



Improving the Health of New Hampshire

Medicaid Care Management Program

Annual Report

July 1, 2014 – June 30, 2015



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Section 1: Executive Summary

This initial Care Management .20 Report profiles Well Sense Health Plan's achievements, focus and successes from July 1, 2014 to June 30, 2015. It details how our managed care efforts have yielded positive outcomes at the individual and community levels, and it discusses our future goals and plans.

Well Sense is committed to engaging with our members in managing their health. In the unmanaged fee-for-service system, care coordination is largely unavailable. Our goal is to connect with all members as soon as they enroll in order to identify their health needs and goals, answer benefit and other questions, connect them to a current or new primary care provider (PCP), and start coordinating their health care needs systemically. We focus on well care and disease management based on the individual needs of the member.

Our care management model supports individuals' needs on a whole-person level, whether medical, behavioral, psychosocial, long term care focused or a combination. Well Sense's managed care approach offers the ability to coordinate these care points so the member is treated in his or her entirety.

Members' care plans are compromised when they cannot get to their appointments. This is a particular challenge for those with complex health issues or for healthy members who want to stay well. Through our vendor, CTS, we offer transportation to appointments for covered services. This solution relies on a robust network of public transportation, wheelchair vans, ambulance companies and livery, as well as offers mileage reimbursement to members, their friends and families. Transportation assistance in the managed care environment is used more often than in the fee-for-service program. In 2015 alone, over 30% of our members accessed the transportation assistance benefit, which is a powerful way to remove a major barrier to accessing care.

Another early marker of our success has been in behavioral health care. There has been a significant decrease in the 30-day readmission rate to New Hampshire Hospital, suggesting better connectivity to community supports and adherence to care plans following discharge. This demonstrates the benefit of the liaison at New Hampshire Hospital with our partner, Beacon Health Strategies, who is located at the Hospital. Additionally, for adult members in the Health Protection Program, access to substance use disorder treatment services has had a marked impact on quality of life. These services were made available quickly and effectively, responding to our members' needs.

An important managed care tool is the use of prior authorization for certain services. Prior authorization is used to get our members the right care. However, its effectiveness must be evaluated continuously based on market and member needs. For many services requiring prior authorization, we increased the amount of time for which the prior authorization is valid. The result has been a decrease in the administrative burden on providers, assuring continuity for the member's service delivery. We now make prior authorization request determinations in no more than five days unless an extension is requested. This is quicker than the federal requirement of a 14-day determination rate. The lessons we learned in this process also will inform our approach to prior authorizations for Step 2 services.

Finally, we have brought a high level of customer service to the program. Our Call Center is held to high performance metrics not previously applied to the fee-for-service program. These include requirements for speed in answering, limits to the duration of on-hold, and limits on call abandonment rates. The Department of Health and Human Services (DHHS) has correctly required this level of performance for our Medicaid members, and Well Sense has responded by providing a high level of service to them.

Our goals for the next reporting year focus primarily on a high touch, member focused implementation of the early phases of Step 2. Our discoveries and the relationships we fostered over the past 18 months have informed our program design, goals, provider engagement strategy and community outreach.

As the New Hampshire Medicaid managed care program evolves, we are prepared to play a leading role in supporting members in attaining and maintaining a higher quality of life.



Susan Coakley, President



Lisabritt Solsky, Executive Director

Section 2: Introduction

Well Sense Health Plan is a not-for-profit managed care organization providing quality quality coverage for New Hampshire Medicaid recipients since December 2013. We proudly serve over 85,000 members as of June 30, 2015. Our members are diverse, ranging from low-income children and adults to disabled adults, seniors and parents. Each member presents unique needs, and each day we work to meet those needs using a whole-person philosophy while relying on local providers and supports.

We are located in downtown Manchester, and our offices are staffed by New Hampshire residents who understand local issues and dynamics. In 2015, our Manchester foot print expanded to include a dedicated New Hampshire Call Center that serves as the entry point for answers and supports to our members.

Section 3: Quality Program

We constantly strive to improve the quality of care and services that our participating providers deliver to our members. That's why we work closely with those providers as well as with our members, community organizations, community health centers, and DHHS to help ensure that our members meet their health care goals.

In 2014 we set quality improvement goals and developed projects to improve the care and services for members. By using measures with national benchmarks, such as the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS), we can monitor and identify opportunities for improvement.

Helping our members to get and stay healthy

In 2014 we focused on member education and outreach to encourage preventive screenings and support self-management of chronic conditions. For example, we mailed seasonal asthma postcards and reminder cards for annual physicals for young children. For members with diabetes, we sent a diabetes self-management screenings check list and calendar. We also placed reminder phone calls to our adolescent members, ages 18-21, who were due for an annual physical. In addition, we developed a wellness guide to provide information on important health milestones and recommended services to maintain a healthy lifestyle.

To help identify barriers to care and enhance quality improvement throughout the year, we conducted member surveys and established a Member Advisory Board. This enabled us to steadily improve approaches to educating and encouraging members to get recommended screenings and improve their overall health.

Working directly with providers

Throughout 2014 we engaged participating providers to help us meet our quality improvement goals and support projects to improve the quality of care and services for members. We furnished providers with reports identifying members who were due for preventive care, and we notified providers about members who should have health care screenings and medications for chronic conditions. Working with providers to identify barriers and opportunities for improvement continues to be a priority.

With the creation of our Quality Incentive Program (QIP), we strived to improve the overall health of our members in key areas such as comprehensive diabetes care and well child visits for three-to-six year olds. Through the QIP we offered additional funding to high volume provider groups who met national benchmarks on specific metrics. The process included meeting regularly with those providers to update them on their performance, sharing patient registries on screenings and treatments, and assisting them in meeting QIP goals.

In 2014 we also convened a Provider Advisory Council to help build partnerships and discuss ways to improve member and provider experiences. These meetings help shape upcoming quality improvement initiatives, including provider reports and member outreach materials.

Well Sense is the largest Medicaid health plan in the Granite State.

As of June 30, 2015

Partnering with community and state agencies

Recognizing that members often receive services and supports from community organizations, we have established strong relationships with the following groups:

- The Foundation for Healthy Communities
- The New Hampshire Pediatric Improvement Partnership (Institute of Health Policy & Practice)
- The Community Health Access Network
- The Diabetes Collaborative (DHHS Division of Population Health)
- The Asthma Control Program and Asthma Strategic Evaluation Workgroup (DHHS Division of Public Health)
- The Healthy Homes & Environment Committee (DHHS Division of Public Health)
- The New Hampshire Immunization Program (DHHS Bureau of Infectious Disease)

By partnering with these and other organizations, we're in a better position to support and coordinate our members' health care needs. We will continue to look for opportunities to expand relationships with additional organizations in support of the program and our members.

Advancing quality improvement rates

In our first year of operation, our efforts to advance quality were demonstrated by significant improvements in the following Healthcare Effectiveness Data and Information Set (HEDIS) measures:

| Areas of improvement | NH Medicaid Pre-MCM rates* | Well Sense rates (CY 2014) | % Improvement |
|--|----------------------------|----------------------------|---------------|
| Appropriate treatment for Children with Upper Respiratory Infections | 89.40% (CY 2010) | 94.02% | 5.17% |
| Appropriate testing for Children with Pharyngitis | 80.50% (CY 2010) | 85.21% | 5.85% |
| HbA1c testing | 78.10% (CY 2010) | 92.47% | 18.4% |
| Adolescent Well Care | 47.40% (CY 2012) | 63.57% | 34.11% |
| Emergency department visits potentially treatable by Primary Care | 16.0% (CY 2012) | 12.5% (CY 2014) | 21.9% |

*Comparability with NH fee-for-service data is influenced by including populations that are not in the Medicaid Managed Care Program program data, such as members who are not mandatory or who opted out of the phased implementation of the NH Medicaid Managed Care Program.

Well Sense will build on these early successes around quality improvement as we move forward.

Section 4: Care Management

Our extensive care management efforts have made a significant contribution to the health of our members. These efforts include some of the activities that follow.

Wellness and Prevention

Through our Care Managers, we guide and support members by providing education and improving self-management skills to help prevent further complications with specific conditions. Well Sense Care Managers counsel members, provide educational materials customized to the member's specific needs and goals, and provide coordination of care with providers and community resources.

Throughout 2014 we also provided general and targeted outreach to members and providers, promoting appropriate preventive screens and resources for members. Our website – WellSense.org – is an additional source that offers key information focused on wellness and prevention. For example, the website's member section contains a document entitled [Your Guide to Wellness](#) that describes age specific information on preventive care, immunizations, tips on eating healthy, staying active, and warning signs of symptoms to be alert for. [Additional member resources](#) available on the website include information to assist with smoking cessation, breast cancer awareness, flu prevention and other seasonal tips on bike safety, pool safety, and sun and bug protection.

Providers have access to their own resources on our [website](#). These include clinical practice guidelines, medical and reimbursement policies, and links to national resources such as the American Diabetes Association.

