State of New Hampshire
Substance Use Disorder, Serious Mental Illness and Serious Emotional Disturbance Treatment and Recovery Access Section 1115 Medicaid Demonstration 11-W-00321/1

SMI/SED Midpoint Assessment Report (July 1, 2022 – December 30, 2024)

May 30, 2025

Prepared by the Pacific Health Policy Group (PHPG)

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COMMONLY USED ABBREVIATIONS AND ACRONYMS

Abbreviation	Definition
ADT	Admission, Discharge, Transfer
BMHS	Bureau of Mental Health Services
BN	Budget Neutrality
CCBHC	Certified Community Behavioral Health Clinic
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DBH	Division for Behavioral Health
DHHS	New Hampshire Department of Health and Human Services
DY	Demonstration Year
ED	Emergency Department
EHR/EMR	Electronic Health Record/Electronic Medical Record
ENS	Event Notification System
FFP	Federal Financial Participation
FFS	Fee-for-Service
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIT	Health Information Technology
IMD	Institution for Mental Diseases
IOP	Intensive Outpatient Services
IP	Inpatient
LTC	Long Term Care
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MP	Monitoring Protocol

Abbreviation	Definition
MPI	Master Patient (or Person) Index
NCQA	National Committee for Quality Assurance
PH	Partial Hospitalization Program
PHE	Public Health Emergency
PHPG	Pacific Health Policy Group
PMPM	Per Member Per Month
QRTP	Qualified Residential Treatment Program
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SMI	Serious Mental Illness
STC	Special Terms and Conditions
SUD	Substance Use Disorder

A. EXECUTIVE SUMMARY

CMS approved the New Hampshire Substance Abuse Treatment and Recovery Access Section 1115 Demonstration on July 10, 2018, for a five-year term ending June 30, 2023. The Demonstration authorized New Hampshire to provide high-quality, clinically appropriate SUD treatment services for short-term stays in residential and inpatient treatment settings that qualify as Institutions for Mental Disease (IMDs). On June 16, 2021, CMS approved an amendment to update the Demonstration's budget neutrality terms and conditions.

On June 2, 2022, CMS approved an amendment to authorize Medicaid payments for psychiatric treatment in residential programs designated as IMDs for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED) who receive services in Qualified Residential Treatment Programs (QRTPs).

On March 17, 2023, CMS approved a third amendment to authorize Medicaid payments for removable prosthodontic (dentures) coverage for adults who reside in nursing facilities. This coverage was effective April 1, 2023, and for the remainder of the Demonstration period ending June 30, 2023. Clarifying, non-substantive revisions were approved on April 14, 2023.

Effective July 1, 2023, the Demonstration was extended for one year while the State and CMS negotiated the terms of a five-year renewal agreement. The five-year renewal was approved July 16, 2024.

This Mid-Point Assessment (MPA) examines the progress of planned enhancements expected as part of the CMS-approved SMI/SED Implementation Plan, as well as the State's performance per CMS-defined metrics, as outlined in its SMI/SED Monitoring Protocol. The Implementation Plan was approved by CMS at the outset of the Demonstration's SMI/SED amendment. The project focuses on hospital based IMD services. Authorities related to adult residential treatment and Qualified Residential Treatment Programs (QRTP) for youth are not yet operational under the Demonstration. The assessment examines the period from July 1, 2022, through December 31, 2024. However, when relevant, activities completed in early 2025 also were included.

The Pacific Health Policy Group (PHPG) assessed progress in each SMI/SED Implementation Plan area by evaluating Demonstration activities to-date and their alignment with the approved plan and timeline. PHPG met with stakeholders (internal and external) to discuss the Mid-Point Assessment activities and the State's progress to-date.

PHPG reviewed quarterly and annual reports to CMS for analysis of policy issues and progress across all Implementation Plan activities. PHPG also performed the following assessment activities to identify trends in performance, evaluate policy and operational alignment with CMS requirements, and identify successes and potential barriers to progress:

- Analysis of treatment program rules, Medicaid State Plan changes, MCO contract, and DHHS program requirements including a review of:
    - Rule He-M 1401 (IMD requirements) adopted November 27, 2023
    - Amendment #8 to the Medicaid Care Management Services Contract, effective July 1, 2022
    - New Hampshire Administrative Code:
        - He-W 543.11 (utilization review)
        - He-P 802.18 (required services/discharge planning)
        - He-M 613.09 (admissions to transitional housing)
    - Training and technical assistance information
    - Provider oversight rules, contract requirements and audit activities,
    - Annual SMI/SED treatment provider availability assessments
    - New Hampshire telehealth laws and regulations
- New Hampshire laws and regulations regarding residential placement for youth and quality monitoring of qualified residential treatment providers including:
    - He-C 6350 (certification of residential programs)
    - He-C 6420 (Medicaid services and provider qualifications)
- Discussions and written feedback with State staff and stakeholders, including Medicaid, Bureau of Mental Health Services, Division for Behavioral Health, Health information Technology staff
- Analysis of CMS-required Monitoring Protocol metrics and quarterly and annual monitoring reports

The SMI metrics identified by CMS as critical are calculated annually by the State based on a calendar year (CY). The first data point (CY2022) included six months of activity prior to the effective date of the Demonstration's SMI amendment. The second data point (CY2023) represents the remainder of year one and the beginning of amendment year two. The evaluators performed a simple test of significance, at the 95 percent confidence level between the two years. However, inclusion of only two data points, representing 18 months of Demonstration activity, should be considered descriptive and interpreted with caution. Thus, the assessment of risk (described below) does not consider metric results as a factor.

The evaluation team defined criteria for risk assessment scores relevant to the information collected as part of the MPA, as follows:

> ***Low Risk*** - The State has fully completed most/all associated action items as scheduled to date (i.e., 75 percent or more). Few stakeholders identified risks related to meeting the milestone, and the risks identified can easily be addressed within the planned timeframe.
>
> ***Medium Risk*** - The State fully completed some of the associated action items as scheduled (i.e., between 25 and 75 percent). Multiple stakeholders identified risks that could cause challenges in meeting the milestone.

High Risk - The State fully completed few or none of the associated action items as scheduled (i.e., under 25 percent). Stakeholders identified significant risks to meeting the milestone.

Where applicable (i.e., medium, and high-risk areas) PHPG examined factors that may have had a negative impact on performance and developed recommendations for performance improvement.

Overall, the assessment found that the State is meeting the goals and objectives of the Demonstration. New Hampshire has completed planned Implementation Plan activities and is making progress in areas of the plan that are on-going. The average length of stay in an IMD was less than the 30-day threshold set by CMS, with an average of 18 days in 2022 and 22 days in 2023.

Performance for the majority of metrics showed no statistically significant difference between 2022 and 2023 results. Results that showed statistical significance are summarized below.

Metrics Showing Statistically Significant Difference at the 95% Confidence Level	2022	2023
Milestone 2		
8(b). Percentage of psychiatric hospital discharges for which adults 18 and older received follow-up within 7 days after discharge	49%	57%
Milestone 4		
26. Access to preventive/ambulatory health services for members with an SMI	97%	98%
29(b). Percentage of children and adolescents on antipsychotics who received cholesterol testing	33%	37%
29(c). Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	32%	36%

No milestones were deemed at medium or high risk of not being met. No concerns were raised by stakeholders who attended the general information and feedback sessions.

A summary of assessment findings and progress is presented on the following page.

SMI/SED Mid-Point Assessment Overview		
CMS Milestone	**Assessment of Risk**	**Key Considerations**
1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	**Low**	All quality of care requirements have been met. The State contemplated expanding program integrity activities to residential treatment programs. However, there are no residential IMD settings under the Demonstration.
2: Improving Care Coordination and Transitions to Community Based Care	**Low**	Discharge planning requirements, including screening for housing stability, have been implemented. In addition, expanded CTI supports for members discharged from inpatient psychiatric treatment are available statewide.
3: Increasing Access to Continuum of Care, including Crisis Stabilization Services	**Low**	The State has implemented planned activities and expanded the continuum of crisis services, community crisis beds and inpatient capacity beyond the steps contemplated in the original SMI/SED Implementation Plan.
4: Earlier Identification, Engagement in Treatment, and Increased Integration	**Low**	The State had implemented quality monitoring of youth programs as planned.
SMI/SED Finance Plan	**Low**	The State has shown a commitment to strengthening the community-based continuum of care through: • Expanding crisis services • Implementing the CCBHC model • Expanding community-based hospital diversion and step-down programs.
SMI/SED IT Plan	**Low**	The State has been engaged in IT planning throughout the Demonstration period. Expected completion dates for key milestones have been updated, as necessary.
Budget Neutrality	**Low**	The State has a cumulative surplus at the end of year three of $5,768,939 for the SMI/SED portion of the Demonstration.

B. IMD DEMONSTRATION BACKGROUND AND POLICY GOALS

CMS approved the New Hampshire Substance Abuse Treatment and Recovery Access Section 1115 Demonstration on July 10, 2018, for a five-year term ending June 30, 2023. The Demonstration authorized New Hampshire to provide high-quality, clinically appropriate SUD treatment services for short-term stays in residential and inpatient treatment settings that qualify as Institutions for Mental Disease (IMDs). On June 16, 2021, CMS approved an amendment to update the Demonstration's budget neutrality terms and conditions.

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COVERED SERVICES

Members have access to the full range of otherwise covered Medicaid services, including SMI/SED treatment services. These SMI/SED services range in intensity from early intervention, short-term crisis stabilization, and acute care in an inpatient or residential setting to ongoing treatment in community-based settings. Benefits under the Demonstration include short-term stays in residential and inpatient SMI/SED treatment settings that qualify as IMDs.

MENTAL HEALTH DELIVERY SYSTEM

The New Hampshire Medicaid delivery system is based on an integrated managed care model for physical and mental health. It utilizes MCOs to deliver integrated physical and mental health services, including SMI and SED treatment services, with a small number of members continuing to receive benefits on a fee-for-service basis. The delivery system operates as approved under Section 1932(a) State Plan authority for managed care and concurrent 1915(b) and 1115 Demonstrations.

The State of New Hampshire supports a comprehensive continuum of community mental health services. Guided by the 10-Year Mental Health Plan reissued in 2019, the Department of Health and Human Services addresses the treatment needs of individuals and families across the continuum of physical and mental health care.

DHHS and its stakeholders are continuously engaged in enhancing the community mental health service system, with a comprehensive approach to mental health across the life span. The State's 10-Year Mental Health Plan calls for strengthening the system of care with evidence-based treatment options and promoting a highly coordinated and integrated system of care to improve physical and mental health outcomes and prevent readmissions.

New Hampshire's SMI/SED Demonstration amendment was identified as a necessary step under its 10-Year Mental Health Plan. The Plan is aimed at increasing access to community-based mental health treatment and creating a cohesive system for crisis response and stabilization, including centralized intake and mobile response teams in each region of the State. The Plan also contemplates increasing bed capacity in community-based treatment programs for psychiatric care. These programs offer hospital diversion, step-down and transitional living options for persons experiencing a psychiatric crisis.

Medicaid members have access to the full continuum of high-quality, evidence-based SMI and SED treatment services. Treatment options range in intensity from short-term acute care for SMI and SED to ongoing chronic care for these conditions in cost-effective community-based settings.

Below is an overview of the range of benefits authorized through the State Plan and under the Demonstration's expenditure authorities.

