10 times more expensive than the cost of preventive care delivered in a dentist’s office.²⁶

For patients, ERs are an expensive source for treatment, and care from these facilities is unlikely to provide lasting relief. Hospitals generally are unable to treat toothaches and dental abscesses effectively. Most emergency rooms are not staffed with dentists, and their physicians and other staff are not trained to treat underlying oral health problems.²⁷

“ERs are not the place to go for dental care,” said John Sattenspiel, chief medical officer of a physicians group in Oregon.²⁸ Generally, hospitals can provide only short-term relief, such as medication to treat an infection or temporarily relieve pain.²⁹ A study of low-income patients with toothaches found that among those who went to an emergency room, 80 percent needed subsequent care from a dentist.³⁰

For these reasons, it is no surprise that patients who take their dental problems to hospitals have a high rate of repeat visits.³¹ A study in Minnesota examined 10,325 dental-related trips to hospital emergency facilities and found that almost 20 percent of them were made by people who had previously sought ER care.³²

In addition, the significant numbers of Americans seeking dental care in hospitals are an added burden on ERs, which are already overcrowded in many areas of the country.³³ In 2009, the American College of Emergency Physicians reported that hospital ERs “are increasingly crowded, over capacity, and overwhelmed,” leading to “increasing delays in care, even when [patients] are in pain or experiencing a heart attack.”³⁴

How widespread is the problem?

The full scope of the problem is unknown for two reasons. First, not all of the 50 states mandate that hospitals submit their discharge records. Second, some states do not interpret and report the ER data they have collected.³⁵ However, data from a number of states reveal that hospitals are a frequent

destination for many people who have dental problems:

California’s ERs received more than 83,000 visits in 2007 resulting from preventable dental problems.³⁶

In 2009, **Tennessee** hospitals had more than 55,000 emergency visits due primarily to teeth or jaw disorders. These conditions were responsible for roughly five times as many ER trips as were burns.³⁷

From 2008 to 2011, **Illinois** hospitals in the Chicago metropolitan area had nearly 77,000 emergency or other types of patient visits for non-injury, dental-related ailments.³⁸

Utah hospitals received more than 8,700 emergency visits in 2009 from patients with dental or jaw disorders.³⁹

In 2010, **Florida** had more than 115,000 hospital ER visits for dental problems.⁴⁰

The nine hospitals in **Ohio’s** second-most-populated county received 8,760 emergency visits in 2009 from Medicaid-enrolled or uninsured patients suffering from dental ailments.⁴¹

Kansas hospitals reported more than 17,500 visits to emergency facilities due to dental-related problems in the 2010

fiscal year. The actual number of ER trips could be significantly higher because more than 20 percent of hospitals in Kansas did not disclose such data.⁴²

In 2009, there were more than 69,000 ER visits to **North Carolina** hospitals due primarily to disorders of the teeth or jaw. These conditions were the 10th most common reason for emergency trips in the state.⁴³

Nevada health officials estimated that the state's hospitals received 6,431 emergency or in-patient visits in 2005 due to decay, gum disease, or abscessed teeth. The charges associated with these patients were projected at nearly \$4 million.⁴⁴

In 2006, dental disease was the leading reason for ER visits to **Maine's** hospitals by Medicaid enrollees and uninsured young people (ages 15 to 24). That year,

abscesses or other dental problems were responsible for 3,400 emergency room visits. A report on Maine's ER visits cited poor access to both preventive and acute dental care as a driving factor.⁴⁵

In one 12 month period (2004-05), seven **Minnesota** hospitals received more than 10,000 emergency room visits for dental ailments, including toothaches and abscesses.⁴⁶

In **Rhode Island**, 864 people under 21 were treated, on average, at an ER for a primary dental-related condition each year between 2005 and 2009.⁴⁷

A **Washington state** survey of 53 hospitals found that during an 18-month period in 2008-09, residents made more than 23,000 visits to ERs for toothaches or other dental problems. Among the uninsured, patients with dental disorders were the most frequent ER visitors.⁴⁸

Dental → Facts

A decade
of rising
dental-related
emergency
room visits

Nearly half of
Arizona's
dental-related ER
visits (2005) were
from Medicaid
enrollees, meaning
taxpayers covered
much of the cost.

one-half



Costs

\$88 million **FL** More than 115,000 hospital ER visits for dental problems produced charges exceeding \$88 million (2010).ⁱ

\$23 million **GA** The approximately 60,000 emergency hospital visits for non-traumatic dental problems or other oral health issues cost more than \$23 million (2007).ⁱⁱ

\$5 million **IA** More than 10,000 visits to hospital ERs for dental reasons cost Medicaid or other public programs almost \$5 million (2007).ⁱⁱⁱ

\$4.7 million **MN** The 10,000-plus dental-related ER visits to seven hospitals in the state's largest urban area cost more than \$4.7 million (2005).^{iv}

\$6.9 million **MO** ER charges for dental-related visits to Kansas City hospitals totaled about \$6.9 million (2001–2006).^v

\$4 million **NV** The cost of dental visits to hospitals was estimated at nearly \$4 million (2005).^{vi}

\$31 million **NY** The cost of treating young children for decay-related ailments in hospital emergency rooms or ambulatory surgery centers jumped from \$18.5 million to more than \$31 million (2004–2008).^{vii}

\$7 million **WI** More than 32,000 emergency room visits resulting from dental ailments cost nearly \$7 million (2009).^{viii}

one-third

Roughly one-third of
Florida's ER dental visits
(2010) were made by
Medicaid patients.



Trends

It is a very rare event when I do not see one dental complaint during a (12-hour) shift.

Dr. Alan Sorkey,
ER physician in Louisiana

2010 ■

FL

In **Florida**, the number of Medicaid-enrolled residents who sought care at a hospital ER for dental reasons jumped **40 percent** from the number two years earlier.^{ix}

OR

The number of dental-related emergency visits by **Oregon's** Medicaid enrollees during this year was **31 percent higher** than the number recorded two years before.^x

2009 ■

SC

In **South Carolina**, emergency-room visits primarily for teeth or jaw disorders **increased 59 percent** from four years earlier.^{xi}

VT

This year's visits to **Vermont** ER facilities for dental-related problems revealed a **9 percent increase** in a three-year span.^{xii}

2008 ■

NY

In **New York** state, the number of young children with decay-related problems who visited hospital ERs or ambulatory surgery facilities was **32 percent higher** than the figure four years earlier.^{xiii}

2007 ■

HI

The number of ER visits to **Hawaii's** hospitals for teeth or jaw ailments **jumped 74 percent** from the number recorded in 2004.^{xiv}

2005 ■

NH

The rate of hospital emergency-room visits for dental ailments in **New Hampshire** climbed **45 percent** from four years earlier. A state report tracked ER visits for eight health conditions and found the "most notable increase" occurred in dental-related problems.^{xv}

16%

2006–2009

Increase in the percentage of ER visits across the United States in which preventable dental conditions were the primary diagnosis.


*Based on research conducted by the Pew Center on the States, 2012.

Appendix E: Public Comments Received and State Responses

What can states do?

This issue brief underscores the need for states to save Medicaid dollars and other public funds by ensuring that more children have access to basic, preventive services in dental offices, pediatricians' offices, schools, or settings other than hospitals.

In a North Carolina study, 70 percent of the children who required dental-related treatments in a hospital operating room before age five had never received routine, preventive dental care.⁴⁹

 **By increasing the likelihood that more young children see a dentist, states can reduce costs from future decay or related problems.**

Research shows that providing early preventive care for children most at risk for decay can reduce the need for restorative treatment (such as fillings) and emergency services, significantly cutting the cost of care.⁵⁰ Some forms of preventive care also can be delivered by dental hygienists through school-based programs.

States cannot expect community health centers to fulfill this unmet need for dental care. Although these safety-net clinics play an important role, they cannot serve all who need care. One study estimates there are 82 million underserved Americans—a need far exceeding the capacity of

clinics, which provide dental services to approximately 3.7 million people annually.⁵¹

State policies can significantly affect—for better or worse—the frequency of dental-related hospital trips:


1. Focus more on preventing decay

The best strategy is preventing tooth decay before it becomes more serious and prompts a hospital visit for emergency care. There are cost-effective approaches that states can use or expand to focus more on prevention. Several cost-effective approaches can help reduce ER visits:

Dental sealants are clear plastic coatings applied to the chewing surfaces of children's molars—the most cavity-prone teeth—that prevent 60 percent of decay at one-third the cost of filling a cavity.⁵² Sealants also impede the growth of cavities, heading off the need for expensive fillings.⁵³ Sealant programs targeting schools with many high-risk children have been recommended by the U.S. Task Force on Community Preventive Services.⁵⁴

Data from 2010 showed that seven states had no school-based sealant programs to reach vulnerable kids: Hawaii, Missouri, Montana, New Jersey, Oklahoma, South Dakota, and Wyoming.⁵⁵ Still, 21 states and the District of Columbia imposed unnecessary hurdles on sealant programs for low-income children.⁵⁶ These states

require that children be examined by a dentist before sealants can be applied by dental hygienists, who are the primary practitioners in school-based sealant programs.

 **Requiring a prior exam makes it more difficult and expensive for sealant programs to reach those in need.**

Such laws or regulations are at odds with the scientific consensus that X-rays and other advanced diagnostic tools are unnecessary to determine the need for sealants.⁵⁷ Hygienists can apply sealants, and ensure that children are referred to a dentist for follow-up care.

Community water fluoridation is another effective vehicle. Fluoridation occurs when the level of fluoride in a public water system is adjusted to the optimal level proven to reduce tooth decay. This practice is endorsed by the American Academy of Pediatrics, the Centers for Disease Control and Prevention, the Institute of Medicine, and other leading health authorities.⁵⁸

Research shows that fluoridated water reduces decay rates for children and adults, avoiding the need for costly, sometimes painful, corrective treatments.⁵⁹ This is why most communities save \$38 for every \$1 invested in fluoridation.⁶⁰ Studies in Texas and New York also have shown that fluoridation saves state Medicaid dollars by lowering treatment costs.⁶¹

According to the most recent federal data, fluoridated water reaches 72 percent of Americans served by community water systems. Yet fluoridated water reaches less than half of the population in nine states: Hawaii, Idaho, Kansas, Louisiana, Montana, New Hampshire, New Jersey, Oregon, and Wyoming.⁶²


Although most states can do more to expand fluoridation, these nine states should make it a priority to ensure that many more residents benefit from this proven intervention. State health administrators should work more closely with local officials to counter misleading information by sharing the significant body of scientific evidence that fluoridated water is safe and effective.^{63,64}

Medical professionals should play more of a role in prevention. Pediatricians, nurse practitioners, and other personnel can provide basic services, including oral health screening and the application of fluoride varnish, a gel that reduces tooth decay. Physicians can also refer parents to a dental office when their kids need additional care. Involving medical providers is important because young children see them earlier and more frequently than they see dentists.

Forty-four states encourage this by reimbursing physicians through Medicaid for providing early dental screenings and care to low-income kids.⁶⁵

2. Expand the dental workforce

Although Medicaid programs are required to provide dental coverage for children, millions of low-income kids struggle to find care because most dentists do not participate in Medicaid. A 2009 survey revealed that in nearly two-thirds of the 39 states reporting data, most dentists treated no Medicaid patients during the previous year.⁶⁶

 **Even for children not enrolled in Medicaid, getting care can be difficult because many areas have relatively few dentists.**

As noted earlier, almost 47 million Americans live in areas with a shortage of dentists.⁶⁷

To close this gap, a number of states—including California, Kansas, Maine, New Hampshire, and Washington—are exploring new types of practitioners to provide quality, routine dental care. These professionals would be supervised by dentists and play a role similar to that performed by nurse practitioners in the medical field. Under federal law, dental therapists are serving the needs of Alaska Native Tribes, and similar professionals will soon be licensed in Minnesota, the only state with a law authorizing them. Dental therapists work in dozens of countries, and have been deployed successfully in Canada, Britain, Australia, and New Zealand for more than 30 years.⁶⁸

These or other kinds of alternative practitioners could perform some services offered by dentists, including both preventive and restorative (e.g., filling cavities) care. A 2010 evaluation of Alaska's dental therapists determined that they were providing safe, competent care that earned high levels of patient satisfaction.⁶⁹

Another approach is additional training for dental assistants or hygienists, so they can perform more services. By licensing new types of dental practitioners or expanding the scope of existing professionals, states can ensure access to care for more children in underserved communities.

3. Maintain reasonable Medicaid policies

Research shows a link between Medicaid reimbursement rates and access to dental care.⁷⁰ States committed to serving more low-income people should ensure their Medicaid reimbursement rates are high enough to cover the cost of care. Doing so will encourage broader Medicaid participation by dentists.

Dental-related hospital visits can spike when states allow Medicaid reimbursement rates to fall below the cost of delivering care, or when states eliminate benefits. Dental professionals in Michigan reported that emergency room visits increased by more than 10 percent after a two-year period during which the state reduced Medicaid dental coverage for adults.⁷¹

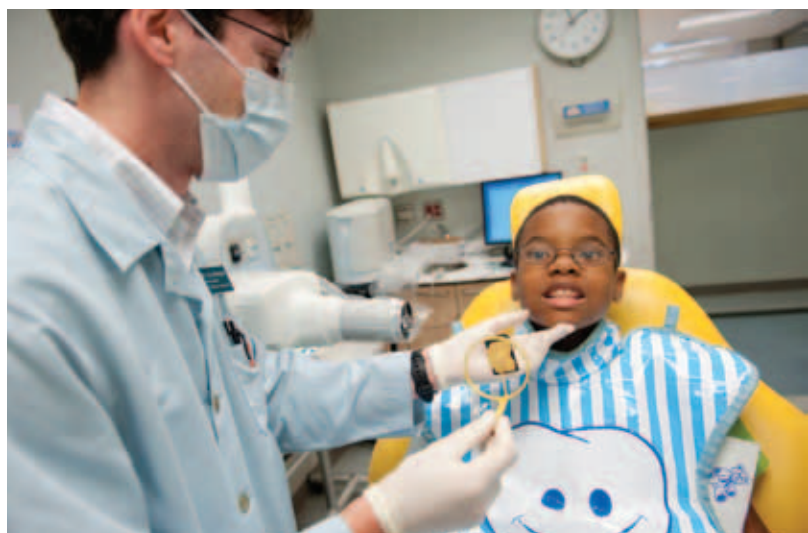
A 2002 study found that the rate of ER dental visits by Medicaid patients in Maryland rose by about 12 percent after the state stopped reimbursing private-practice dentists who treated adult emergencies.⁷²

States that cut reimbursement rates during tough budgetary times might save Medicaid dollars in the short run, but they are likely to pay considerably more later by inadvertently encouraging more people to take their dental problems to hospitals.

Conclusion

States are paying a high price for the significant numbers of children and adults who turn to hospital emergency rooms for dental problems that should have been prevented or treated more effectively elsewhere. Moreover, given the trend in several states, the overall number of ER trips could be rising. Many patients return to hospitals because the treatment they received only addressed pain or other symptoms—not the underlying oral health issue.

States can reduce or contain these costs by making better use of proven forms of prevention, improving access by expanding the number of dental practitioners, and paying reasonable Medicaid rates for dental services.



When so many people seek care at hospitals for preventable dental problems, it wastes taxpayer dollars. This impact is particularly troubling for states at a time when their budgets are severely strained. Investing more in prevention and ensuring access to treatment could save money by reducing the incidence of untreated decay and other dental ailments.

For more information on how states are performing on oral health, see Pew's *The State of Dental Health: Making Coverage Matter*.

For more information on how new types of dental professionals could improve access to care, see Pew's *It Takes a Team: How New Dental Providers Can Benefit Patients and Practices*.

ENDNOTES

1 Agency for Healthcare Research and Quality (AHRQ), “Healthcare Cost and Utilization Project (HCUP) – The Nationwide Emergency Department Sample for the year 2009 and 2006.” AHRQ, Rockville, MD. <http://hcupnet.ahrq.gov/> accessed February 7-8, 2012. The Pew Children’s Dental Campaign identified preventable dental conditions using the International Classification of Diseases (ICD-9) codes of 521 and 522. These codes were chosen in consultation with Dr. Frank A. Catalanotto, DMD, Professor and Chair of the Department of Community Dentistry and Behavioral Science at the University of Florida’s College of Dentistry. Primary diagnosis is defined as visits in which one of these codes was listed first on a patient’s discharge record. One of these two ICD-9 codes was the primary code for 717,032 ER visits in 2006 and for 830,590 visits in 2009, which constituted a 15.8 percent increase over this four-year period. These figures do not include emergency dental visits for which these codes were listed as a secondary code. One of these codes (521 and 522) was listed as either a primary or secondary code for 1,116,569 ER visits in 2006 and for 1,357,217 ER visits in 2009, which constituted a 21.6 percent increase. Secondary diagnosis codes are of interest because the first diagnosis listed for an ER visit may not always coincide with the primary or only reason why the patient was treated.

2 Alison Bath, “Without dental coverage, patients seek pain relief in ER,” *The Shreveport Times*, January 29, 2012. <http://www.shreveporttimes.com/article/20120129/NEWS01/201290311/Without-dental-coverage-patients-seek-pain-relief-ER>.

3 Of the 330,757 ER visits for dental-related causes, 330,599 (99.9 percent) did not require a hospital stay. See: R. Nalliah, V. Allareddy, S. Elangovan, N. Karimbux, and V. Allareddy, “Hospital Based Emergency Department Visits Attributed to Dental Caries in the United States in 2006,” *Journal of Evidence Based Dental Practice* (2010), Vol. 10, 212-222, [http://www.jebdp.com/article/S1532-3382\(10\)00183-1/abstract](http://www.jebdp.com/article/S1532-3382(10)00183-1/abstract).

4 D.B. Graham, M.D. Webb and N.S. Seale, “Pediatric emergency room visits for nontraumatic dental disease,” *Pediatric Dentistry* 22 (2000): 134-140.

5 For example, in 1994 it cost Iowa’s Medicaid program an average of \$2,009 per case to administer general anesthesia to a child in order to perform dental treatments in a hospital. See M.J. Kanellis, P.C. Damiano, and E.T. Momany, “Medicaid costs associated with the hospitalization of young children for restorative dental treatment under general anesthesia,” *Journal of Public Health Dentistry* 60 (2000): 28-32.

- 6 “A Special Message from Governor Rick Snyder: Health and Wellness,” a speech by Michigan Gov. Rick Snyder, (September 14, 2011), accessed November 11, 2011, <http://www.michigan.gov/snyder/0,4668,7-277--262254--,00.html>.
- 7 E.F. Shortridge and J.R. Moore, “Use of Emergency Departments for Conditions Related to Poor Oral Health Care,” Walsh Center for Rural Health Analysis, pg v, (August 2010), accessed January 18, 2012, <http://www3.norc.org/NR/rdonlyres/DCBE76E8-3148-4085-9211-FB79AFD6BA51/0/OralHealthFinal2.pdf>.
- 8 Florida Public Health Institute, “News Release: 315 Patients a Day Seek Dental Treatment in Florida’s Hospital Emergency Rooms,” (December 15, 2011), accessed January 25, 2012, http://cdn.trustedpartner.com/docs/library/FloridaOralHealth2011/ER_Data_Press_Release_Final.pdf.
- 9 Donna Domino, “More NY kids with early caries going to hospitals,” DrBicuspid.com, (January 13, 2012), accessed January 26, 2011, <http://www.drbicuspid.com/index.aspx?sec=sup&sub=pmt&pag=dis&ItemID=309544&wf=33>.
- 10 T.E. Ladrillo, M.H. Hobdell, and A.C. Caviness, “Increasing prevalence of emergency department visits for pediatric dental care, 1997-2001,” *Journal of American Dental Association* 137 (2006): 379-385; R.T. Slifkin, P. Silberman, and V. Freeman, “Moving from Medicaid to North Carolina Health Choice: Changes in Access to Dental Care for NC Children,” *North Carolina Medical Journal*, (January/February 2004), Vol. 65, No. 1, 6, <http://www.ncmedicaljournal.com/wp-content/uploads/NCMJ/jan-feb-04/Slifkin.pdf>; B. Sheller, B.J. Williams and S.M. Lombardi, “Diagnosis and treatment of dental caries-related emergencies in a children’s hospital,” *Pediatric Dentistry*, (November-December 1997), Vol. 19, No. 8, 470-5, <http://www.ncbi.nlm.nih.gov/pubmed/9442540>.
- 11 R.T. Slifkin, P. Silberman, and V. Freeman, “Moving from Medicaid to North Carolina Health Choice: Changes in Access to Dental Care for NC Children,” *North Carolina Medical Journal*, (January/February 2004), Vol. 65, No. 1, 6, <http://www.ncmedicaljournal.com/wp-content/uploads/NCMJ/jan-feb-04/Slifkin.pdf>.
- 12 US Department of Health and Human Services, Centers for Medicare and Medicaid Services, “Medicaid Early Periodic Screening Diagnostic & Treatment Benefit (CMS-416),” (2009). This figure counts children age one to 18. Data from 48 reporting states and the District of Columbia were supplemented with reports obtained directly from Michigan and Oregon.
- 13 Among Americans who are 12-19 years old, 20 percent have untreated decay. See Centers for Disease Control and Prevention, “Oral Health: Preventing Cavities, Gum

- Disease, Tooth Loss, and Oral Cancers at a Glance 2011,” (2011), accessed January 26, 2012, <http://www.cdc.gov/chronicdisease/resources/publications/AAG/doh.htm>.
- 14 C. Lewis and J. Stout, “Toothache in U.S. Children,” *Archives of Pediatrics and Adolescent Medicine* 164 (2010): 1059-1063.
- 15 S.L. Jackson, W.F. Vann, J. Kotch, B.T. Pahel, and J.Y. Lee, “Impact of Poor Oral Health of Children’s School Attendance and Performance,” *American Journal of Public Health* 101 (2011): 1900 – 1906.
- 16 U.S. Department of Health and Human Services, Health Resources and Services Administration, “Designated Health Professional Shortage Areas (HPSA) Statistics as of January 17, 2012,” pg 8, accessed January 18, 2012, <http://datawarehouse.hrsa.gov/quickaccessreports.aspx>. Note: website is continuously updated with new data.
- 17 S. Boyles, “Millions in U.S. Lack Access to Dentists,” WebMD, (July 13, 2011), accessed January 26, 2012, <http://www.webmd.com/oral-health/news/20110713/millions-in-us-lack-access-to-dentists>.
- 18 “U.S. dentist shortage predicted,” DrBicuspid.com, (March 12, 2010), accessed January 26, 2012, <http://www.drbuspid.com/index.aspx?sec=sup&sub=pmt&pag=dis&ItemID=304110>.
- 19 Pew Center on the States “Two Kinds of Dental Shortages Fuel One Major Access Problem,” (February 2011), accessed September 29, 2011, http://www.pewcenteronthestates.org/uploadedFiles/Dentist_shortage_brief.pdf.
- 20 E.F. Shortridge et al., “Use of Emergency Departments for Conditions Related to Poor Oral Health Care.”
- 21 U.S. Government Accountability Office, “Efforts Under Way to Improve Children’s Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns” (November 2010). <http://www.gao.gov/new.items/d1196.pdf>. Note: the GAO analyzed data from 39 states.
- 22 Stacie Crozier, “Insights gained in Hispanic survey,” *ADA News*, American Dental Association, (November 21, 2011), accessed January 25, 2011, <http://www.ada.org/news/6579.aspx>.
- 23 Pan Atlantic SMS Group, “Proprietary Results from the 49th Pan Atlantic SMS Group Omnibus Poll,” (December 2011).
- 24 E. Davis, A. Deinard, and E. Maïga, “Doctor, My Tooth Hurts: The Costs of Incomplete Dental Care in the Emergency Room,” *Journal of Public Health Dentistry* 70 (2010): 205-210.
- 25 B. Sheller, B.J. Williams, and S.M. Lombardi, “Diagnosis and treatment of dental caries-related emergencies in a children’s hospital.” *Pediatric Dentistry* 19 (1997): 470-475.