We also offered many member extras that focus on wellness and prevention. Members have taken advantage of free dental kits, bicycle helmets for kids, infant and toddler safety car seats, breast pumps, diapers, reimbursements for gym memberships and Weight Watchers®, and a free Nurse Advice Line available 24 hours a day, 7 days a week as summarized below:

| MEMBER EXTRAS DISTRIBUTED FROM JULY 1, 2014 TO JUNE 30, 2015 | |
|--|----------------------|
| Member Extra | Quantity Distributed |
| Children's car seats | 4,439 |
| Dental kits | 4,144 |
| Children's bike helmets | 1,339 |
| Manual breast pumps | 591 |

Disease Management and Chronic Care

Well Sense believes that the best member care requires an integrated approach. That's why our Care Management model coordinates physical, social, behavioral health services, pharmacy management and wellness programs, enabling us to fully respond to our members' needs. This collaborative, member-centered approach assesses a member's overall health status, facilitates coverage for medically necessary services, social and community based services, and advocates for the member as he or she navigates the health care system.

Every day we recommit to improving the health of our members with chronic and high-risk conditions. We also know that our members experience many psychosocial and economic challenges that affect their health and ability to navigate the health care system. Language barriers, coverage lapses, low reading ability, lack of transportation, unstable housing or employment, and poverty all contribute to fragmented care, disease progression, emergency department use and hospital readmission risk. To combat these particular barriers, we designed our Care Management programs to help members and providers manage at-risk

We work to ensure that our members can access the right care in the right setting at the right time.

and chronic conditions. We research best practices most relevant to our members' needs and develop key program components based on this research. These include predictive modeling and strategies to address gaps in care and impact, homelessness, medication adherence and patient activation measures.

Our efforts to support members facing these challenges have included the following:

Mobile teams – A Feet on the Street approach

For members living with disabilities and who are at high risk, there may be physical or emotional barriers to accessing care outside their community. For those who have mobility impediments or transportation challenges, we employ our Feet on the Street approach, making site visits to members enrolled in care management in their homes, clinics, shelters and public areas. This ensures that they receive the care they need when they need it regardless of physical or social barriers. Our face-to-face visits increased from 24 in 2014 to 92 to date in 2015 under this approach.

Free locked cell phones for those who need them

For members in our care management programs who do not have active or reliable telephones, we offer individuals cell phones that can be programmed with the contact information for our Member Services Department, their providers and care team, as well as community organizations and agencies, Beacon Health Strategies (our behavioral health partner), and 911. In addition, we offer a variety of ad hoc services specifically designed to respond to some of the unique challenges facing members living with disabilities. These include providing a toll-free telephone number for direct access to our Care Management Department, as well as dedicated Care Management staff for members in the Acquired Brain Disorder program, In-home Services and Supports program, developmentally disabled population, special needs population and the Choices for Independence waiver program. Through the enhanced communication facilitated by these phones, Care Management staff also can coordinate non-emergency transportation services and other wrap services. This increased engagement also enables us to identify broader social or economic factors that can impede access to care, such as through our assistance in helping to prevent utility terminations.

Care Management Program initiatives

We have expanded our Care Management program initiatives to better serve members with complex needs and prepare for new programs, including Step 2 membership. These initiatives enhanced our program supports for the homeless, special needs members, members on waived programs, members with co-morbid behavioral health disorders and those with complex conditions. As part of the process, we have established a collaborative care coordination effort with federally qualified health centers to include high-cost members, those who are frequent emergency department users, those with medication non-adherence and those with other gaps in care. Our focus is always on improving members' health, relationships with their PCPs, and mitigating further use of unnecessary services. We achieve this by studying and applying the practices of the Institute for Healthcare Improvement Better Health, Lower Cost Project and the Agency for Healthcare Research and Quality.

Our fully dedicated Care Management staff actively engages members and their families. Each member of the team receives training on motivational interviewing, trauma informed care, and social determinants among the New Hampshire Medicaid population. For example, in preparation for the New Hampshire Health Protection Program, staff received training on the stages of change for mental health and substance use disorder (SUD) treatment, the 12 core function of SUD treatment, and pathways to recovery. Key Care Managers also attended the Brain Injury Association conference, Family Support conference, Advocate New Hampshire conference, diversity and inclusion training, ethics training, and suicide prevention and intervention training. Our Care Managers attend all provider and member forums, as well as learning sessions offered by DHHS. And our Care Management team developed strong working relationships with area agencies and other community service organizations throughout the state.

Giving expecting moms and their newborns a nurse in the family

With 30% of our members being women between the childbearing ages of 15 and 50, pregnancy programs are a priority for us because evidence-based pregnancy clinical practice guidelines demonstrate that there are multiple interventions that can promote a healthy pregnancy and a healthy baby. For example, smoking cessation efforts can help offset the risks that smoking has on pregnancy, including medical complications, premature births, low birth weight, still birth and sudden infant death syndrome. Addressing weight gain, blood pressure control and prenatal visits, as well as monitoring glucose levels and ensuring that a woman follows up with a timely postpartum visit can all positively impact outcomes. Our prenatal/postpartum program provides education, care coordination, and support to our members to address these sorts of challenges.

Our efforts in this area are well illustrated by our re-engineered Sunny Start program, which became our Maternal Child Health Program in 2015. By using evidence-based guidance from the American Congress of Obstetricians and Gynecologists, we established an assessment and criteria to identify pregnant members at high risk for adverse birth outcomes. The new program created a *Nurse in the Family* where the same Care Manager who manages the mom's prenatal and postpartum care also manages the sick newborn. The program goals are to reduce the prevalence of low birth weight births, reduce hospital days/NICU days, increase the percentage of deliveries that had a postpartum visit, improve timeliness of pre-natal care and increase the percentage of EPSDT services.

Throughout a member's pregnancy and postpartum period, the *Nurse in the Family* establishes a strong relationship with her to support continuity in caring for the newborn through age two years or longer, as appropriate to the child's clinical needs. Care planning includes assisting with coordinating primary and specialty care medical appointments and Early and Periodic Screening Diagnostic and Treatment (EPSDT) services. The clinical team received additional training on neonatal abstinence syndrome, observed various parenting programs offered by network hospitals, and toured maternity units, newborn nurseries and neonatal intensive care units. Care Managers now can share their experiences to help pregnant moms set realistic expectations about their pregnancies, including the delivery of potentially sick newborns. In addition, Care Managers help these moms to understand the importance of attending prenatal and postpartum visits and parenting programs, while coordinating transportation to appointments, as needed. In 2015 we even began offering free diapers to moms who attend their postpartum appointments within 21 to 56 days after delivery.

Transition to Home Program - ensuring seamless care transitions through the continuum

Using the Agency for Healthcare Research and Quality evidence-based guidance and Truven Medicaid specific data for readmission triggers, Well Sense expanded its Transition to Home Program in 2015. It now includes medical diagnoses based on DRGs with the highest readmission rates, which include high-risk maternity conditions and social determinants, and transitions throughout the "healthcare continuum." This is when a member accesses services such as those offered through an emergency department, hospital admissions or nursing home, and then discharges back to his or her home. This change improves real-time identification of members at risk for readmission and in need of actionable care management interventions. The overall program goal is to decrease 30-day readmissions. Our team supports the transition to home from any facility and emergency department by ensuring that members have and understand their discharge instructions, have a follow-up PCP and/or specialist appointment, have and understand their medications and have transportation to medical appointments. For certain individuals, especially those discharged on multiple medications or newly prescribed anticoagulants, an in-home medication reconciliation and education for the member may also be performed.

Enhanced identification of members for enrollment in Care Management

To expand care management for members with complex needs, and to capture more "actionable" members, we refined the member identification criterion in 2014.

Our members' health and safety is our top priority, which is why we offer free car seats and bike helmets for kids.

This involved changes to the Care Management Chronic Condition and High Risk Registry identification methodology, including:

- Identifying homeless members who have a severe and persistent mental illness resulting in a direct referral to behavioral health
- Enhancing special needs population identification
- Expanding the diagnoses for cancer and obesity member identification
- Adding new comorbidities and including smoking to the high-risk pregnancy member identification
- Shortening the claims look-back periods, including laboratory results, and adding new utilization factors such as personal skills use throughout the member identification

We also refined our real-time referral triggers in several areas, including inpatient utilization management and prior authorization. The process included developing a Member Referral Trigger Form. These changes focused on identifying social determinants and the special needs population. Through these efforts, we will further support our members with complex needs.

The following two cases demonstrate the impact of our care management commitment.

SUCCESSFUL CASE 1

Member with diabetes was living in a shelter, but unable to stay there due to the need for an ostomy bag. As a result of diabetes and homelessness, the member was referred to Care Management by the Well Sense Inpatient Utilization Management team.

The member dealt with a number of social barriers: homelessness, possessions – including a glucometer – located in member’s impounded vehicle, and lack of social support. The member could not prepare food in the motel room where he was staying nor get Meals on Wheels. Mobility issues prevented the member from going to the store. The member also was illiterate, so it was a challenge to manage providers, contacts, appointments and self-care. Because the member was in dire financial straits and owed money to the housing authority, being put on a waiting list was not an option.

Through Social Care Management outreach, care coordination was made with multiple entities - Department of Health and Human Services, Bureau of Elderly and Adult Services, the car impound lot, motel, assisted living facilities, Beacon Health Strategies - to piece together the member’s needs. The motel’s landlord was brought in to assist with getting the member food, the former shelter helped recover items in the vehicle at the impound lot, and upon the member’s hospital re-admission from the motel due to medical complications, the hospital’s Care Management team and the DHHS coordinated the application to assisted living programs and guaranteed appropriate discharge planning.

Care Management reached out with multiple face-to-face visits to assist with transition and stabilization after discharge.

