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We are committed to providing high quality comprehensive coverage and care for low-income and underserved individuals.
Section 1: Executive Summary

This second annual Care Management Report provides an overview of Well Sense Health Plan’s efforts and accomplishments over the past year and outlines our goals and plans for the coming year. As an assessment of the evolving Medicaid Care Management Program landscape, this Report demonstrates Well Sense’s ability to be a strong, flexible partner for the State of New Hampshire while effectively meeting the needs of our members and providers.

Step 2 Launch

During the past 12 months, Well Sense successfully welcomed over 5,000 new members who previously had been allowed to opt out of the Program. In February, these members, most of whom were dually Medicare and Medicaid eligible and disabled or high-need children, became mandatory enrollees in the Program. In the months leading up to this change, we ensured that our staff, policies and procedures were prepared for the complex care that many of these members require. We also worked tirelessly to deliver superior customer service with demonstrated competency and sensitivity to their unique needs. In partnership with the Department of Health and Human Services (DHHS), this membership transition was smooth and successful.

NHHPP Transition

Another compelling market shift in the past 12 months was the transition of the New Hampshire Health Protection Program to a premium assistance plan. This meant that most participants gained access to coverage on the Health Exchange rather than through the Medicaid Care Management Program. Only individuals with specific health care challenges were permitted to remain with their Medicaid health plan. Those who chose to remain with Well Sense continue to benefit from our integrated structure that coordinates, among other things, customer service, care management and transportation assistance.

Enhanced Care Management

Well Sense’s care management model continues to support individuals’ unique needs, whether they are medical, behavioral, psychosocial, or involve long-term care. Our ability to align appropriate disciplines to fit members’ needs is a unique aspect that distinguishes managed care from fee-for-service programs. For example, we redesigned our care management model to increase our ‘Feet on the Street’ program with additional care managers going out into the community to visit members in their homes, at shelters, in community centers and physician offices. This approach creates a stronger, more holistic connection with the member.

Support Services

Transportation remains a valued Well Sense member benefit. Not only does transportation or reimbursement for travel to covered appointments eliminate a powerful barrier to comprehensive health care, but it also decreases no-shows at provider offices – a long...
standing issue. Our network of transportation providers has grown substantially since the Program’s inception and now provides full or nearly full-time employment to workers across the state. In this way, the Medicaid Care Management Program is investing in the state economy and helping small business owners.

**Renewed BH Integration**

While we experienced early success in the behavioral health arena, progress was slowed over the last 12 months as the health plans, community mental health centers and DHHS worked to return to a collaborative and innovative model of service delivery. Fortunately, members were largely unaware of this effort, and now we are better positioned to ensure consistent progress in coverage and care delivery for those experiencing behavioral health issues.

**Preparing for other Step 2 Services**

We successfully met many of the goals we set for the past year. We anticipated that Choices for Independence Waiver services and nursing facility services would come under the Care Management umbrella in the last 12 months. While the pace of Step 2 has not been what we expected, we used this time to build relationships within the Step 2 provider community and to become better acquainted with our members who use Step 2 services. We look forward to working with DHHS on the opportunities to improve the Step 2 member experience of care.

**FY17 Goals**

Our goals for the coming year include partnering with DHHS and the team it is assembling to create a blueprint for Step 2, as well as with the Independent Delivery Networks designated by DHHS in connection with its Delivery System Reform Incentive Payment Waiver. This will support our current work of ensuring that our members lead the most independent and healthy lives they can. We will continue working to increase quality outcomes for our members and providers, and establish more strategic partnerships with community agencies that serve our members. Well Sense is optimistic that we will remain New Hampshire’s Medicaid plan of choice.

*Susan Coakley, President*  
*Lisabritt Solsky, Executive Director*
Section 2: Introduction

Since December 2013, Well Sense Health Plan has been a mission-driven, not-for-profit Medicaid managed care organization in New Hampshire. We are committed to providing high quality comprehensive coverage and care for low-income and underserved individuals.