26 A study found that in-patient ER treatment for dental problems averaged \$6,498, compared with the cost of preventive care in a dentist's office, which averaged \$660. See E. Pettinato, M. Webb and S.N. Seale, "A comparison of Medicaid reimbursement for non-definitive pediatric dental treatment in the emergency room versus periodic preventive care," *Pediatric Dentistry* 22 (2000): 463-468; C.N. Bertolami, "Health Care Reform Must Include Dental Care," Roll Call, (April 23, 2009), accessed September 27, 2011, <http://www.rollcall.com/news/-34231-1.html>.

27 P. Casamassimo, S. Thikkurissy, B. Edelstein, and E. Maiorini, "Beyond the DMFT: The Human and Economic Cost of Early Childhood Caries," *Journal of the American Dental Association* 140 (2009): 650-657.

28 Oregon Health Authority, "Dental care in the ER: wrong place, wrong time," (May 17, 2011), accessed October 2, 2011, <http://www.oregon.gov/OHA/features/2011-0517-er-dental.shtml>.

29 C. Lewis, H. Lynch, and B. Johnston, "Dental Complaints in Emergency Departments: A National Perspective," *Annals of Emergency Medicine* 42 (2003): 93-99.

30 L. Cohen, A. Bonito, D. Akin, R. Manski, M Macek, R. Edwards, and L Cornelius "Toothache Pain: A

Comparison of Visits to Physicians, Emergency Departments and Dentists," *Journal of American Dental Association* 71 (2008): 1205-1216.

31 DentaQuest Institute "Early Childhood Caries Initiative," accessed October 3, 2011, <http://www.dentaquestinstitute.org/improvement-initiatives/early-childhood-caries-initiative>.

32 E. Davis, et al., "Doctor, My Tooth Hurts: The Costs of Incomplete Dental Care in the Emergency Room."

33 S. Trzeciak and E.P. Rivers, "Emergency department overcrowding in the United States: an emerging threat to patient safety and public health," *Emergency Medicine Journal*, 20 (2003): 402-405.

34 American College of Emergency Physicians, "The National Report Card on the State of Emergency Medicine," (2008), accessed January 18, 2012, <http://emreportcard.org/overview.aspx?id=82>.

35 J.A. Schoenman et al., "The Value of Hospital Discharge Databases," NORC at the University of Chicago, (May 2005), 37-38, http://www.hcup-us.ahrq.gov/reports/final_report.pdf; Pew Center on the States telephone conversation with Denise Love, executive director of the National Association of Health Data Organizations, January 30, 2012.

36 California HealthCare Foundation, “Emergency Department Visits for Preventable Dental Conditions in California,” (2009), accessed October 13, 2011, <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/E/PDF%20EDUseDentalConditions.pdf>.

37 “State Statistics – 2009 Tennessee,” Agency for Healthcare Research and Quality, (2009), http://hcupnet.ahrq.gov/Hcupnet.jsp?Id=7A2F5E4AC8D65100&Form=SelEDVisit&JS=Y&Action=%3E%3ENext%3E%3E&_EDVisit=AllEDVisit.

38 “Chicago Area Communities Non-Injury Dental Discharges 2008-2011,” Illinois Department of Public Health, Office of Policy, Planning and Statistics, (October 2011), e-mail from Julie Janssen, Illinois Department of Public Health, December 1, 2011.

39 “State Statistics – 2009 Utah,” Agency for Healthcare Research and Quality, (2009), http://hcupnet.ahrq.gov/Hcupnet.jsp?Id=7A2F5E4AC8D65100&Form=SelEDVisit&JS=Y&Action=%3E%3ENext%3E%3E&_EDVisit=AllEDVisit.

40 Florida Public Health Institute, “News Release: 315 Patients a Day Seek Dental Treatment in Florida’s Hospital Emergency Rooms,” (December 15, 2011), accessed January 25, 2012, http://cdn.trustedpartner.com/docs/library/FloridaOralHealth2011/ER_Data_Press_Release_Final.pdf.

41 Data for 2009 were obtained from the Ohio Hospital Association, and explanations of these data were provided by Jeff Klingler of the Central Ohio Hospital Association. Pew Center on the States interview with Jeff Klingler, Central Ohio Hospital Association, January 18, 2012. Email confirmation of number received January 25, 2012 and January 26, 2012 from Jeff Klingler.

42 These data were reported by the Kansas Hospital Association (December 2011). E-mail from Tanya Dorf Brunner, executive director, Oral Health Kansas Inc., December 12, 2011. Thirty Kansas hospitals did not report data on dental-related ER visits; federal data show there were 142 hospitals in Kansas in 2009. See Agency for Healthcare Research and Quality, “Introduction to the HCUP Nationwide Inpatient Sample (NIS) 2009,” (May 2011), accessed January 26, 2011, http://www.hcup-us.ahrq.gov/db/nation/nis/NIS_Introduction_2009.jsp#figure4.

43 “State Statistics – 2009 North Carolina,” Agency for Healthcare Research and Quality, (2009), http://hcupnet.ahrq.gov/Hcupnet.jsp?Id=7A2F5E4AC8D65100&Form=SelEDVisit&JS=Y&Action=%3E%3ENext%3E%3E&_EDVisit=AllEDVisit.

44 Nevada Department of Health and Human Services, “2005 Nevada Hospital In-Patient and Emergency Room Use for Cavities, Gum Disease and Dental

- Abscesses,” (May 2007), accessed October 2, 2011, <http://health.nv.gov/PDFs/OH/Final2005NevadaHospitalReport.pdf>.
- 45 B. Kilbreth, B. Shaw, D. Westcott, and C. Gray, “Analysis of Emergency Department Use in Maine,” Muskie School of Public Service, (January 2010), accessed October 3, 2011, <http://muskie.usm.maine.edu/Publications/PHHP/Maine-Emergency-Department-Use.pdf>.
- 46 E. Davis, et al., “Doctor, My Tooth Hurts: The Costs of Incomplete Dental Care in the Emergency Room.”
- 47 Rhode Island Kids Count, “Access to Oral Health Care for Children in Rhode Island,” pg 4 (September 2011) accessed October 3, 2011, <http://www.rikidscount.org/matriarch/documents/Issue%20Brief-OralHealth2011-FINAL.pdf>.
- 48 Washington State Hospital Association, “Emergency Room Use,” pg 8-12 (October 2010) accessed February 8, 2011, <http://www.wsha.org/files/127/ERreport.pdf>.
- 49 M.F. Savage, J.Y. Lee, J.B. Kotch and W.F. Vann, Jr., “Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs,” *Pediatrics* 114 (2004): e418-422.
- 50 J.Y. Lee, T.J. Bouwens, M.F. Savage, and W. F. Vann, “Examining the Cost-effectiveness of Early Dental Visits,” *Pediatric Dentistry* 28 (2006): 102-105.
- 51 H. Bailit, T. Beazoglou, N. Demby, J. McFarland, P. Robinson, and R. Weaver, “Dental safety net: Current capacity and potential for expansion,” *Journal of the American Dental Association* 137 (2010): 807-815; Health Resources and Services Administration, “2010 National Report,” pg 49, accessed December 12, 2011, http://bphc.hrsa.gov/uds/doc/2010/National_Universal.pdf.
- 52 Centers for Disease Control and Prevention Task Force on Community Preventive Service, “Recommendations on Selected Interventions to Prevent Dental Caries, Oral and Pharyngeal Cancers, and Sports-Related Craniofacial Injuries,” *American Journal of Preventive Medicine* 23 (2002):16-19.; In 2009, the national median charge among general practice dentists for procedure D1351 (dental sealant) is \$44 and national median charge for procedure D2150 (two-surface amalgam filling) is \$134. See American Dental Association, “2009 Survey of Dental Fees,” pg 17 (2009).
- 53 Bureau of Health, Maine Department of Human Services, “Dental Sealants,” (2004), accessed March 30, 2011, http://www.cdc.gov/OralHealth/publications/library/burdenbook/pdfs/DS_factsheet.pdf.
- 54 Centers for Disease Control and Prevention Task Force on Community

Preventive Service, “Recommendations on Selected Interventions to Prevent Dental Caries, Oral and Pharyngeal Cancers, and Sports-Related Craniofacial Injuries.”

55 See Pew Center on the States “The State of Children’s Dental Health: Making Coverage Matter” Exhibit D: Pew Center on the States Analysis of Eight Key Policy Indicators, pg 24 (May 2011) accessed January 26, 2012, http://www.pewcenteronthestates.org/uploadedFiles/The_State_of_Children’s_Dental_health.pdf.

56 The 21 states are Alabama, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Mississippi, Montana, New Jersey, North Carolina, Ohio, Rhode Island, South Dakota, Tennessee, Texas, Virginia, West Virginia and Wyoming. See: Pew Center on the States “The State of Children’s Dental Health: Making Coverage Matter” Exhibit D: Pew Center on the States Analysis of Eight Key Policy Indicators.

57 Systematic reviews by the CDC and the ADA indicate that it is appropriate to seal teeth that have early non-cavitated lesions, and that visual assessments are sufficient to determine whether non-cavitated lesions are present. See J. Beauchamp, P.W. Caufield, J.J. Crall, K. Donly, R. Feigal, B. Gooch, A. Ismail, W. Kohn, M. Siegal, R. Simonsen, and American Dental Association Council on Scientific Affairs, “Evidence-Based

Clinical Recommendations for Use of Pit-and-Fissure Sealants: A Report of the American Dental Association Council on Scientific Affairs,” *Journal of the American Dental Association* 139 (2008): 257-267. Accreditation standards for dental hygiene training programs include standard 2-11, relating to education of dental hygiene students on dental-specific anatomy and pathology, with the intent of providing “the student with knowledge of oral health and disease as a basis for assuming responsibility for assessing, planning and implementing preventive and therapeutic services.” See Commission on Dental Accreditation, “Accreditation Standards for Dental Hygiene Education Programs,” pg 19, accessed December 1, 2010, <http://www.ada.org/sections/educationAndCareers/pdfs/dh.pdf>.

58 “Fluoridation of Public Water Supplies,” a policy statement of the American Academy of Family Physicians, accessed on January 24, 2011, <http://www.aafp.org/online/en/home/clinical/clinicalrecs/guidelines/fluoridation.html>; Institute of Medicine. *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*, pg 2-17 (July 2011).

59 The children who experienced this reduction in the median decay rate were aged 4 to 17. See: The U.S. Task Force on Community Preventive Services, “Summary of Task Force Recommendations and Findings,” (2002)

accessed November 22, 2011, <http://www.thecommunityguide.org/oral/fluoridation.html>.; S.O. Griffin, E. Regnier, P.M. Griffin and V. Huntley, “Effectiveness of Fluoride in Preventing Caries in Adults,” *The Journal of Dental Research* 86 (2007): 410-415.

60 Centers for Disease Control and Prevention, “Cost Savings of Community Water Fluoridation,” (September 1, 2009) accessed January 25, 2012, http://www.cdc.gov/fluoridation/fact_sheets/cost.htm.

61 Texas Department of Oral Health Website “Water Fluoridation Costs in Texas: Texas Health Steps (EPSDT-Medicaid),” (2000) accessed on August 1, 2010, www.dshs.state.tx.us/dental/pdf/fluoridation.pdf.; J.V. Kumar, O. Adekugbe, and T.A. Melnik, “Geographic Variation in Medicaid Claims for Dental Procedures in New York State: Role of Fluoridation Under Contemporary Conditions,” *Public Health Reports* 125 (September-October 2010): 647-54. (Note: The original figure, \$23.63, was corrected in a subsequent edition of this journal and clarified to be \$23.65. See: “Letters to the Editor,” *Public Health Reports* 125 (November-December 2010): 788.)

62 Centers for Disease Control and Prevention, “2008 Water Fluoridation Statistics,” (October 2010) accessed December 9, 2010, <http://www.cdc.gov/fluoridation/statistics/2008stats.htm>. Note: At the time of this brief 2008 is the latest year of CDC data available.

63 Anti-fluoride groups have misrepresented the findings of the 2006 National Research (NRC) report on fluoride. For example, the group Fluoride Action Network (FAN) has cited the NRC report to back its contention that optimally fluoridated water poses health harms to the public. Yet the NRC’s concerns about potential health issues were focused on Americans who live in areas whose wells or water supplies have high *natural* levels of fluoride that are roughly two to four times the level used to fluoridate a public water system. In a summary of its own report, the NRC stated, “it is important to note that the safety and effectiveness of the practice of water fluoridation was outside the scope of this report and is not evaluated.” See: “Fluoride in Drinking Water: A Scientific Review of EPA’s Standards,” Report in Brief, prepared by the National Research Council (March 2006), accessed on April 20, 2011, http://dels.nas.edu/resources/static-assets/materials-based-on-reports/reports-in-brief/fluoride_brief_final.pdf.

64 Pew Center on the States, “Water Fluoridation: What the Science Says,” http://www.pewcenteronthestates.org/initiatives_detail.aspx?initiativeID=85899367159.

65 The Pew Center on the States and the American Academy of Pediatrics, “Reimbursing Physicians for Fluoride Varnish,” accessed January 3, 2012, http://www.pewcenteronthestates.org/initiatives_

detail.aspx?initiativeID=328928. Note: The 44 states include two states (TN and NJ) that have approved Medicaid reimbursement rates for fluoride varnish under certain circumstances, such as for children in a specified age range.

66 U.S. Government Accountability Office, “Efforts Under Way to Improve Children’s Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns,” pg 12 (November 2010) accessed December 22, 2011, <http://www.gao.gov/new.items/d1196.pdf>.

67 U.S. Department of Health and Human Services, Health Resources and Services Administration, “Designated Health Professional Shortage Areas (HPSA) Statistics as of January 17, 2012.”

68 U.S. Government Accountability Office, “Efforts Under Way to Improve Children’s Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns,” pg 22, 33-34.

69 S. Wetterhall, J.D. Bader, B.B. Burrus, J.Y. Lee, and D.A. Shugars, “Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska,” (October 2010), accessed November 28, 2011, <http://www.wkkf.org/knowledge-center/resources/2010/10/Alaska-Dental-Therapist-Program-RTI-Evaluation-Report.aspx>.

70 L.E. Felland, J. Lauer, and P.J. Cunningham, “Community Efforts to Expand Dental Services for Low-Income People,” Brief No. 122, Center for Studying Health System Change (July 2008), accessed September 2, 2011, <http://hschange.org/CONTENT/1000/#ib4>; U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, “Dental Care: Improving Access and Quality,” Research in Action: Issue 13, accessed September 14, 2011, <http://www.ahrq.gov/research/dentalcare/dentria2.htm#Conclusion>.

71 “Dental Crisis Looming in the State,” The Lansing State Journal, (November 24, 2009), accessed September 27, 2011, <http://www.mPCA.net/article.html?a=Dental-Crisis-Looming-in-the-State>.

72 L. Cohen, R. Manski, L. Magder and C.D. Mullins, “Dental visits to hospital emergency departments by adults receiving Medicaid,” *Journal of the American Dental Association* 133 (2002): 715-724.

INFOGRAPHIC NOTES

i “315 Patients a Day Seek Dental Treatment in Florida’s Hospital Emergency Rooms,” a news release by the Florida Public Health Institute, (December 15, 2011).

ii Andy Miller, “Fight over Georgia dental rules flares again,” *Georgia Health News*, September 7, 2011, <http://www.georgiahealthnews.com/2011/09/fight-dental-rules-flares/>.

iii “2007 OP ED Visits to District E Hospitals,” Oral Health Bureau, Iowa Department of Public Health, e-mail from Bery Engebretson, M.D., Primary Health Care Inc., October 14, 2011.

iv E. Davis, A. Deinard, and E. Maiga, “Doctor, My Tooth Hurts: The Costs of Incomplete Dental Care in the Emergency Room,” *Journal of Public Health Dentistry* (2010), 205-210.

v *Community Health Assessment: 2010*, City of Kansas City, Mo., Health Department, (September 2010), 233, <http://www.kcmo.org/idc/groups/health/documents/health/cha2010-fullreport.pdf>.

vi “2005 Nevada Hospital In-Patient and Emergency Room Use for Cavities, Gum Disease and Dental Abscesses,” Nevada Department of Health and Human Services, (May 2007), <http://health.nv.gov/PDFs/OH/>

Final2005NevadaHospitalReport.pdf (accessed October 2, 2011).

vii S. Nagarkar, J. Kumar and M. Moss, “Early Childhood Caries-related Visits to Emergency Departments and Ambulatory Surgery Facilities and Associated Charges in New York State,” *Journal of the American Dental Association* (2012), 59-65.

viii David Wahlberg, “Too few dentists, too much pain in rural Wisconsin communities,” *The Wisconsin State Journal*, May 23, 2010, http://host.madison.com/wsjs/special-section/rural_health/article_82a4d6ae-65c1-11df-9a2f-001cc4c002e0.html#ixzz1ZgQKz9hj, (accessed September 28, 2011).

ix “315 Patients a Day Seek Dental Treatment in Florida’s Hospital Emergency Rooms,” a news release by the Florida Public Health Institute, (December 15, 2011).

x Data from the Oregon Health Plan (Medicaid), submitted by Upstream Public Health. These data on ER visits include both the fee-for-service and managed care components of Oregon’s Medicaid program. E-mail from Mel Rader, Upstream Public Health, December 14, 2011.

xi “State Statistics – 2009 South Carolina,” Agency for Healthcare Research and Quality, (2009), <http://hcupnet.ahrq.gov/>

HCUPnet.jsp?Id=7A2F5E4AC8D65100&Form=SelEDVisit&JS=Y&Action=%3E%3ENext%3E%3E&_EDVisit=AllEDVisit.

xii “Emergency Department Visits for Vermonters at VT & NH Hospitals, 2003-2009: Primary Diagnosis Clinical Classification Software (CCS) Category 136, Disorders of Teeth and Jaw,” Vermont Department of Health, shared via e-mail (January 11, 2012) by David Jordan, Community Catalyst.

xiii S. Nagarkar, J. Kumar and M. Moss, “Early Childhood Caries-related Visits to Emergency Departments and Ambulatory Surgery Facilities and Associated Charges in New York State,” *Journal of the American Dental Association* (2012), 59-65.

xiv “State Statistics – 2007 Hawaii” and “State Statistics – 2004 Hawaii,” Agency for Healthcare Research and Quality, (2009), http://hcupnet.ahrq.gov/HCUPnet.jsp?Id=7A2F5E4AC8D65100&Form=SelEDVisit&JS=Y&Action=%3E%3ENext%3E%3E&_EDVisit=AllEDVisit.

xv “Ambulatory Care Sensitive Emergency Department Visits: Chronic Disease Conditions – New Hampshire, 2001-2005,” New Hampshire Department of Health and Human Services (2008), <http://www.dhhs.state.nh.us/dphs/cdpc/documents/emergencydeptvisits.pdf>.

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The Pew Children's Dental Campaign works to promote policies that will help millions of children maintain healthy teeth, get the care they need, and come to school ready to learn.

The Pew Center on the States is a division of The Pew Charitable Trusts that identifies and advances effective solutions to critical issues facing states. Pew is a nonprofit organization that applies a rigorous, analytical approach to improve public policy, inform the public, and stimulate civic life.

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Improved Health and Lower Medical Costs:

Why good dental care is important

A white paper



Research continues to associate oral health with overall health. Gum disease may have a potentially significant impact on systemic health, and the implications for cost of care and quality of life can be staggering. For example, did you know that when a dentist diagnoses periodontal (gum) disease, other serious health problems may also be lurking? If oral disease is left unchecked, it may result in health complications that take a real toll on quality of life for an affected employee. Those problems can also be a drain on your and your employees' health dollars. The good news is that treating oral diseases like gum disease may improve overall health and lessen complications with other medical conditions. Regular routine oral care helps address minor problems before they become major, and more expensive to treat. **Every dollar spent on preventive dental care could save \$8 to \$50 in restorative and emergency treatments¹** – and potentially more in additional types of medical treatment. That's why CIGNA is always working to develop and deliver solutions that include highly effective dental coverage. It's good for your employees' health, and good for your company's bottom line.