The goals of this member’s case were care coordination, discharge planning and a Bureau of Elderly and Adult Services referral. Among the positive outcomes of the case, the member has:

- been discharged to assisted living
- re-gained weight after being out of the hospital 3+ months
- accepted on CFI waiver
- been engaged in behavioral health Care Management

Additionally, the member has expressed satisfaction with the outcomes, telling the Social Care Manager, “The fact that you drove up here tells me I’m important.”

Every day we have employees on the phone or out in the community using one of our most powerful tools – ears – listening and learning how a new medical treatment or therapy is working for a member and to identify what might be missing.

SUCCESSFUL CASE 2

Male member is married with young children and was referred to the Social Care Manager from the home care agency based on psychosocial and financial needs. Among the social barriers identified:

- Refugee family
- Language barrier (jobs, accessing assistance)
- Financial constraints (refugee cash assistance limited, Social Security income, food stamps)
- Health (painful skin infection)
- Trauma (behavior health, depression, post-traumatic stress disorder, anxiety)
- Lack of support (fear due to religious affiliation, family/friends)
- Loss of job due to health needs

Social Care Management made referrals to the Office of Minority Affairs, a refugee support organization, food pantries, town welfare and fuel assistance programs.

Care Management also provided face-to-face outreach in the form of meetings between refugee support organization and the member to discuss employment and fuel assistance, in addition to personal meetings with an interpreter.

The goals of this case were care coordination, job assistance, cell phone provision, vehicle repairs and assistance with utility bills. As a result of this intervention, the member has obtained a job and received funding from a community organization, and can pay for car repairs and a cell phone.

The member's satisfaction was evident in the conversations following the successful case outcome. "Thank you so much for bringing me hope," he said. "You would always call when you said you would and would ask how I'm doing. Nobody has ever helped me like this before, in my country or anywhere. I want to be able to repay you and the interpreters some day!"

"The Care Manager was wonderful," the member continued. "This wouldn't have happened without her and I highly recommend her. I was able to get all of the services I needed. I would have been lost without the Care Manager's calls and explanations. She helped me with everything. You guys are wonderful."

Non-emergency medical transportation

We work closely with Coordinated Transportation Solutions (CTS), a not-for profit transportation management organization, to provide non-emergency medical transportation for our members. CTS has a network of transportation companies throughout the state allowing members to contact CTS directly to request transportation to their qualified medical appointment.

As a transportation broker, CTS:

- Ensures compliance with contract requirements and state and federal rules and regulations
- Recruits and maintains an adequate transportation provider network
- Assigns and schedules trips with the most appropriate transportation provider
- Monitors and processes complaints
- Protects member confidentiality under HIPAA and applicable state law
- Coordinates payment to transportation providers
- Ensures quality throughout the program
- Monitors and reports on program progress

Member satisfaction

The overall transportation satisfaction score since program inception is 99.7%. Complaints are consistently below 0.3% of all trips provided with 99% resolution in 72 hours or less.

Getting a ride to a medical appointment is only a phone call away.

Network of transportation providers

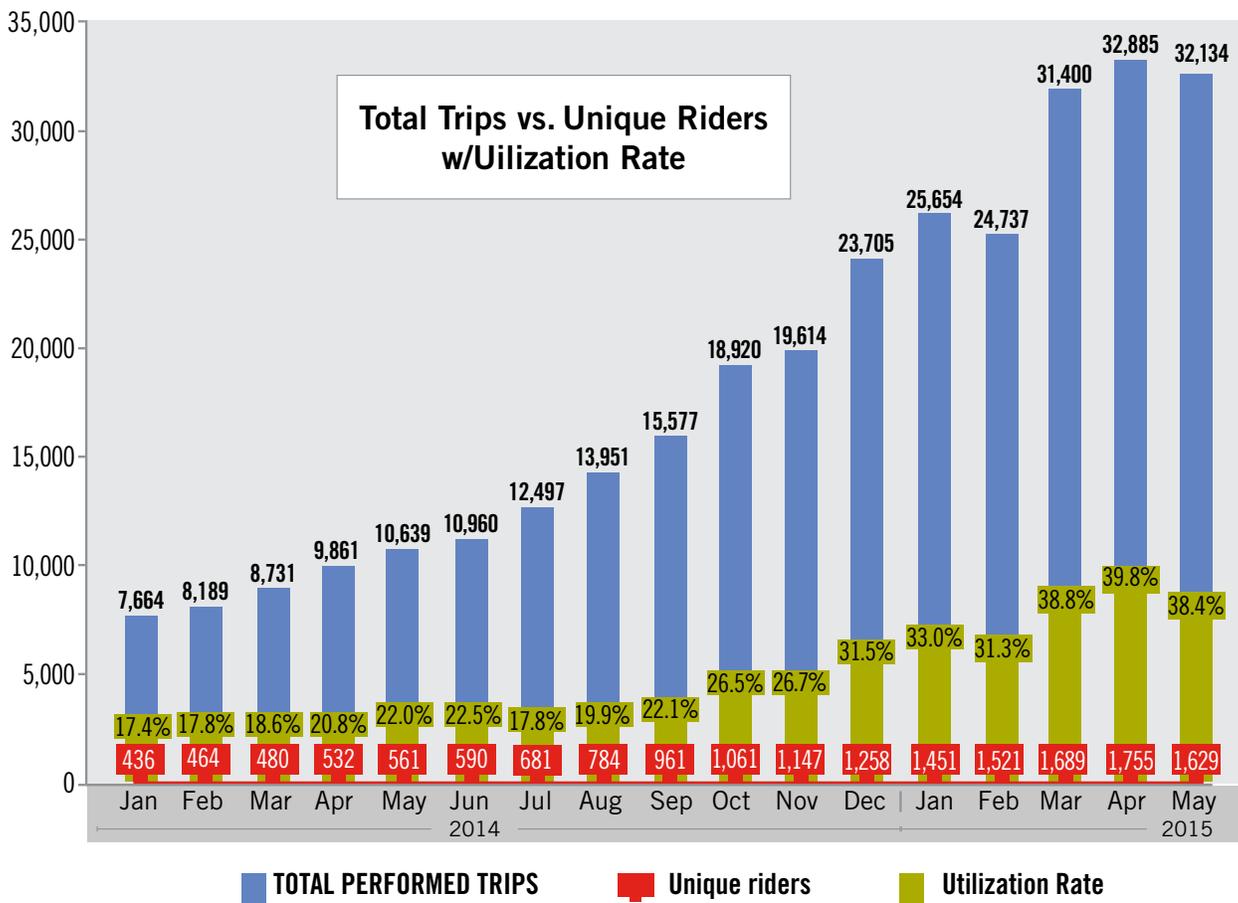
The CTS network of transportation providers includes 43 credentialed transportation companies operating 399 vehicles and engaging 500 qualified drivers. CTS ensures that transportation is available to all of our members, regardless of locale.

Friends and Family Reimbursement Program

CTS operates a cost-effective, efficient Friends and Family Mileage Reimbursement Program that has accounted for over 50% of all trips scheduled for Well Sense members during fiscal year 2015. This is one of the most preferred forms of transportation since it allows members to participate in their own transportation and promotes independence. Members commend the program for its two-week reimbursement cycle and the excellent customer support services.

Total trips performed

As membership has risen, so too have the number of trips CTS provided. Trip utilization is a key measure of member usage of the transportation benefit. It is calculated as a percentage of the total number of trips by the total membership. Since inception, utilization rose from 17.4% to as high as 39.8%.



Call Center

Since December 2013, the CTS Call Center *Total Service Factor* has averaged 91.2%. CTS exceeded all service level requirements despite a nearly 100% increase in the number of calls for transportation during the period.

Our average call statistics for the period if January 1, 2014 through June 30, 2015 are:

- Service Level: 91.2%
- Call Abandonment Rate: 1.9%
- Average Speed of Answer: 13 seconds

Behavioral Health and Substance Use Disorder Program

Well Sense has effectively managed the behavioral health and substance use disorder needs of our members through our close partnership with Beacon Health Strategies, an NCQA-accredited managed behavioral health organization. Through Beacon we offer a unique care management model by using Technical Assistance Clinicians who deliver provider-level oversight. A large number of our members receive their services through New Hampshire's community mental health centers. In order to facilitate system change, Beacon has Technical Assistance Clinicians assigned to each center. This allows them to provide increased member-focused care management by working with the provider and member to ensure improved delivery of services.

For members who do not receive care through the centers, the Well Sense/Beacon Care Manager assists members with accessing care and providing care management services. In addition, building upon discussions and meetings with the New Hampshire Community Mental Health Association and individual meetings with the 10 community mental health centers, a substance use disorder component has been incorporated into the training plan for the community mental health centers.

We apply the Technical Assistance Model of Care for several reasons. Members treated at community mental health centers are eligible for case management services through the centers. The Technical Assistance Clinician works with the member and the center to facilitate care, while the behavioral health Care Manager provides similar services for members treated elsewhere. The Beacon model has resulted in many positive changes, such as early identification of substance use disorders and creative advocacy for comprehensive services to help meet the wide variety of member needs.