As of June 30, 2016, Well Sense proudly serves over 72,000 New Hampshire citizens. Our members are diverse, ranging from low-income children and adults to disabled adults, seniors and parents. We collaborate with providers and organizations in our members’ communities to ensure that their specific needs are met by using a whole-person approach.

Well Sense is located in Manchester, New Hampshire, but many of our staff members come from all parts of New Hampshire and understand the issues impacting the state. We continue to build out our New Hampshire-based operations. In 2016, we expanded our Call Center to answer calls from providers as well as members. In addition, the Manchester Call Center now is responsible for interacting with members in new ways, including making outbound new-member welcome calls and documenting health needs assessments. In this year’s Care Management Report, we provide important updates and other information on quality, care management, member services, utilization management, provider relations, and fraud, waste and abuse efforts. Well Sense is proud to report on these important efforts to advance New Hampshire’s Medicaid Care Management Program.

Section 3: Quality Program

We continue to advance quality of care

Well Sense Health Plan ensures the highest-quality coverage and care through an ongoing commitment to quality measurement and continuous quality improvement. Our Quality Improvement (QI) Program repeatedly assesses and focuses on improving all aspects of health care delivery. 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®), Well Sense monitors and identifies opportunities for improvement. At least annually, Well Sense assesses and evaluates the effectiveness of the QI Program, and we make mid-course modifications when data indicate the need for other tactics and strategies. Throughout the year, we develop and implement member and provider focused interventions to encourage preventive care and improve member self-management of chronic health conditions. These interventions include mailings, outreach calls, provider reports, and rewards programs.

Well Sense Health Plan’s Medicaid HMO has been awarded Commendable Accreditation status by the National Committee for Quality Assurance (NCQA), which is the highest award level available for the program. Well Sense Health Plan’s HMO also is rated a 4 out of 5 among Medicaid plans in the U.S. according to NCQA’s Medicaid Health Insurance Plan Ratings 2015–2016.

We are educating our members on the importance of staying healthy

In 2015 Well Sense continued to focus on health interventions that have proven successful from previous years. These included mailing seasonal asthma postcards, sending diabetes self-management check lists and calendars, and placing reminder phone calls to adolescent members, ages 18-21, who were due for annual physical appointments. We also implemented new initiatives such as sending reminder postcards to parents and guardians of members ages 3-6 who were due for well visits. In July, Well Sense sent information on the importance of HbA1c testing to members with diabetes who had not completed a test within the previous year. We also conducted a focus group for diabetic members to explore ways to improve diabetes education and discuss barriers to obtaining important screenings such as dilated eye exams, HbA1c tests, and kidney function tests. In December, we implemented a pilot program designed to remind members of the importance of postpartum visits, and offered
Our contracted providers are our partners in improving the quality of care and services delivered to our members.

We engage providers to help us improve quality of care

Our contracted providers are our partners in improving the quality of care and services delivered to our members. Examples of how we enhanced the quality program for providers include:

- Expanded participation in the Provider Quality Incentive Program (QIP) to help meet our goals of improving care and services provided to our members.
- Offered additional funding through the QIP to provider groups that achieve national benchmarks for elements of care, such as well child visits, asthma care, diabetes care and preventive screenings.
- Consulted with individual provider groups to review their performance, review barriers, share best practices and assist them in meeting their quality improvement goals.
- Furnished providers with reports to monitor ongoing performance and help them identify members needing specific preventive care.
- Developed a new provider portal on our website that offers providers 24-hour self-service access to member eligibility information and preventive care reports.
- Developed a provider HEDIS Billing & Coding Guide to educate providers and help clarify billing and documentation issues.
- Utilized the feedback obtained from quarterly Provider Advisory Council meetings to help build partnerships, discuss quality improvement initiatives, revise reports, update materials, share best practices, and discuss ways to improve member and provider experiences.

These offerings gave providers new and valuable tools to support members’ care.