The right dental plan may lower medical costs

Our nationally published study supports an association between treated gum disease and lower medical costs for individuals with diabetes, cardiovascular disease and stroke. When compared with patients undergoing **initial treatment** for gum disease, patients who were previously treated for gum disease and were receiving **maintenance care** had reduced medical costs. CIGNA's ongoing dental and medical cost study supports a potential adverse association between untreated gum disease and higher medical costs for these three medical conditions. The numbers speak for themselves:

Periodontal care reduces overall medical costs in the first year

Study Summary All results reflect enrollment of individuals in both CIGNA's Medical and Dental plans.

Diabetes	↓\$1,418	}	Average Reduction in First Year Medical Costs for Individuals Receiving Periodontal Treatment
Cardiovascular Disease	↓\$647		
Stroke	↓\$10,142		

"Periodontal Treatment and Medical Costs in Diabetes and Cerebrovascular Accident" Presented at the International Association for Dental Research Meeting 2009, Miami

CIGNA follows the research closely. While studies continue, we believe in the current information concerning the link between oral and overall health, and we share that belief with our clients – we offer a credit for new clients who package their medical and dental plans through CIGNA. An additional credit may be available when CIGNA's disease management programs for diabetes and heart disease are included. Credits may also apply to existing accounts that add a CIGNA medical or dental plan.

Reviewing the evidence and CIGNA's action

The CIGNA Dental Oral Health Integration Program® was first to use improved oral health to reduce risks related to pregnancy, diabetes and heart disease. Studies show that patients with the following conditions are frequently prone to dry mouth, a condition associated with a higher risk of dental cavities: head and neck cancer radiation, organ transplants and chronic kidney disease. As a result, we've enhanced our Program. Dental customers can now get 100 percent reimbursement of their copay/coinsurance for certain dental services if they have any of the following medical conditions: maternity, diabetes, heart disease, stroke, head and neck cancer radiation, organ transplants and chronic kidney disease.

Pregnancy and prematurity	CIGNA's Action
<p>Pregnant women with untreated gum disease are up to eight times more likely to give birth prematurely.²</p> <p>The facts: The rate of premature births is on the rise, with 12.5 percent of all newborns born prematurely. The medical costs that businesses pay to care for one premature baby for a year could cover the costs of 10 healthy, full-term infants (\$49,000 versus \$4,550). When combined, maternity and first-year costs for a premature baby were four times as high as those for a baby born without any complications (\$64,713 and \$15,047 respectively). Health plans pay more than 90 percent of those costs.³</p>	<p>Enhanced dental coverage during pregnancy</p> <p>Research has shown that timely treatment for gum disease may reduce the risk of preterm birth.⁴ That's why pregnant women with CIGNA dental coverage can take advantage of the extra dental services covered through our Oral Health Integration Program.</p>
Diabetes and heart disease	
<p>Gum disease can be a risk factor for complications of diabetes, and it can also put diabetics at a higher risk for additional gum problems. Studies show that gum disease may also make it more difficult for diabetics to control their blood sugar.⁵</p> <p>The facts: The estimated economic cost of diabetes in 2007 was \$174 billion. Approximately one of five health care dollars in the United States is spent caring for someone diagnosed with diabetes.⁶ Bacteria present in gum disease may help trigger the formation of blood clots, which can contribute to a heart attack or stroke. The 2010 estimated direct and indirect cost of cardiovascular disease and stroke is \$503.2 billion.⁷</p>	<p>Enhanced dental coverage for people with diabetes and heart disease</p> <p>Studies continue to present evidence that good oral health may contribute to reduced risk of heart disease, stroke and diabetic complications. That's why it makes sense to offer enhanced coverage for eligible customers with these conditions.</p>
Oral cancer	
<p>Early detection may help save a life – about 60 percent of all patients with oral cancer survive more than five years.⁸</p> <p>The facts: Approximately 36,000 people in the U.S. will be diagnosed with oral cancer this year. It will cause over 8,000 deaths, killing roughly one person per hour, 24 hours per day. This is the fourth year in a row showing an increase in the occurrence of oral cancers – in 2007 alone the rate jumped by 11 percent. It is estimated that approximately \$3.2 billion is spent in the U.S. each year on treatment of head and neck cancers.⁹</p>	<p>Enhanced Oral Cancer screening coverage</p> <p>Surgical biopsies may not be generally prescribed unless something in the mouth appears "very suspicious." However, by the time a lesion looks like a problem, it may be beyond a cure. Our Brush Biopsy coverage offers dentists and patients a nonsurgical way to evaluate a suspicious area for abnormal cells.</p> <p>Dental customers undergoing head and neck cancer radiation are eligible for enhanced dental coverage through our Oral Health Integration Program.</p>

Why CIGNA for both medical and dental coverage?

The benefits go beyond simplified administration. Our unique capabilities as a health services company allow us to treat the whole person – not just a condition. And our customer service representatives are available 24/7 at 1.800.CIGNA24 for any questions our customers may have, any time of day, about any plan.

- Integration and total health management have been a focus for CIGNA throughout the past several years. In addition to initiatives like the Oral Health Integration Program (OHIP), we have integrated capabilities across all CIGNA units.
- Being a fully integrated health services company has been instrumental to our success in creating programs and initiatives that involve the integration of medical and dental coverage information. And we'll continue to leverage CIGNA's capabilities in disease management and case management to help our customers enjoy a better quality of life – and help our clients recognize improved productivity as a result.
 - We've trained our medical staff to include the message that oral health may affect an individual's medical conditions. Our staff also encourages individuals with related conditions to seek dental care and make an appointment with the dentist.
 - CIGNA is also able to identify dental customers who have recently been treated for gum disease. If those customers also have CIGNA medical coverage, we can provide that data to clinical staff for disease management (diabetes and cardiovascular).
- We use an evidence-based approach to dentistry to create our innovative dental plan designs and policies. To further this approach we established a clinical advisory panel of well known leaders and researchers in the dental profession. Their scientific knowledge and input helps us continue to create and deliver innovative coverage options that address medical/dental integration, as well as new and developing dental technologies.

Raising awareness in the workplace

Another benefit of having CIGNA medical and dental coverage is our comprehensive communication and education capabilities. After all, what good is a dental benefit if your employees aren't enrolling in it? And of those who enroll, how many are choosing the right dental plan? Effective communications can move individuals from passive players to active participants. Based on the National Assessment of Adult Literacy, approximately 36 percent of the U.S. population has low health literacy. This means they can't understand documents written above a sixth grade reading level. A significant body of research has demonstrated that there is a relationship between lower health literacy and higher health care costs from less frequent preventive care, longer and more frequent hospital stays, and lower medication adherence.¹⁰

As a result of these findings, CIGNA has implemented the "Words We Use" guidelines in all of our customer communications – this means using clear, simple, easy to understand words while doing away with industry jargon. We help our clients send the right message to the right people in the right way:

- **PREPARE** employees to choose the best dental plan at enrollment based on their specific needs
- **ENGAGE** employees at enrollment meetings, benefit fairs, or wellness events
- **TEACH** employees how to maximize their dental care dollars year-round
- **TRAIN** your HR team and/or managers to answer your employees' questions
- **ENCOURAGE** employees to stay well by getting regular preventive dental care

From dental health flyers, to e-cards, to event posters and more – we have the communications and resources to get your employees enrolled and in the dentist's chair.

Learn more

Find out how CIGNA can help you design a dental plan that impacts the health and well-being of your employees without compromising your bottom line.

Call your broker or CIGNA representative today. Or, email us at **CIGNADentalSales@cigna.com**.

- 1 American Dental Hygienists Association, 2006
- 2 Journal of the American Dental Association, July 2001
"Oral Health During Pregnancy: An Analysis of Information"
- 3 March of Dimes® Release, 2009
- 4 Journal of Periodontology, August 2003
- 5 Journal of the American Dental Association, September 2002
- 6 American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2007. Diabetes Care. 2008;31(3):596–615.
- 7 American Heart Association: Heart Disease and Stroke Statistics, 2010 Update, p. 5
- 8 American Cancer Society, www.cancer.org
- 9 www.oralcancerfoundation.org
- 10 Health Literacy — A Prescription to End Confusion (2004).
Institute of Medicine, Committee on Health Literacy.
Editors: Nielsen-Bohlman, Lynn; Panzer, Allison; & Kindig, David.
<http://www.nap.edu/catalog/10883.html>



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State's Response:

This Demonstration Waiver aligns with the objectives of the 2012 Oral Health Care During Pregnancy: A National Consensus Statement publication. The narrative for the Demonstration Waiver has been revised to reference this publication. DHHS will continue considering it during the implementation planning phase.

Thank you for the information and white papers, as well as support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.

Comment Received via Email from Hope Saltmarsh – Executive Director, Greater Derry Oral Health Collaborative Corporation

Date Received: 5/20/2014 at 1:09 PM
From: Hope Saltmarsh, RDH, M.Ed., Executive Director
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Thank you for providing this opportunity for comment. Please see Appendix.



Greater Derry Oral Health Collaborative Corporation

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Working Together for Healthier Kids

May 20, 2014

"Building Capacity for Transformation" Section 1115 Waiver Comments

Kathleen Dunn, Director, Medicaid Program
Brown Building
NH Department of Health and Human Services
129 Pleasant St.
Concord, NH 03301

Dear Ms. Dunn:

Greater Derry Oral Health Collaborative Corporation is a 501(c) 3 non-profit organization operating two mobile school-based dental programs in the greater Derry area of NH. The largest and longest-running program is the Children's Dental Network (CDN) that is in its 21st year. CDN has been providing oral health education and preventive services for Derry Head Start children for most of those years. Children's Dental Network works closely with schools (grades K-8) and over thirty dentists in the towns it serves: Derry, Londonderry, Chester, Sandown, Windham and Hampstead. Most recently, CDN has been providing services at the Derry WIC clinic. A second and very similar program has been operating in Salem schools for 6 years.

Dianne Powers, RDH and CDN Program Director writes of her experience working at WIC during the summer months for the past three years: *Originally, the intent of our program was to offer basic services and education to mothers of WIC children ages 0-5 years. What we discovered very quickly was that the WIC mothers needed services and education just as much, if not more, than their children. Most WIC mothers have not been to the dentist in several years. Most tell me that their OB/GYN doctors have not advised them about the importance of dental care before, during, and after pregnancy. They are unaware of the relationship of oral health and overall health.*

I have examined young WIC mothers with rampant decay, problems with impacted and partially erupted third molars, missing teeth, broken teeth, gingivitis, poor eating and drinking habits, smoking habits, and even one young mother who after five years still had braces on all her teeth although she hadn't been under the care of an orthodontist for years. She had broken brackets and wires as well as decay on many anterior teeth and claimed that she wished she "could just have all her teeth out".

Most of the young mothers believe that dental care during pregnancy is not safe when all the evidence points to its importance. These young mothers help to shape the health of their babies and children and run the risk of sharing their unhealthy bacteria with their little ones during normal mother and child contact. Many of these mothers want to seek care but without insurance, resources, or dental clinics available to them, they have no choice but to do nothing. My experiences at Derry WIC have been enlightening and sad as I have few options to offer them.



I am writing to strongly support the NH DHHS *Building Capacity for Transformation* Section 1115 Demonstration Waiver, specifically, the DSHP oral health program for pregnant women. CDN's data show that only 18% of the pregnant women and mothers at WIC in Derry report having had a dental appointment in the previous 12 months. Dianne Powers, RDH performed brief visual screenings for them and found 51% appeared to have untreated cavities. If performed in a dental office with X-rays available, the number with untreated cavities would surely have been significantly higher. An accurate assessment of periodontal disease status has not been possible under our screening conditions at the Derry WIC center.

The National Oral Health Curriculum, *Smiles for Life*, is a product of the Society for the Teachers of Family Medicine. It is an online oral health modular curriculum for physicians, which is very widely endorsed by professional organizations including the American Dental Association (ADA), the American Association of Public Health Dentistry, (AAPHD) and the Association of State and Territorial Dental Directors (ASTDD), and the American College of Nurses and Midwives (ACNM). According to the curriculum, "Preterm birth is the number one cause of neonatal mortality in the U.S. and costs \$5.5 billion per year." Additionally, "Numerous studies have documented an association between maternal periodontal disease and preterm birth and low birth weight." Furthermore, "Studies do demonstrate that periodontitis improved with treatment and that treatment is safe during pregnancy."

In January 2011, the Journal of American Public Health published *An Examination of Periodontal Treatment, Dental Care, and Pregnancy Outcomes in an Insured Population in the United States*. Researchers found that women who received preventive dental care had better birth outcomes than did those who received no treatment. They observed no evidence of increased odds of adverse birth outcomes from dental or periodontal treatment.

Periodontal disease isn't the only dental disease that can adversely affect birth outcomes. Dental decay, left untreated, can pose a threat to a pregnant woman's health and the health of her baby. For example, a bad tooth infection could spread throughout the woman's body.

The 1115 Demonstration Waiver, by launching a comprehensive, adequately long-term oral health pilot program for pregnant women, targets exactly the population that has the greatest potential to realize real health improvement. There is every reason to expect that their health gains will be accompanied by reduced costs to Medicaid. Women who are pregnant have an increased likelihood to become pregnant again in the future. Because of this demonstration project, participants will have improved oral health from the start of a subsequent pregnancy thus decreasing their risk of preterm birth or a problem from urgent tooth decay.

In 2012, National Maternal and Child Oral Health Resource Center published *Oral Health Care During Pregnancy: A National Consensus Statement – Summary of an Expert Workgroup Meeting*. This guideline states, "In addition to providing pregnant women with oral health care, educating them about preventing and treating dental caries is critical, both for women's own oral health and for the future oral health of their children. Evidence suggests that most infants and young children acquire caries-causing bacteria from their mothers. Providing pregnant women with counseling to promote healthy behaviors may reduce the transmission of such bacteria from mothers to infants and young children, thereby delaying or preventing the onset of [tooth decay]."

The Demonstration Waiver includes a strong education component. To maximize its effectiveness, we encourage development of an education program and incentives that are based on the best available evidence, best practices, and established principles of learning and behavior change that are suited for the variety of settings where this education could take place.



According to a 2013 Cochrane Systematic Review, “Psychosocial interventions to support women to stop smoking in pregnancy can increase the proportion of women who stop smoking in late pregnancy, and reduce low birth-weight and preterm births.” Smoking has another somewhat unexpected relationship to oral health. Early evidence shows a relationship between secondhand smoke and tooth decay in primary dentition, as reported in the February, 2014 issue of the Journal of the American Dental Association. There are multiple, strong reasons to encourage pregnant women to stop smoking. Our organization supports the inclusion of a smoking cessation component in the 1115 Demonstration Waiver.

The most accurate predictor of tooth decay is previous decay. An excellent opportunity is available for prevention of tooth decay in the children of the women who will be eligible to participate in this Oral Health Pilot Program. Based on our experience at the Derry WIC, children we screen who are under age 12 mos. have virtually no tooth decay. We currently recommend that mothers take their children to a dentist by age 12 months and there are dental offices that are ready to accept these referrals. We anticipate that, if this pilot program takes place, more mothers will understand and value good oral health for their children. Increased primary prevention of decay will result in the best outcomes for children, their families, and for Medicaid.

In our school programs, we are often frustrated by the lack of follow-up by parents when we identify a child’s need for dental treatment that is not yet urgent. When the child has Medicaid coverage this is especially disheartening. In conversations with the parents of these children, we usually find they have very low oral health literacy and they often have substantial untreated dental problems of their own. The pilot project holds the promise that in the future there will be more low-income mothers who do understand how to prevent cavities and value oral health for themselves and their children.

From the broader perspective of total health, the target population of the 1115 Demonstration Waiver may well enjoy more significant benefits than those expected. According to the American Academy for Oral Systemic Health, “We know that gum disease is linked to heart disease, stroke, diabetes, pregnancy complications, Alzheimer’s, ... oral cancer, oral airway and sleep apnea, TMJ – headaches & migraines, dental decay... These connections between the mouth and the body highlight the importance of good oral health and dental stability in assuring better general health.”

Thank you for consideration of these comments on behalf of the Greater Derry Oral Health Collaborative Corporation. Please contact me if you have questions.

Sincerely,

Hope Saltmarsh, RDH, M.Ed.
hopesal@comcast.net
Executive Director

Greater Derry Oral Health Collaborative Corporation
Derry Village School
28 S. Main St.
Derry, NH 03038
603-434-2327

State’s Response:

Thank you for the comment and support of the Waiver.



This Demonstration Waiver aligns with the objectives of the 2012 Oral Health Care During Pregnancy: A National Consensus Statement publication. The narrative for the Demonstration Waiver has been revised to reference this publication. DHHS will continue considering it during the implementation planning phase.

Comment Received via Email from Effie Malley – Director, New Hampshire Children's Behavioral Health Collaborative

Date Received: 5/20/2014 at 1:49 PM
From: Effie Malley, Director
New Hampshire Children's Behavioral Health Collaborative
10 Ferry St. – Suite 307
Concord, NH 03301
Tel: (603) 225-9540 x119 | Fax (603) 415-9543

Dear Sir or Madam,

Members of the New Hampshire Children's Behavioral Health Collaborative steering committee enthusiastically support New Hampshire's application for a Section 1115 Medicaid demonstration waiver. We want to assure that Centers for Medicare and Medicaid Services understand the importance of this waiver to our state.

Our Collaborative, which includes over 60 organizations and family and youth representatives, developed a comprehensive plan which outlines the transformation of the delivery system and services available to children, youth, and their families. The waiver would allow flexible funding and development of the youth-serving behavioral health workforce, key strategies in our plan, which affect both providers and beneficiaries. The waiver allows us to build community based culturally competent behavioral health services for our most vulnerable youth and their families, such as mobile crisis services, flexible funding, and attendance at wraparound meetings, and would provide needed services in screening for and treatment of substance use disorder.

We recommend that the waiver explicitly cite the Collaborative's Children's Behavioral Health plan, as it has cited the New Hampshire Ten-Year Mental Health Plan and the recent settlement with the Department of Justice.

If you have any question about the Collaborative's work or specifics about the Collaborative plan, please feel free to contact Effie Malley, Collaborative director.

Sincerely yours,



New Hampshire Department of Health and Human Services

Building Capacity for Transformation Section 1115 Demonstration Waiver Application

Effie Malley

Director, Children's Behavioral Health Collaborative

Ellen Fineberg

Executive Director, New Hampshire Kids Count

Children's Behavioral Health Collaborative Steering Committee

Ken Jue

NH Kids Count Board of Directors

Children's Behavioral Health Collaborative Steering Committee

Susan McKeown

Children's Behavioral Health Collaborative Steering Committee

Linda Saunders Paquette, Esq.

Executive Director, New Futures, Inc.

Children's Behavioral Health Collaborative Steering Committee"

State's Response:

Thank you for the comment and support of the Waiver.

Based upon public comment, the efforts of the Children's Behavioral Health Collaborative and its Children's Behavioral Health Plan, as well as the System of Care/F.A.S.T. Forward service array are now incorporated into the Demonstration Waiver.

Comment Received via Email from Martha Green on behalf of Brian Collins – Executive Director, Community Partners

Date Received: 5/20/2014 at 3:02 PM

From: Brian Collins, Executive Director

Community Partners, Behavioral Health and Developmental Services of Stratford County, Inc.

113 Crosby Rd, Suite 1

Dover, NH 03820

Mr. Meyers,

Attached letter is from Brian Collins, Executive Director, regarding Waiver 1115.

Thank you.



New Hampshire Department of Health and Human Services

Building Capacity for Transformation Section 1115 Demonstration Waiver Application

Martha Green, Executive Assistant/Office Mgr – Community Partners
603-516-9300



New Hampshire Department of Health and Human Services

Building Capacity for Transformation Section 1115 Demonstration Waiver Application



May 20, 2014

NH Department of Health & Human Services
Building Capacity for Transportation
Section 1115 Demonstration Waiver Application
c/o Jeff Meyers
129 Pleasant Street
Concord, NH 03301

Dear Mr. Meyers,

113 Crosby Road
Suite 1
Dover, NH 03820
(603) 516-9300
Fax: (603) 743-3244

50 Chestnut Street
Dover, NH 03820
(603) 516-9300
Fax: (603) 743-1850

26 Old Dover Road
Rochester, NH 03867
(603) 516-9300
Fax: (603) 335-9278

A United Way
Partner Agency



I am submitting comments regarding Section 1115 Demonstration Waiver that the Department will be submitting to the Senate for Medicaid & Medicare services at the end of May.

I would like to commend the Department for its innovative thinking and approach to the populations being served through this waiver. In particular, in several program initiatives such as In Shape and Substance Abuse, it should have far reaching effects on the population of New Hampshire citizens.

With respect to the In Shape program, I would urge the state to consider additional supportive services for the population engaged in In Shape beyond gym memberships and health mentors. It has been our experience that individuals in this program would also benefit from assistance with financial planning, nutritional concepts and cooking programs to create an overall healthier lifestyle.

I separately would urge careful consideration to policies which enhance rates to new programs that could compete directly with existing ones.

Thank you for the opportunity to provide this feedback.

Sincerely,

Brian Collins
Executive Director

Community Partners

Behavioral Health & Developmental Services of Strafford County, Inc.



State's Response:

Thank you for the comment and support of the Waiver.

Over the course of the Waiver, DHHS will evaluate the range of services provided to InSHAPE enrollees and make changes based on that evaluation.