Our Technical Assistance Clinicians and Care Managers positively impact member care by prompting and promoting active discharge planning from the beginning of an inpatient admission. They also facilitate transportation to appointments and conduct reminder outreach calls to members at high risk of missing an appointment. This has had a substantial impact on reducing 30-day hospital re-admission rates from 13.27% in 2014 to 7.39% YTD in 2015. As a result, members are hospitalized less frequently and stay in their community with local outpatient supports for longer periods of time. If a member has issues with pharmacy reimbursement, the Technical Assistance Clinicians and Care Managers can escalate the issue quickly for resolution. They also serve as a bridge between inpatient and outpatient providers, including substance use disorder providers, to ensure that discharge plans meet the member's ongoing complex care needs. For example, the Technical Assistance Clinicians and behavioral health Care Managers identify members with co-morbid medical issues, such as asthma, diabetes and high blood pressure, and connect them to the medical Care Managers for comprehensive co-management of behavioral health and medical concerns.

With the Technical Assistance and Care Management Model, we have been able to influence both inpatient and outpatient providers to increase use of evidence-based practices. These include dialectical behavioral therapy, cognitive behavioral therapy, illness management and recovery, evidence based supportive employment, trauma focused cognitive behavioral therapy, and use of American Society of Addiction Medicine principles for substance use disorders. We also have improved communication between inpatient and outpatient treatment teams, which resulted in consistent treatment plans between levels of care and sustained therapeutic gains for members.

We work with community providers and emergency departments to help avoid an inpatient admission when a member is in crisis. The Care Manager calls emergency departments daily to find out if any Well Sense members await inpatient admission. The Care Manager offers assistance, such as help finding placement, as well as provides other therapeutic interventions. In this way we can help avert some inpatient admissions while the member is still in the emergency department. Our Beacon Medical Director can consult with the emergency department physician about medication management while the Technical

We work with our members who need special care so they can take charge of their own health and manage their conditions.

Assistance Clinician outreaches to health center staff to discuss alternative safety and placement plans.

Another unique aspect of our model is that Beacon has a Liaison at New Hampshire Hospital full time, four days a week. The Liaison has been instrumental in reducing inpatient length of stay by promoting early and collaborative discharge planning and facilitating connection to outpatient specialists to assist the member's transition back to the community. The Liaison meets with all members or their guardians to assess what the member feels he or she needs to be able to stay out of the hospital. Member seven-day follow-up outpatient appointments are now consistently scheduled for all adult members prior to discharge from New Hampshire Hospital. The Liaison facilitates member transition back to the community by introducing the member to additional value-added benefits such as transportation to follow-up appointments, and educating the member about the importance of medication adherence and follow-up appointments.

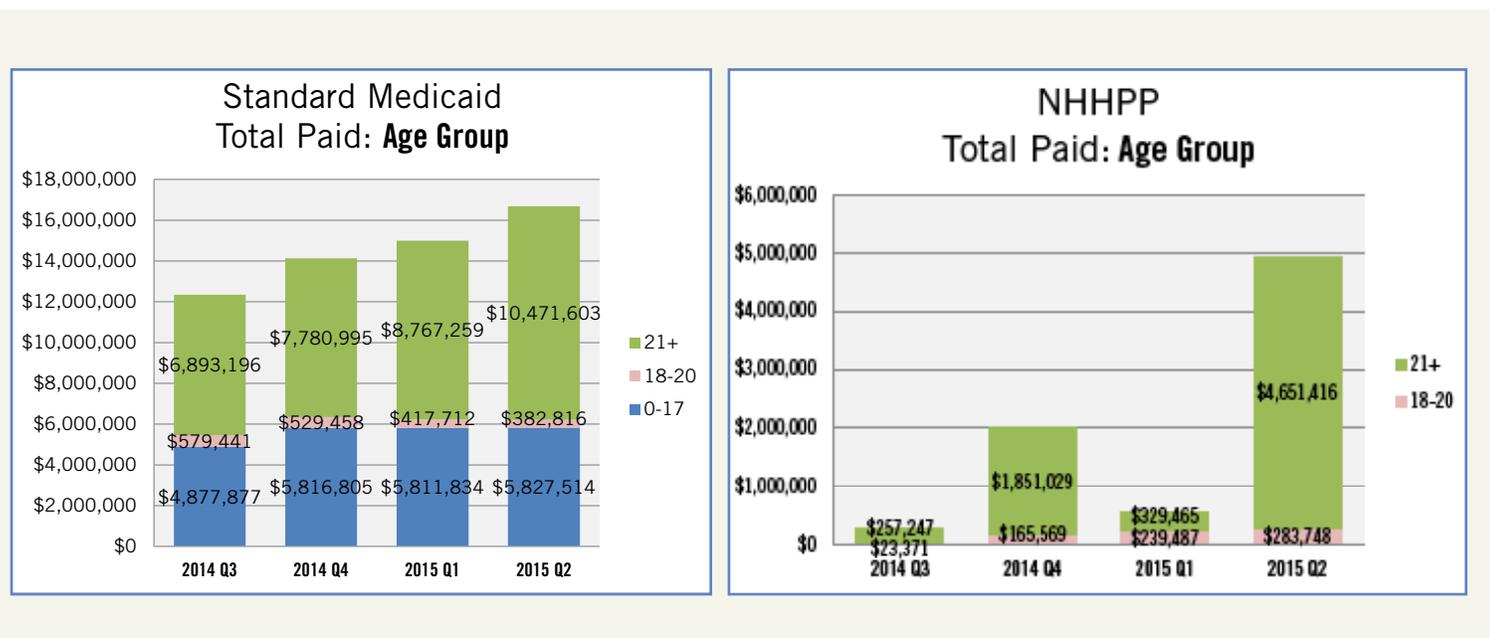
To obtain optimal outcomes for all members, our model uses a whole-person approach to all care management aspects, incorporating clinical expertise and guidance from behavioral health, substance use disorder, medical, and psychosocial experts located in the Manchester, New Hampshire office. In addition to the Technical Assistance Clinician and Care Manager, the Clinical Substance Use Disorder Coordinator acts as both a Care Manager and a resource to other Care Managers for co-management, education, provider access and referrals. The Clinical Team Lead provides oversight to the Care Managers, Utilization Review Clinician, the New Hampshire Hospital Liaison and the Technical Assistant Clinicians. The Team Lead is familiar with all complex cases and provides real-time clinical supervision to ensure that a whole-person approach is used for each member.

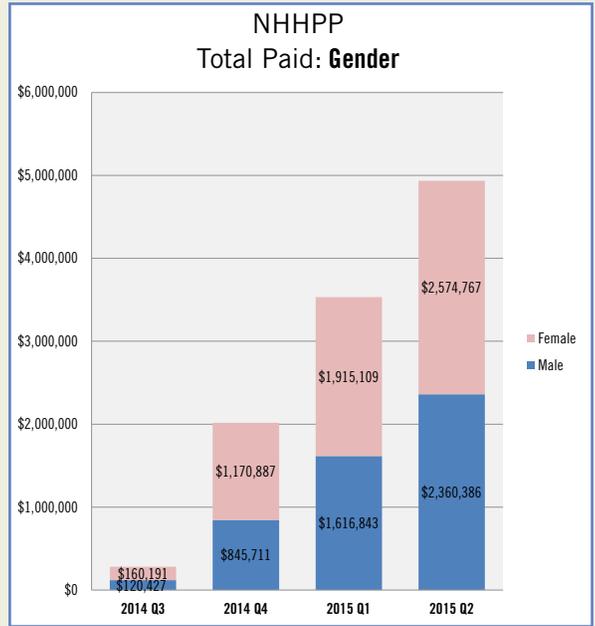
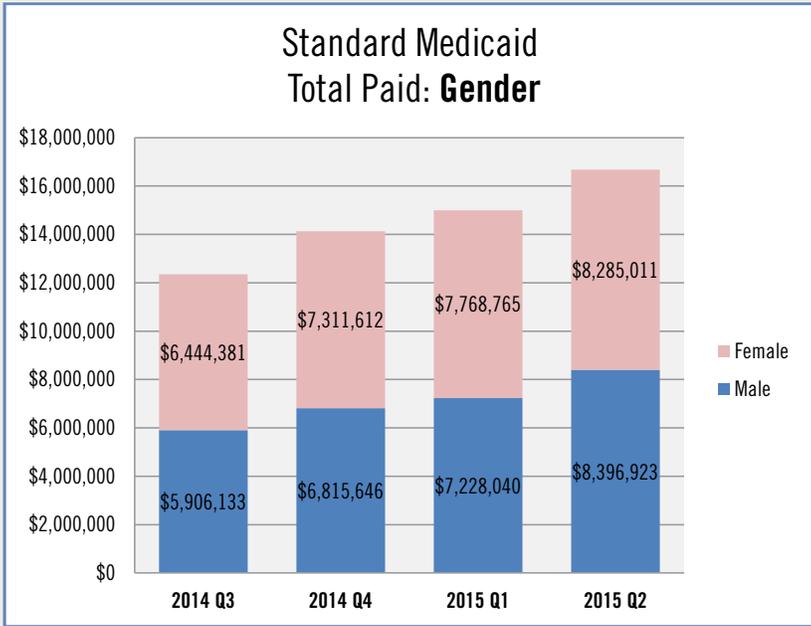
Pharmacy

Well Sense has made important improvements to pharmacy services under the program. For example, we promote the use of generic drugs instead of brand-name drugs where clinically appropriate. This is a key factor in helping to ensure cost-effective management of the pharmacy benefit while getting our members the drugs they need.