Our partnerships with community and state agencies allow us to advance quality of care

Well Sense actively collaborates with community organizations to improve the quality of care and develop services for our members. We also work with the Department of Public Health to promote preventive programs in the community and to align initiatives to improve member access to self-management and prevention programs. Some of these programs include the diabetes prevention program, childhood lead prevention program, asthma outreach and education, and improvement in behavioral health screening. We continue to look for opportunities to expand our partnerships to support and coordinate services to address our members’ ongoing health care needs. Our staff has established strong relationships with the following community based programs and groups:

- Granite State Independent Living
- The Community Health Institute
- 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 organizations like these, Well Sense works to support members within their communities.

**We continue to advance our quality improvement rates**

In 2015 we continued to demonstrate improvements in comparison to the pre-Medicaid Care Management (MCM) program and to calendar year (CY) 2014 for the following HEDIS measures:

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

**Comparability with New Hampshire fee-for-service data is influenced by the difference in collection methods for HEDIS hybrid measures and the use of medical record review, which is performed by Well Sense Health Plan but was not reflected in pre-MCM rates.**

### Section 4: Care Management

Well Sense Health Plan’s care management programs are designed to meet members’ needs and maintain outcome measures that meet or exceed program requirements. We support an integrated, holistic member-and-family approach for delivering high quality member care. Our care managers play an integral role by ensuring that our members receive the physical, social and behavioral health services they need, and coordinating the appropriate pharmacy management and wellness programs. We respond to our members’ needs as they access services throughout the continuum of care while at the same time engaging providers and social service organizations. This approach allows care managers to assess a member’s overall health status, facilitate coverage for medically-necessary services, social and community-based services, and serve as member advocates as they navigate the health care system.

### Wellness and Prevention

Well Sense has continued to advance wellness and prevention for our members. Our care managers continue to focus on guiding and supporting our members by providing them with the education and self-management skills necessary to improve their health. They counsel members, provide customized educational materials, and ensure that care is being coordinated with providers and the proper community resources.
Our care management program continues to provide general and targeted member and provider outreach. Throughout the past year, we have promoted preventive screenings and resources. Our website – WellSense.org – contains information focused on wellness and prevention. It includes Your Guide to Wellness that lists specific information on preventive care, immunizations, tips on eating healthy, staying active, and warning signs of symptoms. The website also provides additional member resources such as information on smoking cessation, breast cancer awareness, flu prevention and seasonal safety tips.

The website’s member portal contains interactive self-management tools that support wellness and healthy living. Topics include smoking cessation, healthy eating, managing stress, avoiding at-risk drinking, and encouraging physical activity. Members can complete a health risk assessment via the member portal, by phone or by mail. We use the completed health risk assessments to better coordinate care and services for members. The information also helps identify members who may benefit from specific care management programs.

Providers have their own section on our website with information that includes clinical practice guidelines, medical and reimbursement policies, and links to national resources.

We also continue to offer our members a number of extras that focus on wellness and prevention. These include free dental kits, bicycle helmets for children, 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. Below is a summary of the member extras that Well Sense distributed over the past year.

<table>
<thead>
<tr>
<th>Member Extra</th>
<th>Quantity Distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s car seats</td>
<td>2,680</td>
</tr>
<tr>
<td>Dental kits</td>
<td>1,866</td>
</tr>
<tr>
<td>Children’s bike helmets</td>
<td>660</td>
</tr>
<tr>
<td>Manual breast pumps</td>
<td>394</td>
</tr>
</tbody>
</table>

Disease Management and Chronic Care

We are committed to improving the health of our members and to help them manage chronic and high-risk conditions. Our members experience a variety of social and economic challenges, including poverty, limited literacy, language barriers, lapses in coverage, unavailability of transportation, lack of housing, and employment issues. All these factors make it difficult for our members to navigate the health care system. They also contribute to fragmented care, disease progression, emergency department use, and hospital readmission risk. In our efforts to combat these barriers, we designed our care management programs to help these members and their health care providers manage at-risk and chronic conditions. In addition, we research best practices, including predictive modeling and strategies to help combat care gaps, homelessness, medication adherence and patient activation measures. Partnering with community organizations across the state provides us with access to extensive resources, which allow us to bring down barriers.