Benefit	Type	State Plan Authority	Demonstration Authority
Outpatient services	SMI, SED	✓	
Intensive outpatient services	SMI, SED	✓	
Inpatient services	SMI, SED	✓ (non-IMD)	✓ (IMD)
Residential treatment services	SMI, SED	✓ (non-IMD)	✓ (IMD)
Partial Hospitalization	SMI, SED	✓	

The New Hampshire Division for Behavioral Health (DBH) within DHHS oversees community-based mental health services through the Bureau of Mental Health Services (BMHS). These services are provided through a network of ten regional community mental health centers (CMHCs) and other licensed mental health practices across the State. Under the SMI/SED Implementation Plan, the State initiated planning to assess the feasibility of implementing the Certified Community Behavioral Health Clinic (CCBHC) model of care.

DHHS operates two psychiatric care facilities designated as IMDs. The New Hampshire Hospital maintains 187 inpatient beds serving adults. Hampstead Hospital, a private facility purchased by the State in 2022, maintained forty beds for youth with psychiatric and behavioral health challenges and fifteen beds for young adults. In 2025, the management of Hampstead Hospital was transferred from the State to Dartmouth Health. The hospital will focus exclusively on serving children and adolescents under 18 years old.

POLICY GOALS

In the period immediately prior to the Demonstration amendment request, DHHS observed an increase in individuals utilizing Emergency Departments for mental health and psychiatric crisis. The State's inpatient psychiatric bed capacity could not meet the increased demand. This in turn resulted in long wait times for treatment. Psychiatric boarding in the ED, previously reduced to near zero, had increased dramatically.

In May of 2021, a State Supreme Court decision required the State to hold probable cause hearings for mental health patients within three days of completion of an Involuntary Emergency Admission (IEA) certificate, regardless of any wait list or ED boarding status. In response, Governor Sununu signed Executive Order 2021-0915 on May 13, 2021, requiring DHHS to enact emergency rules and expand the number of available beds and other resources available to state residents in crisis.

These actions, coupled with the State's commitment to strengthening community-based mental health treatment, caused DHHS to seek a Demonstration amendment in support of a full continuum of psychiatric care options for individuals with a SMI or SED. The full continuum of care includes evidenced-based psychiatric treatment services in residential and inpatient settings, including those classified as IMDs.

The SMI Demonstration amendment was implemented to ensure that Medicaid enrollees have access to a full continuum of evidenced-based treatment services for SMI and SED, including inpatient and residential treatment provided by facilities that are classified as IMDs.

C. MID-POINT ASSESSMENT METHODOLOGY

The Pacific Health Policy Group (PHPG) was retained as the independent evaluator for the Demonstration and to conduct the SMI/SED Mid-Point Assessment (See Appendix 1). PHPG also serves as the independent evaluator of Section 1115 SMI/SUD Demonstrations in several other states.

In developing the SUD and SMI/SED Mid-Point Assessment methodology, stakeholder information and input sessions were offered in the spring of 2025. Invitations for the general discussion sessions were distributed to members of the Medicaid, Managed Care and Behavioral Health advisory boards, providers, the New Hampshire Hospital Association and the National Alliance on Mental Illness. Stakeholder sessions are listed below.

Date	Meeting
February 18, 2025	Internal State staff and stakeholders kick off session
February 20, 2025	1915(i) Supportive Housing State Planning Team
February 24, 2025	State Quality Monitoring Team
March 21, 2025	Bureau of Mental Health Services staff
April 2 & 7, 2025	General Stakeholder Information and Feedback Sessions (open to all internal and external stakeholders)

PHPG offered meeting attendees the option to provide input during each session, as well as by email, phone, or through one-on-one meetings any time up to May 1, 2025.

PHPG reviewed quarterly and annual reports to CMS for analysis of policy issues and progress across all Implementation Plan activities. PHPG also performed the following assessment activities to identify trends in performance, evaluate policy and operational alignment with CMS requirements, and identify successes and potential barriers to progress:

- Analysis of treatment program rules, Medicaid State Plan changes, MCO contract, and DHHS program requirements including a review of:
    - Rule He-M 1401 (IMD requirements) adopted November 27, 2023
    - Amendment #8 to the Medicaid Care Management Services Contract, effective July 1, 2022
    - New Hampshire Administrative Code:
        - He-W 543.11 (utilization review)
        - He-P 802.18 (required services/discharge planning)
        - He-M 613.09 (admissions to transitional housing)
    - Training and technical assistance information
    - Provider oversight rules, contract requirements and audit activities,
    - Annual SMI/SED treatment provider availability assessments
    - New Hampshire telehealth laws and regulations

- New Hampshire laws and regulations regarding residential placement for youth and quality monitoring of qualified residential treatment providers including:
    - He-C 6350 (certification of residential programs)
    - He-C 6420 (Medicaid services and provider qualifications)
- Discussions and written feedback with State staff and stakeholders, including Medicaid, Bureau of Mental Health Services, Division for Behavioral Health, Health information Technology staff
- Analysis of CMS-required Monitoring Protocol metrics and quarterly and annual monitoring reports

CMS-REQUIRED MONITORING METRICS

PHPG examined results of the CMS-required metrics. Metrics reported annually were examined for CY2022 – CY2023. Consideration was given to metrics identified as "critical" by CMS in its Mid-Point Assessment technical assistance document (v.1) outlined below.

Critical SMI/SED Metrics*
Milestone 1. Ensuring quality of care in psychiatric hospitals and residential settings • #2 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
Milestone 2. Improving care coordination and transitions to community-based care • #4 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) • #7 Follow-up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH) • #8 Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD) • #9 Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD) for Members Ages 18 and Older • #10 Follow-up After Emergency Department Visit for Mental Illness (FUM-AD) for Members Ages 18 and Older
Milestone 3. Increasing access to continuum of care including crisis stabilization services • #19 Average Length of Stay (ALOS) in Institutions of Mental Diseases (IMDs)
Milestone 4. Earlier identification and engagement in treatment including through increased integration • #26 Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries with SMI • #29 Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH) • #30 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication

*Critical Metric #3 (All cause ED use, PMH-20) was eliminated from reporting by CMS in 2021

PERFORMANCE ASSESSMENT

This Mid-Point Assessment examines the progress of planned enhancements expected as part of the CMS-approved Implementation Plan, as well as the State's performance per CMS-defined metrics, as outlined in its SMI/SED Monitoring Protocol. PHPG assessed progress in each Implementation Plan area by evaluating Demonstration activities performed through December 2024 and their alignment with the approved plan and timeline. In some cases, actions completed in the first quarter of 2025 were included where relevant. The assessment of the availability of treatment services is addressed in Milestone 3.

PHPG assessed overall progress in accordance with CMS guidance. However, the SMI metrics identified as critical are calculated annually by the State based on a calendar year (CY). The first data point (CY2022) included six months of activity prior to the Demonstration's SMI amendment. The second data point (CY2023) represents the remainer of year one and the beginning of amendment year two. The evaluators performed a simple test of significance, at the 95 percent confidence level between the two years. However, inclusion of only two data points, representing 18 months of Demonstration activity, should be considered descriptive and interpreted with caution. Thus, the assessment of risk (described below) does not consider metric results as a factor.

Absolute and percent changes from baseline were calculated for each metric designated by CMS as critical. The direction of the change was assessed against the State's desired goal. When the percentage change was less than one, the direction of the metric performance was scored as consistent with the prior year.

The evaluation team defined criteria for risk assessment scores relevant to the information collected as part of the MPA, as follows:

> ***Low Risk*** - The State has fully completed most/all associated action items as scheduled to date (i.e., 75 percent or more). Few stakeholders identified risks related to meeting the milestone, and the risks identified can easily be addressed within the planned timeframe.
>
> ***Medium Risk*** - The State fully completed some of the associated action items as scheduled (i.e., between 25 and 75 percent). Multiple stakeholders identified risks that could cause challenges in meeting the milestone.
>
> ***High Risk*** - The State fully completed few or none of the associated action items as scheduled (i.e., under 25 percent). Stakeholders identified significant risks to meeting the milestone.

Where applicable (i.e., medium, and high-risk areas) PHPG examined factors that may have had a negative impact on performance and developed recommendations for performance improvement.

D. SMI/SED MILESTONES AND MID-POINT ASSESSMENT FINDINGS

The SMI/SED Implementation Plan was approved concurrently with the Demonstration's start date. The New Hampshire Implementation Plan focuses on hospital based IMD services. Authorities related to adult residential treatment and Qualified Residential Treatment Programs (QRTP) for youth are not yet operational under the Demonstration. Five requirements across three Milestones were deemed to be met by CMS. These were:

- Milestone 1 – Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
  - 1b (oversight process, including unannounced visits)
- Milestone 3 – Increasing Access to Continuum of Care
  - 3d (use of patient placement assessments)
- Milestone 4 – Identification, Engagement, and Integration
  - 4a (early engagement of clients with SED/SMI)
  - 4b (integration of behavioral health in community settings to support early identification of SED/SMI)
  - 4d (other State efforts at early identification and engagement)

CMS approved modifications to the technical specification requirements for the SMI/SED Monitoring Protocol metrics. Specifically, New Hampshire excludes dual eligible Medicare and Medicaid members in the calculation of the following metrics:

- Metric 4 – 30 day all cause unplanned readmission following discharge from psychiatric hospitalization
- Metric 6 – Medication continuation following inpatient psychiatric discharge

The SMI/SED Implementation Plan included a range of activities, such as developing rules for providing technical assistance to providers and exploring the feasibility of supporting Certified Community Behavioral Clinic (CCBHC) planning statewide. The expected Implementation Plan activities are delineated for each milestone, including the SMI/SED-HIT plan.

The remainder of this section presents findings for each Milestone, and the State's progress in meeting its action steps and timelines outlined in the SMI/SED Implementation Plan.

MILESTONE 1 ENSURING QUALITY OF CARE IN PSYCHIATRIC HOSPITALS AND RESIDENTIAL SETTINGS

Milestone 1 includes the following six subsections:

1-A. Participating hospitals are licensed or approved as meeting standards for licensing established by the agency responsible for licensing hospitals. Participating residential treatment providers are licensed, or otherwise authorized, by the State. They must also be accredited by a nationally recognized accreditation entity.

1-B. Establishment of oversight processes that include unannounced visits for ensuring participating facilities meet State licensure or certification requirements, as well as a national accrediting requirement.

1-C. Use of a utilization review process to ensure beneficiaries have access to the appropriate care levels and types and ensure lengths of stay are medically necessary.

1-D. Compliance with federal program integrity requirements and State compliance assurance process.

1-E. State requirements that participating facilities screen enrollees for co-morbid physical health conditions and substance use disorders and suicidal ideation and facilitate access to treatment for those conditions.

1-F. Other State requirements/policies to ensure good quality care in inpatient and residential settings.

During the first few years of the Demonstration, enhancements were made to the rules to require national accreditation for all IMDs (1-A). Currently, there are two state-operated facilities participating in the Demonstration. Both are inpatient hospital settings authorized through legislation and administrative code. New Hampshire's administrative code includes licensure requirements in alignment with the CMS IMD criteria, including extensive state oversight processes (1-B).

The New Hampshire administrative code (He-W 543.11 Utilization Review) requires an evaluation of the quality, medical necessity, appropriateness of care and length of stay determinations for all inpatient hospital services. Under the Demonstration, the State revised its fee-for-services utilization review policies to include post discharge follow-ups. In addition, all MCO contracts were amended to explicitly require MCOs to include admission and utilization review criteria in all of their IMD provider agreements with New Hampshire IMDs. (1-C). Section 4.11.5.18 of the MCO contract ensures that MCOs maintain written collaborative agreements that include requirements to: ensure members are served in the most integrated setting appropriate to their needs; ensure a seamless transition of care upon admission and discharge; mutually develop admission and utilization review criteria for determining the appropriateness of admissions to or continued stays, both within and external to New Hampshire Hospital and other State determined IMDs for mental illness. Prior to admission to New Hampshire Hospital or other state-determined IMDs for mental illness, the MCO must ensure that a crisis team

consultation has been completed for all Members evaluated by a licensed physician or psychologist.