Comment Received via Email from Peter Kelleher – CEO/President, Harbor Homes Inc. and the Partnership for Successful Living

Date Received: 5/20/2014 at 3:25 PM

From: Peter Kelleher, CEO/President

Harbor Homes Inc. and the Partnership for Successful Living

<http://www.nhpartnership.org>

<http://www.harborhomes.org>

Dear Mr. Myers,

On behalf of Harbor Homes, Inc. and its five affiliates that together comprise the Partnership for Successful Living, [1] I appreciate the opportunity to comment on New Hampshire's draft 1115 Demonstration Waiver Request, Building Capacity for Transformation. A core set of leadership staff reviewed the concept paper and application, and we believe that it will result in maximum stewardship and leveraging of available public resources. As the CEO of six health and human service agencies that provide a broad array of care to New Hampshire's long-term homeless population, it is especially refreshing to see the emphasis on mental health/substance use services and integration across systems. Harbor Homes and the Partnership for Successful Living agencies operate a Federally Qualified Health Center, more than 400 units of supportive housing, a 54-bed substance use disorder treatment facility that specializes in serving pregnant and postpartum women, a home-care agency, and many other behavioral health care programs.

Lastly, Harbor Homes has provided over 2,000 crisis behavioral health evaluations in Nashua's emergency departments over the last year. This provides the context from which I offer the following recommendation to designate the homeless population as a special population in the Waiver.

My main recommendation is to assign an official designation to the homeless as a special population in the Waiver. I'd like to suggest that specific language be used that will target the long-term/chronically homeless and incentivize providers and health systems to develop services/programs that improve the health of these community members. The long-term homeless are a special subpopulation of Medicaid enrollees that use significant resources. The New England Journal of Medicine recently published an article demonstrating the extraordinary cost impact to



Medicaid by the long-term homeless, and how critical supportive housing is to help mitigate these costs.[2] Including Supported Housing within the Waiver is an important part of a systemic approach to overall mental health reform, particularly among the homeless. Incentivizing the provision of health and supportive housing services to the chronically homeless is very likely to result in significant cost savings across the five proposed Designated State Health Program areas, as well as the entire Medicaid system.

There may be some additional benefits to including the homeless as a special population. For example, if the Waiver includes the homeless as a special population, more sources of funding may be available as a match to federal dollars. Additionally, if the homeless are intentionally targeted through this Waiver, a specific health program designed to provide medical and behavioral health respite for the homeless could be included. Homeless individuals often need an alternate level of medical care that is a step between a hospital and a home, or lack thereof. It is precisely because these individuals do not have a home to receive services or recuperate that a concept called “medical/ behavioral respite care “is needed. Medical and behavioral respite care facilities serve people who are not ill enough to stay in a hospital, but are too sick to go “home” (which in the case of the homeless population, may include a shelter, a friend's apartment, or the streets.). Seventy programs exist nationwide and this model of care is well-recognized as a best practice throughout the homeless health care arena. The National Health Care for the Homeless Council demonstrates its impact and cost savings: homeless patients discharged to medical respite experience 50% fewer hospital readmissions within 90 days than those discharged to their own care.[3] Medical respite is a promising solution to the challenging issue that health systems face with care transitions (a sub-category of care coordination), which are exacerbated for homeless patients.[4] This is a new concept in NH, but a cutting-edge, cost-effective model that is currently funded elsewhere through CMS’ Innovation grant program.

If you are interested in learning more about this, or speaking to national experts about how this model could benefit NH, I would be happy to connect you to the National Health Care Homeless Council.

Finally, I have two clarifying questions:

- Can you define what a “health system” is? What entities are part of the system? What are not? Does this include Federally Qualified Health Centers (FQHCs)?*
- Re: the community reform pool, is the capacity reform program exclusive to hospitals or can FQHCs participate?*

Thank you for allowing the opportunity to submit these comments and questions. The Building Capacity for Transformation waiver represents an important step forward in the use of Medicaid to fund an integrated health care delivery system. I can be reached for clarification at 603-882-3616 or by email at p.kelleher@nhpartnership.org.

*Thank you,
Peter Kelleher*



New Hampshire Department of Health and Human Services

Building Capacity for Transformation Section 1115 Demonstration Waiver Application

CEO/President

Harbor Homes Inc. and the Partnership for Successful Living

<http://www.nhpartnership.org>

www.harborhomes.org

[1] The Partnership for Successful Living is comprised of Harbor Homes, Healthy at Home, Keystone Hall, the Southern NH HIV/AIDS Task Force, Welcoming Light, and Milford Regional Counseling Services.

[2]

http://www.nejm.org/doi/full/10.1056/NEJMp1310121?query=featured_home&&&&#t=article

[3] <http://www.nhchc.org/wp-content/uploads/2011/09/LeftColArt.pdf>

[4] http://www.nhchc.org/wp-content/uploads/2012/12/Policy_Brief_Care_Transitions.pdf

State's Response:

Thank you for the comment and support of the Waiver.

The Waiver contains on a number of initiatives that impact the homeless population. Pilot programs focused on the homeless population will be considered for funding under the Community Reform Pool DSHP.

After the approval of the Waiver, DHHS will publish for public comment the rules associated with the community reform pool. FQHCs will be eligible to apply for community reform pool pilot programs.

Comment Received via Email from Kristine Stoddard – NH Director of Public Policy, Bi-State Primary Care Association

Date Received: 5/20/2014 at 3:42 PM

From: Kristine E. Stoddard, Esq., NH Director of Public Policy

Bi-State Primary Care Association

525 Clinton Street, Bow, NH 03304

Office: 603-228-2830 Ext. 113

kstoddard@bistatepca.org

Good afternoon,

Attached are Bi-State Primary Care Association's comments to the 1115 Waiver.

Please feel free to contact me if you have any questions or concerns.



525 Clinton Street
Bow, NH 03304
Voice: 603-228-2830
Fax: 603-228-2464



www.bistatepca.org

61 Elm Street
Montpelier, VT 05602
Voice: 802-229-0002
Fax: 802-223-2336

May 18, 2014

Jeffrey A. Meyers
Director of Intergovernmental Affairs
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301
1115waiver@dhhs.state.nh.us

Dear Jeffrey:

Thank you for the opportunity to provide comments on the State's Building Capacity for Transformation 1115 Demonstration Waiver (Waiver). Bi-State is a non-profit, two-state organization that represents 15 non-profit Community Health Centers (CHCs) with 39 locations in New Hampshire. Bi-State advocates for access to health care for all New Hampshire citizens, with a special emphasis on medically underserved areas. Bi-State and our members appreciate and support the State's goals of improving the health of our citizens and containing health care costs by improving the quality of care, health care integration, and improving New Hampshire's access to mental health, substance use disorder (SUD) treatment, and oral health. Our comments outlined below address the concerns of Bi-State and our members as the Waiver relates to health care delivery in New Hampshire.

New Hampshire's CHCs serve over 100,000 residents annually, of which 30,000 are uninsured. The CHCs see firsthand how integrated care and using the whole-person approach for health care delivery benefits every resident, especially low-income families. New Hampshire's CHCs, including the Federally Qualified Health Centers (FQHCs), hope to continue to be "strong partners in driving the health care outcomes" of our state.¹ Bi-State and our members agree that the managed care model should be strengthened in the State as it encourages care coordination and chronic disease management.

Problem Statement

The Problem Statement within the Waiver expresses the State's desire to: change how it delivers mental health and SUD services; increase the number of psychiatric providers; promote overall health of individuals with a persistent and/or severe mental illness; and improve the oral health of low-income pregnant women and mothers of young children.² However, the Problem Statement does not clearly state the need to improve the overall health of every New Hampshire citizen. Bi-State is encouraged to read that the State wants to focus on population health and understands the focus of the Designated State Health Programs, but the application needs to be clear that the need for a healthy population extends to all individuals, not just those mentioned above.

¹ NH DHHS, Building Capacity for Transformation, § 1115 Demonstration Waiver, 13 (April 2014).

² See *id.* at 9.



Community Reform Pool

The Community Reform Pool is an incentive program that will benefit community providers, including CHCs, for which Bi-State and our members are very grateful. Bi-State appreciates the State's efforts to retain current capacity, expand capacity, expand new services, establish a pilot program designed to coordinate care, and establish a provider incentive pool. We have general concerns due to the lack of specificity of the Waiver in its current form, and hope that these will be clarified in time. First, what mechanism will the State use to make payments to the providers that participate in the Community Reform Pool? Will the payments be made to the providers via the Managed Care Organizations (MCOs), or will the State make direct payments to the providers? If the State makes Community Reform Pool payments through the MCOs, will the MCOs use a portion of the funds to pay for the administration of the funds? Lastly, which division within the Department of Health and Human Services (DHHS) will administer the Community Reform Pool?

Capacity retention payments

The Waiver, as currently drafted, emphasizes losses the hospital system has experienced since the 1990s. While Bi-State and our members sympathize with the reductions the hospitals have made over the last two decades, other community providers were required to make capacity reductions as well, especially during the recession of the last six years and the State's recent funding reductions. We believe that it is important CMS understand that the lack of treatment options are systemic, statewide, and include providers such as the CHCs and the Community Mental Health Centers. If the State wants to encourage statewide retention of mental health and SUD services, non-hospital health systems and community providers should also be eligible for capacity retention payments. In addition, how will providers demonstrate their current capacity levels? Will there be an established threshold that the hospitals (and hopefully other community providers) will have to meet in order to become eligible to receive the capacity retention payments?

Capacity Expansion and New Service Payments

We support the State's efforts to expand capacity within the State by use of the Community Reform Pool. These payments will help providers address the need for mental health and SUD services within their communities. Community-based care allows the individual seeking treatment to better access care. This payment, tied with the New Service Payments, will allow community providers to increase capacity and services that their communities desperately need.

Pilot Program Pool

The Pilot Program will assist the CHCs and other community-based providers in meeting the goals of the State, including better population health and integrated health care delivery. Again, we think it is important to include more specificity in the Waiver application including which division within DHHS will administer this program, and what the criteria the State will use when funding a grant application.

Provider Incentive Pool

Incentive payments can be wonderful tools for encouraging reform by monitoring quality outcomes. It is unclear whether participation in the Provider Incentive Pool is mandatory for



providers who participate in other components of the Community Reform Pool. Is the percentage of the holdback based on 20% of the individual provider's contribution, or is it based on total payments made pursuant to the Community Reform Pool? Finally, as the State knows, there was one Qualified Health Plan (QHP) in the Health Insurance Marketplace in 2014. As currently written, the Waiver requires providers contract with at least one MCO and one QHP beginning in 2016. We hope that there will be more than one QHP in place in 2016; however, if in the event that there is not, we hope the State would make this a requirement only if there is more than one QHP in the Marketplace.

Enhance Community-Based Mental Health Services

Bi-State and our members are thankful that the State seeks to enhance community-based mental health services. We believe that proper prevention, treatment, and monitoring can mitigate and even prevent many of the tragedies our communities have experienced in the last decade. The Waiver clearly supports the components contained in the Ten Year Plan and the settlement agreement in *Amanda D., et al. v. Hassan*, which we are very supportive of. However, Bi-State and its members believe that the goal of a whole-person approach mentioned on page 5 of the Waiver should also be incorporated into the programs outlined on pages 19 and 20 of the Waiver.³ We believe that integrated primary care settings, such as patient-centered medical homes, should be the foundation of mental health treatment. Integrated care is cost effective and goes hand-in-hand with the Assertive Community Treatment teams, mobile crisis teams, and supported housing included in the Waiver.⁴ If the State is not allowed to request matching funds for integrated primary and preventive care services, which includes mental health, please make it clear in the Waiver that these too are a priority for the State.

Invest in SUD Workforce Development

Bi-State and our members appreciate the State's focus on SUD treatments and services. We understand the State's Health Improvement Plan focuses on reducing the non-medical use of pain relievers and drug-related overdose deaths; however, the substance use problems in New Hampshire are greater than those two issues.⁵ We respectfully request the State broaden its Waiver application to make it clear that there are more issues in this state to address, including but not limited to: alcohol abuse, adolescent use of marijuana, and prescription drug abuse.

Bi-State recognizes the importance of workforce development and training, especially in areas such as mental health and substance use. We believe a funding pool for hospitals, health systems, and community providers will be a great resource for workforce development in the state. We hope the funding will also be available for use by health care providers to participate in existing programs if the programs meet the criteria developed by the State. We also ask that the State recognize and designate the following practitioners as eligible for reimbursement under the State's Medicaid and the NH Health Protection Program: Master Licensed Alcohol and Drug Counselors (MLADCs), Licensed Alcohol and Drug Counselors (LADCs), and Certified Recovery Support Workers (CRSWs). All three practitioner groups are great assets to their communities and if they are eligible for reimbursement, New Hampshire will have better access to SUD treatment.

³ Waiver at 5, 19-20.

⁴ See *id.* at 19-20.

⁵ See *id.* at 21.



The FQHCs receive what is known as the Medicaid Encounter Rate for a number of services they provide, as outlined in the FQHC Billing Manual.⁶ FQHCs are permitted to bill separately for different types of services provided on the same day. For example, if a patient has separate appointments with her primary care provider and her behavioral health specialist on the same day, the FQHC can bill Medicaid for two visits at the Encounter Rate. We respectfully request the FQHCs continue to be allowed to bill the Encounter Rate for each appointment, including SUD services.

Expand the InShape Program

We applaud the expansion of the InShape Program as a tool for addressing the health care needs of individuals with persistent and/or severe mental illness.⁷ Bi-State and its members agree with the need to expand the InShape Program to include additional populations and a smoking cessation program. We ask the State to clarify that this benefit is a mental health benefit for which the FQHCs may bill the Encounter Rate.

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

Bi-State and our members are very pleased to see the inclusion of an oral health pilot program for pregnant women and mothers of young children.⁸ Each CHC, including those without dental programs, sees firsthand the effects of a lack of oral health education and oral health care on their patients and communities on a daily basis. We hope that one day every Medicaid recipient will have access to oral health care, but understand the realities surrounding that goal. The CHCs want to be a great partner with the State in implementing this program. We ask that the State clarify whether every service provided under this pilot program is a dental service or whether some aspects, such as smoking cessation programs, are mental health programs. The categorization of these services changes how the FQHCs bill the State for the services provided to their communities as dental services are considered fee-for-service and mental health services are billed at the Encounter Rate.

Thank you again for giving us the opportunity to comment on the Waiver. Bi-State and our members look forward to working with the State in future.

Sincerely,

Kristine E. Stoddard, Esq.
Director of NH Public Policy
603-228-2830, ext. 113
kstoddard@bistatepca.org

⁶ FQHC & RHC Billing Manual Provider Manual Volume II, 12-13 (January 2013).

⁷ See Waiver at 22.

⁸ *Id.* at 24.



State's Response:

Thank you for the comment and support of the Waiver.

The waiver is focused on improving overall health through the various DSHPs. The narrative on current healthcare challenges has been revised.

The Waiver application states that the community reform pool payments “will be in the form of supplemental payments.” The narrative has been revised to clarify that oral health benefits will continue to be paid on a fee-for-service basis and MCOs will provide InSHAPE services and, at a later date, System of Care/F.A.S.T. Forward services. All other payments will be made outside of Medicaid Care Management (MCM).

DHHS has not yet made a determination of which division will administer the community reform pool.

The provider incentive pool is mandatory for providers who participate in community reform pool. The 20% withhold will be made on the payments to each provider made from the community reform pool.

After the approval of the Wavier, DHHS will publish for public comment rules associated with the community reform pool.

The recommendation to recognize and designate the practitioners (Masters Licensed Alcohol and Drug Counselors (MLADCs), Licensed Alcohol and Drug Counselors (LADCs), and Certified Recovery Support Workers (CRSWs)) as eligible for reimbursement under Medicaid and NHHPP is outside the scope of this Waiver.

DHHS is not changing FQHC reimbursement policy under this Waiver. The narrative has been revised to describe the current InSHAPE program and the proposed DSHP.

Please see Appendix C for a description of the tobacco cessation for pregnant women benefit under this Waiver.



Comment Received via Email from Marie Mulroy – President, New Hampshire Public Health Association

Date Received: 5/20/2014 at 4:27 PM

From: Marie Mulroy, President

New Hampshire Public Health Association

info@nhpha.org

nhpha.president@gmail.com

Telephone: 603-228-2983

Attached please find NHPHA's comments with regard to the above Waiver.

Thank you for providing the opportunity for providing input.



"Improving Health, Preventing Disease, Reducing Costs for All"

May 20, 2014

"Building Capacity for Transformation" Section 1115 Waiver Comments

Kathleen Dunn, Director, Medicaid Program
Brown Building
NH Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

Dear Ms. Dunn:

New Hampshire Public Health Association is a public health membership organization that serves its members through the provision of quality health information, member resources and serving as our members' voice for public health issues.

While we support all of the provisions in the 1115 Waiver, we would respectfully request that you consider adding Medicaid's clients usage of the Northern New England Poison Control Center to the 1115 Waiver for New Hampshire. The NH Public Health Association has been charged with convening stakeholders to identify sustainable sources to cover the total costs of providing Poison Center Services for the people and institutions of NH. Currently the total annual cost is estimated to be about \$748,500. This includes \$70,000 which comes from the Federal Health Resources and Services Administration directly to the NNE Poison Center. Thus, the total cost to New Hampshire is \$678,500. Currently the NH Department of Health and Human Services is contributing about \$553,500. \$520,000 comes from State General Funds with an additional \$33,500 passed through from the Federal CDC Public Health Emergency Preparedness Funds. This leaves unfunded approximately \$125,000 to fully fund NH's share. This would provide for all of the surveillance and reporting functions that are available to other states as well as allowing all information calls to the Poison Center to be answered.

We are asking for long-term funding for the Poison Center. Insurers both public like yourself and private insurers, the NH Hospital Association, the Drug and Alcohol Abuse Prevention community and the Department of Safety are all being invited to participate. The 1115 Waiver is an excellent venue to help with some of the funding as it pertains to Medicaid clients.

WHY:

- Poison centers save lives, protect the public's health, and save more than a billion dollars each year
- Poisoning deaths and injuries – including those resulting from intentional and unintentional misuse of prescription drugs – are a growing public health issue



- For every \$1 spent on Poison Center Services, there is a savings of \$13.39 in reduced health care costs and lost productivity of which \$8.78 are from avoided medical utilization and reduced length of stay alone. The Lewin Group, Value of the Poison Center System, September, 2012 –<http://www.aapcc.org/about/lewin-group-report>
- In the absence of the Poison Center with a total price tag of \$748,500, the health care services for these patients would cost insurers, hospitals and the state and federal governments an estimated \$6.6 million.

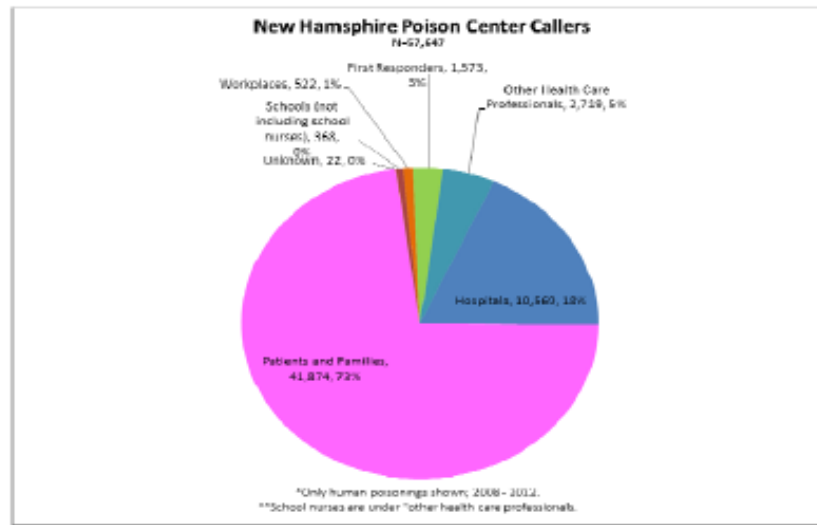
WHO benefits from Access to these Services?

The public benefits directly from having access to Poison Center services 24/7. About 74% of NH calls to the Poison Center are from patients and families, workplaces and schools. Sixty-nine% of these calls can be safely treated and monitored at home representing significant health care costs. Based on the latest Poison Center Survey of consumers, in the absence of the Poison Center:

- 44% would have gone to the ED
- 31 % would have called or gone to the doctor
- 15% would have called 911

Regarding insurance coverage the breakdown is as follows:

- 45.0% have private insurance
- 32.5% have Medicaid or SCHIP
- 10.0% said they have no insurance



It for this reason that we ask that for your consideration in adding funding for the Poison Control Center to your 1115 Waiver.

For any questions and additional clarification, please contact me at the address below.

Thank you.

Sincerely,

Marie Mulroy, President
New Hampshire Public Health Association
info@nhpha.org
Telephone: 603-228-2983



State's Response:

DHHS will consider pilot programs related to poison control under the community reform pool.

Thank you for commenting on the Waiver.

Comment Received via Email from Janet Monahan – Deputy Executive Vice President, New Hampshire Medical Society and Executive Director, NH Society of Eye Physicians & Surgeons

Date Received: 5/20/2014 at 4:34 PM

From: Janet H. Monahan

Deputy Executive Vice President, New Hampshire Medical Society and Executive Director, NH Society of Eye Physicians & Surgeons

7 North State Street, Concord, NH 03301-4018

603 224-1909

Fax: 603 226-2432

<http://www.NHMS.org>

Please see the attached letter.

Thank you,

Janet



New Hampshire
MEDICAL SOCIETY ADVOCATING FOR PHYSICIANS & PUBLIC HEALTH SINCE 1791

May 20, 2014

Medicaid 1115 Waiver Comments
New Hampshire Department of Health & Human Services

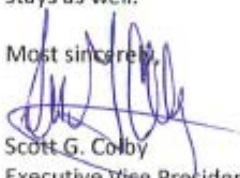
To Whom it May Concern:

On behalf of the physician members of the New Hampshire Medical Society, I strongly encourage the inclusion of the maintenance of the increased reimbursement for primary care physicians in the 1115 waiver application.