Examples of agencies that provide resources to our members include:

- Juvenile Justice and Adult Community Corrections
- WIC
- Head Start
- Community Action Programs
- Local Income Programs
- Nutrition Assistance
- Housing Assistance
- Locally administered Social Services Programs
- Family, Youth, and Consumer Organizations
- Faith Based Organizations
- Public Health Agencies
- Schools

Partnering with community organizations across the state provides us with access to extensive resources, which allow us to bring down barriers.
Complex Care Management targets the most complex, highest-risk members, including those with special health care needs.

In addition, Well Sense offers three levels of medical care management (disease management for some conditions) to further support our members with diseases and chronic conditions: Health Care Education, Population Management, and Complex Care Management. The same care manager will manage the member as he or she changes levels within the Population Management and Complex Care Management program, in lieu of another care manager being responsible at different intervals. This approach supports our whole-person model.

**Health Care Education (Level I Disease Management)**

Health Care Education is the least intensive level of care management. It consists of targeted member educational materials, tools and resources to promote wellness and prevention and to provide new and easy ways for members to manage illness and stay healthy. Members receive condition-specific education, such as diabetes-specific educational materials.

**Population Management (Level II Disease Management)**

At the intermediate level of care management, Population Management includes arranging services for members with specific medical, behavioral and social needs and interventions for specific conditions:

- Diabetes
- Pregnancy and high-risk pregnancy maternal child health (Sunny Start)
- Asthma (adult and childhood)
- Heart failure
- Coronary artery disease
- Obesity (adult and childhood)

In addition to these conditions, members with special health care needs who have a lower risk or need level also may be managed in this program. Programs include medical, social and behavioral health care management. They involve assessing the member’s condition by phone, coordinating care, and determining available benefits and resources, including family support, collaboration with area agencies and community resources. Each member also receives an Individual Care Plan emphasizing psychosocial support, self-management goals, care coordination, ongoing monitoring, and appropriate follow-up.

**Complex Care Management (Level III Disease Management)**

Complex Care Management targets the most complex, highest-risk members, including those with special health care needs. We offer this program to members with the targeted conditions listed above who have a higher risk score or greater medical needs. In addition to these conditions, Complex Care Management focuses on members with

- HIV/AIDS
- Special needs
- Brain disorders
- Cancers
- Strokes
- Degenerative, neurological, metabolic, and genetic diseases
- Shaken baby syndrome
- Homelessness
- Polypharmacy
- Increased need for personal skills items
- Rare diseases

% Actively Managed Members Level II Disease Management
(1,808 managed out of 3,939 outreached) 7/1/2015 - 5/31/2016

- Asthma 33%
- Diabetes 38%
- CHF 4%
- CAD 2%
- COPD 9%
- Obesity 12%
- Other Medical 2%
- Pregnancy 4%
- Postpartum 0%
COMPLEX CARE MANAGEMENT (LEVEL III DISEASE MANAGEMENT)

Complex Care Management targets the most complex, highest-risk members, including those with special health care needs. We offer this program to members with the targeted conditions listed above who have a higher risk score or greater medical needs. In addition to these conditions, Complex Care Management focuses on members with:

- HIV/AIDS
- Special needs
- Brain disorders
- Cancers
- Strokes
- Degenerative, neurological, metabolic, and genetic diseases

It also focuses on:

- Complex newborns
- Members requiring wound care
- Members with high acuity scores
- High emergency department utilizers
- Those who are in the Prescription Drug Monitoring Program

As with the Population Management level, we develop and implement an individual care plan for each member who consents to participating in Complex Care Management, emphasizing psychosocial support, self-management goals, care coordination, ongoing monitoring, and appropriate follow-up care. Complex Care Management also serves as Level III of the Disease Management Program. Members with comorbidities or complex conditions managed in Level II are enrolled in Complex Care Management (Level III Disease Management).