The DHHS Program Integrity Unit (PIU) routinely performs audits and monitors data to identify any potential anomalies in billing and/or reimbursements (1-D). Under the Demonstration, the PIU performed enhanced provider monitoring to ensure that reimbursement practices at participating IMDs were in compliance with the Demonstration's STCs. The review was initiated at the end of March of 2023 and included claims submitted for reimbursement to the MMIS between June 1, 2022, through March 25, 2023. The random sample included Medicaid Fee For Service members and members served in each of the three MCOs operating in the State, including an equal cross section of members who received follow-up care at each of the different CMHCs throughout the State.

The DHHS PIU review resulted in two findings and recommendations. In one facility serving young adults and youth, reviewers found that care was not always provided in discrete, physically separate residential and programmatic ways for adolescents and young adults. Since the review, the facility programming has been modified to serve only youth under age 18. The second recommendation suggested that protocols be put in place to ensure clients receive a post discharge contact within 72 hours of discharge (see Milestone 2-C). This recommendation was included in the administrative rules adopted later that same year.

During the first few years of the Demonstration, rules were promulgated that require all IMDs to screen for co-morbid conditions and support access to treatment as needed (1-E).

The Implementation Plan included the development of a review process for residential IMD providers, including testing and refinement through DY5. However, to date, there are no residential programs that qualify as IMDs participating in the Demonstration. This activity was considered not applicable (N/A) by the evaluator. A summary of requirements, implementation actions and the State's progress is provided below.

Milestone Requirements	Actions	Completed
a. Assuring participating residential and inpatient programs are licensed and residential facilities have national accreditation	Promulgate administrative rules to require accreditation for all IMDs; public comment starting by Jan 1, 2023	Yes
b. Oversight processes to ensure hospital and residential settings meet standards	N/A – Milestone met	Yes
c. Utilization review process to ensure proper level of care and lengths of stay	The State will amend MCO contracts to explicitly require MCOs to include admission and utilization review criteria in all IMD contracts by June 30, 2022	Yes

Milestone Requirements	Actions	Completed
d. Compliance with federal program integrity requirements and state compliance assurance process.	PIU will implement monitoring including a six-month random sampling of paid claims from the Fee-for-Service and MCO populations to determine if there are patterns or irregularities. Activities begin by March 2023 to refine the sampling process; full review by Nov 2023	Yes
e. Screening for co-morbid conditions in psychiatric hospital and residential settings and facilitate access to treatment	Promulgate administrative rules to require screening for all IMDs; public comment starting by Jan 1, 2023	Yes
f. Other Requirements to ensure good quality care in inpatient and residential settings	PIU will develop residential program review processes and pilot the process by DY2. Following refinements, as needed, the PIU will transition the review process to program staff by year 5.	N/A*

*There are currently no residential IMD programs participating in the Demonstration

MILESTONE 1 PERFORMANCE METRICS

The table below provides results for the Milestone 1 critical performance measure.

Metric		Results		Change at Mid-Point			State Goal	Statistically Significant Change
#	Name	2022	2023	Absolute	Percent	Direction		
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	66%	64%	-1%	-2%	Decrease	Increase	No

MILESTONE 1 ASSESSMENT

The State has completed all expected Implementation Plan activities and met all timelines. One activity, related to enhanced monitoring for residential IMD providers, was on hold as there are no adult residential treatment or QRTP programs over 16 beds participating in the Demonstration.

One critical metric was reviewed, the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. Results for CY 2022 showed 66 percent of youth received psychosocial care prior to medication therapies. In CY2023 the percentage dropped to 64 percent. However, there was no statistically significant change at the 95 percent confidence level between the years.

SMI/SED Milestone 1 Assessment			
Assessment Area	**Completed or Progressing/Expected**	**Key Considerations**	**Assessment of Risk**
Implementation Plan	5/5	The State has completed all but one activity. The PIU examination of residential data has not yet begun. However, there are no residential settings currently participating in the Demonstration.	**Low Risk** **100% progress in actions (5/5)**
Stakeholder Input	No Concerns	No concerns were raised during stakeholder sessions.	

MILESTONE 2 IMPROVING CARE COORDINATION AND TRANSITIONS TO COMMUNITY-BASED CARE

Milestone 2 includes the following five subsections:

2-A. Actions to ensure facilities carry out intensive pre-discharge planning and include community-based providers in care transitions.

2-B. Actions to ensure facilities assess the member's housing situation and coordinate with coordinate housing service providers when needed and available.

2-C. State requirements to ensure facilities contact each discharged member and their community-based provider through the most effective means possible (e.g., email, text, or phone) within 72 hours of discharge.

2-D. Strategies to prevent or decrease the length of stay in Emergency Departments among beneficiaries with SMI or SED prior to admission.

2-E. Other State requirements/policies to improve care coordination and connections to community-based care.

Discharge Planning

The state-operated hospitals participating in the Demonstration operate under New Hampshire Administrative Code He-P 802.18 (Required Services) which includes extensive discharge planning requirements (2-A). The New Hampshire Hospital also is governed by Administrative Code He-M 613.09 (Admissions to Transitional Housing) which includes procedures for assessment and pre-discharge coordination of housing needs with a CMHC housing specialist (2-B).

Under the Demonstration, new administrative rules were promulgated to extend these requirements to all IMDs, including the requirement that facilities outreach to members and community providers within 72-hours of discharge (2-C). The State also heightened its expectations for the Managed Care delivery system. New requirements were included in the State's re-procurement of vendors for the Managed Care program to ensure that network providers have explicit responsibility and accountability for care coordination and facilitating transitions to community-based care.

To further support discharge planning, the State received approval for a 1915(i) Supportive Housing Program under the Medicaid State Plan. The supportive housing program is available for individuals who have a disability or disabling condition and have, or are at risk of, chronic homelessness or who have a history of chronic homelessness. Eligibility is determined by the State. Housing stabilization services include targeted activities to: support individuals during transitional periods; assist members to plan for, find, and move to homes of their own in the community; assist in identifying community services and housing benefits; assist with housing

searches, application processes, budgeting, and negotiating leases; and fostering a positive relationship with the landlord.

Supportive housing staff also assist with services that help sustain long-term housing arrangements for members. This includes activities such as creating and reviewing crisis support plans with the member, proactively identifying behaviors that may jeopardize continued housing, understanding rights and responsibilities of the tenant and property manager, coaching to develop and maintain key relationships with property managers and neighbors, advocacy with community resources, assistance with the housing recertification and benefits to retain housing.

State Plan coverage was approved in 2022. Since that time, DHHS has been collaborating with CMS to finalize operational guidelines, billing and reimbursement methods and provider manuals. In addition, the State is engaging in technical assistance (TA) through the Housing and Services Partnership Accelerator Program. The TA is sponsored by the Administration for Community Living (ACL), the Substance Abuse and Mental Health Services Administration (SAMHSA) and CMS. The State began soliciting program referrals in early 2025.

Preventing and Decreasing ED Use

To prevent or decrease length of stay in the EDs prior to admission in specialized settings (2-D), the State has focused on a variety of strategies to enhance the mental health system and accelerate activities established as part of the 10-year Mental Health Plan.

Community Crisis and Diversion Beds

Under the Demonstration, the State enhanced its contracts with CMHCs to increase the community-based bed capacity across the State by 60 beds. The State exceeded its goal with 63 beds developed as part of this expansion project.

60 Bed Expansion Project	
CMHC Region	**Number of Beds**
1	6
2	2
3	10
4	12
5	6
6	9
7	6
9	6
10	6
Total	**63**

Critical Time Intervention

DHHS launched Critical Time Intervention (CTI) programs across the State during the first year of the Demonstration. CTI is an evidence-based program that offers intensive transition support for individuals leaving psychiatric inpatient settings. The approach has been shown to reduce homelessness and increase service engagement use among different populations[1].

CTI coaches work with participants to develop goals as they prepare to return home and continue to provide support throughout the first nine months following discharge. Participants receive intensive support at the beginning of the program, which gradually decreases as they grow more comfortable working with the connections created within their communities.

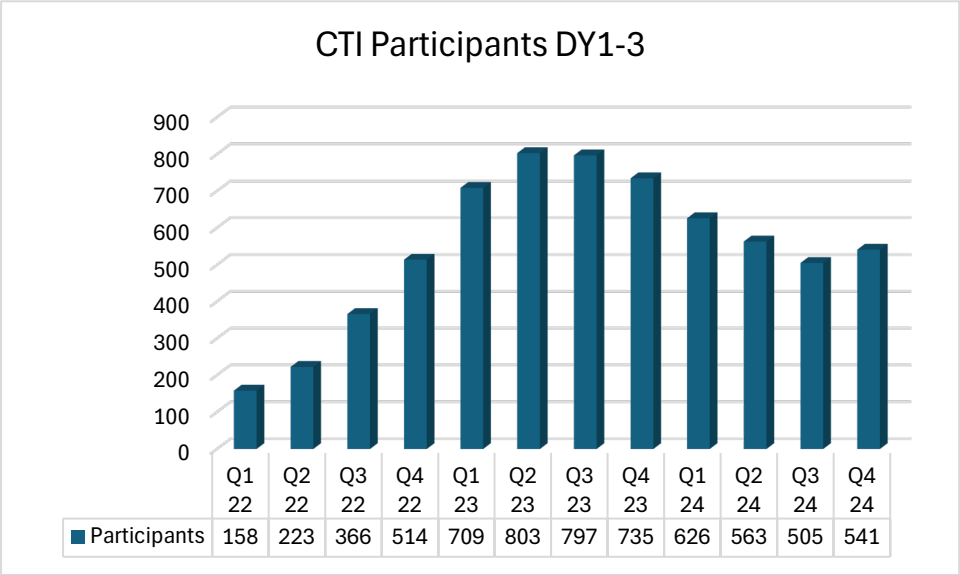
CTI teams have been staffed in all ten CMHC regions since 2022. The program receives referrals from the State's Designated Receiving Facilities (i.e., specialized psychiatric inpatient units across the state) and the New Hampshire Hospital. Available data shows that over 1,234 unique clients received CTI services from January 1, 2022, through December 31, 2024[2]. Enrollments peaked in 2023, the first full year following implementation statewide. While services have begun to level off, data should be interpreted with caution as several agencies are experiencing reporting limitations due to electronic health record conversions occurring at the time of the data reporting. Mental health staff also noted that many agencies are experiencing staffing shortages that have also limited their ability to provide CTI services. DBH updates the CTI service dashboards monthly and expects changes to be made to the final counts once more complete data is received.

During the stakeholder feedback sessions, it was noted that the program has been successful in maintaining continuity of care and housing stability following discharge. One participant suggested that expanding the target group beyond those transitioning from a psychiatric hospital setting should be considered.

An overview of CTI participants each quarter is provided in the figure on the following page (members may be served across multiple quarters).