As you know, section 1902 of the ACA increased Medicaid payments for certain primary care physicians to Medicare levels for CY 2013 and 2014. To receive the 100 percent federal match for the payment increase, states had to submit a State Plan Amendment to CMS by March 31, 2013 and payment increases were retroactive to January 1, 2013. This provision of the ACA (100% Federal funding) is due to sunset on December 31, 2014.

New Hampshire's Medicaid rates are the lowest in the country and we must do all that we can to help our primary care physicians to be able to afford to keep their practices open to the Medicaid population. Access to primary care is critical to providing the basic prevention services to low-income or disabled patients, especially those with a chronic illness. A strong primary care relationship for this population may reduce the number of visits to our emergency departments and hopefully reduce inpatient hospital stays as well.

Most sincerely,



Scott G. Colby
Executive Vice President



State's Response:

Primary care physician reimbursement for services provided to the NHHPP population will be set through contract amendments with the three MCOs that are brought to the Governor and Executive Council in June. At this time, primary care physician reimbursement is outside the scope of the Waiver.



Comment Received via Email from Erika Argersinger – Policy Director, New Hampshire Kids Count

Date Received: 5/20/2014 at 4:24 PM
From: Erika Argersinger, Policy Director
New Hampshire Kids Count
2 Delta Drive, Concord, NH 03301
603.225.2264 x15
nhkidscount.org

Dear Jeff -

Thank you again for the opportunity to submit questions related to the draft application. I am wondering where exactly the answers will be posted. Is it on the same page that currently has the draft application, presentations, etc.? Or a separate page?

Again, I'd like to reiterate NH Kids Count strong support for the oral health pilot program. As we re-read the draft application, we'd like to make the suggestion that some incentives for innovation on the part of oral health providers might help ensure participants' success at achieving the compliance goals outlined on page 24. Specifically, providing more mobile services - bringing services to locations that pregnant mothers and mothers with young children frequent (i.e. grocery store parking lots, WIC clinics, child care centers/Head Start, community centers) - and providing services for mothers at existing school-based clinics could be helpful in facilitating mothers' access to services. In addition, providing dental care outside of work hours could also be helpful. These are strategies encompassed in the 2011 IOM report Improving Access to Oral Health Care for Vulnerable and Underserved Populations. and could be used as a basis for provider-based innovation incentives.

Thank you,
ERIKA ARGERSINGER
Policy Director

State's Response:

Thank you for the comment and support of the Waiver.

Public comments and the State's responses are an appendix to the Waiver application.

DHHS will consider oral health related pilot programs under the community reform pool.



Comment Received via Email from Steve Wade – Executive Director, Brain Injury Association of New Hampshire

Date Received: 5/20/2014 at 4:58 PM

From: Steven D. Wade, Executive Director

Brain Injury Association of New Hampshire

109 North State, Suite 2

Concord, NH 03301

(603) 225-8400

steve@bianh.org

Dear Mr. Meyers,

Attached is a letter outlining comments/input by the New Hampshire brain injury community on the Draft 1115 Demonstration Waiver.

Specifically, on the need to include both of the 1915 (c) HCBS Waiver populations served by the Bureau of Developmental Services – DD and ABD – in the InShape program.

Thank you.

Steve



**Brain Injury Association of New Hampshire
109 North State Street
Concord, NH 03301**

May 19, 2014

Mr. Jeffrey A. Meyers
Director, Intergovernmental Affairs
NHDHHS
129 Pleasant Street
Concord, NH 03301

Re: Draft 1115 Demonstration Waiver comments and input

Dear Mr. Meyers,

On behalf of the member families and caregivers of the Brain Injury Association of New Hampshire, we respectfully request that the Department consider including both of the 1915(c) HCBS Waiver populations - DD and ABD - in the InShape Program.

The NH Bureau of Developmental Services currently serves two population groups, those with developmental disabilities (DD) and those with acquired brain disorders (ABD). It would be unfair to include one of these populations at the exclusion of the other. The Bureau is equally committed to both populations.

People living with brain injury and those living with developmental disabilities, will both strongly benefit by participation in the InShape program. The additional federal dollars that will be leveraged for NH will be a tremendous opportunity to improve the quality of life for people with DD and ABD.

Overall, the New Hampshire brain injury community wishes to congratulate and thank the team that has developed the draft 1115 Demonstration Waiver. The entire disability community is appreciative of this effort to build capacity to transform and enhance health care service delivery on our state.

We remain hopeful that both of the 1915 (c) HCBS populations served by the Bureau of Developmental Services – DD and ABD - will be included in the draft to be presented to the Fiscal Committee on May 23rd.

Thank you!

Sincerely,
Steven D. Wade
Executive Director



State's Response:

Thank you for support of the Waiver.

At this time, DHHS is not including the 1915(c) HCBS-ABD waiver enrollees in the InSHAPE program.

Comment Received via Email from Matthew Herndon, Interim Chief Legal Officer & VP of Government Affairs, BMC HealthNet Plan / Well Sense Health Plan

Date Received: 5/20/2014 at 5:00 PM

From: Matthew H. Herndon, Interim Chief Legal Officer & VP of Government Affairs

BMC HealthNet Plan / Well Sense Health Plan

Two Copley Place, Suite 600

Boston, MA 02116-6597

617-748-6383 (t)

617-897-0894 (f)

matthew.herndon@bmchp-wellsense.org

Please find attached comments from Well Sense Health Plan in response to the Department's Building Capacity for Transformation Section 1115 Waiver Application. Please feel free to contact me with any questions or comments. Thank you.



May 20, 2014

Via Electronic Mail

New Hampshire Department of Health and Human Services
Attn: "Building Capacity for Transformation" Section 1115 Demonstration Waiver Application
129 Pleasant Street
Concord, NH 03301-3852

Re: "Building Capacity for Transformation" Section 1115 Demonstration Waiver Application

Dear Sir/Madam:

Well Sense Health Plan (Well Sense) appreciates the opportunity to comment on the New Hampshire (NH) Department of Health and Human Services' (DHHS) Section 1115 Demonstration Waiver proposal, "Building Capacity for Transformation." Well Sense is committed to supporting DHHS in its stated approach to healthcare reform, including comprehensive reform of its Medicaid program and the health care delivery system.

As you know, Well Sense participates in New Hampshire's Medicaid program by serving as a managed care partner that currently covers over 48,000 enrollees. We are pleased that the Waiver proposal reiterates DHHS' desire to "integrate and align with NH Medicaid Care Management program." While Medicaid Care Management is in its infancy, we already see early program successes.

For example, Well Sense's person-centered model of care is an important initiative. Under this model, our clinicians, social workers, and behavioral health care managers work closely with members who have complex conditions, and their families, to coordinate care with primary care practices and state and community agency case managers. This approach helps members get the appropriate care at the right time and in the right setting, especially in their communities.

Well Sense is pleased to build on such efforts through further collaboration with DHHS, including the components of its Section 1115 Waiver. Well Sense offers the following specific comments for your consideration on the Section 1115 Waiver proposal.

Mental Health Community Reform Pool:

Well Sense supports DHHS' efforts to increase behavioral health access. Well Sense recognizes that member access may be challenging and is actively working to expand its network to further strengthen this access. Capacity retention and expansion as well as new service payments may be a positive step. Well Sense supports the appropriate funding of our provider-partners, especially for those providing community-based mental

1155 Elm Street • 6th floor • Manchester, NH 03101 • WellSense.org



Department of Health and Human Services

May 20, 2014

Page 2 of 2

health services, and we look forward to working with DHHS further in this area pursuant to this Waiver proposal. While any payments and the incentive pools are important steps, Well Sense looks forward to enhanced coordination of physical and mental health services to improve health outcomes and avoid unnecessary, costly care.

Oral Health Pilot:

Well Sense agrees that it is important to demonstrate that Medicaid dental coverage for pregnant women and children positively impacts birth outcomes and early childhood oral health. Studies show that periodontal disease can be detected in up to 30 percent of pregnant women and addressing this may not only decrease birth complications and associated costs, but also early childhood care costs.¹ Moreover, providing ongoing dental services to mothers of young children may increase the likelihood that they will seek routine dental care for their children. Well Sense looks forward to working with DHHS to implement this pilot and developing innovative strategies to encourage dental provider Medicaid participation. Well Sense hopes that this investment serves as a building block towards further investments in oral health coverage.

Population Health:

Finally, Well Sense appreciates DHHS' effort to proactively invest in preventive population health issues that impact at-risk populations. Specifically, we commend DHHS for "following the data" and working to addressing tobacco use and physical fitness/obesity in individuals with substance abuse disorders or mental illness. Well Sense is similarly focused on "following the data" by enhancing its population health analytics to understand member needs. As Well Sense works to expand alternative payments based on an accountable care framework, it will rely on such data to identify looming and existing problems that can be averted before costly medical care is needed.

Again, Well Sense appreciates the opportunity to work with DHHS toward improving health care in New Hampshire. Please feel free to contact me at 617-748-6000 if you have questions or would like to discuss any of the issues raised here.

Sincerely,

Matthew H. Herndon

Interim Chief Legal Officer & VP of Government Affairs

cc: Jeff Meyers, Esq.

¹ Children's Dental Health Project. *Improving Access to Perinatal Oral Health Care: Strategies and Considerations for Health Plans*, July 2010.



State's Response:

Thank you for the comment and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.

Comment Received via Email from Jennifer Frizzell – Senior Policy Advisor, Planned Parenthood of Northern New England

Date Received: 5/20/2014 at 5:15 PM

From: Jennifer Frizzell, Senior Policy Advisor

Planned Parenthood of Northern New England

Planned Parenthood of Northern New England Action Fund

18 Low Avenue | Concord, NH 03301

O: 603.513.5334 | C: 603.340.1593

www.ppnne.org | jennifer.frizzell@ppnne.org

Comments from Planned Parenthood attached.



May 20, 2014

Commissioner Nick Toumpas
New Hampshire Department of Health and Human Services
Office of the Commissioner
129 Pleasant St.
Concord, NH 03301

Re: Building Capacity for Transformation Section 1115 Demonstration Waiver

Dear Commissioner Toumpas:

Planned Parenthood of Northern New England ("Planned Parenthood") is pleased to submit comments on the proposed Building Capacity for Transformation Section 1115 Demonstration Waiver ("Waiver"). As a trusted women's health care provider and advocate, Planned Parenthood supports the commitment of the Department of Health and Human Services ("Department") to seeking input from a cross section of stakeholders on this important proposal.

Planned Parenthood is the largest provider of reproductive and sexual health care for women, men and teens across the State of New Hampshire. We serve New Hampshire residents through 6 health centers in Claremont, Derry, Exeter, Keene, Manchester and West Lebanon. Last year we saw nearly 16,000 patients at these sites.

We strongly support the Department's efforts to implement the Waiver and provide health care coverage to more low-income individuals and their families throughout New Hampshire. As the Department works to formalize the Waiver and seek federal approval, we urge the Department to refine the terms of the Waiver to safeguard women's health care access. Unfettered access to the full range of women's health services and qualified medical providers enables each woman to obtain critical health care, such as family planning services and pregnancy-related care, resulting in better health outcomes for women and their families.

I. The Department Should Explicitly Clarify that Enrollees Retain Freedom of Choice for Family Planning Providers

We are concerned that the Waiver draft application and concept paper do not explicitly address access to family planning services and family planning providers. As the Department is aware already, multiple provisions of federal law explicitly require state Medicaid programs to provide family planning services without cost-sharing, as well as ensure freedom of choice for family planning providers. These provisions of federal law are designed to ensure access to critical family planning services, including birth control, cervical cancer screenings, and screening for sexually transmitted infections (STIs). As such, to ensure access to these essential health services, we urge the Department to align the Waiver proposal with existing law and policy so that enrollees have timely access to family planning services from the providers they trust.

Under federal law, Medicaid enrollees – both traditionally eligible and newly eligible individuals – are entitled to family planning services¹ without cost-sharing.² Benchmark or benchmark-equivalent

¹ 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R. § 441.20 (requiring family planning services coverage for traditionally eligible Medicaid enrollees); Affordable Care Act (ACA) § 2303(c) (adding 42 U.S.C. § 1396u-7(b)(7)); 42 C.F.R. § 440.345(b)



coverage for the new adult population also must consist of at least the Essential Health Benefits (EHB), which includes coverage of women's preventive health services without cost-sharing, including the full range of FDA-approved contraceptive methods, family planning counseling, and office visits necessary to obtain a contraceptive service.³ Notably, federal law is clear that individuals receiving premium assistance, such as Health Insurance Premium Program and Mandatory Premium Assistance Program coverage, are entitled to all Medicaid-covered benefits and cost-sharing protections.⁴

Existing federal law and policy also unequivocally protects an enrollee's ability to receive family planning services from any qualified Medicaid provider. Federal law explicitly maintains an individual's ability to receive family planning services from any qualified Medicaid provider, even if the individual is enrolled in a plan with a limited provider network.⁵ In fact, CMS has explicitly stipulated that a "recipient may obtain family planning services and supplies from outside of the HMO without an HMO referral, even if the HMO contracts with Medicaid to provide the same services."⁶ Notably, the Centers for Medicare and Medicaid Services (CMS) has rightly enforced the "family planning freedom of choice" protection in 1115 demonstration waivers, including recent 1115 demonstration waivers to expand Medicaid coverage via premium assistance.⁷

II. The Department Should Ensure Timely Access to All Pregnancy-Related Care.

(requiring family planning services coverage for the new adult population); ACA § 2001(c) (adding 42 U.S.C. § 1396u-7(b)(5)); 78 Fed. Reg. 42160, 42307 (Jul. 15, 2013) (to be codified at 42 C.F.R. § 440.347(a) (requiring the Alternative Benefit Plan to provide coverage of the Essential Health Benefits, which includes women's preventive health services, such as FDA-approved contraceptives).

² 42 U.S.C. § 1396o(a)(20)(D), 1396o(b)(2)(D), 1396o-1(b)(3)(B)(vii); 42 C.F.R. § 447.53(b)(5); 78 Fed. Reg. at 42307 (requiring that women's preventive health services be made available to the new adult population without cost-sharing).

³ ACA § 2001(c) (adding 42 U.S.C. § 1396u-7(b)(5)); 78 Fed. Reg. at 42307; 78 Fed. Reg. 12834, 12843 (Feb. 25, 2013) ("a plan does not provide EHB unless it meets the standards in 45 C.F.R. § 147.130") (to be codified at 45 C.F.R. § 156.115(a)(4)); 45 C.F.R. § 147.130(a)(iv) (specifying coverage of the women's preventive health services). Notably, the requirement to cover the full range of FDA-approved contraceptives derives from § 2713(a)(4) of the ACA, which is a separate and additional standard to the EHB prescription drug requirement. Accordingly, contraceptive access is maintained even if the plan limits its formulary or the EHB benchmark plan formulary does not include coverage of all contraceptive methods.

⁴ 42 C.F.R. § 435.1015(a)(2), (b); CMS, *Medicaid and the Affordable Care Act: Premium Assistance* (March 2013), available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>.

⁵ 42 U.S.C. § 1396a(a)(23)(B); 42 C.F.R. § 431.51(a)(4); CMS, *State Medicaid Manual* § 2088.5. See also CMS, *Informational Bulletin* (Jun. 1, 2011) (reiterating the federal requirement that states must provide Medicaid enrollees freedom of choice of family planning providers); U.S. Statement of Interest at 4, 8-9, *Planned Parenthood of Indiana v. Comm'r of the Ind. State Dep't of Health*, 699 F.3d 962 (7th Cir. 2012) (cert denied) (asserting that freedom of choice is a longstanding provision and that a State may not exclude certain providers from the Medicaid program because of a provider's scope of practice).

⁶ CMS, *State Medicaid Manual* § 2088.5.

⁷ CMS, *Special Terms and Conditions Iowa Marketplace Choice Plan* (2013) ("The state Medicaid program will ensure payment at state plan rates of family planning services that the QHP considers to be out-of-network, subject to all third party liability rules"); CMS, *Letter to Billy Millwee, Deputy Executive Commissioner of the Texas Health and Human Services Commission* (Dec. 12, 2011) (notifying the State of Texas that CMS will not renew the 1115 family planning demonstration waiver because Texas sought to waive freedom of choice of family planning providers).



We strongly support the Department's proposal to provide oral health care to pregnant women. Leading medical research has shown that routine dental care for pregnant women helps avert the development of serious oral health conditions that can negatively impact pregnancy and improves lifelong oral care habits for women and their children.⁸ Yet, pregnant women often forgo dental care if it is too expensive. Including dental care in Medicaid coverage for pregnant women will reduce access barriers and ensure pregnant women can receive the care they need to continue and maintain a healthy pregnancy.

We are concerned, however, that the Waiver draft application and concept paper do not detail how women who become pregnant after enrolling in the Bridge Plan, Mandatory Premium Assistance Program, or Health Insurance Premium Program will access pregnancy-related care. While we assume the lack of information regarding pregnancy coverage was an oversight, we urge the Department to clarify that women who become pregnant after enrolling in either of these options will be able to obtain all Medicaid-covered pregnancy-related coverage. Specifically, we encourage the Department to provide pregnant women the choice to remain enrolled in one of the coverage options created under the Waiver or transfer to traditional Medicaid pregnancy coverage.⁹ Providing pregnant women this choice is ideal because it enables each pregnant woman the option to continue to receive care from her current network of providers during and after her pregnancy.

Additionally, we urge the Department to explicitly clarify that pregnant women are entitled to all covered pregnancy-related services without cost-sharing,¹⁰ including abortion as allowed under federal law. This clarification is particularly important if the state permits pregnant women to remain enrolled in the Mandatory Premium Assistance Program and the Health Insurance Premium Program. Private plans, including plans offered in the Marketplace, are not required to cover abortion;¹¹ yet federal law entitles a Medicaid enrollee to abortion services when continuing the pregnancy endangers the life of a woman or when the pregnancy results from rape or incest.¹² Although federal law entitles individuals enrolled in premium assistance to all Medicaid-covered services and cost-sharing protections,¹³

⁸ Hugh Silk et al., *Oral Health During Pregnancy*, 77 Am. Family Physician 1139, 1140 (2008), available at <http://www.aafp.org/afp/2008/0415/p1139.html>; Adam Allston, *Improving Women's Health and Perinatal Outcomes: The Impact of Oral Diseases* (2002), available at <http://www.jhsph.edu/bin/u/x/oralbrief.pdf>; Am. Acad. Of Pediatric Dentistry, *Guideline on Oral Health Care for the Pregnant Adolescent*, 31 Clinical Guidelines 108, 109 (2007), available at http://www.aapd.org/media/Policies_Guidelines/G_Pregnancy.pdf.

⁹ CMS has explicitly provided a state option to permit pregnant women to remain in the newly eligible group until the next eligibility determination. CMS, *Medicaid/CHIP Affordable Care Act Implementation Frequently Asked Questions* (May 22, 2012), available at <http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf>.

¹⁰ Federal law exempts pregnancy-related services from cost-sharing. 42 U.S.C. §§ 1396o(a)(2)(B), 1396o(b)(2)(B), 1396o-1(b)(3)(B)(iii); 42 C.F.R. § 447.53(b)(2).

¹¹ ACA § 1303(b)(1); 45 C.F.R. § 156.280(c)(2).

¹² Due to the Hyde Amendment, abortion is considered medically necessary only when pregnancy will endanger the life of the woman or when the pregnancy results as an act of rape or incest. CMS, *Dear State Health Official Letter* (Feb. 12, 1998).

¹³ 42 C.F.R. § 435.1015(a)(2), (b); CMS, *Medicaid and the Affordable Care Act: Premium Assistance* (March 2013), available at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>; CMS, *Medicaid and CHIP FAQ: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing* (December 2013), available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/FAQ-12-27-13-FMAP-Foster-Care-CHIP.pdf> (requiring states that permit pregnant women to remain in the new adult group to provide access to any additional pregnancy-related benefits afforded under Medicaid pregnancy-only coverage).



clarification that the state will provide wrap-around services to pregnant women who cannot access care will minimize administrative confusion and access barriers in the future.

Moreover, we encourage the Department to have sufficient mechanisms in place for reporting pregnancy so that enrollees can have timely access to prenatal and maternal care. If the state plans to continue existing mechanisms, we ask that the Department confirm that the current system is sufficient to accommodate the influx of newly eligible enrollees and will be integrated seamlessly into the Waiver's framework.

III. The Department Should Ensure Plans Participating in the Mandatory Premium Assistance Program Have Robust Provider Networks that Include Women's Health and Family Planning Providers.

We request the Department ensure that plans participating in the Mandatory Premium Assistance Program have robust provider networks that include women's health and family planning providers. Specifically, the Department should ensure that plans participating in the Mandatory Premium Assistance Program meet the highest Essential Community Provider (ECP) standard set forth by the U.S. Department of Health and Human Services Letter to Issuers,¹⁴ as well as any state network adequacy requirements that require a plan to provide sufficient access to women's health providers.¹⁵

Newly insured women may experience barriers when attempting to access care from women's health providers. For example, when Massachusetts initially implemented health reform, wait times for OB/GYN appointments in Boston increased from 45 days to 70 days. This was the longest wait time for any type of health care provider in Boston and was primarily the result of insufficient providers in plan networks. It is also important to note that most women (and in particular, low-income women) consider women's health providers their main source of health care. As such, reduced access to women's health providers effectively impedes access to the broader health care system.

Therefore, to ensure women have access to health care in a timely manner, it is imperative that plans participating in the Mandatory Premium Assistance Program have a sufficient number of in-network women's health providers. Moreover, the Department should make sure that enrollees can access services out-of-network if in-network care is unavailable or cannot be accessed in a timely manner.

IV. The Department Should Explicitly Clarify that In-Network Providers Receive Reimbursement from Private Health Plans or Managed Care Plans for the Newly Eligible Population.