...we develop and implement an individual care plan for each member who consents to participating in Complex Care Management...
Members in our Care Management programs often have more than one condition. All Population Management and Complex Care Management Programs manage comorbid conditions, including:

- Cancer
- Hypertension
- Chronic obstructive pulmonary disease
- Encouraging member/provider communication and suggesting effective methods of communication
- Providing educational materials
- Chronic condition monitoring, including self-monitoring, and clinical and laboratory assessment
- Adherence to treatment plans (including medication adherence/management, as appropriate)
- Care coordination and transitional care management (as appropriate)
- Lifestyle issues and management
- External resource referrals, programs and services available in the community to help members with a condition or comorbidity
- Chronic condition management

Each program addresses the following:

- Medical and behavioral health comorbidities and other health conditions, such as cognitive deficits and physical limitations
- Health behaviors that may impede a member's ability to manage a condition, such as quitting smoking and keeping his or her house dust free due to asthma, or eating healthy foods and exercising regularly if the member is diabetic
- Psychosocial issues, including beliefs and concerns about the condition and treatment, perceived barriers to meeting treatment requirements, education, and access and financial barriers to obtaining treatment assistance in dealing with family issues
- Depression screening
- Caregiver communication
- Care coordination and transitional care management (as appropriate)
- Lifestyle issues and management
- External resource referrals, programs and services available in the community to help members with a condition or comorbidity
- Chronic condition management

The three levels of medical care management allow our care managers to provide more frequent and real-time outreach and support to members with the highest need level. This allows them to continue to support and monitor our members as they stabilize with ongoing care coordination services.

**Maternal Child Health Program**

For our pregnant members, we also offer a Maternal Child Health Care Management Program. The main focus of this program is to promote a healthy pregnancy by identifying risks early, working with members to monitor these risks through delivery, and preparing members for what to expect and what they may need if they deliver a sick newborn. Improved health throughout pregnancy likely will prevent complications with delivery and increase the chances for a healthy baby. Additionally, the Maternal Child Health Program focuses on the post-partum period to ensure that members receive their post-partum checkup 21-56 days after delivery.

In order to identify at-risk pregnant members early, we conduct an initial screening assessment to determine the member’s risk for adverse events during pregnancy and for delivering a complex newborn. We complete this assessment each trimester if the member is not identified as being at-risk. Through our Care Transitions Program, we identify at-risk members from automated daily authorization reports. We also receive referrals from providers and our inpatient utilization management team. Once we identify a member as being at-risk, a registered nurse care manager, who is specifically trained in high-risk maternity, manages the member on a schedule that is appropriate for the member’s needs. The care manager ensures coordination of prenatal and parenting programs, prenatal and postpartum physician appointments, psychosocial and socioeconomic needs, as well as coordination of community resources needs such as transportation to medical appointments.
We also provide enhanced care to members who deliver a newborn with complex medical needs, such as neonatal abstinence syndrome (NAS). We assign the same care manager who managed the mother’s pregnancy to manage the newborn’s care, establishing a “Nurse in the Family” whenever possible. Our care managers are trained on network hospital NAS clinical treatment protocols to include discharge care plans. Care managers work closely with mothers to help them understand discharge instructions and to help ensure that follow-up care occurs. Our care managers will continue to manage the mother and sick newborn up to one year of age addressing any clinical, social and behavioral health needs. In addition, members who deliver an infant with NAS automatically are referred to Beacon Health Strategies (Beacon) for outreach and management.

Non-Emergency Medical Transportation

Well Sense works closely with Coordinated Transportation Solutions (CTS), a not-for profit transportation management organization, to provide members with non-emergency medical transportation (NEMT). Members contact CTS directly to arrange transportation to medical appointments from their statewide network of transportation providers.