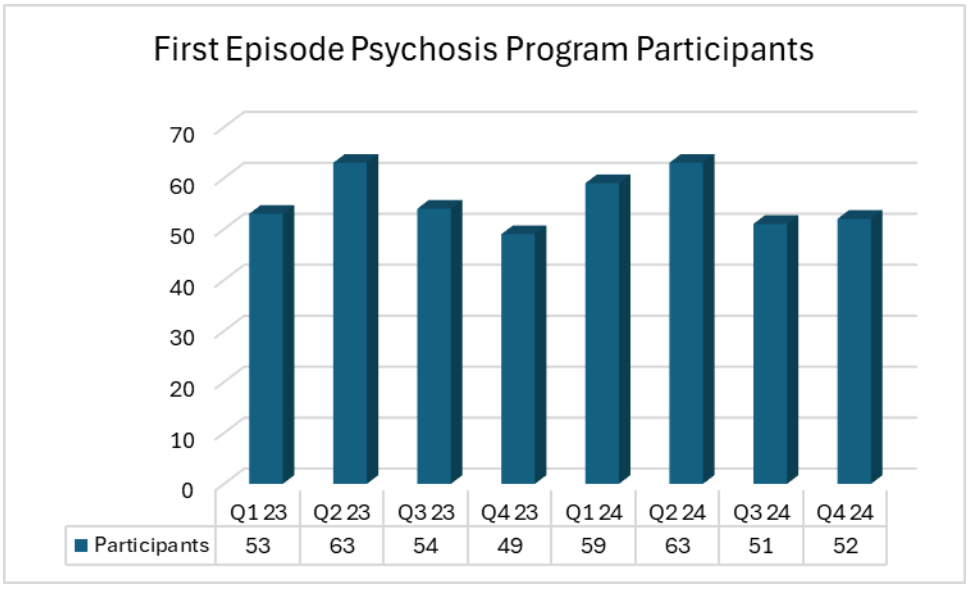
[1] Manuel JI, Nizza M, Herman DB, Conover S, Esquivel L, Yuan Y, Susser E. Supporting Vulnerable People During Challenging Transitions: A Systematic Review of Critical Time Intervention. Adm Policy Ment Health. 2023 Jan;50(1):100-113. doi: 10.1007/s10488-022-01224-z. Epub 2022 Oct 14. PMID: 36229749; PMCID: PMC9832072. https://pubmed.ncbi.nlm.nih.gov/36229749/

[2] Data was compiled 2/5/2025 and represent an undercount of services as several sites are engaged in EHR conversions that have limited data reporting capabilities



Early Serious Mental Illness

New Hampshire's Helping Overcome Psychosis Early (HOPE) program is a team-based approach to treating first-episode psychosis. New Hampshire has established four teams to address early serious mental illness (ESMI), including first-episode psychosis (FEP). Teams are located in the Nashua, Derry, Seacoast, and Monadnock regions. An average of fifty-six participants have been served each quarter since CY2023.



The Division for Behavioral Health also applied for TA to address ESMI and improve community outreach and public education, increase the number of individuals served, and plan for future expansion. One of the State's current priorities is to expand FEP eligibility to include affective disorders with psychosis (e.g., bipolar disorder with psychotic features). State staff and

community teams are engaged in TA through Stanford University, supported with SAMHSA funding, to understand multiple models of care that will meet the needs of an expanded state program and support the long-term sustainability of the current ESMI/FEP programs. This also includes understanding financing models such as Medicaid, managed care, private insurance, and block grant funds.

Other policies to improve care coordination and connections to community-based care

Event Notification System

The New Hampshire administrative code (He-M 405.12) requires case coordination for anyone admitted to an IMD or a designated receiving facility. To support these efforts the State has developed an electronic Event Notification System for admissions, discharges and transfers.

On March 12, 2024, the Governor and the Executive Council authorized DHHS, Office of the Commissioner, to enter into a contract with Unite USA, Inc. with the option to renew for up to five (5) additional years through September 30, 2029. The project is formally known as the NH Care Connections Network (NHCCN) and includes two platforms: Unite Us (NH Closed Loop Referral System - NHCLRS); and Point-Click-Care (Events Notification System for Admissions, Discharges and Transfers).

Where applicable, providers who join the NH Care Connections Provider Network also are offered to join the Point-Click-Care platform. The Department is working with Point-Click-Care to determine ways to improve integration with the closed loop referral system vendor and the Event Notification System vendor's Advanced Ambulatory Solution, with the goal to enhance care coordination in New Hampshire.

Additional details regarding the NH Care Connections Network (NHCCN) platforms are provided in the SMI IT plan section of this report.

A summary of Milestone 2 requirements and progress is provided on the following page.

Milestone Requirements	Actions	Completed
a. Ensure residential and inpatient programs carry out intensive pre-discharge planning and include community-based providers in care transitions	Promulgate administrative rules to require intensive pre-discharge planning for all IMDs; public comment starting by Jan 1, 2023	Yes
b. Ensure residential and inpatient settings assess housing needs and coordinate with community-based housing agencies	Promulgate administrative rules to require housing assessments for all IMDs; public comment starting by Jan 1, 2023	Yes
	Seek CMS approval of a 1915(i) Supportive Housing Waiver by 7/1/2022	Yes
c. Ensure residential and inpatient settings contact beneficiaries and community-based providers within 72-hours post discharge	Promulgate administrative rules to require follow up post discharge for all IMDs; public comment starting by Jan 1, 2023	Yes
d. Strategies to prevent or decrease length of stay in the EDs prior to admission in specialized settings	Contract with ten CMHCs for 6 new supported housing beds per region including, but not limited to, transitional or community residential beds. Full capacity is anticipated by December 2022	Yes
	Phase One CMHCs will launch Critical Time Intervention (CTI) services in January. 2022. Phase Two of CTI launch for remaining CMHCs by July 2022	Yes
	First Episode Psychosis (FEP) Programs in Derry, Seacoast, and Monadnock regions began accepting clients in January 2022.	Yes
e. Other policies to improve care coordination and connection to community-based care	Submit an advanced planning document to support the design, development, and implementation of the event notification system (ENS) statewide including the development of a steering committee for ENS and outcome-based referrals and a provider network user group committee	Yes

MILESTONE 2 PERFORMANCE METRICS

The table on the following page provides the results for each Milestone 2 measure identified as critical by CMS. The significance of the change year to year was assessed at the 95% confidence level.

Metric		Results		Change at Mid-Point			State Goal	Statistically Significant Change
#	Name	2022	2023	Absolute Change	Percent Change	Direction		
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization	10%	11%	0%	2%	Increase	Decrease	No
7a	Follow-up after Hospitalization for MH: 30-day Ages 6-17	82%	86%	4%	5%	Increase	Increase	No
7b	Follow-up After Hospitalization for MH: 7-day Ages 6-17	66%	69%	3%	5%	Increase	Increase	No
8a	Follow-up After Hospitalization for MH: 30-day Age ≥18	68%	67%	0%	-1%	Consistent	Increase	No
8b	Follow-up After Hospitalization for MH: 7-day Age ≥ 18	49%	57%	8%	17%	Increase	Increase	Yes
9a	Follow-up After ED Visit for Alcohol and Other Drug Abuse: 30-day ≥18	59%	57%	-2%	-3%	Decrease	Increase	No
9b	Follow-up After ED Visit for Alcohol and Other Drug Abuse: 7-day	46%	44%	-1%	-3%	Decrease	Increase	No
10a	Follow-Up After ED Visit for MH: 30-day ≥18	69%	71%	2%	2%	Increase	Increase	No
10b	Follow-Up After ED Visit for MH: 7-day ≥18	60%	62%	2%	4%	Increase	Increase	No

Milestone 2 Other Monitoring Protocol Metrics

Metric		Results					State Goal	Statistically Significant Change
#	Name	2022	2023	Absolute Change	Percent Change	Direction		
6	Medication Continuation Following Inpatient Psychiatric Discharge	76%	75%	-1%	-2%	Decrease	Increase	No

MILESTONE 2 ASSESSMENT

The State has completed all expected Implementation Plan activities and met all timelines. There were no statistically significant changes, at the 95 percent confidence level, in metric performance, apart from the percentage of members under the age of 18 years old who received follow-up within seven days of discharge from psychiatric hospitalization. The rates of seven-day follow-up improved by 17 percent in CY 2023.

SMI/SED Milestone 2 Assessment			
Assessment Area	Completed or Progressing/Expected	Key Considerations	Assessment of Risk
Implementation Plan	8/8	The State completed all activities and continues to focus on strengthening the community-based continuum of care and stability post discharge.	**Low Risk 100% progress on actions**
Stakeholder Input	No Concerns	No concerns were raised during stakeholder sessions. One participant noted that the CTI program is successful at working with members to promote stability following discharge from psychiatric hospitals. It was suggested that the State consider expanding eligibility to members in transition from other settings.	

MILESTONE 3 INCREASING ACCESS TO CONTINUUM OF CARE INCLUDING CRISIS STABILIZATION SERVICES

Milestone 3 includes the following five requirements:

3-A. Establishment of a process to annually assess the availability of mental health services throughout the State, particularly crisis stabilization services, and updates on steps taken to increase availability.

3-B. Commitment to implementation of the SMI/SED financing plan described in STC 103(e). (See Section E)

3-C. Strategies to improve State tracking of availability of inpatient and crisis stabilization beds.

3-D. State requirement that providers use a widely recognized, publicly available patient assessment tool, to determine the appropriate level of care and length of stay.

3-E. Other State requirements/policies to improve access to a full continuum of care, including crisis stabilization.

Milestone requirement 3-B is described in Section E. In addition, requirement 3-D was deemed met at the outset of the Demonstration. No additional activities were expected under the Implementation Plan.

Annual Assessment of Availability and the States Capacity to Provide SMI/SED Treatment Services

The State is using the CMS-defined annual assessment of the availability of mental health services and has completed two years of tracking (3-A). The CMS tool contemplates using information on the number of practitioners licensed and the number of practitioners enrolled in Medicaid. Due to data limitations, DHHS was not able to obtain licensing data for non-Medicaid providers. With approval from CMS, the State's Annual Assessment of Mental Health Service Availability focuses on Medicaid-enrolled providers.

The State has submitted two Annual Assessments of Availability of Mental Health Services, dated September 2023 and May 2024. The total number of Medicaid members declined by approximately 12 percent between 2023 and 2024. This coincided with the reinstatement of eligibility reviews following the end of the covid-19 public health emergency.

The table on the following page provides an overview of Medicaid enrollment and beneficiaries with an SMI/SED designation.

Medicaid Enrollment	2023	2024
Number of Medicaid Beneficiaries	209,455.00	183,972.00
Number of Medicaid Beneficiaries with SMI or SED Designation	12,229.00	11,150.00
Percentage of Beneficiaries with SMI or SED Designation	5.84%	6.06%

The number of providers enrolled to provide community-based outpatient services remained the same over the two years reported. There were 569 psychiatrists and other prescribers reported, 1604 mental health practitioners, thirteen Community Mental Health Centers, and six programs providing intensive outpatient services.

Residential/inpatient treatment capacity remained the same across the two years. The State has no adult residential or Psychiatric Residential Treatment Facilities (PRTF) that qualify as IMDs. Two providers designated as IMDs are freestanding inpatient psychiatric hospitals.

In early 2025, New Hampshire reported an expansion of the availability of inpatient mental health treatment for acute patients statewide. Designated Receiving Facilities (DRF) are inpatient hospitals designated by the State to provide psychiatric treatment for individuals who are involuntarily admitted to the hospital. New Hampshire had 7 DRFs in 2024. In 2025, the State added two new Designated Receiving Facilities, one at Dartmouth Hitchcock Medical Center (DHMC) in Lebanon and one at the Hampstead Hospital. The Hampstead Hospital was recognized as a DRF following the transfer of facility management from DHHS to Dartmouth Health (DH). This added 5 additional adult beds at DHMC and changed the designation of 12 beds at Hampstead Hospital to a DRF for children and adolescents.