The Waiver intends for private plans or Medicaid managed care plans to provide health care coverage for the newly eligible population. As such, it is understood that in-network providers will receive reimbursement, at generally applicable rates, from those health plans for services provided to newly

¹⁴ HHS, *2015 Letter to Issuers in the Federally-facilitated Marketplace* (March 2014), available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>. Issuers are expected to demonstrate that at least 30 percent of available ECPs in each plan's service area participate in the provider network, but issuers can still satisfy the ECP standard if they include only 10 percent of available ECPs in-network along with a satisfactory narrative justification for meeting enrollee's health care needs.

¹⁵ See, e.g., N.H. Insurance Department, *Draft 2015 QHP Certification*; N.H. Code Admin. R. Ins. 2701.06.



eligible enrollees. We ask that the Department explicitly clarify this reimbursement framework in the Waiver so that it is made clear that private plans and managed care plans must contract with providers in good faith with generally applicable reimbursement terms. Specifically, we urge the Department to ensure that Bridge Plan-participating managed care plans provide reimbursement rates that are no less than current Medicaid rates, as required by law.¹⁶

We thank the Department for the opportunity to submit these comments, and we look forward to working together in our shared goal to improve health care access and coverage. If you have any questions, please do not hesitate to contact me at 603.513.5334 or jennifer.frizzell@ppne.org.

Sincerely,

/jff/

Jennifer Frizzell
Senior Policy Advisor
Planned Parenthood of Northern New England

¹⁶ S.B. 413 (3:2)(XXIV)(amending RSA 126-A:5).



State's Response:

The issues raised concerning freedom of choice in family planning providers, access, and reimbursement that are raised in Planned Parenthood of Northern New England's comments are related to MCO contracting, prior authorization processes and the terms and conditions of a Premium Assistance waiver as part of the New Hampshire Health Protection Program, and are all outside the scope of this Building Capacity for Transformation Section 1115 Demonstration Waiver. The Department looks forward to addressing these issues in the context of the Premium Assistance waiver later this year and the implementation of the New Hampshire Health Protection Program.

Comment Received via Email from Tom Bunnell – Policy Consultant, New Hampshire Voices for Health

Date Received: 5/21/2014 at 9:19 AM
From: Thomas G. Bunnell, Esq., Policy Consultant
New Hampshire Voices for Health
4 Park Street, Suite 403
Concord, NH 03301
603.224.5157 (home office)
603.491.1924 (mobile)
Tom@NHVoicesforHealth.org (e-mail)

Please see my written testimony, attached



Proposed Section 1115 Medicaid Innovations Waiver

**DENTAL COVERAGE for PREGNANT WOMEN and
MOTHERS of CHILDREN UP TO AGE 5**

**Public Hearing
May 12, 2014**

NH VOICES for HEALTH TESTIMONY

Good afternoon. My name is Tom Bunnell. I am a consultant attorney and health policy specialist with NH Voices for Health, also known as "Voices." I would like to offer a brief statement on Voices' behalf.

First, I and we want to thank the Department broadly for the proposed Waiver, and for seeking to leverage federal funds for helpful *and* cost-effective Medicaid innovations.

But in particular, I want to speak to our support for the draft Waiver's Oral Health program for pregnant women and mothers of children up to the age of 5:

- Studies have shown that basic oral health services for pregnant women reduce adverse pregnancy outcomes, including pre-term *and* low birth-weight babies.
- Basic oral health care for pregnant women *also* has been shown to reduce the transmission of dental disease from mothers to children.
- As a result, the public health benefit to mothers and children of this proposed Oral Health demonstration is groundbreaking.
- At the same time, the *cost-savings* likely to result to Medicaid *and* to our overall health system – whether it's avoiding the expense of *neo-natal intensive care* for even a small number of newborns, or reducing the cost of dental caries and decay for children – is impressive.
- In addition, oral health coverage for mothers of children up to the age of 5 provides moms *and* kids with a meaningful opportunity for access to essential dental care to stay healthy.
- Studies indicate that the best way to ensure that kids are healthy, and have access to the care they need, is when parents are covered as well.

New Hampshire Voices for Health • 4 Park Street, Concord, NH 03301 • 603-369-4767 • www.nhvoicesforhealth.org



- Mothers whose coverage includes basic oral health care are in better overall health to work, to care for their families, and to take part in communities.

While helping mothers to gain better health, the proposed Oral Health program promotes newborns' and children's health in ways that are meaningful and even profound.

The proposed Oral Health pilot is a humane, pragmatic, sensible, and cost-effective opportunity for our state.

We are grateful to the Department for proposing this helpful dental benefit and promising demonstration program.

Thank you.



State's Response:

Thank you for the comment and support of the Waiver.



Public Comments Received at Public Hearings on *Building Capacity for Transformation* Section 1115 Demonstration Waiver

The questions, comments, and testimonies transcribed below were captured during two public hearings convened by the New Hampshire Department of Health and Human Services with regards to its *Building Capacity for Transformation* Section 1115 Demonstration Waiver. The first public hearing was held on Thursday, May 8, 2014 from 4:30 to 6:30 PM EST. The second public hearing was held on Tuesday, May 12, 2014 from 1:00 to 3:00 PM EST. Please note that these questions, comments, and testimonies have been paraphrased and may also be supported by written documents.

Public Comments Received at Public Hearing #1 – May 8, 2014

Comment from Jay Couture – Executive Director, Seacoast Mental Health Center (SMHC)

We commend the State for moving forward to access funding for CNOM; this is critical to support infrastructure. It is important to clarify language about bricks and mortar funding and the limits in the CMHC agreement regarding this payment. Beginning on page 14 of the draft application, there is a description of a community reform pool; given the State has already delegated payment authority, how does DHHS assure money will be paid through MCOs? Will the MCOs have to pass this through 100%?

The second component of the community reform pool is incentives for expanding capacity. SMHC would want to ensure that if CMHCs would be included, in interest and in parity of provider comparison, that other providers will be held to the same documentation that CMHCs currently are.

On page 23 of the draft application, the InSHAPE program is described as a covered mental health Medicaid benefit; if you review HEM 426 it is not the case; only clinical support services for client to participate in the program are covered; Healthy Choices Healthy Changes program is not a Medicaid covered service currently.

The SUD Benefit: this is important for DHHS to clearly outline credential expectations so providers can ensure this service is made available. CMHCs work tirelessly to meet states most eligible populations, and are willing to work with DHHS to do so.

State's Response:

Thank you for supporting of the Building Capacity for Transformation Section 1115 Demonstration Waiver.

The Demonstration Waiver application states that the community reform pool payments “will be in the form of supplemental payments.” The narrative has been revised to clarify that oral health benefits will continue to be paid on a fee-for-service basis and MCOs will provide InSHAPE services



and, at a later date, System of Care/F.A.S.T. Forward services. All other payments will be made outside of Medicaid Care Management (MCM).

The narrative of the Demonstration Waiver application has been revised to clarify Medicaid covered services related to the InSHAPE. InSHAPE is a treatment approach in the same way that cognitive behavior therapy or motivational interviewing is a treatment approach. None of these treatments have specific billing codes. Those treatment approaches are employed by the clinician when providing specific services prescribed in a treatment plan. Therapeutic Behavioral Services are the covered community mental health service that would most often be provided for an individual who required the provider to employ the InSHAPE treatment approach. Therapeutic Behavioral Services are a covered community mental health service.

Comment from Joan Fitzgerald – Former President of the New Hampshire Dental Hygienists' Association and serves on Board of Trustees of the American Dental Association

I commend DHHS for a sound program that focuses on wellness and prevention. I know from my years of experience in leadership and advocacy that we cannot solve tomorrow's problems with yesterday's thinking. One thing in particular involves the oral health program for pregnant women. Oral health care has been shown to reduce adverse pregnancy outcomes and has also shown to reduce transmission of disease from mothers to children and low birth weight babies. As it relates to smoking cessation, I have experience working in collaboration with oral health stakeholders and community health stakeholders who agree that oral health providers play a key role in enrolling patients in smoking cessation programs. This will go a long way in reducing overall disease.

State's Response:

Thank you for the comment and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.

Comment from Nancy Martin – Oral Health Program, New Hampshire Department of Health and Human Services, Division of Public Health Services

I would like to follow up Joan's comments and explain a pilot project that we have that is caring for pregnant women now and launched two weeks ago, showing early successes. This pay for prevention project addresses oral health unmet needs of pregnant women and children enrolled in the WIC program, and is located in Keene, Concord, and Pittsfield. We take preventive services to this vulnerable population of high risk women to WIC clinics where they receive other services



already, and they return to WIC everyone 3 months. We are using comprehensive evidence based preventive interventions that include replacement of dental sealants, applying fluoride varnish to both pregnant women and children, and provider referrals to a dental office for restorative treatment when found. Our program includes a smoking cessation component. In the first 4 days, we serviced 31 very young children of 3 months to 5 years of age and served 6 pregnant women. We hope to see more as they become more familiar. We referred 1-2 very young children to dental providers based upon needs. We are optimistic that this 18-month long project will introduce vulnerable populations to preventive oral health care.

State's Response:

Thank you for information on the oral health program for WIC recipients.

Public Comments Received at Public Hearing #2 – May 12, 2014

Comment from Kenneth Jue – Ken Jue & Associates and creator of the InSHAPE program

I have provided testimony via email to the public comment email address but will highlight a few points verbally. I am addressing the InSHAPE Program. I created the program in 2003 when I was employed as the CEO of Monadnock Family Services in Keene, NH. It is currently helping persons across the State of NH who have a SMI to improve their life span, which is about 25-30 years shorter than the average life span of other Americans in the US. The program has been replicated in NH with funds from CMS and has also been replicated in mental health agencies in Michigan, Texas, Pittsburgh, PA, and Providence, RI. Each of these agencies have been evaluating and studying the health effects and benefits for their clients who are experiencing SMIs. These agencies have expressed their great satisfaction with having implemented the program. I believe that the program would be highly suitable for children/youth populations as well as the Developmentally Disabled population. In fact, in Keene, the mental health agency has begun the implementation of a program for children and I am assisting them to adapt this program more to the needs of young people. Eventually, we will create a manual for this program as we have a manual for the adult program.

So, what do participants who are in the program say about it? Here are quotes: "Today I go to the gym three times a week. I meet wonderful people. InSHAPE has literally saved my life. It gave me hope. I suffer from depression and feelings of worthlessness. It has given me new life. I have been given a gift of InSHAPE. I have several diagnoses, including chronic depression, severe personality disorder, and PTSD. I have been able to make changes because of InSHAPE. If I can lose this weight, I can do anything. When I am working and healthy I feel my best."

InSHAPE is trying to establish a program that is based on people taking control and responsibility



of their health status despite mental illness and taking charge of it in a way that they establish their own personal aspirations for health status and pursue those goals and are supported by staff in the program called health mentors who are certified personal trainers and serves as consultants and advocates for these individuals. Philosophy embraces the control of one's health plan to the consumer and to the client. Health mentors are merely there to assist the clients in carrying out this plan. Those plans include physical activity, healthy eating activity; provide advocates for ready and routine access to primary care and community partnerships are formed with small and large business to support the program, e.g. fitness facilities and nutrition education resources. A lot of this is intended to attack the degrees of social discrimination that many experience that have a SMI so that social inclusion and community engagement is very important to the program. A few findings from studies from the Dartmouth Medical Center's Center for Health and Aging include three areas: 1. Improved cardiovascular status for those involved, 2. improved negative symptoms related to mental illness in the participants being studied, and 3. health mentor relationship is highly valued by the participants who often credit their individual progress and success to the support and consultation by the health mentors. In closing, I would like to urge support of this type of approach and that it can be adapted to the two other identified populations.

For oral health, I am on the Board of Directors of a community based nonprofit dental profit named Dental Health Works. We established this in 2003 in Keene, NH and a significant component of the program is to target people who have demonstrated disabilities, and who are Medicaid insured, including children and the uninsured. We have been able to do this and maintain a strong financial picture. In addition to treatment of dental issues, a significant component is prevention of dental issues and the education of young parents and families. We have staff dental professionals in preschools and public schools to understand and implement education and prevention efforts with regards to dental care for young people. All of this to say is that as a member of the Board I think that including oral health for pregnant Medicaid moms who often have other children as well is an important priority and want to express appreciation to the Commissioner for supporting the introduction of this priority into the waiver.

State's Response:

Thank you for the information and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver. DHHS looks forward to your continued involvement in during the implementation planning phase.

Comment from Ken Norton – Executive Director, National Alliance on Mental Illness New Hampshire

This plan ties into existing initiatives, e.g. MCM, SIM, and NHHPP, and NAMI NH very much supports it moving forward. NAMI strongly supports the waiver as its been written and believes the



focus on an integrated and whole person approach will have an important impact on reducing hospitalization for people with mental health needs and other use of the ED in terms of an increased waiting period that we are aware of. This impact will be important economically and socially. We also feel that the design will improve the service delivery system for individuals and improve the health care delivery system overall. There is a lot to like, without restating others. For example, the implementation of evidence based programs contained in the 10 Year Mental Health Plan is important and also outlined in the DOJ Settlement. In terms of the identification and focus on workforce develop for SUD, one thing we are clearly seeing is that while people are being held in ED, the ED staff don't have skills necessary to treat them; would be helpful if treatment could be initiated while waiting for a bed. The recognition of data relative to people with SMI dying 25 years earlier than general population is important. We support expanding the InSHAPE program for adults and children within the Development Disabled population. This will promote increased availability of inpatient MH treatment at regional and local hospitals as there has been a loss of a lot of capacity at the local level; likewise for group homes, supervised apartments, and residential programs. We also believe that tobacco cessation and oral health is important to overall health.

NAMI NH has recommendations for DHHS. Both the Ten Year Mental Health Plan and DOJ Settlement are essentially silent about adults, and DOJ Settlement only talks about children. We would like to see the NH Children's Behavioral Health Plan incorporated and referenced as part of this waiver. Children's BH is talked about and mentioned in ACT teams, but the NH Children's Behavioral Health Plan had identified a different model rather than ACT teams. Also, SUD focuses exclusively on prescription and opioid use. Alcohol is drug of choice in NH, and any substance use issue should be more comprehensive to include it.

Also, while the waiver talks about SUD and MH, it would be helpful to incorporate the term "co-occurring disorders" in here for treatment of both MH and SUD without siloes; need to expand workforce capacity to treat people with concurring disorders.

We suggest that for the community reform pool pilots, nationally there have been a lot of initiatives around zero suicide for health care systems; this is being promoted for National Action Alliance on Suicide Prevention and focuses on an integrated approach to physical and BH across health systems, which would accomplish the goals of waiver.



Mr. Jeff Myers
NH Dept of Health and Human Services
Brown Building
106 Pleasant St.
Concord, NH 03301

Dear Jeff,

On behalf of NAMI NH, the NH chapter of the National Alliance On Mental Illness, I would like to offer our strong support for the Building Capacity for Transformation Section 1115 Demonstration Waiver the Department of Health and Human Services (DHHS) has drafted to submit to the Center For Medicare and Medicaid Services (CMS).

Our overarching comments about the plan are that we firmly believe that the specific plans laid out in the draft waiver and their whole person approach and focus on integrating physical health with mental illness/wellness, substance use disorders, and oral health will result in a reduction of inpatient admissions, emergency department visits and other economically and socially costly services. The integrated approach taken in the waiver will focus both on improving the delivery of health care services to individuals as well as make needed improvements and reforms across New Hampshire's Health Care delivery systems. These improvements will promote recovery for individuals with mental illness and/or substance use disorders.

There is much in this plan to like and without restating the whole plan a few key areas we would like to specifically mention include:

- Implementation of evidenced based programs contained in NH's "Ten Year Mental Health Plan" as well as the settlement agreement with the US Dept of Justice
- Identification and focus on workforce development programs particularly those focused on substance abuse treatment disorders
- Recognition of the data indicating people with severe mental illness die up to 25 years earlier than the general population and that a more integrated approach to care can help decrease this statistic
- Expanding the In Shape program – to make it available for children
- Promoting increased availability for inpatient mental health treatment at regional/local hospitals
- Increasing the availability of groups home and other residential programs for people with mental illness.
- Training and workforce development in the area of mental health and substance use disorders for Emergency Department personnel
- NAMI NH also recognizes and supports the importance of tobacco cessation and oral health as key parts of this waiver.

Find Help, Find Hope

NAMI New Hampshire • 85 North State Street • Concord, NH 03301

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There are a few areas that we would like to comment on and/or offer suggestions for consideration for incorporating into the plan

- While the plan repeatedly mentions “NH’s Ten Year Mental Health Plan,” the ten year plan is essentially silent regarding children. Likewise the Dept. of Justice settlement is only focused on adults. Although the waiver does reference some improvements in the area of children’s mental health – for instance the chart on page 21, it will be important for the waiver to specifically mention and incorporate aspects of the NH Children’s Behavioral Health Plan (2013). It should be noted for instance that the NH Children’s Behavioral Health plan does not promote use of ACT teams for children, but instead proposes a different model.
- Statements regarding need in the waiver relative to substances use disorders focus exclusively on prescription drugs and opioids. Alcohol continues to be the primary drug of choice across the lifespan in New Hampshire and the waiver should emphasize the importance of substance abuse treatment for all drugs of abuse.
- Although the waiver specifies numerous areas relative to substance use disorders it would be very helpful to specifically consider adding in language about co-occurring mental health and substance use disorders. There is certainly need for building staff and program capacity for treating all substance use disorders. However to further promote integration and in recognition that individuals with co-occurring mental illness and substance use disorders have poorer outcomes specifically promoting this area would be helpful as well.
- One area of consideration for a pilot in the Community Reform Pool section IV might be to focus on the national initiative of the National Action Alliance on Suicide Prevention regarding Zero Suicides. By focusing on training, integration and improvements in the area of behavioral health across systems several major health care systems have shown an ability to decrease suicide rates as well as improve other behavioral health outcomes.

NAMI NH strongly believes the proposed waiver incorporates other key systemic initiatives underway in NH such as the implementation of managed care, health care expansion and the State Innovation Model plan submitted to CMS and that the waiver if approved will greatly improve the health and behavioral health service delivery system in New Hampshire.

Please feel free to contact me if you have any questions regarding NAMI NH’s comments.

Sincerely,

Kenneth Norton LICSW
Executive Director

State’s Response:

Thank you for the information and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.

The narrative of the Demonstration Waiver application has been revised to incorporate NH Children’s Behavioral Health Plan and the System of Care/F.A.S.T. Forward services. The narrative has also been revised to use the term “co-occurring disorders” and include initiatives to reduce suicide deaths as potential pilot programs under the community reform pool. DHHS looks forward to your continued involvement in during the implementation planning phase.



Comment from James Williamson – Executive Director, New Hampshire Dental Society

The New Hampshire Dental Society is in support of this waiver and the mention of oral health and plans to improve it through waiver. We would like to be a part of the process of working out the details with DHHS, and offer our expertise. We fully support and look forward to working with DHHS in this effort.

State's Response:

Thank you for the comment and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver. DHHS looks forward to your continued involvement in during the implementation planning phase.

Comment from Deb Scheetz – Communications Director, Gateways Community Services

In reviewing the waiver, we support three areas:

- (1) the extension of InSHAPE to the DD population; we see a lot of value in this provided that Gateways can wrap around the accommodations necessary for this population and support the State's focus on improved population health;*
- (2) the mental health capacity building aspect; we are seeing more of the DD population experience complexities with MH; the State's focus on this and commitment is much appreciated;*
- (3) the pilot programs; we want to call attention to opportunities that telehealth affords across the State, which includes rural communities; clinical capacity may not be local to Nashua, for example, but telehealth option could have terrific impact to those and those with dual diagnoses.*

One question of clarity for DHHS is in regards to long term care services. DHHS mentioned the possibility of amending this 1115 waiver for Step 2 of the MCM program; how would doing so effect the current health home pilots underway in the State, as Gateways is currently implementing one?

State's Response:

Thank you for supporting the Building Capacity for Transformation Section 1115 Demonstration Waiver. Health homes are potential pilot programs under the community reform pool. DHHS looks forward to your continued involvement in during the implementation planning phase.



Comment from Gail Brown – Director, New Hampshire Oral Health Coalition

We are in support of the oral health pilot program and see the need for education on the effects of smoking coupled with current and new benefit for children up to age five. We support education and prevention as being important based upon these principles: oral health as part of overall health, and children's cavities are based upon bacteria from mothers. We suggest that DHHS looks at evidence-based data and practices and professional standards including the consensus statement on oral health care for pregnant women that includes consensus from the American College of Gynecologists, and others. We appreciate inclusion and are ready to help implement the program.

State's Response:

Thank you for supporting the Building Capacity for Transformation Section 1115 Demonstration Waiver.

In the development of the Demonstration Waiver, the consensus statement on oral health care for pregnant women was reviewed. DHHS will consider evidence-based data, best practices, and professional standards including the consensus statement on oral health care for pregnant women during the implementation planning phase.

Comment from Michele Merritt – Policy Director, New Futures, Inc.

New Futures fully supports the 1115 waiver and applauds the work done by DHHS particularly with regards to SUD and the inclusion of multiple systems to support the SUD network. We reiterate that as the backbone for the Children's Behavioral Health Collaborative, we are in support of integrating the Children's Behavioral Health Plan into the waiver.

We have a recommend in terms of the capacity retention payments provision that is limited to hospitals, currently. We recommend considering expanding to SUD providers given the need and urgency to expand this network. This is important because many providers are in the process of trying to sign up with Medicaid and have to negotiate with MCO; this is a stressful process deterring them and completely changes back office systems. Extending this payment would ensure that current providers in NH retain the amount of services they are providing.

We have a recommendation for the pilot program. We urge DHHS to consider a State Plan Amendment (SPA) because there is match under the ACA for health homes and PCMHs; if there is



an opportunity to receive money, we encourage DHHS to seek it out.