Total Paid by Well Sense Health Plan, July 1, 2014 – June 30, 2015

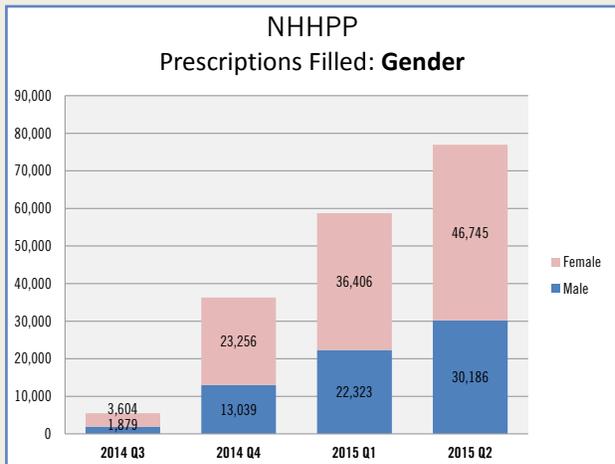
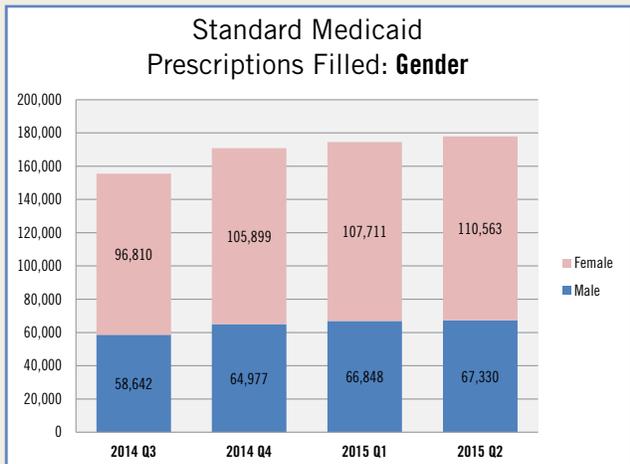
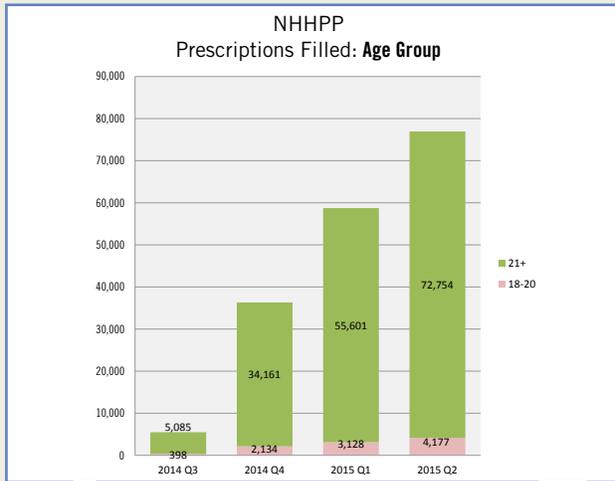
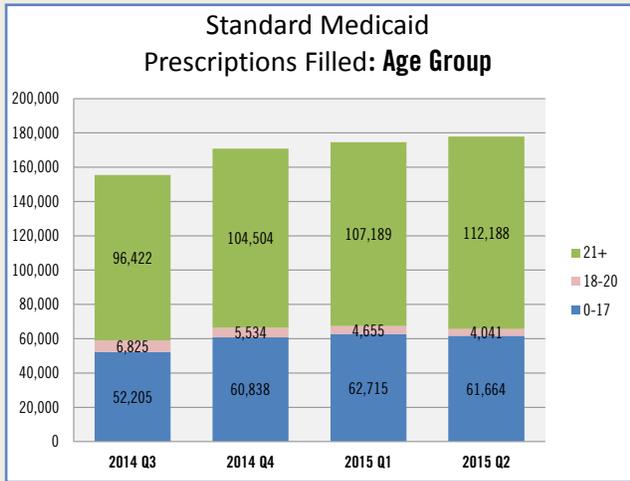
The four graphs that follow illustrate the total amount paid by Well Sense for prescriptions based on age and gender. In the 21+ age group, there is a greater use of medications in general and high cost medications in particular. However, based on gender alone, the costs are approximately equal.





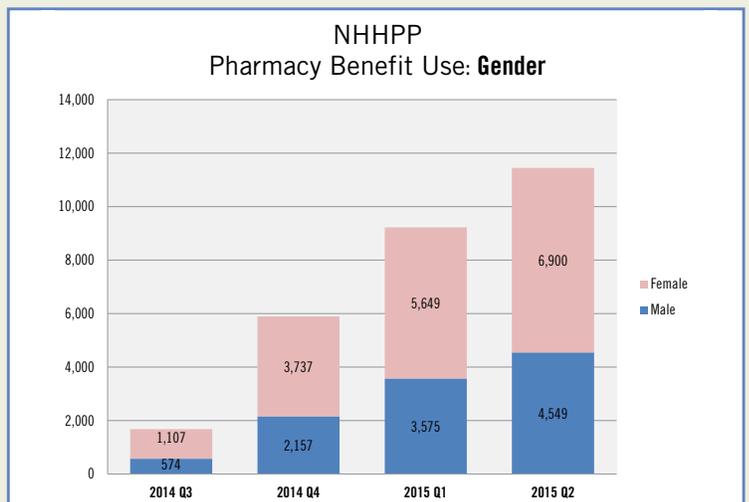
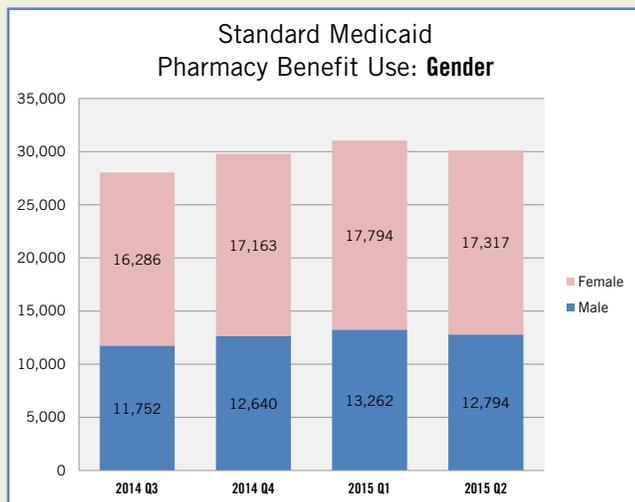
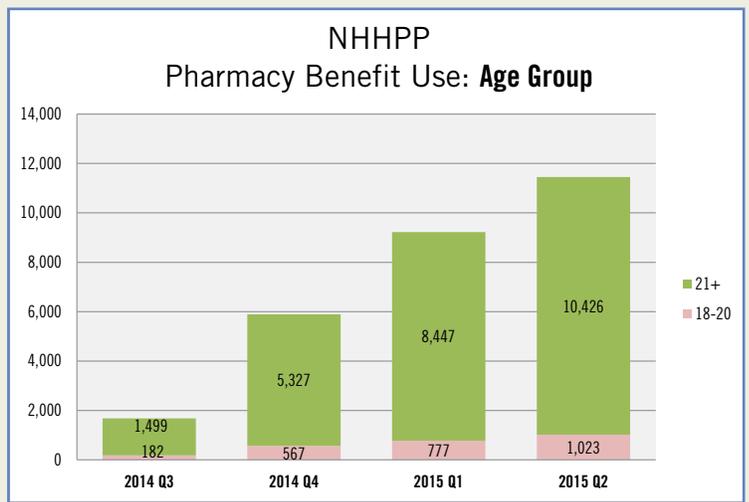
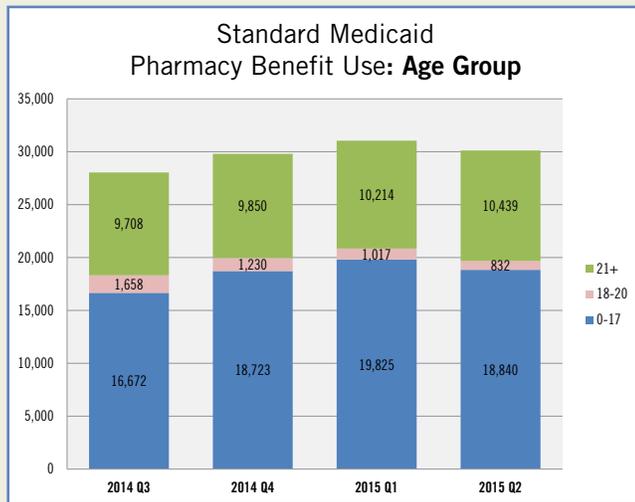
Volume of Prescriptions Processed, July 1, 2014 – June 30, 2015

The next set of four graphs indicates the number of prescriptions filled by members based on age and gender. As with the previous graphs, the volume of medications used was higher in the 21+ age group. Females also filled more prescriptions than males.



Volume of Members Using the Pharmacy Benefit, July 1, 2014 – June 30, 2015

These four charts represent how many of our members fill prescriptions. There are more members who are ages 0-17 using the benefit than in the 21+ age range, and females access the benefit more than males.



Generic Substitution Rate, July 1, 2014 – June 30, 2015

This rate evaluates the percentage of our prescription claims for generic versions of drugs. This is important since there are brand-name versions of the same drugs available.

- Standard Medicaid: 98.45% of prescription drug claims were for generic drugs instead of brand-name drugs.
- NHHPP: 99.32% of prescription drug claims were for generic drugs instead of brand-name drugs.