To increase capacity for voluntary and emergency inpatient admissions throughout the system, the State also is constructing a 24-bed high security unit at the New Hampshire Hospital for patients who are court ordered or civilly committed. This additional capacity is expected to result in improved availability of services in other units of the hospital, resulting in more capacity for short-term inpatient treatment. The high security unit is expected to begin serving patients in 2026.

In addition, the State has been expanding its network of community-based residential and hospital diversion beds statewide (See Section E).

A summary of inpatient/residential capacity reported as part of the CMS-defined assessment of mental health service availability included one adult residential facility, one psychiatric residential treatment facility for youth, and twelve public and private psychiatric hospitals/units in each year.

New Hampshire centralized its network of crisis call centers and mobile crisis units between 2020 and 2022. Two location-based crisis response/assessment centers were added during the Demonstration. The State reported six crisis call centers, thirteen mobile crisis units/community response teams and three crisis observation/assessment centers in each year.

Improve Tracking and Availability of Inpatient and Crisis Stabilization Beds

DHHS generates a daily report that tracks psychiatric bed capacity. The report includes the facility name and the number of: involuntary emergency psychiatric beds, unit caps, if any (e.g., due to case mix/milieu or staffing consideration), available beds, and adults waiting for a designated receiving facility bed. In addition, the NHH utilizes a web-based portal to track beds for voluntary admissions.

New Hampshire incorporated additional requirements as part of its Closed Loop Referral procurement to support assessment of the availability of mental health services across the state. This functionality is expected to provide real-time bed-tracking capacity and care coordination for psychiatric crisis and inpatient needs. Currently, staff communicate with EDs several times a day to manage beds and ensure timely access for members waiting for placement (3-C).

In response to long wait times in the ED for psychiatric placement, DHHS is working to accelerate the development of a variety of initiatives identified in the 10-Year Mental Health Plan as part of Mission Zero. Mission Zero was created in the fall of 2023 and is a public private partnership aimed at reducing psychiatric boarding in the ED. Projects that have been identified for an accelerated implementation timeline include the:

- Expansion of Certified Community Behavioral Health Clinics (CCBHC) to increase the availability of integrated mental and substance use disorder treatment. Two CCBHC programs were designated in 2024 and a third is expected by July 1, 2025.

- Creation of two location-based community-based crisis stabilization programs as part of the Rapid Response Crisis Center continuum. The centers provide care for up to 23 hours and referrals to community-based resources.

- Enhancement of coordination and oversight of all adult inpatient referrals to ensure timely care in the right place, including the adoption of the Level of Care Utilization System (LOCUS) assessment tool.

- Expansion of Designated Receiving Facility (DRF) Beds. Five psychiatric inpatient beds were added in 2025 through the Dartmouth Hitchcock community hospital system. Discussions and feasibility assessments are on-going regarding the construction of additional IMD treatment beds.

- Expansion in transitional housing and step-down beds, including the creation of residential program for individuals with co-occurring behavioral health issues, intellectual disabilities, and/or complex medical needs. Twenty specialized beds are under development and two five-bed homes opened in 2024.

- Expansion of landlord incentives to support individuals to remain in their existing housing, including working directly with rental property owners, landlords, and municipalities on strategies that mitigate risks and provide permanent, supportive housing.

Planning and ongoing oversight for Mission Zero is a collaborative effort between DHHS, the hospital system, CMHCs and the New Hampshire chapter of the National Alliance for Mental Illness (NAMI). Representatives from each of these organizations have been identified to serve as an executive steering committee and day-to-day operational workgroup members.

The executive committee advises the DHHS on the strategic implementation of Mission Zero, ensures that working groups are established, and ensures that processes are transparent. The executive committee also oversees progress. The operational workgroup ensures patients are admitted to the most clinically appropriate and least restrictive level of care and facility as quickly as possible.

Rapid Response Access Point (Crisis Outreach and Stabilization)

At the outset of the Demonstration, the State was in the process of transforming the behavioral health crisis response and stabilization system (3-E), including the development of a centralized call center and mobile crisis outreach teams. Under the Demonstration, the State monitors the implementation and performance of the new system. New Hampshire's Rapid Response Access Point acts as one of two 988 Call Centers for the State of New Hampshire. In 2023, the Access Point had 30,833 crisis contacts via phone, text, and chat. In 2024, that volume expanded to 33,237 crisis contacts.

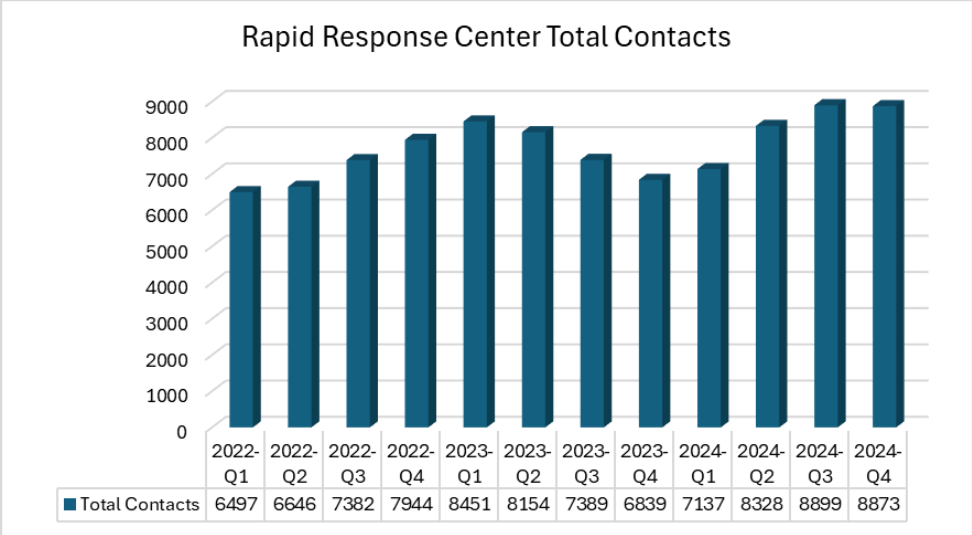
The Access Point also dispatches mobile crisis teams statewide to respond to individuals in crisis either in person or via video assessment. In 2023, the Access Point dispatched mobile teams 7,340 times and in 2024 they dispatched mobile teams 7,493 times. In 2024, the Access Point also started providing dispatches to a new, location-based, Rapid Response Crisis Center in Derry, New Hampshire (one of two location-based centers developed by the State).

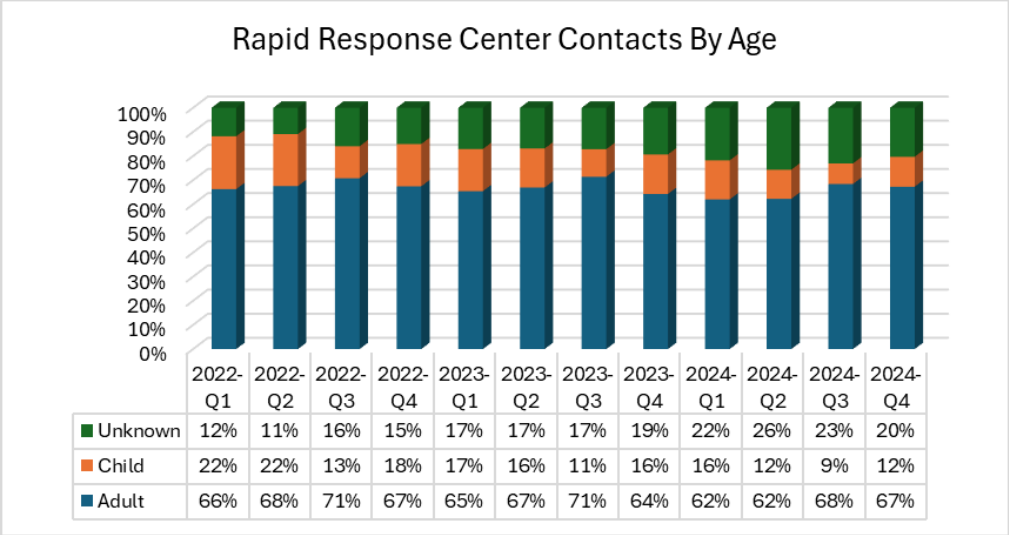
As illustrated on the following pages, the volume of Rapid Response Access Point contacts (e.g., calls, text, chats) have steadily increased since 2022. In Q1 2022, the Access Point reported 6,497 contacts, by Q4 2024, contacts increased to 8,873.

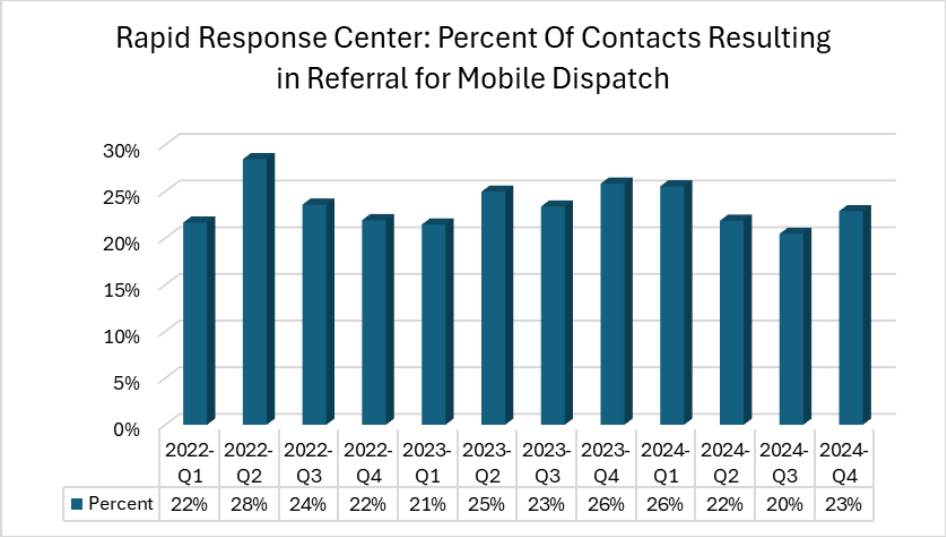
The majority of individuals using the Access Point are adults, with 66 percent of the contacts in Q1 2022, 65 percent in Q1 2023 and 62 percent in Q1 2023. The number of calls related to

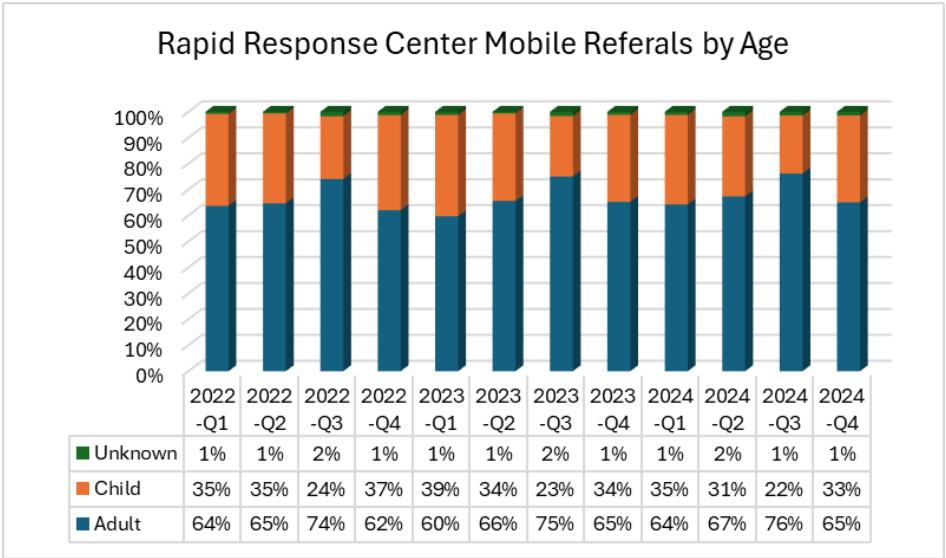
children has dropped from 22 percent in Q1 2022 to 12 percent in Q4 2024, while the number of calls with unknown age has risen.