We have a question: to define criteria for the grant applications for pilot pool and defining outcome measures, is CMS providing guidance on this and will stakeholder input be considered? Is DHHS doing this process internally to develop criteria and outcome measures?

We recommend for the SUD workforce development component, that DHHS considers allowing this for professional associations for SUD development as well.

State's Response:

Thank you for supporting the Building Capacity for Transformation Section 1115 Demonstration Waiver. Based upon public comment, the efforts of the Children's Behavioral Health Collaborative and its Children's Behavioral Health Plan, as well as the System of Care/F.A.S.T. Forward service array are now incorporated into the Demonstration Waiver.

SUD providers have been included as eligible providers for the capacity expansion and new services payment pools within the community reform pool.

Within the Demonstration Waiver, the pilot program pool within the community reform pool has been further described. Proposals from providers for health homes and PCMHs pilot programs would be accepted and reviewed by DHHS for the community reform pool.

DHHS confirms that it will work with stakeholders and CMS in the development outcome measures for the community reform pool.

DHHS will accept and review proposals from professional associations for Behavioral health workforce development. Criteria for interested parties will be drafted and shared with interested parties when the application process begins.

Comment from Maggie Pritchard – Executive Director, Genesis Behavioral Health

With regards to the capacity retention payments, the recommendation is to expand this to other providers, and to include CMHCs for group home bed capacity because over last few years we have decreased from 10 CMHCs to 3 CMHCs with group home capability.

With regards to capacity expansion and new service payments, the APRTP RFP will come in line on July 16th; if bricks and mortar is available, DHHS needs to ensure timing with this and also needs to ensure timing with the programs in the 10 Year Mental Health Plan.



If DHHS is asking CMS for a waiver, can we think about money we lose on “incident to” billing for psychiatrists? The current rule is that in order to bill a therapy session, a doctor must be in the building. We feel that we should be able to bill “incident to” if there is telehealth capacity and a doctor is in another building.

State’s Response:

Based upon public comment, the narrative for the Demonstration Waiver has been revised. A hospital or CMHC could receive a capacity retention payment if it pledged not to reduce access to mental health and/or SUD related services in their health system

Funding for capacity expansion and new service payments will be made available as soon as the Demonstration Waiver and implementation is approved by CMS.

DHHS will consider reviewing “incident to” billing for psychiatrists outside of this Demonstration Waiver process.

Comment from Erika Argersinger – Policy Director, New Hampshire Kids Count

We would like to thank the Department for including an oral health program in NH. Many have trouble accessing oral health services today and there are too many children not getting them. This benefit will increase access for both mothers and kids, and supports oral health improvements. Overall, we applaud DHHS for this effort.



May 12, 2014

Re: Proposed Medicaid Innovations Waiver

Dear Commissioner Toumpas,

My name is Erika Argersinger and I'm the Policy Director for New Hampshire Kids Count. New Hampshire Kids Count is dedicated to improving the lives of all children by advocating for public initiatives that make a real difference. We ensure that laws, policies and programs in the Granite State are effective and improve kids' lives. We promote program and policy changes that improve children's education, economic security, safety and health. We support the draft Innovations Waiver's proposed Oral Health program for pregnant women and mothers of children up to age 5 because we believe it will do just that.

Good oral health care is an essential part of children leading a full, healthy life. Unfortunately, **dental caries remains the most common chronic disease in childhood** and it is increasing in prevalence among young children. **When left untreated, oral diseases can have far reaching impacts.** Beyond pain, they can lead to problems in eating, sleeping, speaking, and learning. Research shows a direct connection between children's oral health and how well they perform in school.

We support the Waiver's proposed oral health program because we believe it will help improve the health of the mothers and, in turn, the health of their children. Oral health care for pregnant women has shown to reduce the transmission of dental disease from mothers to children and to reduce adverse pregnancy outcomes, including premature and low birth-weight babies. In addition, research demonstrates that maternal and family factors can increase children's risk for caries, including poor oral hygiene and recent maternal caries. The proposed oral health program's education component as well as the benefit providing coverage for dental services would improve these maternal factors and decrease their children's risk for caries.

Further, a recent article in *Pediatrics* (*Pediatrics* 2014; 133; e1268) documents the importance of the caregiver's establishment of a dental home for themselves as a factor that can improve children's receipt of preventive dental visits. Therefore, the proposed program's oral health coverage for mothers of children up to age 5 would provide mothers *and* children with meaningful opportunities to access essential care. This could help improve the rate at which children on Medicaid access services, as we know that despite coverage, still nearly 40% of children on Medicaid in 2011 did not receive dental services.

The Waiver's proposed oral health program is an opportunity to improve the health of mothers and children in New Hampshire that should not be missed. We are pleased to see the state take this step and strongly support it.

Please feel free to contact me with any questions. Thank you,

Erika Argersinger
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eargersinger@nhkidscount.org

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1

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State's Response:

Thank you for the comment and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.

Comment from Sarah Mattson – Policy Director, New Hampshire Legal Assistance

We are in support of the oral health pilot program.



www.nhla.org

NEW HAMPSHIRE LEGAL ASSISTANCE

Working for Equal Justice Since 1971

May 12, 2014

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Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

RE: Draft "Building Capacity for Transformation" Section 1115
Demonstration Waiver Application

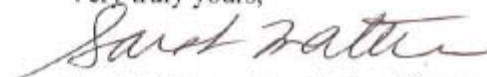
To Whom It May Concern:

I am writing on behalf of New Hampshire Legal Assistance (NHLA) to convey our support for the April 28, 2014 draft "Building Capacity for Transformation" Section 1115 Demonstration Waiver Application. In particular, NHLA supports the proposed Waiver's establishment of a pilot program to provide oral health education, tobacco cessation, and Medicaid coverage for dental services for women during pregnancy and up to the child's fifth birthday.

NHLA is a non-profit law firm offering legal services in civil cases to low-income and elderly people. We assist our clients with cases impacting their basic needs, such as access to subsistence income, housing, and healthcare. Based on our experience representing low-income clients who need oral health care, we enthusiastically support expanding low-income mothers' access to dental services.

Oral health care for women who are pregnant or have young children has significant public health benefits. It has been shown to reduce adverse pregnancy outcomes and to reduce the transmission of dental disease from mothers to their children. It also has profound positive impacts on individual women, as untreated dental disease not only causes pain and suffering but can also reduce a person's ability to complete the basic functions of daily living, including work. We thank the Department of Health and Human Services for proposing this important oral health pilot program and look forward to continuing to support it.

Very truly yours,


Sarah Mattson, Esq., Policy Director



State's Response:

Thank you for the comment and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.

Comment from Nancy Martin – Oral Health Program, New Hampshire Department of Health and Human Services

I support the oral health component. DHHS is currently in the middle of a pilot project for WIC titled the Pay for Prevention project. We are in the business now of taking services to most vulnerable populations. The pilot project is in Keene, Concord, and Pittsfield. An early success story is that we launched on 4/22, and in Pittsfield have treated 8 children and 4 pregnant women – 2 were ages 24 and 23, respectively. She had such badly decayed teeth and bleeding gums that she could not brush her teeth and her first child was born at three pounds. This shows the need to think about how to do things differently.

State's Response:

Thank you for the comment and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.

Comment from Tom Bunnell – Policy Consultant, New Hampshire Voices for Health

We thank DHHS broadly for the proposed waiver and seeking to leverage federal funding for helpful and cost effective Medicaid innovations. We support the draft waiver's oral health program. So much has already been said, but we want to thank the Department for a humane, sensible, pragmatic, ground-breaking public health opportunity.

State's Response:

Thank you for the comment and support of the Building Capacity for Transformation Section 1115 Demonstration Waiver.



Comment from Erika Argersinger – Policy Director, New Hampshire Kids Count

We want to submit a question regarding the oral health pilot program. On page 24, it reads that the scope of dental benefits will be provided to women who participate with compliance goals and has a bulleted list. To what extent are these compliance goals eligibility criteria? If I don't meet the goals, am I limited to services?

State's Response:

The narrative in the waiver application has been revised to emphasize that rewards and incentives would be provided to women and children who meet certain performance criteria developed by DHHS. These performance criteria are not tied to women's eligibility or access to the dental benefit. It is a standalone component of the proposed pilot to offer incentives to motivate participation and compliance with a dental prevention and treatment plan for mothers and their children.

Comment from Cindy Robertson – Senior Staff Attorney, Disability Rights Center

In terms of the community reform pool and its five subsections, it sometimes reads mental health/SUD or mental health and/or SUD – is the expectation that both will be addressed?

State's Response:

The narrative in the Demonstration Waiver application has been revised to clarify mental health, SUD, and/or behavioral health where applicable.



Appendix F: Budget Neutrality

This appendix includes the information requested in the Budget Neutrality Form available at <http://www.medicaid.gov> regarding historical expenditure data and projected expenditures. The budget neutrality projections using the CMS template are included as *Appendix I*.

Historical Data

Base data was derived from New Hampshire's CMS-64 reports for calendar years 2008 – 2012.

The historical year expenditures:

- Include both Medicaid and CHIP expenditures with all prior period adjustments
- Include all covered Medicaid services (i.e., acute care and long term services and supports)
- Exclude administrative expenditures and collections
- Exclude DSH, GME, and supplemental payments

Medicaid Populations

Population Name: Total Medicaid Population

Brief Description: All New Hampshire Medicaid and CHIP beneficiaries

Relationship to Eligibility Section: New Hampshire is not requesting any changes in Medicaid program eligibility through this Demonstration Waiver. Coverage for groups of individuals currently covered under the State's Medicaid and CHIP State Plans, previous waiver programs, and previously state-funded programs will continue.

Bridge Period to Base Year

Building Capacity for Transformation will begin on April 1, 2015. There are 27 months between the end last historical year (CY 2012) and the end of the Base Year (April 1, 2014 – March 31, 2015) prior to the first demonstration year (April 1, 2015 – March 31, 2016). The following trend rates are used to establish estimates for the Base Year in the template worksheet (April 1, 2014 – March 31, 2015):

- Annual enrollment trend = 3.5%

New Hampshire has seen a dramatic increase in the number of Medicaid beneficiaries since January 1, 2014. CMS reports total Medicaid and CHIP enrollment in New Hampshire was 134,699 in March 2014. The bridge period enrollment trend rate is set to be consistent with March 2014 enrollment levels.

- PMPM cost trend = 4.7%



Historical per member per month (PMPM) expenditures were trended to the Base Year using a 4.7% annual trend rate. The 4.7% annual trend rate assumption is consistent with the President's budget trend. The assumed trend exceeds New Hampshire's historical trend rate as calculated in the budget neutrality worksheet. The historical trend rate is not a reasonable estimate of future trend for the New Hampshire Medicaid program for the following reason:

- Enrollment trend increases in the five year historical period were more heavily weighted towards lower cost eligibility categories such as low income children and adults and CHIP, artificially suppressing the overall historical PMPM cost trend.

Without-Waiver Projections

The following trend rates are used to trend the Base Year estimates to the demonstration period:

- Annual enrollment trend = 1.0%

New Hampshire expects the growth in its current Medicaid population to slow from recent trends. A 1.0% annual growth rate throughout the demonstration period is assumed. Medicaid expansion populations are not part of the budget neutrality projections for the *Building Capacity for Transformation* Section 1115 Demonstration Waiver at this time.

- PMPM cost trend = 4.7%

The Base Year PMPM expenditures were trended to the demonstration period using the same 4.7% annual trend rate used to trend the Historical Period to the Base Year. The 4.7% annual trend rate assumption is consistent with the President's budget trend. The assumed trend exceeds New Hampshire's historical trend rate as calculated in the budget neutrality worksheet. The historical trend rate is not a reasonable estimate of future trend for the New Hampshire Medicaid program for the following reason:

- Enrollment trend increases in the five year historical period were more heavily weighted towards lower cost eligibility categories such as low income children and adults and CHIP, artificially suppressing the overall historical PMPM cost trend.

Budget Neutrality Methodology

New Hampshire expects to establish a "Per Capita Method" budget neutrality methodology where



it will be at risk for the PMPM Cost of individuals under the Demonstration. Under a per capita method, New Hampshire will not be at risk for the number of member months of participation in the Demonstration.

With-Waiver Projections

The with-waiver projections use the same enrollment and PMPM trend as the without-waiver projections. The with-waiver projections include the following modifications to the without-waiver projections:

- Managed care savings related to the implementation of the Medicaid Care Management (MCM) program. With-Waiver cost projections include savings related to Step 1 of the MCM program (i.e., acute care and mental health services) and Step 2 of the MCM program (i.e., expanding the MCM program to include long term services and supports and mandatory enrollment for all eligible beneficiaries). Managed care effectiveness is expected to increase over time; therefore an increasing net savings related to the MCM program is projected. Savings are applied to the entire Medicaid program assuming mandatory MCM enrollment of the vast majority of beneficiaries.
 - DY 1 = 3% savings
 - DY 2 = 4% savings
 - DY 3 = 5% savings
 - DY 4 = 6% savings
 - DY 5 = 7% savings
- Impact of the New Hampshire state premium tax. With-waiver cost projections include costs related to the 2% state premium tax on MCM payments. The premium tax cost is an offset to managed care savings.
- Net expenditures related to the six Designated State Health Programs (DSHPs) included in the *Building Capacity for Transformation* Section 1115 Demonstration Waiver. *Appendix G* provides a summary of the expenditures for each DSHP and related savings expected to offset the DSHP expenditures.
 - The cost of the DSHPs was estimated based on “best estimates” of the cost of each program during the demonstration period. Best estimates were established using New Hampshire FFS Medicaid data, expected funding levels for pilot pools, planned expenditures under the *Community Mental Health Agreement* and *Ten Year Mental Health Plan*, and the judgment of DHHS program personnel.



- Related savings estimates were developed in three “savings categories” to group DSHPs with similar objectives and expected return on investment (ROI). *Appendix G* documents the DSHPs that are included in each savings category.
 - Savings category A includes DSHPs that expand access to existing and new mental health and/or SUD services and other services targeted to beneficiaries with mental health/SUD needs. New Hampshire is targeting a 105% ROI over the five year demonstration period, with a lower ROI in earlier years and a higher ROI in later years.
 - Savings category B includes the “Pilot Program Pool” component of the Community Reform Pool. New Hampshire expects to fund only proposals with a high expected ROI under this pool. New Hampshire is targeting a 170% ROI over the five year demonstration, with a lower ROI in earlier years and a higher ROI in later years.
 - Savings category C includes the oral health benefit for pregnant women and mothers of children under age five. New Hampshire expects savings related to reduced acute care costs for the mothers with new dental benefits, reduced incidence of low birth weight and pre-term babies, reduced facility costs for children with dental needs due to better compliance with preventive dental visits.

Note the Capacity-Retention Payment component of the Community Reform Pool was excluded from the savings calculation because it does not introduce new services into the delivery system.

Disproportionate Share Hospital Expenditure Offset

New Hampshire is not proposing to use a reduction in Disproportionate Share Hospital (DSH) claims to offset Demonstration costs in the calculation of budget neutrality.

Budget Neutrality Worksheet

The budget neutrality projections using the CMS template are included as *Appendix I*. The CMS template is customized to be consistent with New Hampshire’s budget neutrality approach.

DHHS and its consulting and actuary teams look forward to working with CMS to discuss and



refine the budget neutrality projections.¹

¹ **Caveats and Limitations on Use**

This letter is intended for the internal use of the New Hampshire Department of Health and Human Services (DHHS) and it should not be distributed, in whole or in part, to any external party without the prior written permission of Milliman. We do not intend this information to benefit any third party even if we permit the distribution of our work product to such third party. We understand this letter will be part of New Hampshire's application to CMS.

This letter is designed to provide DHHS with budget neutrality projections for the *Building Capacity for Transformation* Section 1115 Demonstration Waiver. This information may not be appropriate, and should not be used, for other purposes.

Actual without-waiver and with-waiver results will vary from estimates due to costs and savings under the demonstration being higher or lower than expected. 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.



Appendix G: Total Funds Expenditures and Savings for DSHP Initiatives

Total Funds Expenditures and Savings for DSHP Initiatives							
	DY1	DY2	DY3	DY4	DY5	Total	Savings Category
Summary – Total Funds Expenditures for DSHP Initiatives							
<u>DSHP: Community Reform Pool</u>							
Capacity Retention	\$15,932,857	\$13,194,318	\$13,658,098	\$14,138,180	\$14,635,137	\$71,558,591	None (existing services)
Capacity Expansion	\$3,762,363	\$3,115,688	\$3,225,205	\$3,338,571	\$3,455,921	\$16,897,749	A
New Service	\$1,240,565	\$1,027,337	\$1,063,448	\$1,100,828	\$1,139,522	\$5,571,700	A
Pilot Program Pool	\$21,800,000	\$12,000,000	\$12,000,000	\$12,000,000	\$10,400,000	\$68,200,000	B
Provider Incentive Pool	\$0	\$0	\$5,867,469	\$5,989,350	\$6,115,516	\$17,972,335	Included in A and B below
<i>Subtotal</i>	<i>\$42,735,786</i>	<i>\$29,337,343</i>	<i>\$35,814,219</i>	<i>\$36,566,929</i>	<i>\$35,746,097</i>	<i>\$180,200,374</i>	
<u>DSHP: Enhance Community Based Mental Health Services</u>	\$8,534,851	\$11,022,950	\$12,456,169	\$13,021,057	\$13,411,689	\$58,446,716	A
<u>DSHP: Invest in Behavioral Health Workforce Development</u>	\$2,000,000	\$1,500,000	\$500,000	\$500,000	\$500,000	\$5,000,000	A
<u>DSHP: InSHAPE Program</u>							
Expand program to children with SMI and individuals enrolled in DD waiver	\$1,752,681	\$2,502,344	\$2,918,077	\$3,349,439	\$3,794,317	\$14,316,858	A
Cover additional SMI Adults not currently enrolled in InSHAPE	\$87,872	\$179,258	\$271,794	\$370,480	\$473,004	\$1,382,407	A
Add smoking cessation for all InSHAPE enrollees	<u>\$36,447</u>	<u>\$79,244</u>	<u>\$116,610</u>	<u>\$128,830</u>	<u>\$141,492</u>	<u>\$502,625</u>	A
<i>Subtotal</i>	<i>\$1,877,000</i>	<i>\$2,760,846</i>	<i>\$3,306,482</i>	<i>\$3,848,749</i>	<i>\$4,408,813</i>	<i>\$16,201,890</i>	
<u>DSHP: Oral Health for Pregnant Women and Mothers</u>							
Education	\$43,481	\$44,351	\$45,238	\$46,142	\$47,065	\$226,277	C
Dental Coverage (mothers age <21 at delivery)	\$0	\$41,224	\$76,428	\$106,581	\$132,802	\$357,036	C
Dental Coverage (mothers age 21 and over at delivery)	\$995,531	\$1,845,592	\$2,576,864	\$3,211,050	\$3,766,184	\$12,395,221	C
<i>Subtotal</i>	<i>\$1,039,012</i>	<i>\$1,931,166</i>	<i>\$2,698,530</i>	<i>\$3,363,774</i>	<i>\$3,946,051</i>	<i>\$12,978,534</i>	
<u>DSHP: System of Care / FAST Forward</u>							



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Total Funds Expenditures and Savings for DSHP Initiatives							
	DY1	DY2	DY3	DY4	DY5	Total	Savings Category
Cover new services	\$212,197	\$218,563	\$225,120	\$231,874	\$238,830	\$1,126,585	A
Transition services from grant to DSHP	\$184,291	\$189,819	\$195,514	\$201,379	\$207,421	\$978,424	None (existing services)
Subtotal	\$396,488	\$408,383	\$420,634	\$433,253	\$446,251	\$2,105,009	
Total Funds Expenditures for DSHP Initiatives	\$56,583,137	\$46,960,689	\$55,196,034	\$57,733,762	\$58,458,901	\$274,932,523	
Summary – Total Funds Savings for DSHP Initiatives							
<u>Savings Category A: Expansion of Community Mental Health/SUD Services</u>							
DSHP Expenditures	\$17,626,977	\$19,645,385	\$20,776,423	\$22,041,079	\$23,154,776	\$103,244,640	
<u>Provider Incentive Withholds for Category A Expenditures</u>	\$0	\$1,035,756	\$1,072,163	\$1,109,850	\$1,148,861	\$4,366,630	
Subtotal	\$17,626,977	\$20,681,141	\$21,848,586	\$23,150,928	\$24,303,637	\$107,611,270	
<u>Return on Investment</u>	50%	75%	100%	125%	150%	104%	
<u>Subtotal Category A Savings</u>	(\$8,813,488)	(\$15,510,856)	(\$21,848,586)	(\$28,938,660)	(\$36,455,455)	(\$111,567,047)	
Savings as a % of Inpatient and ER Expenditures							
<u>Savings Category B: Pilot Program Pool Savings</u>							
DSHP Expenditures	\$21,800,000	\$12,000,000	\$12,000,000	\$12,000,000	\$10,400,000	\$68,200,000	
<u>Provider Incentive Withholds for Category B Expenditures</u>	\$0	\$3,000,000	\$3,000,000	\$3,000,000	\$2,600,000	\$11,600,000	
Subtotal	\$21,800,000	\$15,000,000	\$15,000,000	\$15,000,000	\$13,000,000	\$79,800,000	
<u>Return on Investment</u>	75%	150%	200%	225%	250%	169%	
<u>Subtotal Category B Savings</u>	(\$16,350,000)	(\$22,500,000)	(\$30,000,000)	(\$33,750,000)	(\$32,500,000)	(\$135,100,000)	
<u>Savings Category C: Oral Health for Pregnant Women and Mothers</u>							
DSHP Expenditures	\$1,039,012	\$1,931,166	\$2,698,530	\$3,363,774	\$3,946,051	\$12,978,534	
<u>Return on Investment</u>	50%	50%	50%	50%	50%	50%	
Savings	(\$519,506)	(\$965,583)	(\$1,349,265)	(\$1,681,887)	(\$1,973,026)	(\$6,489,267)	
Savings due to avoided low birth weight and/or pre term babies	(\$434,039)	(\$447,061)	(\$460,472)	(\$474,287)	(\$488,515)	(\$2,304,374)	
<u>Savings due to avoided hospital-based dental claims for children</u>	(\$188,116)	(\$193,759)	(\$199,572)	(\$205,559)	(\$211,726)	(\$998,732)	
<u>Subtotal Category C Savings</u>	(\$1,141,661)	(\$1,606,403)	(\$2,009,309)	(\$2,361,733)	(\$2,673,267)	(\$9,792,373)	



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Total Funds Expenditures and Savings for DSHP Initiatives							
	DY1	DY2	DY3	DY4	DY5	Total	Savings Category
Total Funds Savings for DSHP Initiatives	(\$26,305,150)	(\$39,617,259)	(\$53,857,896)	(\$65,050,393)	(\$71,628,722)	(\$256,459,420)	
Summary – Net Total Funds Expenditures / (Savings) for DSHP Initiatives							
Total Funds Expenditures for DSHP Initiatives	\$56,583,137	\$46,960,689	\$55,196,034	\$57,733,762	\$58,458,901	\$274,932,523	
Total Funds Savings for DSHP Initiatives	(\$26,305,150)	(\$39,617,259)	(\$53,857,896)	(\$65,050,393)	(\$71,628,722)	(\$256,459,420)	
Net Total Funds Expenditures / (Savings) for DSHP Initiatives	\$30,277,987	\$7,343,430	\$1,338,138	(\$7,316,631)	(\$13,169,821)	\$18,473,103	



Appendix H: Total Funds for Pilot Program Pool in Community Reform Pool DSHP Initiative

Pilot Program Pool Expenditures						
	DY1	DY2	DY3	DY4	DY5	Total
Summary – Total Funds Expenditures for Pilot Program Pool in Community Reform Pool DSHP (in Millions)						
DSHP: Community Reform Pool						
Activity: Pilot Program Pool						
Alternative Delivery Models to increase access to services	\$4.8	\$3	\$3	\$3	\$2	\$15.8
Telehealth Delivery Models to increase access to services and improve coordination of behavioral and physical health services	\$1.8	\$1	\$1	\$1	\$1	\$5.8
Care Models to Support MCM Step 1 Initiatives	\$5.8	\$4	\$4	\$4	\$3	\$20.8
Care Models to Support Integration of Behavioral Health, Physical Health, and Long Term Care	\$3.8	\$3	\$3	\$3	\$3	\$15.8
Quality Improvement projects related to mental health	\$2.8	\$2	\$2	\$2	\$2	\$10.8
Initiatives Supporting <i>SHIP</i>	\$2.8	\$2	\$2	\$2	\$2	\$10.8
Subtotal for Pilot Program Pool	\$21.8*	\$15	\$15	\$15	\$13	\$79.8
Quality Withholds for Provider Incentive Pool	(\$0)	(\$3)	(\$3)	(\$3)	(\$2.6)	\$11.6
Total Funds Expenditures for Pilot Program Pool	\$21.8	\$12	\$12	\$12	\$10.4	\$68.2

*Quality Withholds for the Provider Incentive Pool start in Demonstration Year 2. In Demonstration Year 1, this amount will be paid out through the Pilot Program Pool.