As a transportation broker, CTS:

- Ensures compliance with contractual requirements and state and federal rules and regulations
- Recruits and maintains an adequate transportation provider network by projecting monthly trip volume
- 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
- Monitors and reports on program progress
- Oversees, monitors and audits all provider vehicle inspections for safety and roadworthiness
- Ensures drivers are properly insured and have current licenses and vehicle registrations

Member Satisfaction

Member satisfaction with the NEMT program is extremely high, with an overall satisfaction score of 99%. Complaints are consistently low with a rate of below 0.1% of all trips provided, with a 99% rate of resolution in 72 hours or less.

Network of Transportation Providers

The CTS provider transportation network includes 48 credentialed transportation companies operating 693 vehicles and engaging 983 qualified drivers. CTS ensures that transportation is available to all Well Sense members, regardless of location.

Friends and Family Reimbursement Program

The Friends and Family Mileage Reimbursement Program accounted for over 50% of all trips scheduled for Well Sense members during fiscal year 2015. This cost-effective, efficient program is highly preferred by members since it allows them to participate in their own transportation and promotes independence. The program’s two-week reimbursement cycle and superior customer service continue to make it a member favorite.

Total Trips Provided

As membership has risen, so too have the number of trips CTS has 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, transportation utilization increased from 33.26% to 49.08%. This demonstrates that the transportation service is proving effective in helping members access needed care.
CTS Call Center

Since July 2015, the CTS Call Center Total Service Factor has averaged 91.08%, and CTS has exceeded all service level requirements. CTS collaborated with the Well Sense Care Management Department to simplify the appointment pre-verification process when arranging transportation.

Average CTS call statistics for the period of July 1, 2015 through April 30, 2016 are:

- Service Level: 91.08%
- Call Abandonment Rate: 1.57%
- Average Speed of Answer: 12 seconds

Special Needs Program and Social Services & Community Care Coordination

Well Sense also has effectively served members with special needs such as those with chronic physical, developmental, behavioral, or emotional conditions. Members with special needs include both children and adults. In particular, we have dedicated social care managers that support the needs of members in the Acquired Brain Disorder waiver program, In-home Services and Supports waiver program, Developmentally Disabled waiver program, special needs population and the Choices for Independence waiver program.

We identify special needs members based on the member’s physical, developmental or behavioral condition, or adverse social circumstances, including members living with:

- at least two chronic conditions
- one chronic condition and at risk for another chronic condition
- one serious and persistent mental health condition
- HIV/AIDS
- children in foster care
- children and clients of DCYF receiving services through a court order
- homeless members

We obtain this information through monthly claims-based registries, health assessments and through information provided to us by the State.

Our care managers also continue to develop strong working relationships with area agencies, provider groups and other support services organizations throughout New Hampshire. Below is a partial list of agencies we worked with in 2015-2016 to support our members, including those with special needs:

- Healthcare for the Homeless
- MidState Health Center
- NH Brain Association
- Nashua Children’s Home
- Nashua Rescue Mission
- Pine Haven Boy’s Center
- Manchester Health Department
- NH Bureau of Developmental Services
- Office of Minority & Refugee Affairs
- Southern NH Human Services Council
- Seacoast Elder Services
- Gateways Community Services
- Elliott Hospital
- Upreach Therapeutic Riding Center
- Community Care Team, Portsmouth Hospital
- Community Care Team, Frisbie Hospital
- People 1st of NH
- FIT
- Concord Hospital discharge planning department
- One Sky Community Services
- NH Healthcare Association
- NH Benefit Planners at GSIL
- Crotched Mountain Community Care
By partnering with organizations like these, we have advanced patient-centered care that meets members where they are.

The graph below identifies the percentage of members who were actively engaged by a social care manager or medical care manager in each of the previously referenced waiver programs.