Generic vs. Brand Name Utilization Rate, July 1, 2014 – June 30, 2015

This rate demonstrates the percentage of our prescription claims for generic drugs compared to all prescription claims.

- Standard Medicaid: 81.67% of all prescription drug claims were for generic drugs.
- NHHPP: 85.13% of all prescription drug claims were for generic drugs.

Top 10 Drugs Utilized by Members

Standard Medicaid

- | | |
|---------------------------|----------------------------------|
| 1. Abilify | 6. Advair Diskus |
| 2. Methylphenidate HCL ER | 7. Norditropin Flexpro |
| 3. Suboxone | 8. Amphetamine/Dextroamphetamine |
| 4. Vyvanse | 9. Flovent HFA |
| 5. Harvoni | 10. Proair HFA |

New Hampshire Health Protection Program

- | | |
|------------------|-----------------------------------|
| 1. Suboxone | 6. Atripla |
| 2. Abilify | 7. Latuda |
| 3. Advair Diskus | 8. Humira Pen |
| 4. Copaxone | 9. Proair HFA |
| 5. Sovaldi | 10. Amphetamine/Dextroamphetamine |



Substance Use Disorder Program

Well Sense has effectively supported our members through our Substance Use Disorder Program. A central component of this program is our Substance Use Disorder (SUD) Coordinator who serves a two-fold role. First, the SUD Coordinator provides care management services for members who have any degree of substance use difficulty. Care management is delivered directly to the member in consultation with a behavioral health or medical Care Manager, or as part of co-management. SUD care management is woven into every aspect of our model with Beacon, as prevention, detection, education and treatment of substance use disorders are essential to a person's wellbeing. Additionally, the SUD Coordinator works with SUD programs throughout the state, primarily intensive outpatient programs and residential programs, to ensure that Well Sense standards of care are met. Part of the SUD Coordinator's role is to furnish support and guidance to providers operating within a managed care system. The Coordinator regularly visits programs to offer support and provide trainings related to SUD treatment. Through these functions the SUD Coordinator facilitates comprehensive care management focused on a member's unique treatment needs.

The Clinical SUD Coordinator is also involved with key stakeholders groups, such as the New Hampshire Providers Association and the Bureau of Drug and Alcohol Services. To better understand member needs, the Clinical SUD Coordinator attends community forums to stay informed about what is happening throughout the state. An essential job function is to maintain an awareness of the issues that Well Sense members face on a day-to-day basis when they struggle with a substance use disorder. For example, the Clinical SUD Coordinator is well versed in substance use disorder treatment options, and the impact that substance use brings to a person's daily life. The Beacon New Hampshire Medical Director, as well as its SUD specialists, work closely with the Clinical SUD Coordinator to integrate core SUD principles and concepts into all of Beacon's clinical activities.

We appreciate the vital importance of this program to our members and will continue to advance efforts to assist those with substance use disorders under it.

Medical care needs to go above and beyond. It needs to include behavioral health and substance abuse support.

Section 5: Member Services

General

We support our members and respond to their questions and concerns in many ways. Our Member Services staff, which maintains the Call Center, often represents a member's first contact with Well Sense. Through Member Services we help our members understand their benefits as well as answer any questions about their coverage. Member Services always focuses on ensuring that our members receive the excellent service they deserve.

In addition, our Community Outreach team has forged relationships throughout New Hampshire, supporting a number of non-profit organizations and causes. For example, between July 1, 2014 and June 30, 2015, Well Sense Community Outreach Representatives attended 102 events in communities across the state.

Call Center

Despite nearby offices in Massachusetts, we opened a dedicated Member Services Call Center in downtown Manchester in 2015, staffing it with employees from the New Hampshire area. We currently have a 12 person team composed of a Manager, Team Leader and 10 Member Services Representatives. They are available 8 a.m. – 8 p.m. Monday, Tuesday and Wednesday, and 8 a.m. – 6 p.m. Thursday and Friday.

Grievances

Members or their authorized representatives may file grievances if they are not satisfied with any aspect of our operations or the care and services they receive in connection with their membership.

Grievances may be filed with our Member Services Call Center by phone, in writing or in person at our offices. We review and respond to all grievances in writing as quickly as the member's condition warrants, but no later than 30 calendar days from the day we receive the grievance. Administrative grievances, including dissatisfaction with Well Sense policies, procedures and areas of operations, as well as the service of staff in provider offices and facilities, are investigated by the Grievance Department. Grievance staff documents the member's concerns and outreaches to area departments or providers to relay and investigate the member's dissatisfaction. A written response letter is sent to the member explaining our findings.

Quality of care grievances, which involve dissatisfaction regarding actual health care or health care discussions, are reviewed by nurses and/or medical directors, depending upon the severity of the grievance.

Grievances are grouped into the categories identified below. We have received the following total number of grievances through May 31, 2015:

| Grievance Type | Quantity |
|-------------------------------------|-----------|
| Access | 0 |
| Attitude/Service | 29 |
| Quality of Care | 6 |
| Billing/Financial | 0 |
| Quality of Practitioner Office Site | 0 |
| Total | 37 |

Well Sense continuously reviews grievance data to determine potential patterns of causes and identifies opportunities for appropriate intervention.

The member Call Center answered nearly 60,000 calls between July 1, 2014 and June 30, 2015.

Cultural competency

Well Sense constantly strives to deliver culturally competent services to all our members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. To better understand our members' needs, we collect information on race, ethnicity and preferred spoken and written language directly from them on their Health Risk Assessment forms. Members complete these forms at enrollment and during telephone calls with the Member Services and Care Management departments. Our commitment to this effort and extensive employee training has resulted in collecting this information for 35% of our members.

We also collect and monitor member demographic information such as prevalent health conditions to increase the opportunity to meet members' needs. Data collected directly from members, as well as from the state, help us identify possible disparities and opportunities for improvement based on HEDIS[®] and utilization measures.

Our Care Management staff takes into consideration this information when reaching out to members and when helping members to coordinate and navigate the health care system. During an initial assessment for care management, we ask members to identify whether they have cultural and/or religious beliefs that should be considered when developing their care plan, and if their needs were met when their care management ended.

Well Sense uses Language Line, which offers interpreters in over 170 languages. In addition, Lutheran Social Services provides in-person interpreter services; providers can request interpreters directly through Lutheran Social Services for members with language interpreter needs.

We also develop member educational and marketing materials in additional languages and distribute to appropriate community agencies throughout the state. In the past year, we translated informational materials into five languages other than English.

All providers receive a welcome kit and an overview about cultural competency during face-to-face orientations. The Well Sense [Provider Manual](#) also outlines cultural competency requirements. During the past year, we conducted over 300 face-to-face orientations for providers representing all practices and hospitals.

Section 6: Utilization Management and Appeals

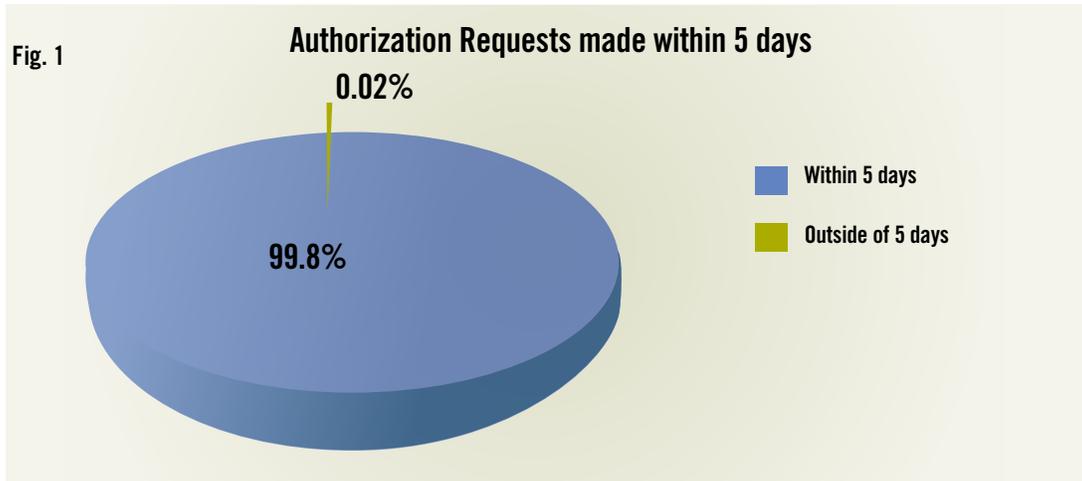
General/Utilization Management

As a managed care organization, Well Sense applies utilization management (UM) to help our members access the right care in the right setting at the right time. Our UM process begins with the PCP and member working together to create a treatment plan, which may include referrals to specialists, hospital inpatient care, home health services, equipment, or prescription medications. We review requests for care to make sure they're medically necessary, which helps us keep the cost of benefits appropriate. Most benefits and services that we cover are available without prior authorization, though some require it.