Appendix I. Budget Neutrality Form

The following pages contain the Budget Neutrality Form required by CMS.

Five Years of Historic Data						
	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	5-Years
Total Medicaid Population						
Total Expenditures	\$1,041,213,613	\$1,109,688,206	\$1,101,532,435	\$1,102,609,042	\$1,162,047,422	\$5,517,090,718
Eligible Member Months	1,255,934	1,354,083	1,426,495	1,438,278	1,500,169	
PMPM Cost	\$829.04	\$819.51	\$772.20	\$766.62	\$774.61	
Trend Rates	Annual Change					5-Year Average
Total Expenditures		6.58%	-0.73%	0.10%	5.39%	2.78%
Eligible Member Months		7.81%	5.35%	0.83%	4.30%	4.54%
PMPM Cost		-1.15%	-5.77%	-0.72%	1.04%	-1.68%

Demonstration Without Waiver (WOW) Budget Projection: Coverage Costs For Populations										
Eligibility Group	Trend Rate 1	Months of Aging	Base Year	Trend Rate 2	DEMONSTRATION YEARS (DY)					Total WOW
Total Medicaid Population			DY 00		DY 01	DY 02	DY 03	DY 04	DY 05	
Eligible Member Months	3.5%	27	\$1,620,899	1.0%	\$1,637,108	\$1,653,479	\$1,670,014	\$1,686,714	\$1,703,581	
PMPM Cost	4.7%	27	\$858.94	4.7%	\$899.31	\$941.58	\$985.83	\$1,032.16	\$1,080.67	
Total Expenditure					\$1,472,267,650	\$1,556,882,890	\$1,646,349,835	\$1,740,958,797	\$1,841,009,109	\$8,257,468,281



Demonstration With Waiver (WW) Budget Projection: Coverage Costs For Populations								
Eligibility Group	Base Year	Demo Trend Rate	DEMONSTRATION YEARS (DY)					Total WW
Total Medicaid Population Pop Type: Medicaid	DY 00		DY 01	DY 02	DY 03	DY 04	DY 05	
Eligible Member Months	1,620,899	1.0%	1,637,108	1,653,479	1,670,014	1,686,714	1,703,581	
PMPM Cost	\$858.94	4.7%	\$899.31	\$941.58	\$985.83	\$1,032.16	\$1,080.67	
Net Managed Care Savings			-3.0%	-4.0%	-5.0%	-6.0%	-7.0%	
Impact of State Premium Tax			2.0%	2.0%	2.0%	2.0%	2.0%	
PMPM Cost After Managed Care			\$889.78	\$922.00	\$955.27	\$989.64	\$1,025.12	
Total Expenditure After Managed Care			\$1,456,666,010	\$1,524,507,768	\$1,595,314,210	\$1,669,239,714	\$1,746,375,173	\$7,992,102,875
Net DSHP Expenditures (refer to waiver application narrative and Appendices F-I for detail)			\$30,277,987	\$7,343,430	\$1,338,138	-\$7,316,631	-\$13,169,821	\$18,473,103
CNOM Expenditures			\$40,000,000	\$40,000,000	\$40,000,000	\$40,000,000	\$40,000,000	\$200,000,000
Total Expenditure			\$1,526,943,997	\$1,571,851,198	\$1,636,652,348	\$1,701,923,083	\$1,773,205,352	\$8,210,575,978



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Budget Neutrality Summary						
	Demonstration Years (DY)					
Without-Waiver Total Expenditures	DY 01	DY 02	DY 03	DY 04	DY 05	Total
Total Medicaid Population	\$1,472,267,650	\$1,556,882,890	\$1,646,349,835	\$1,740,958,797	\$1,841,009,109	\$8,257,468,281
Medicaid Pop 2	\$0	\$0	\$0	\$0	\$0	\$0
Medicaid Pop 3	\$0	\$0	\$0	\$0	\$0	\$0
DSH Allotment Diverted	\$0	\$0	\$0	\$0	\$0	\$0
Other WOW Categories						
Category 1						\$0
Category 2						\$0
Total Without-Waiver Expenditures	\$1,472,267,650	\$1,556,882,890	\$1,646,349,835	\$1,740,958,797	\$1,841,009,109	\$8,257,468,281
With-Waiver Total Expenditures	DY 01	DY 02	DY 03	DY 04	DY 05	Total
Total Medicaid Population	\$1,526,943,997	\$1,571,851,198	\$1,636,652,348	\$1,701,923,083	\$1,773,205,352	\$8,210,575,978
Medicaid Pop 2	\$0	\$0	\$0	\$0	\$0	\$0
Medicaid Pop 3	\$0	\$0	\$0	\$0	\$0	\$0
Expansion Populations						
Exp Pop 1	\$0	\$0	\$0	\$0	\$0	\$0
Exp Pop 2	\$0	\$0	\$0	\$0	\$0	\$0
Excess Spending From Hypotheticals						\$0
Other WW Categories						
Category 3						\$0
Category 4						\$0
Total With-Waiver Total Expenditures	\$1,526,943,997	\$1,571,851,198	\$1,636,652,348	\$1,701,923,083	\$1,773,205,352	\$8,210,575,978
Variance	-\$54,676,347	-\$14,968,308	\$9,697,488	\$39,035,713	\$67,803,757	\$46,892,303



Appendix J. Demonstration Financing Form

The following form accompanies *Section VI – Demonstration Financing and Budget Neutrality* of the application in order to describe the financing of the Demonstration. Responses from the State are italicized.

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):

- ☒ State General Funds
- ☐ Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).
- ☐ Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).
- ☐ Provider taxes. (Provide description the narrative section – Section VI of the application).
- ☒ Other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

☒ Yes ☐ No

If no, provide an explanation of the provider payment arrangement. *Not Applicable*

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

☐ Yes ☒ No

If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.). Please indicate the period that the following



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data is from. *Not Applicable*

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

NFS for Medicaid payments comes from appropriations for the legislature to the Medicaid agency, provider taxes, and drug rebate amounts.

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

Total Expenditures and NFS Amounts for Medicaid Payments				
Time Period	Total	Federal Share	Other/County Share	State Share
State Fiscal Year 2012	\$1,152,649,425	\$583,659,708	\$132,551,145	\$436,438,572
State Fiscal Year 2013	\$1,199,721,676	\$614,556,941	\$168,783,501	\$416,381,234

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. *Not Applicable*

If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Payments Funded by CPE or IGT					
Name of Entity Transferring/ Certifying Funds	Type of Entity (State, County, City)	Amount Transferred or Certified	Does the entity have taxing authority?	Did the entity receive appropriations?	Amount of appropriations
Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable



Section 1902(a)(30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period that the data is from.

Supplemental or Enhance Payment Amounts		
Time Period	Provider Type	Supplemental or Enhance Payment Amount
State Fiscal Year 2014	Primary Care Rate Increase	\$12,192,676
State Fiscal Year 2014	Children's Hospital of Boston	\$5,140,772

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

New Hampshire Medicaid Test of the Upper Payment Limit for Inpatient Services

In order to make a reasonable estimate of what Medicaid and Medicare would pay for equivalent services in accordance with 42 CFR Part 447.272, the Department applied a cost-based methodology using data from the New Hampshire MMIS and the Medicare Cost Reports (Form CMS-2552 or equivalent) filed with the Medicare Fiscal Intermediary for New Hampshire.

There is one State Government Owned/Operated Psychiatric hospital, which is reimbursed on an all-inclusive per diem basis. A Cost to Charge Ratio (CCR) methodology is used to estimate the Medicare Upper Payment Limit. For the State owned/operated hospital, data sources are the Medicare Cost Report (Form CMS 2552-10 or equivalent) as filed, and the New Hampshire Medicaid Management Information System (MMIS). First, the Medicare UPL test was determined from data for financial reporting period ending during 2012. A trending factor was calculated to project actual reported data forward through the mid-point of State Fiscal Year 2015 using the Actual Regulation Market Basket Updates for Inpatient Hospital PPS rates of 3.0%, 2.6% and 2.5% as published on the CMS website. Medicare cost data were summarized from Worksheet D-1, D-4 Part III if applicable, and Worksheet E-4. Medicare charge data were summarized from Worksheet D-3 and D-4 if applicable. The total Medicare costs were then divided by the total Medicare charges to establish the Medicare CCR. New Hampshire (NH) Medicaid charges extracted from MMIS were multiplied by the CCR and projected forward using the abovementioned trending factor to establish the Upper Payment Limit. NH Medicaid payments extracted from MMIS were projected forward using the abovementioned trending factor. NH Medicaid trended payments were subtracted from the UPL to determine the inpatient upper payment limit gap for the State owned hospital.

There are no Non-State government owned/operated hospitals in New Hampshire; therefore no comparison is possible or necessary.



For Privately owned/operated hospitals, a Cost to Charge Ratio (CCR) methodology is used to estimate the Medicare Upper Payment Limit. For privately owned/operated hospitals, data sources are the Medicare Cost Report (Form CMS 2552-10 or equivalent) as filed, and the New Hampshire Medicaid Management Information System (MMIS).

For PPS Hospital Portion of the UPL

The methodology for determining the inpatient upper payment limit gap for these hospitals is the same as described above for State Government Owned/Operated Psychiatric hospital.

For Cost Based Critical Access Hospital Portion of the UPL

First, the Medicare UPL test was determined from data for financial reporting period ending during 2012. A trending factor was calculated to project actual reported data forward through the mid-point of State Fiscal Year 2015 using the Actual Regulation Market Basket Updates for Inpatient Hospital PPS rates of 3.0%, 2.6% and 2.5% as published on the CMS website. Medicare cost data were summarized from Worksheet D-1, D-4 Part III if applicable, and Worksheet E-4. Medicare charge data were summarized from Worksheet D-3 and D-4 if applicable. Then, the total Medicare costs were multiplied by 101% then divided by the total Medicare charges to establish the Medicare CCR. NH Medicaid charges extracted from MMIS were multiplied by the CCR and projected forward using the abovementioned trending factor to establish the Upper Payment Limit. NH Medicaid payments extracted from MMIS were projected forward using the abovementioned trending factor. NH Medicaid trended payments were subtracted from the UPL to determine the inpatient upper payment limit gap for these hospitals.

Overall Inpatient UPL Gap

The overall hospital inpatient Upper Payment Limit Gap was determined by summing the total state hospital inpatient upper payment limit, private acute and rehabilitation hospital inpatient upper payment limit portion and the total private Critical Access Hospital inpatient upper payment limit portion.

New Hampshire Medicaid Test for the Upper Payment Limit for Outpatient Services

In order to make a reasonable estimate of what Medicaid and Medicare would pay for equivalent services in accordance with 42 CFR Part 447.321, the Department applied a cost-based methodology using data from the New Hampshire MMIS and the Medicare Cost Reports (Form CMS-2552 or equivalent) filed with the Medicare Fiscal Intermediary for New Hampshire.

There is one State Owned/Operated Psychiatric hospital that does not render outpatient care; therefore no comparison is possible or necessary.



There are no Non-State owned/operated hospitals in New Hampshire; therefore no comparison is possible or necessary.

For Privately owned/operated hospitals, a CCR methodology is used to estimate the Medicare Upper Payment Limit. For privately owned/operated hospitals, data sources are the Medicare Cost Report (Form CMS 2552-10 or equivalent) as filed, and the New Hampshire MMIS.

For PPS Hospital Portion of the UPL

First, the Medicare UPL test was determined from data for financial reporting period ending during 2012. A trending factor was calculated to project actual reported data forward through the mid-point of State Fiscal Year 2015 using the Actual Regulation Market Basket Updates for Inpatient Hospital PPS rates of 3.0%, 2.6% and 2.5% as published on the CMS website. Medicare cost data were summarized from Worksheet D Part V and Worksheet E-4 if applicable. Medicare charge data were summarized from Worksheet D Part V. The total Medicare costs were then divided by the total Medicare charges to establish the Medicare CCR. NH Medicaid charges extracted from MMIS were multiplied by the CCR and projected forward using the abovementioned trending factor to establish the Upper Payment Limit. NH Medicaid payments extracted from MMIS were projected forward using the abovementioned trending factor. NH Medicaid trended payments were subtracted from the UPL to determine the outpatient upper payment limit gap for these hospitals.

For Cost Based Critical Access Hospital Portion of the UPL

First, the Medicare UPL test was determined from data for financial reporting period ending during 2012. A trending factor was calculated to project actual reported data forward through the mid-point of State Fiscal Year 2015 using the Actual Regulation Market Basket Updates for Inpatient Hospital PPS rates of 3.0%, 2.6% and 2.5% as published on the CMS website. Medicare cost data were summarized from Worksheet D Part V and Worksheet E-4 if applicable. Medicare charge data were summarized from Worksheet D Part V. The total Medicare costs were then multiplied by 101% then divided by the total Medicare charges to establish the Medicare CCR. NH Medicaid charges extracted from MMIS were multiplied by the CCR and projected forward using the abovementioned trending factor to establish the Upper Payment Limit. NH Medicaid payments extracted from MMIS were projected forward using the abovementioned trending factor. NH Medicaid trended payments were subtracted from the UPL to determine the outpatient upper payment limit gap for these hospitals.

Overall Outpatient UPL Gap

The overall hospital outpatient Upper Payment Limit Gap was determined by summing the total acute and rehabilitation hospital outpatient upper payment limit portion and the total Critical Access outpatient upper payment limit portion.



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Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

☐ Yes ☒ No

If yes, provide an explanation. *Not Applicable*

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

☐ Yes ☒ No ☐ Not Applicable

If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations? *Not Applicable*

If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

☐ Yes ☐ No *Not Applicable*

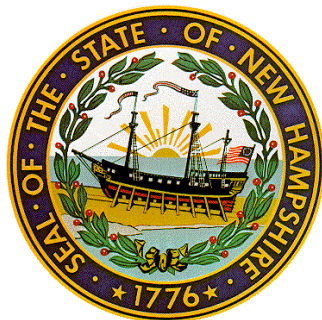
Use of other Federal Funds

Are other federal funds, from CMS or another federal agency, being used for the Demonstration program?

☐ Yes ☒ No

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Grants the State is Receiving from CMS or other Federal Agencies		
Source of Federal Funds	Amount of Federal Funds	Period of Funding
<i>Not Applicable</i>	<i>Not Applicable</i>	<i>Not Applicable</i>



New Hampshire
Department of Health and Human Services

Building Capacity for Transformation
Section 1115 Demonstration Waiver

Application Addendum

June 30, 2014



Waiver Application Addendum

On May 30, 2014, the New Hampshire Department of Health and Human Services (DHHS) submitted an application for a Section 1115 Demonstration Waiver (Waiver) from the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) to support the continuing reform of its Medicaid program and of New Hampshire's health care delivery system as a whole. The Waiver, titled *Building Capacity for Transformation*, proposes to address:

- The fragility of the current behavioral health delivery system;
- The challenges facing the behavioral health delivery system in meeting the needs of individuals; and
- The fragmented delivery system for individuals with complex health needs.

On June 13, 2014, CMS requested that New Hampshire submit information pertaining to the appropriate evaluation indicators under 42 CFR 431.412(a)(1)(vii) ("The research hypotheses that are related to the demonstration's proposed changes, goals and objectives, a plan for testing the hypotheses in the context of an evaluation, and, if a quantitative evaluation design is feasible, the identification of appropriate evaluation indicators.").

This addendum to the Waiver application presents a summary of the potential indicators that will be included in New Hampshire's demonstration evaluation.

Potential Evaluation Indicators

The State will work with CMS and other external stakeholders to develop a draft evaluation plan (Plan). The Plan will include a discussion of the goals, objectives, and evaluation questions specific to the entire demonstration and describe the methodology that will test the hypotheses proposed in the initial Waiver application submitted on May 30, 2014. The Plan will also describe the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, and include the data sources and sampling methodology for assessing these outcomes. The Plan will also identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation. The Plan will be structured to evaluate the effectiveness of the individual DSHPs described in the Waiver, and the impact of the Waiver as a whole on the State's behavioral health system and the State's overall health care system.

When identifying potential evaluation indicators, the State reviewed nationally-recognized sources and national measures sets, including CMS's Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (CMS Adult Core Set)¹, CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (CMS Pediatric Core Measure Set)², and measures required by the Affordable Care

¹ Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/AdultCoreMeasures.pdf>

² Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/ChildCoreMeasures.pdf>



New Hampshire Department of Health and Human Services

Building Capacity for Transformation Section 1115 Demonstration Waiver Application

Addendum dated June 30, 2014

Act³.

Below are potential evaluation indicators that the State will consider while developing the Plan. Please note that these potential evaluation indicators are preliminary in nature and are anticipated to evolve with the evaluation design and implementation plan of each Designated State Health Program (DSHP).

[Care/Downloads/ChildCoreMeasures.pdf](#)

³ Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html>



New Hampshire Department of Health and Human Services

Building Capacity for Transformation Section 1115 Demonstration Waiver Application

Addendum dated June 30, 2014

Addendum Table 1. Potential Evaluation Indicators.

Potential Evaluation Indicators for Designated State Health Programs (DSHPs)						
Measure Sets Framing the Evaluation (n.b. individual measures will be determined during subsequent Evaluation Design)	(1) Community Reform Pool DSHP	(2) Community-Based Mental Health Services DSHP	(3) System of Care (SOC) / F.A.S.T. Forward DSHP	(4) Behavioral Health Workforce Development DSHP	(5) InSHAPE DSHP	(6) Oral Health Pilot Program for Pregnant Women DSHP
CMS Adult Measure Set	✓	✓			✓	
CAHPS Health Plan Survey 5.0H – Adult Questionnaire	✓	✓			✓	
CMS Pediatric Core Measure Set	✓		✓			
CAHPS Health Plan Survey 5.0H – Child Questionnaire	✓		✓			
Access to Behavioral Health Workforce	✓	✓	✓	✓	✓	
New Hampshire Hospital Utilization	✓	✓	✓		✓	
Behavioral Health Satisfaction Survey	✓	✓	✓		✓	
Substance Use Disorder Services Utilization	✓	✓	✓			
Access to SUD Providers	✓	✓	✓	✓		
SOC Practice Adherence			✓			
National Outcome Measures (NOMS)	✓	✓	✓		✓	
Outcome Rating Scale (ORS)			✓			



New Hampshire Department of Health and Human Services

Building Capacity for Transformation Section 1115 Demonstration Waiver Application

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Routine Dental Care Utilization						✓
Tobacco Cessation Service Utilization					✓	✓
Emergency Dental Services Utilization						✓
Hospital Dental Services Utilization						✓
Preventable Dental Care (e.g. crowns, extractions, pulpotomies)						✓
Costs for Dental Services						✓
Periodontal Disease and Birth Outcomes						✓