This graph shows the percentage of members who were actively engaged by our social care managers and community care coordination teams by the categories of psychosocial, socioeconomic and clinical needs.
### Care Transitions Program: Ensuring Seamless Care Transitions

In addition to the three levels of medical care management programs noted earlier, Well Sense also has a comprehensive Care Transitions Program that includes a variety of initiatives targeting both members and providers. Through these initiatives, the Care Transitions Program aims to reduce inpatient readmission within 30 days for specific targeted medical, surgical, high-risk pregnancy conditions and social determinants that typically yield high rates of readmission, according to the Agency for Healthcare Research and Quality evidence-based guidance and Truven Medicaid specific data. The Care Transitions Program is staffed by a dedicated team of clinicians and non-clinicians. Those members who are actively engaged in the program continue to be managed by the same care manager to ensure continuity of the whole-person approach. The goal of the program is to support care transitions as members access care throughout the continuum (emergency department, hospital, post-acute facilities such as skilled nursing facilities and rehabilitation hospitals) while also managing the member in the appropriate risk program. Members receive the following:

- Pharmacist support for medication reconciliation, as needed
- Home safety visits by a Well Sense care manager or community health worker, as needed
- Nursing support to ensure that discharge plans are implemented, discharge instructions are understood, PCP and/or specialist appointments are scheduled, and transportation to medical appointments is in place

We also provide the following specific services to our members:

### Continuing Our “Feet on the Street” Approach with Mobile Teams

Well Sense recognizes that certain members in care management may benefit from a face-to-face home visit to enable a more comprehensive assessment of their medical and psychosocial needs, especially those who are living with disabilities, who are at high risk or who have had a recent care transition. For these members, we use our “Feet on the Street” approach, making site visits to their homes, clinics, shelters, and public areas. This helps us to assess and observe members in their home environments and determine what other resources and/or services may be beneficial. We ensure that they receive the care they need when they need it regardless of physical or social barriers. Under our “Feet on the Street” initiative, our face-to-face visits increased from 24 in 2014 to 92 during the 2015 reporting period, and to 315 for this period.

### Free locked cell phones

Well Sense also offers cell phones to members in our care management programs who do not have active or reliable telephones. These phones are programmed with the contact information for our Member Services Department, the member’s providers and care team, as well as community organizations and agencies, Beacon, and 911. We offer additional services for our members living with disabilities, including a toll-free telephone number for direct access to our Care Management Department. As these phones offer enhanced communication, Care Management staff also can coordinate non-emergency transportation and other wrap services. These phone offerings increase engagement that enable us to better identify broader social or economic factors that can negatively impact access to care.

### Care Management Program Initiatives

**Enhanced Member Identification**

We have enhanced our processes under our Care Management programs to identify members presenting with the greatest need for care management. We have done this through automated daily authorization reports, which is quicker than waiting for data otherwise not
available until a claim is received. These reports include notifications of skilled nursing and rehabilitation admissions, targeted medical and surgical inpatient admissions and pre-admissions, home health, nursing and hospice services, members with inpatient lengths of stay greater than seven days, and services and admissions authorized for the medically frail population. Earlier identification allows us to outreach and engage with members when they are most vulnerable.

We also developed a pre-admission assessment for use with targeted elective admissions. This assessment is completed prior to a planned admission and is designed to identify potential discharge needs and clinical and psychosocial barriers to discharge that may lengthen a member’s stay. It also serves to educate members about what may occur prior to or during the admission and after hospital discharge. We perform a home safety evaluation, if necessary, prior to the admission to assist with identifying and preparing for discharge needs. Additionally, a member may be encouraged to tour potential post-acute facilities, such as skilled nursing facilities or rehabilitation hospitals. Components of the pre-admission assessment include consideration of:

- Reason for admission
- Review of prior hospitalizations
- Assessment of advance directives
- Transportation needs
- Home conditions
- Social supports
- Prior use of and relationship with homecare, skilled nursing facilities or rehabilitation hospitals
- Long-term support services
- Functional and cognitive ability
- Medication inventory
- Preparation treatment prior to admission

**Care Management Team Growth and Services**

This year Well Sense expanded the care management team by offering a certification-eligible community health worker program to our care coordinators. As a result, two care coordinators are now certified community health workers (CHWs), joining our care management team of registered nurses, clinical social workers, dedicated care managers for the waivered population, care coordinators and a clinical care management trainer.