The number of contacts that resulted in a dispatch to a mobile crisis team has remained fairly stable with an average of 23 percent each quarter. The majority of dispatches to mobile crisis teams are for adults with an average of 67 percent each quarter.






Rapid Response Center: Percent Of Contacts Resulting in Referral for Mobile Dispatch
30%
25%
20%
15%
10%
5%
0%
2022-Q1 2022-Q2 2022-Q3 2022-Q4 2023-Q1 2023-Q2 2023-Q3 2023-Q4 2024-Q1 2024-Q2 2024-Q3 2024-Q4
Percent 22% 28% 24% 22% 21% 25% 23% 26% 26% 22% 20% 23%


Rapid Response Center Mobile Referals by Age
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2022-Q1 2022-Q2 2022-Q3 2022-Q4 2023-Q1 2023-Q2 2023-Q3 2023-Q4 2024-Q1 2024-Q2 2024-Q3 2024-Q4
Unknown 1% 1% 2% 1% 1% 1% 2% 1% 1% 2% 1% 1%
Child 35% 35% 24% 37% 39% 34% 23% 34% 35% 31% 22% 33%
Adult 64% 65% 74% 62% 60% 66% 75% 65% 64% 67% 76% 65%

A summary of Milestone 3 requirements and progress is provided below.

Milestone Requirements	Actions	Completed
a. Complete Annual Assessment of Availability of Mental Services	Complete CMS-defined workbook annually	Yes
b. Complete Financing Plan	See finance plan Section E	Yes
c. Improve tracking of inpatient and crisis stabilization beds	Explore options to add capacity including building another IMD facility in the State to mitigate the need for waiting list	Yes
d. Use of nationally recognized assessment tools for patient placement and length of stay decisions	N/A – Milestone met	Yes
e. Other requirements to improve access to a full continuum of care including crisis stabilization	Continue the provision of enhanced mobile crisis services by CMHCs as monitored by the Bureau of Mental Health Services	Yes

MILESTONE 3 PERFORMANCE METRICS

The table below provides the results for each Milestone 3 measure defined as critical by CMS.

Metric		Results		Change at Mid-Point			State Goal
#	Name	2022	2023	Absolute Change	Percent Change	Direction	
19	Average Length of Stay in IMDs (all populations) *	18	22	3	17%	Increase	Stabilize

**CMS requires the average lengths of stay to be no more than 30 days*

The table below provides an overview of other mental health service utilization metrics related to Milestone 3.

Metric		Results					State Goal
#	Name	2022	2023	Absolute Change	Percent Change	Direction	
13	Psychiatric Inpatient	135	131	-5	-4%	Consistent	Consistent
14	Intensive Outpatient and Partial Hospitalization	68	69	1	2%	Consistent	Consistent
15	Outpatient MH	8,046	7,478	-569	-7%	Decrease	Increase
16	ED for MH	182	123	-59	-32%	Decrease	Decrease
17	MH Telehealth Services	4,681	3,555	-1126	-24%	Decrease	Increase
18	Any MH Service	11,248	9,770	-1478	-13%	Decrease	Increase
20	IMD Services	257	184	-73	-28%	Decrease	Consistent

MILESTONE 3 ASSESSMENT

The State has accomplished all expected Implementation Plan activities. The average length of stay in an IMD was less than 30 days in each year measured. The most recent Annual Assessment of the Availability of Mental Health Services showed that service capacity has remained stable throughout the first two reporting periods.

SMI/SED Milestone 3 Assessment			
Assessment Area	**Completed or Progressing/Expected**	**Key Considerations**	**Assessment of Risk**
Implementation Plan	5/5	The State has completed all expected activities. In addition, two crisis centers were developed as part of the Rapid Response initiative.	**Low Risk** **100% progress actions**
Assessment of State Capacity	2/2	The State has completed two assessments of MH service availability. Capacity in the categories defined by CMS has remained stable in the first two years of the Demonstration. The State has also focused on expanding capacity in other areas of community-based services such as peer support, hospital diversion and step-down programs.	
Stakeholder Input	No Concerns	No concerns were raised during stakeholder sessions.	

MILESTONE 4 EARLY IDENTIFICATION, ENGAGEMENT IN TREATMENT, AND INCREASED INTEGRATION

Milestone 4 includes the following four requirements:

4-A. Strategies for identifying and engaging members with or at risk of SMI/SED in treatment sooner (e.g., supported employment and education).

4-B. Plan for increasing integration of behavioral health care in non-specialty care settings, to improve early identification of SMI/SED and linkages to treatment.

4-C. Establishment of specialized settings and services, including crisis stabilization services, for young people experiencing SMI or SED.

4-D. Other State strategies to increase earlier ID, engagement, integration, and specialized programs for young people.

CMS deemed the State to be meeting the requirements of Milestone Four at the outset of the Demonstration. The State made a commitment to continue current operations and enhance quality monitoring for new residential treatment programs for children and youth.

Quality oversight practices for residential programs serving children and adolescents include a comprehensive assessment for treatment by utilizing the referral information, interviews, documentation and the results of a Child and Adolescent Needs and Strengths assessment (CANS). All referrals for residential treatment include a review to determine eligibility for the behavioral health residential treatment level of care. The assessments include short- and long-term goals and a recommended length of stay. These assessments help streamline the referral and admissions process for behavioral health residential treatment and divert youth to a lower level of care, when clinically appropriate.

Residential treatment programs serving New Hampshire youth are required to deliver evidence-based and trauma-informed clinical services to reduce reliance on emergency rooms, hospital settings, and residential treatment programs outside of New Hampshire and New England. The target population includes children and youth who have behavioral and/or medical needs and mental health symptoms that require treatment in residential settings. Youth may also have specialized care needs, such as intellectual and developmental disabilities, fire setting behaviors, problematic sexual behaviors, extreme aggression, past attempts of suicide or significant self-harm.

The quality monitoring team at the Bureau for Children's Behavioral Health is responsible for the oversight of the certified residential programs, which includes activities related to Initial Certification, Recertification, Quality Assurance Monitoring and Contract Oversight.

Certification: New residential treatment programs submit an application for initial certification which is reviewed by State staff for compliance with applicable statutes (state and federal) and a verification of items such as program licensure, accreditation documents, program and policy

descriptions. In addition to conducting a site visit, the quality team reviews available information from agency partners such as Medicaid, the State Department of Education, the Division for Children, Youth and Families' Provider Enrollment team and others. Certifications are typically effective until the last day of the state fiscal year.

Recertification: The recertification process involves a desk audit of required licensing reports, policies and other documents annually.

Quality Assurance (bi-annual) Site Review: Formal on-site reviews are conducted every other year, including a second unannounced visit as required by law. Site reviews include, but are not limited to, surveys and data reviews prior to the visit, an entrance interview, human resources policy and file reviews, as well as interviews with youth, staff, clinical and specialty service providers, tours, and file reviews. Referrals to a certified program that has not had a site visit (formal or TA related) in 120 days may not be approved prior to the quality team conducting a visit to the facility to ensure all appliable quality standards continue to be met.

Technical Assistance and Monitoring: Technical assistance visits are less formal; however, they include an entrance interview with key staff, a facility tour, observation of the children, and an abbreviated file review. TA reviews may focus on education and awareness of new program standards or a review of a facility's formal corrective action plan, if applicable.

A summary of Milestone 4 requirements and progress is provided in the table below.

Milestone Requirements	Actions	Completed
Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner	N/A – Milestone met	Yes
Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification and linkages to treatment	N/A – Milestone met	Yes
Establish specialized settings including crisis stabilization for young people experiencing SMI/SED	Conduct ongoing monitoring to ensure new residential treatment programs for youth and mobile crisis outreach programs are implemented in a high-quality manner	Yes
Other State strategies to increase earlier identification/engagement, integration, and specialized programs for young people	N/A – Milestone met	Yes

MILESTONE 4 PERFORMANCE METRICS

The table below provides the results for each Milestone 4 measure defined as critical by CMS.

Metric		Results		Change at Mid-Point			State Goal	Statistically Significant Change
#	Name	2022	2023	Absolute Change	Percent Change	Direction		
26	Access to preventive, ambulatory care	97%	98%	0	0%	Increase	Increase	Yes*
29 a	Percentage of youth on antipsychotics who received blood glucose testing	55%	59%	3%	6%	Increase	Increase	No
29 b	Percentage of youth on antipsychotics who received cholesterol testing	33%	37%	4%	12%	Increase	Increase	Yes
29 c	Percentage of youth on antipsychotics who received blood glucose and cholesterol testing	32%	36%	4%	12%	Increase	Increase	Yes
30	Follow-up care for adults who are newly prescribed an antipsychotic medication	67%	68%	1%	1%	Increase	Increase	No

*Population size decreased following the reinstatement of eligibility reviews, resulting in a statistically significant difference between 2022 (N=30,457) and 2023 (N=25,505) even though performance remained steady

The table below provides an overview of other metrics related to Milestone 4.

Metric		Results					State Goal
#	Name	Baseline	Mid-Point	Absolute Change	Percent Change	Direction	
21	Count of Beneficiaries With SMI/SED (average monthly)	25,535	20,628	-4908	-19%	Decrease	Increase
22	Count of Beneficiaries With SMI/SED (annually)	36,601	31,606	-4995	-14%	Decrease	Increase
23	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	51%	41%	-10%	-20%	Decrease	Decrease*

*The difference from 2023 to 2024 was statistically significant at the 95 percent confidence level

MILESTONE 4 ASSESSMENT

CMS deemed that the State met three of the four requirements under this Milestone at the outset of the Demonstration, no additional actions were identified in the Implementation Plan. In one area (specialized settings for young people), the State supported enhanced quality monitoring to ensure new standards for residential treatment programs for youth were implemented.

SMI/SED Milestone 4 Assessment			
Assessment Area	Completed or Progressing/Expected	Key Considerations	Assessment of Risk
Implementation Plan	4/4	The State developed oversight and quality monitoring standards for children's residential treatment programs in alignment with state and federal laws and best practices.	Low Risk 100% progress in actions
Stakeholder Input	No Concerns	No concerns were raised during stakeholder sessions.	

E. SMI/SED FINANCING PLAN

CMS requires States to submit a SMI/SED financing plan to ensure the on-going maintenance of effort on funding outpatient community-based services, to ensure that resources are not disproportionately drawn into increasing access to IMD treatment. This includes efforts to:

A. Increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to: crisis call centers, mobile crisis units, coordinated community response services that include law enforcement and other first responders, and observation/assessment centers.

B. Increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings.

Milestone Requirements	Actions	Completed
a. Increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to: crisis call centers, mobile crisis units, coordinated community response services that include law enforcement, other first responders, and observation/assessment centers.	Integrate Rapid Response Call Center with existing crisis lines to federal 9-8-8 mandate by July 16, 2022	Yes
b. Increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings.	Conduct a readiness assessment related to the CCBHC model. If feasible, begin planning for CCBHC implementation	Yes
	Finalize and launch CTI services	Yes
	Inventory IOP/PH services	No

Increase Availability of Community Crisis Services

As described in Milestone 3 above, the State successfully launched the Rapid Response Access Point and mobile crisis teams January 1, 2022. All crisis call center lines were successfully integrated with the 9-8-8 crisis line launch in July of 2022. In addition, the State developed two location-based community crisis centers in 2024 and expanded the availability of community-based crisis beds in each CMHC region of the State.

Increase the Availability of Community Based Services

As described in Milestone 2, CTI teams have been staffed in all ten CMHC regions since 2022. Also, under the Demonstration the State assessed the feasibility of implementing the CCBHC model. Care coordination and integration underpins all aspects of behavioral health care in the CCBHC model. CCBHCs are expected to provide a broad array of services and care coordination across settings and providers on a full spectrum of health, including acute, chronic, and behavioral health needs. The CCBHC model also requires integrating mental health, substance use disorder, and physical health services at one location.

New Hampshire began exploring the CCBHC model in 2022 and received a grant to develop CCBHC capacity, effective March 2023 - March 2025. As a result, the State applied for and was one of 10 states added to the CCBHC Medicaid Demonstration Program on June 3, 2024. Two clinics became fully certified CCBHCs in 2024, and a third clinic is expected in July 2025. The State is exploring interest and capacity for additional CCBHCs to be added under the CCBHC Demonstration.

The State is also working to increase the use of peers across the behavioral health system and services provided within it, including increasing the number of Medicaid covered services that can be provided by peers, career ladder options, and types of facilities and sites in which they can be provided.

The State's original implementation plan contemplated an inventory of intensive outpatient and partial hospitalization options in the State. These programs are not part of the service array supported under the State's contracts with its CMHCs. The State does support a comprehensive statewide network for Assertive Community Treatment (ACT). ACT is a team-based approach to delivering comprehensive, flexible treatment and support to individuals with the most severe and persistent mental health challenges. CMHCs must ensure that ACT services are:

- Available 24 hours per day, 7 days per week with on-call availability midnight to 8:00 am
- Comprehensive and individualized service delivery in consumer homes, natural environments, and community settings, or by telephone where appropriate
- Staffed with a multidisciplinary team and include 7 to 10 professionals serving no more than 10 consumers per ACT team member
- Able to de-escalate crises without removing consumer from home or community program, consistent with safety concerns
- Work with law enforcement personnel to respond to consumers experiencing a mental health crisis.

ACT offers individuals struggling with mental illness an intensive, community-based mental health program model to support a holistic approach to treatment, including medication management, crisis planning, physical and mental health treatment planning, employment support, and well-being.

As part of its commitment to a strong community-based network of services, the State has been engaged in expanding the housing and community- based residential treatment supports. This includes supporting long-term housing stability and providing an array of shorter-term options such as crisis beds, hospital diversion and step-down beds, and respite beds. Options in these categories have been steadily increasing over the past several years.

The table below provides an overview of community-based bed capacity that has increased over the last six fiscal years.

Community-Based Bed Capacity	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25*
60-bed expansion (Demonstration Milestone 2): Various housing models including supported apartments, community residence and home providers	0	0	18	42	51	63
Peer-Run Recovery Oriented Step-up/Step-down: In collaboration w/CMHCs for clinical services; stays up to 120 days to facilitate transitions from as well as to prevent hospitalization	0	0	12	15	15	15
Peer Respite: Non-clinical short-term respite (up to 10-days)	6	6	6	4	4	4
Transitional Housing Programs: To support transitions from NHH to the community; length of stay up to 2 years	76	95	95	95	109	114
Community Residence: To provide 24/7 services to support community living; stays are often permanent or long term	132	132	135	135	120	120
Permanent Supportive Housing Voucher: Tied to unit with housing support services	56	105	182	246	271	271
Integrative Subsidy: Vouchers for people who are not eligible for other subsidies due to criminal records. Length of subsidy approx. 5 years	0	0	25	50	50	50
Housing Bridge Subsidy: Vouchers and housing support integrated with CMHC services	425	425	500	500	500	500
TOTAL	**695**	**763**	**973**	**1087**	**1120**	**1137**

*As of February 1, 2025

In addition, DHHS supported value-based payments through the continuation of performance-based payments ($4.1m) in the Assertive Community Treatment (ACT) program for members with an SMI and through the development of a new capitated payment to support community mental health services across the State ($5m). These models were approved by CMS in 2024 and 2025, respectively.

In 2024, CMS approved the renewal of a state directed, per member per month (PMPM) payment for ACT programs that meet SAMHSA fidelity standards and for whom the member received a face-to-face service from a member of the ACT team within the calendar month. CMHCs also receive an enhanced payment for:

- **Same-day Access Following Psychiatric Hospitalization**: Individuals seen within the same/next business day of discharge, and an additional payment for each subsequent week the individual is seen face-to-face within 7 days of the prior visit (applicable to all 10 CMHCs)
- **Timely Prescriber Services Following Intake**: Individuals who receive a prescriber appointment within 21 days of a new intake appointment (applicable to all 10 CMHCs)
- **Timely Access to Services Following Application for CMHC Services:** Individuals who receive an Intake appointment within 30 days of making application for CMHC services (applicable to all 10 CMHCs)
- **Specialty Residential Service Payment Enhancement for Individuals with Co-occurring Developmental Disabilities Discharged from Hospital:** Individuals who are dually diagnosed with Serious Mental Illness (SMI) and Developmental Disability (DD) who are admitted to a community residential bed that provides "step down" services to individuals upon discharge from NHH (Applicable to one CMHC with specialized programming)

In early 2025, CMS approved a new value-based payment model that incorporates a risk-based adjustment for each eligible CMHC for behavioral health outpatient services. CMHCs receive a PMPM based on members attributed to one of the following groups: serious mental illness (SMI), serious persistent mental illness (SPMI), serious emotional disturbance (SED), a low utilizer (LU), and a having received a defined set of community mental health services. Each CMHC specific PMPM rate is actuarially developed and based on historic utilization. To receive payment, CMHCs must meet specific criteria, including having provided an attributed member a qualifying service in the three months prior to the payment of a PMPM for such member.

F. SMI/SED INFORMATION TECHNOLOGY PLAN

The SMI/SED Health IT plan was approved concurrently with the Demonstration's start date. Five requirements across three sections were deemed to be met by CMS. These were:

- Section 2 Electronic Care Plans
  - 2.3 Medical records transition from youth oriented systems of care to the adult BH system through electronic communications
  - 2.4 Electronic care plans transition from the youth-oriented system of care to the adult BH system through electronic communications
- Section 3 Electronic Consent
  - 3.1 Individual consent is electronically captured and accessible to patients and care team members
- Section 7 Identity Management
  - 7-1 As appropriate the care team has the ability to link a child's electronic medical records with their parent/caretaker
  - 7.2 Electronic medical records capture all episodes of care and can be linked to the correct patient

At the outset of the SMI/SED-IMD Demonstration amendment CMS received and approved the following assurances from the State.

Assurance 1: The State has a sufficient health IT infrastructure ecosystem at every appropriate level to achieve the goals of the Demonstration.

Assurance 2: The State's SMI Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's BH IT Plan.

Assurance 3: The State intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B.

Outlined below is an overview of the State's SMI/SED Health IT planning.

Closed Loop Referrals and Event Notification Systems

In May 2022, DHHS contracted for event notification system technology to use with its provider community. All Community Mental Health Centers, as well as New Hampshire Hospital, onboarded to the technology. Closed loop referral technology also was pursued as part of an Advanced Planning Document authorized by CMS. An initial Request for Proposal (RFP) was issued and then later cancelled in June 2023. The State redesigned the RFP to include a more integrated IT approach to address care coordination at all levels of care and to expedite transitions from acute level of care in IMDs to community-based treatment. This broader vision also incorporated enhanced engagement with the Medicaid Managed Care delivery system.

On March 12, 2024, the Governor and Executive Council authorized DHHS to enter into a contract with Unite USA, Inc. with the option to renew for up to five (5) additional years through September 30, 2029. Through this contract the DHHS transitioned the Care Coordination Initiative (CCI) into the broader project formally known as the NH Care Connections Network (NHCCN). The NHCCN is currently comprised of two platforms: 1. Unite Us, New Hampshire's Closed Loop Referral System (NHCLRS) and 2. Point-Click-Care, an Events Notification System for Admissions, Discharges and Transfers. Where applicable, providers seeking to join the NHCCN also are offered Point-Click-Care if their service array fits into its scope.

NHCCN is comprised of health care and human services providers along with other community-based organizations supporting individuals' and families' needs. The goal is the delivery of real-time information, making it easier to navigate and connect people to the services they need while protecting confidentiality and privacy to ensure effective follow-up care and positive health outcomes.

The closed loop referral system (Unite Us) consists of providers offering health and/or human services across the entire continuum of care, including healthcare, government, nonprofit, and other community based social service organizations. DHHS has been working closely with the Unite Us vendor to complete a thorough review of information security, privacy safeguards, and compliance with State and federal regulations. This includes establishing Network Participating Provider Requirements that encompass both Unite Us requirements and specific DHHS requirements to ensure the highest level of protection for client privacy and confidentiality.

DHHS worked to complete initial steps for system development including:

- Transitioning Project Managers following project delays due to staff turnover (12/26/2024)
- Outlining platform specific training to be conducted through the NHCLRS Platform's Learning Management System (1/14/2025)
- Finalizing the NH DHHS standard contract language (1/14/2025)
- Launching communication and outreach for the NH Care Connections Network (2/3/2025)
- Establishing a Network Participating Provider Agreement (NPPA) (2/18/2025)
- Finalizing NH DHHS-specific consent requirements (2/24/2025)

DHHS also updated the project timeline for foundational work and onboarding providers, as follows:

Foundational Work

- Website launch of NH Care Connections Network including functionality for providers to request to join the network (3/14/2025)
- Finalize initial data segmentation work with criteria based on DHHS-Specific Consent policy and DHHS funded services/programs (3/14/2025)

- Finalize network governance, including a Privacy Impact Assessment and completion of DHHS Information Security request for Authority to Operate (3/31/2025)
- Finalize Authority to Operate Approval from Department of Information Technology and Chief Information Security Officer (4/18/2025)
- Operationalize the NPPA and NH DHHS-Specific Consent documentation within the Unite Us Platform (May 16, 2025).
- Align any historical/existing providers on the Unite Us platform with the new DHHS provider requirements (May 23, 2025)
- Establish NHCLRS Network with tentative "Go Live" for Network Participating Providers meeting NPPA Terms and Conditions to send and receive referrals (6/2/2025)
- Establish data and information delivery from Unite Us to DHHS sFTP (7/1/2025)
- Establish oversight and management processes for received data to ensure data accuracy and validity (10/1/2025)
- Operationalize oversight and management process of received data (12/31/2025)

Provider Onboarding and Engagement

- Complete on-boarding of Managed Care Organizations, including Care Managers (4/18/2025)
- Complete on-boarding of New Hampshire Hospital Discharge Planning Team (6/2/2025)
- Complete on-boarding of all 10 Community Mental Health Centers, specifically focused on post-crisis stabilization services (6/29/2025)
- Complete on-boarding of 2-1-1 and NH Doorways locations (6/2/2025)
- Schedule Informational Webinar Series (1 of 2) to onboard and engage State of NH Providers (4/18/2025)
- Schedule Informational Webinar Series (2 of 2) to onboard and engage State of NH Providers (5/13/2025)
- Continue outreach, informational sessions, marketing to rapidly build capacity (Ongoing)
- Continue on-boarding and integration of targeted providers, CBOs, FQHCs, Hospitals (3/31/2026)
- Continue on-boarding and integration of Local Government, Education, and Justice Systems (8/31/2026)

Electronic Records, Consent, Security and Privacy

DHHS' vision is to reduce administrative burden by aligning clinical and data workflows, as well as creating a seamless clinical user experience that addresses disparate systems. DHHS has collaborated with Unite Us and Point-Click-Care to identify ways participating providers can leverage Single Sign On (SSO) and integration through Smart on FHIR connections. Since each organization onboarded to the NHCLRS has potentially differing IT expertise, technological capabilities, funding, processes, systems, and internal clinical workflows, the State is offering a selection of options to meet all levels of need. DHHS encourages network participating providers to consider industry standards for interfaces (such as HL7, FHIR Integration, Single Sign On (SSO), etc.) whenever possible. These deliver an improved user experience and add

security through protected, bi-directional data flow and added user authentication. If these advanced interfaces are not possible at the time of implementation, standard interfaces are available with each platform and the advanced capabilities can be adopted by network providers as they advance their IT systems.