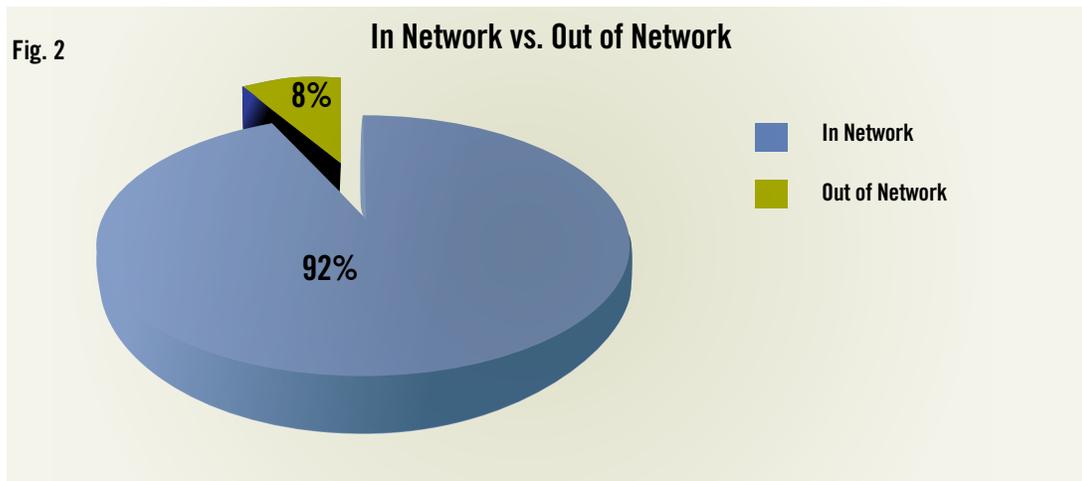
When we authorize a request for care, it means we have evaluated the request to ensure that it is medically necessary. Elective services – those planned in advance – may require prior authorization, also called prior approval. Prior approval is required when we do not cover a treatment, service, or drug, or when a member wants care from a provider who is not in our network. The [Member Handbook](#) contains a list of benefits, noting those requiring prior approval. Providers contact us directly to obtain prior approvals and other authorizations. A PCP can assist in the prior approval process by furnishing information about why the request is medically necessary based on the member's medical history and health needs. (Well Sense never requires prior approval for emergency care, urgent care performed outside our service area, or family planning services.)

**Spanish? Portuguese?
French? No problem.
If a member's first
language isn't English,
we offer translation
services through our
Call Center, and our
website is available in
90 languages.**

Beginning in December 2014, we shortened the time period to make a routine coverage decision when prior authorization has been requested. It dropped from up to 14 days to within five calendar days of receiving all required clinical information. We must meet this requirement in over 95% of all cases. Since December 2014, 99.8% of all routine requests for prior authorization were completed in 5 calendar days or fewer. (See Fig. 1.)



Most member care and services are performed by providers already in our network, as illustrated in Figure 2.

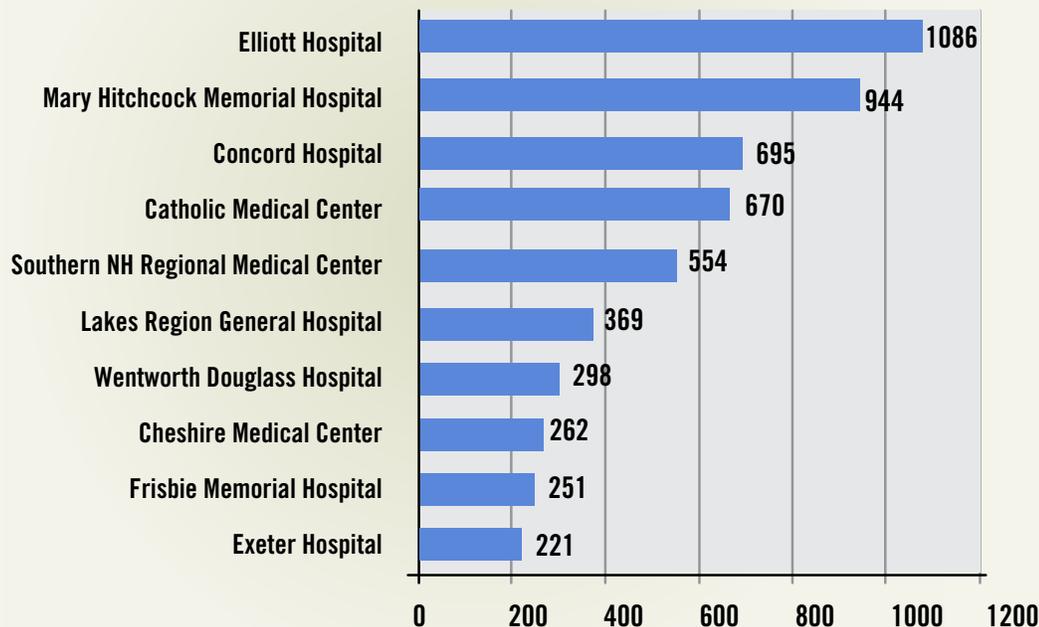


Members who need hospital care most often choose hospitals from within our network. Figure 3 lists the most frequently used hospitals.

Fig. 3

Top 10 Most Frequently Used Hospitals for Inpatient Admissions

(between 7/1/2014 and 6/30/2015)



We also regularly monitor prior authorization requests to learn how often services are requested. In 2014 we made several changes to our prior authorization program based on this analysis. In May 2014 we reviewed our prior authorization list and removed prior authorization requirements from approximately 513 procedure codes. This administrative simplification helps providers ensure that members have quicker access to services for these procedures.

For example, beginning in October 2014, we changed authorization requirements for functional therapies (physical therapy, occupational therapy, and speech therapy). Providers now can offer an initial evaluation and two visits without prior authorization so members can begin treatment immediately while requests for further visits are being reviewed.

In 2014 we also analyzed requests for post hospitalization home care services and determined that a change in the prior authorization process for those services would improve transitions of member care back to the community. Beginning in December 2014, we increased the number of covered home health visits after hospital discharge before requiring authorization.

We approve the vast majority of authorization requests for care and services. If we ever deny a request for coverage, the member always can appeal the decision.

Appeals

When a request for a service, supply or medication is denied, members or their authorized representatives may file an appeal with us. Information on the appeals process and the steps members may take to file an appeal are documented in the denial letter the member and their provider(s) receive. This information can also be found in the Member Handbook and on our website. We ensure that the appeals process is fair, thorough and consistent for all members.

In the past year, the highest percentage of member appeals received was for pharmacy related services (65%). The highest percentage of dismissed appeals was also pharmacy related

We removed prior authorization requirements from approximately 513 procedure codes to help ensure quicker access to services for members.

(33%). Some denials are made for administrative reasons. Specifically, if a provider files an appeal on behalf of a member, we are required to obtain permission from the member for the provider to act as their authorized representative during the appeals process. We must dismiss the appeal if we do not obtain such authorization. The Appeals Department makes reasonable attempts to reach members through telephone and written correspondence, but is not always successful. If this is the case, we are required to dismiss the appeal. Conversely, we sometimes “dismiss” appeals when the provider sends additional information showing the member meets clinical coverage criteria. In these cases the request is approved and the appeal is dismissed. Members and providers have 30 calendar days from the date of the initial denial letter to file standard member appeals with us. If we receive an appeal after that timeframe, barring good cause, the appeal is dismissed.

We also identified several opportunities for improvement that include additional training for providers on submitting all required medical information for initial requests to the Prior Authorization Department. Clinical coverage criteria are available on our website so providers have the necessary information for a thorough review. We also identified and remedied the need for additional training for our Member Services Department on the member appeals process. Finally, we continue to strive to educate our members and providers on the importance of keeping a member’s care within our network. In the past year we have seen a decrease in out-of-network appeals.

Section 7: Provider Relations and Services

General

Well Sense works closely with our provider partners in support of our members. In our Manchester office we have a dedicated Provider Relations team that is the primary liaison between the provider community and Well Sense Health Plan across the state. The staff assists providers on how to work with us and our procedures, including sharing information on plan policies and procedures, offering provider office visits, orientations and/or forums, and ensuring that effective channels of communication are maintained. Provider Relations navigates the Well Sense system for providers and recommends improvements to help increase provider satisfaction.

The Well Sense provider experience includes a multi-faceted communication approach that includes:

- Regional provider forums: comprehensive education on Well Sense operations including administrative updates, Well Sense programs, and policies and procedures
- Provider Relations Consultants who visit provider offices
- Provider welcome/introduction letters
- Welcome kit: including welcome letters, quick reference guide and all materials needed to do business with us
- Comprehensive [website](#) including Well Sense policies and reports available via a secure portal
- New-provider orientations
- Quarterly provider [e-newsletter](#)
- Office staff meetings and trainings as required or requested by the provider
- Provider Advisory Council that meets quarterly
- Electronic notifications on all Well Sense updates and programs

Our goal is to make our provider partners successful and limit their administrative time. The Provider Relations team not only offers personal service, but also emphasizes the value of online support tools, including our website and how it supports providers’ daily operations. All of this means that providers can be assured of prompt and efficient answers to their questions or concerns.

Members benefit when we collaborate with providers to ensure that office visits are scheduled in the required amount of time.

Provider Relations Consultants review the online Provider Manual to ensure ease of navigation. Providers receive Network Notifications and provider notices – also posted on our [website](#) – that describe changes in policies and processes. We also inform providers about their ability to electronically verify member eligibility through our secure [website portal](#) or HIPAA standard 270/271 transactions.

Timely access and use of care

Well Sense offers a comprehensive network of PCPs, specialists, and behavioral health providers to meet our members’ needs. We continuously strengthen our network through ongoing contracting with new groups and individual providers. We are in compliance at all regional levels for member access and availability to services. The few exceptions that have been reported are for specialties in the more remote areas of the state.