DHHS and its NH Care Connections partners prioritize the privacy and confidentiality of all data entered, processed, and shared on the NHCLRS. In collaboration with Unite Us, DHHS created a single, unified Network Participating Provider Agreement which includes NH DHHS Specific Terms and Conditions to be followed by all network participating providers such as:

- Following the HIPAA minimum necessary rule and accessing or disclosing the minimum amount of Protected Health Information (PHI) required to complete a referral or assistance request
- Obtaining all necessary individual consent(s) and/or authorization(s) as required by HIPAA and 42 CFR Part 2, or state law regarding the storage, use, and disclosure of network participant data
- Assisting and processing requests from individuals for NHCLRS consent revocations in collaboration with the NHCLRS Vendor (Unite Us) without delay
- Establishing and maintaining policies and procedures regarding privacy, information security, and confidentiality of an individual and ensuring that all authorized users comply with those policies and procedures
- Ensuring that all authorized users complete initial and annual training requirements of the NHCLRS as defined by NH DHHS
- Ensuring that either a Business Associate Agreement (BAA) or Qualified Service Organization Agreement (QSOA) is signed, as applicable, by any Business Associate or QSOA that processes PHI or Part 2 information on behalf of the Network Provider
- Ensuring the terms and conditions outlined in the agreement are followed. Failure to do so may result in immediate termination of the Network Participant to the NHCLRS

Additionally, providers have the responsibility to obtain informed consent through the NHCLRS and are required to review the DHHS closed loop referral system information guide with clients who are interested in using the system as part of their care coordination. Individual consent is required to participate in NHCLRS through Unite Us and for DHHS to have access to personally identifiable information and private health information (including additional authorization for information that falls under 42 CFR Part 2). Consent is captured electronically within the NHCLRS and is required for each referral. The individual consent can be printed or downloaded in PDF format for patient accessibility and is available on the platform for all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations.

To utilize the NHCLRS referral functionality, an individual is required to create a Client Profile (Face Sheet) that includes detailed intake information. At minimum, the Client Profile must

include the client's first name, last name, and date of birth. Data required for referrals vary depending on the specific referral type.

All network participating providers are required to maintain an up-to-date organizational profile that outlines the programs/services they offer and the specific eligibility requirements for those programs/services to encourage all network participating providers to follow HIPAA minimum necessary rule and only share applicable information for the programs/services being requested for the client. Additionally, the NHCLRS offers the ability to develop, deploy, and store assessments and screening tools through the platform. This ensures structured data capture and aligns workflows to promote interoperability and a seamless Health Information Technology (HIT) ecosystem for all NH stakeholders.

Analytics and Other State Efforts

DHHS plans to evaluate applicable data (as permitted through individual consents) to:

- Ensure DHHS-funded programs are properly administered
- Identify gaps in care
- Identify resource shortage areas by region and statewide
- Identify program or service shortage areas by region and statewide
- Create reports/data visualizations (trends) to inform public policy, legislation, and/or program funding needs
- Perform case management and assist in care coordination for state-operated programs

Such analysis and review of findings could also support local care team notifications, dashboards, and management reports.

In addition to the work on the IT platforms, the State incorporated enhanced expectations for MCOs to ensure that facilities and providers have responsibility and accountability for care coordination, including screenings in primary care settings for behavioral health needs, using a closed loop referral solution to connect individuals to treatment sooner and support information exchange with members, providers and care teams, as appropriate.

In corresponding contractual arrangements with CMHCs, centers will assume greater responsibility and accountability for early identification and engagement in treatment, care coordination using the closed loop referral solution and event notification system. These efforts include the implementation of CCBHCs to support integrated care in more regions in the state.

Telehealth

The State legislature authorized the use of remote patient monitoring and telehealth services in the New Hampshire Medicaid program, effective October 1, 2023.

G. BUDGET NEUTRALITY

Annual data on budget neutrality is presented here as contextual. CMS and the State continue to monitor progress quarterly. CMS assesses results and progress directly.

SMI expenditures were under the budget neutrality limit in each of the first three years reviewed. Total expenditures were $645,275 in year one of the amendment, $578,781 in year two and $612,516 in year three. At the end of amendment year three there was a cumulative surplus of $5,768,939.

The table below provides an overview of the budget neutrality limits for the SMI portion of the Demonstration, as reported by the State.

	DY5 (SMI DY1)	DY6 (SMI DY2)	DY7 (SMI DY3)
With Waiver (Actual)			
SMI Medicaid Adults	$372,915	$343,858	$199,051
SMI Expansion Adults	$272,360	$234,923	$107,207
Total Expenditures (Actual)	**$645,275**	**$578,781**	**$612,516**
Budget Neutrality Limit	$3,707,548	$2,678,544	$1,219,418
Annual Surplus/(Deficit)	**$3,062,273**	**$2,099,763**	**$606,902**
Cumulative Budget Neutrality Limit	$3,707,548	$6,386,092	$7,605,510
Cumulative Surplus/(Deficit)	**$3,062,273**	**$5,162,036**	**$5,768,939**

H. ASSESSMENT SUMMARY AND RECOMMENDATIONS

Overall, the State has largely completed the activities outlined in the SMI/SED Implementation plan as expected and within the approved timelines. Two activities were suspended. Under Milestone One the monitoring for residential IMD settings was deemed as not applicable, as there are no residential treatment programs designated as IMDs participating in the Demonstration. Under the SMI/SED finance plan, the State had anticipated creating an inventory of intensive outpatient/partial hospitalization programs. However, the State focused its efforts on strengthening the community-based continuum of care articulated in its 10-Year Mental Health Plan. IOP/PH programs are not part of the array of services supported by the Bureau of Mental Health Services.

Where on-going work is anticipated (i.e., the SMI IT Plan), the State is meeting expectations outlined in its Implementation Plan. The ALOS in IMDs is under the 30-day threshold set by CMS. Expenditures for the first three years of the Demonstration amendment are within budget neutrality limits.

The SMI/SED metrics identified by CMS as critical are calculated annually by the State based on a calendar year (CY). The first data point (CY2022) included six months of activity prior to the Demonstration's SMI amendment. The second data point (CY2023) represents the remainer of year one and the beginning of amendment year two. The evaluators performed a simple test of significance, at the 95 percent confidence level between the two years. However, inclusion of only two data points, representing 18 months of Demonstration activity, should be considered descriptive and interpreted with caution.

Performance for the majority of metrics showed no statistically significant difference between 2022 and 2023 results. Results that showed statistical significance are summarized below.

Metrics Showing Statistically Significant Difference at the 95% Confidence Level	2022	2023
Milestone 2		
8(b). Percentage of psychiatric hospital discharges for which adults 18 and older received follow-up within 7 days after discharge	49%	57%
Milestone 4		
26. Access to preventive/ambulatory health services for Members with an SMI	97%	98%
29(b). Percentage of children and adolescents on antipsychotics who received cholesterol testing	33%	37%
29(c). Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	32%	36%

A summary of assessment findings and progress is on the following page; no milestones were deemed at medium or high risk of not being met. No concerns were raised by stakeholders who attended the general information and feedback sessions.

SMI/SED Mid-Point Assessment Overview		
CMS Milestone	**Assessment of Risk**	**Key Considerations**
1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	**Low**	All quality of care requirements have been met. The State contemplated expanding program integrity activities to residential treatment programs. However, there are no residential IMD settings under the Demonstration.
2: Improving Care Coordination and Transitions to Community Based Care	**Low**	Discharge planning requirements, including screening for housing stability have been implemented. In addition, expanded CTI supports for members discharged from inpatient psychiatric treatment are available statewide.
3: Increasing Access to Continuum of Care, including Crisis Stabilization Services	**Low**	The State has implemented planned activities and expanded the continuum of crisis services, community crisis beds and inpatient capacity beyond the steps contemplated in the original SMI/SED Implementation Plan.
4: Earlier Identification, Engagement in Treatment, and Increased Integration	**Low**	The State had implemented quality monitoring of youth residential programs as planned.
SMI/SED Finance Plan	**Low**	The State has shown a commitment to strengthening the community-based continuum of care through: • Expanding crisis services • Implementing the CCBHC model • Expanding community-based hospital diversion and step-down programs.
SMI/SED IT Plan	**Low**	The State has been engaged in IT planning throughout the Demonstration period. Expected completion dates for key milestones have been updated, as necessary.
Budget Neutrality	**Low**	The State has a cumulative surplus at the end of year three of $5,768,939 for the SMI/SED portion of the Demonstration.

STATE RESPONSE

The New Hampshire Department of Health and Human Services (NH DHHS) will continue to collaborate closely with the evaluation team and key stakeholders to monitor the State's progress toward the waiver's goals and objectives. As highlighted in the midpoint assessment, the activities outlined in the State's implementation plans have been completed within expected timelines. Moving forward, the State will identify potential strategies to address stakeholder concerns that align with the waiver's overarching goals. While all milestones are currently considered low-risk, NH DHHS will closely monitor them for any changes in risk status. The Department remains prepared to respond to any updated directives from CMS and looks forward to continued collaboration on this demonstration.

APPENDIX 1. INDEPENDENT EVALUATOR

The State of New Hampshire procures evaluation services through an RFP process, in which potential contractors furnish information on their qualifications, along with references through which the State can verify past performance. The State selected the Pacific Health Policy Group (PHPG), to perform the independent evaluation of various programs operated by New Hampshire, including the Section 1115 IMD Demonstration and Mid-Point Assessment.

The State selected PHPG because the firm has performed multiple independent evaluations of Section 1115 Demonstrations, including IMD components over the past decade. In addition to its evaluation and Mid-Point Assessment work in New Hampshire, PHPG serves as the Independent Evaluator and Mid-Point Assessor for Section 1115a evaluations in Oklahoma and Maine and previously served in this role in New Mexico (under subcontract to Deloitte Consulting) and Vermont.

The State schedules regular meetings with PHPG's Project Manager/Principal Investigator to receive updates on the evaluation and address any issues that arise with respect to data collection and clarity/accuracy of findings.