Through our Access and Availability Workgroup we evaluate data and then collaborate with providers on areas where opportunities for improvement are found. On an ongoing basis the Workgroup reviews the following:

- Grievances and appeals submitted by members related to access and availability
- Telephone survey data based on a random sample of provider offices
- Practitioner self-reported data that is collected during on-site visits by Provider Relations Consultants

We also conducted two Lead Time Surveys of primary, specialty and home health care providers to assess wait times for a first-available appointment. Providers were measured against the following standards:

| Appointment Time | Primary Care | Specialty Care | Home Health |
|-------------------------------------|---|---|---|
| Urgent Care | 48 hours | 48 hours | n/a |
| Non-urgent symptomatic | 10 calendar days | 10 calendar days | n/a |
| Non-symptomatic (preventative care) | 30 days | 30 days | n/a |
| Transitional Healthcare | 7 calendar days of a member discharge from in-patient or institutional care | 7 calendar days of a member discharge from in-patient or institutional care | 2 calendar days of a member discharge from in-patient or institutional care |

The first Lead Time Survey was completed in March 2014. For specialists, we completed 316 evaluations among the top-five high volume providers in neurology, cardiology, otolaryngology, orthopedics, ophthalmology, along with OB/GYNs. Additionally, age-specific appointments (adult vs. pediatric) were evaluated.

Primary care providers were characterized by a very high level of performance within wait time standards across all appointment types evaluated. This was also true for home health care agencies, with 100% indicating that they were able to schedule a visit with a member within two days of the member being discharged from an inpatient facility.

Some specialty care provider appointment waits times for urgent, non-urgent and routine well-care were below target. For these providers, we sent targeted letters and conducted phone outreach to discuss the results. We furnished education on the required wait times, and many indicated that they were in compliance with standards. Specialty care offices had high levels of compliance in meeting the transitional health care requirement of being able to see a member within seven days of the member being discharged from an inpatient facility.

The Provider Relations staff led another Lead Time Survey assessment in March 2015 for PCPs, home health providers and “Network 01” regulatory report provider specialties. The results showed high levels of provider compliance with lead time standards. We believe

that the education and support that we offer has been a key factor in the rise of compliance with the standards. The Provider Relations team continues to promote awareness of access and available wait times through a multi-faceted approach, including articles in provider and member newsletters, discussions at onsite provider meetings, and distribution of care management materials.

For relevant reporting periods, there were no grievances or appeals submitted by members related to access and availability.

Behavioral Health Services

As described in Section 4, we delegate management of behavioral health services to our partner, Beacon Health Strategies. Beacon approves policies and procedures under this agreement.

Through Beacon, we monitor the network to ensure that the following minimum timely access to service delivery standards are met:

| Appointment Time | Behavioral Health |
|--------------------------------|-------------------|
| Non-Life Threatening Emergency | 6 hours |
| Urgent Care | 48 hours |
| Routine Appointment | 10 days |

To ensure timely access to behavioral health outpatient services, we do not require a prior authorization for the first 18 visits for an adult, or for 24 visits for a child at a contracted provider. Beacon’s Care Management teams collaborate with the Liaison to New Hampshire Hospital to ensure members receive timely, appropriate and coordinated services upon discharge. Beacon also works directly with our Care Managers to integrate a member’s medical treatment needs with their behavioral health care.

Through Beacon we educate all newly credentialed providers about the Provider Manual, which supplies information regarding operations and authorization requirements. The Provider Manual includes details on appointment standards and hours of operation. Providers are required to contact us through Beacon if they are temporarily or permanently unable to meet these standards, and are contractually obligated to furnish notification of practice change and appointment access limitations.

In order to monitor and ensure adequate access and availability, we annually contact through Beacon 10% of network providers. This outreach allows us to address and evaluate network access, availability and provider wait times; discrepancies are addressed with the specific providers.

Beacon analyzes and reports on member requests for assistance in accessing providers, Emergency department utilization, inpatient utilization, and annual HEDIS and CAHPS measures, all of which are broken down by metropolitan and non-metropolitan counties.

Through Beacon, we have processes in place to review access compliance based on two parameters: providers offer 24/7 access for medically necessary requests, and the hours of operation are no less than hours offered to commercial or Medicaid FFS enrollees. Beacon collects the initial information from providers as part of the onboarding process. Providers also must include information on 24/7 coverage for clinical and psychopharmacological services, and detailed information on office hours.

Beacon logs all grievances and appeals to identify trends. If trends are identified in the access or availability category, Beacon’s Ombudspersons or Appeals Coordinators work with the appropriate staff to address these barriers. Beacon delivers quarterly reports to the state on the categories and results of all Well Sense grievances and appeals. Since contract initiation, we have not identified any trending issues with access or availability for Well Sense members.

Call Center

The Well Sense Provider Services Call Center responds to inquiries from in-network and out-of-network providers regarding member benefits, eligibility and claims payment status. Responding to providers' questions with accuracy and in a timely manner is always the goal of the Call Center. Although the Provider Services team does not process claims, it researches and may request claims adjustments as appropriate. In addition we have cross-trained additional representatives to assist in periods of higher than normal call volume.

To ensure that all providers receive the highest possible customer service, we may record calls to ensure accuracy and quality.

Section 8: Fraud, Waste and Abuse

Our Compliance and Privacy Officer provides programmatic oversight of our program integrity initiatives, including fraud, waste and abuse (FWA). The program's operations are delegated to the Vice President of Provider Audit and Special Investigations. The Manager of the Special Investigations Unit (SIU), who serves as the New Hampshire Fraud and Abuse Coordinator, coordinates the unit's day-to-day operations. SIU management frequently communicates with Department of Health and Human Services Program Integrity Unit (DHHS PIU) and Special Investigations Unit (DHHS SIU), and attends meetings with DHHS and the Attorney General's Medicaid Fraud Control Unit, as requested.

Preventing and detecting fraud, waste and abuse during fiscal year 2015

We attempt to prevent FWA by educating providers, members and employees through a number of different avenues such as:

- FWA-related content in the Provider Manual and Member Handbook and in provider and/or member newsletters
- Dedicated provider, member and employee Web pages publicizing FWA information and the routes by which suspected FWA can be reported
- Onsite new-provider orientations on policies, procedures and business practices
- Mandatory new-employee FWA awareness training, employee review of and attestation to the Code of Conduct and Conflict of Interest policies, and annual retraining for all employees
- Periodic FWA-related employee communications and department-specific FWA education
- Continuing education for SIU staff related to FWA

There are a number of approaches we use to detect FWA, including:

- Collaborating with the SIUs of our clinical vendors, each of whom maintain an FWA program and report suspected fraud, as well as attend quarterly FWA meetings with us
- Contracting with a third-party vendor to provide extensive post-payment data mining and to populate an FWA-related database for direct use by SIU staff.
- Maintaining dedicated FWA fax and email boxes for external and internal use
- Managing pharmacy system controls such as the Controlled Substance Management Program
- Applying medical claim controls, including pre-payment application of NCCI and OCE edits
- Conducting random samplings of members to verify that services billed were provided
- Leveraging data warehouse querying tools

We adhere to the highest standard of professional and ethical behavior.

Investigating fraud, waste and abuse during fiscal year 2015

Provider or member-related outliers, trends and referrals come from various sources, including all clinical vendors, and are routed to SIU staff for referral. As appropriate, the SIU promptly submits an MCO Fraud Referral or, after a preliminary evaluation, submits a Request to Open Investigation to the DHHS PIU or the DHHS SIU, refers the issue to Provider Audit or another department, or closes it. Following DHHS approval to proceed, an investigation ensues. During the investigation, if we suspect FWA, we suspend the investigation and submit an MCO Fraud Referral to the DHHS PIU or DHHS SIU. In the absence of such a determination, and as reviewed or approved by the DHHS PIU or DHHS SIU, the SIU will remediate identified errors.

Summary of results during fiscal year 2015

In FY15, we received 412 referrals related to member eligibility; 70 members were referred to DHHS for eligibility determinations. Including cases carried over from FY14, we managed an active member-eligibility caseload of 77 members during FY15.

Our SIU received and evaluated 46 referrals related to suspected FWA in FY15. Three are currently being evaluated while 18 were closed, either by being triaged to another functional area, by providing the appropriate information to the requesting agency or by being found to not be FWA related. SIU cases were opened for 25 of the FY15 referrals. Including cases carried over from FY14, we managed an active suspected FWA caseload of 34 cases during FY15. Ten cases were closed with no findings and seven are currently under review; the disposition of the remaining cases is as follows:

- 12 cases – findings resulting in overpayments were identified
- 5 cases – findings not resulting in overpayments were identified

The total value of claims reviewed for these open cases was \$629,953 with potential overpayments of \$123,326. We calculated that \$66,600 is recoverable based on settlement agreements/agreed-upon audit findings. As of June 30, 2015, we collected \$14,100.

We mailed a total of 1,800 Verification of Services Received letters to members. One response required a review of the member's medical record; the billed services were verified as provided.

We are proud of our robust SIU, which is actively engaged in fighting health care fraud committed against the state's Medicaid program. We are confident that our efforts have not only met the letter of our contractual requirements, but also have exceeded their intent; we look forward to continuing to do so as the program evolves.