In particular, the CHWs have been trained to conduct in-home environmental assessments to identify allergen triggers, using the Environmental Protection Agency assessment tool. The CHWs assess, educate and assist members in removing asthma triggers in the home. CHWs also educate members on the appropriate use of controller and rescue medications and coach members on the importance of developing an asthma action plan with their primary care providers. This includes identifying how to manage symptoms and when to seek care prior to the need to go to the emergency room. The CHWs also perform a comprehensive medication inventory while in the home. Following the visit, the CHW collaborates with the primary medical care manager who incorporates the assessment and home visit findings into the member’s care plan, and provides follow-up with the member and provider, as needed.

Well Sense care managers also received training on the following topics this past year:

- Complex newborn management
- Health wise knowledge base materials
- Autism, as presented at Grand Rounds
- HEDIS
- Patient engagement
- Mindfulness
- Staff and home visit safety as provided by the Manchester Police Department
- Early intervention program services
- Social determinants
- Catholic Medical Center portal access
- 3-part communications, motivational interviewing and member engagement
- Preadmissions assessment
- Choices For Independence Waiver Program
In an effort to better integrate the overall care management of our members’ psychosocial and medical needs, Well Sense established “buddy” teams this year with side-by-side seating among the medical and social work staff. This allows for real-time consultation of members’ needs through subject matter clinical and psychosocial experts. This provides a deeper team approach in meeting the whole-person needs of our members while maximizing collaboration with providers and community organizations.

**Step 2 Transition**
There were 5,205 Step 2 members who transitioned to Well Sense as of February 2016. The transition followed intensive collaborative care management through the “High Touch” transition process developed by DHHS in collaboration with medical and social care management, utilization management, and Beacon. This process included weekly internal meetings and attendance at all provider and member forums, as well as learning sessions offered by DHHS. Additionally, the care management team attended:

- DHHS sponsored learning sessions on the Health Risk Screening Tool and the Supports Intensity Scale, which are administered by the Developmentally Disabled Waiver Program and a meeting with Special Medical Services.
- Five High Touch meetings with DHHS
- 21 High Touch meetings with area agencies (developmentally disabled, acquired brain disorder, and in-home supports)
- Two High Touch meetings with nursing facilities
- A successful readiness case review with DHHS where Well Sense staff presented 10 adult and five cases for children under age 18 showcasing the Well Sense system applications.

Review components included:

- Identification of individuals with special needs
- Evaluation of specialty care, equipment and medication management
- Evaluation of the impact of special needs
- Cultural/linguistic competence
- Care plan development
- Patient/family involvement in care planning
- Transition planning
- Comprehensive coordination of care

In total we reviewed 229 High Touch members. For each member, care managers attempted at least one outreach call, which included requesting guardianship paperwork, as applicable. There were 28 High Touch transitions of care cases managed by Well Sense in January, and 34 in February 2016. There also were several High Touch members requiring private duty nursing services for which we held multiple internal integrated meetings with social and medical care management and utilization management, as well as meetings with DHHS to ensure the health and safety of these members.

**Collaborative Meetings with NH Case Management Agencies**
Just over 1,500 Well Sense members are seniors or adults with physical disabilities who participate in the Choices for Independence (CFI) waiver program. These members receive community based long-term services and supports that are coordinated by community case managers. Well Sense care management staff partners with independent case management agencies so that medical services are coordinated with community-based services to ensure comprehensive, whole-person care that is member-focused, and cost effective.

In addition to individual-member communications, in 2015 our care management team began engaging and further collaborating in monthly meetings with DHHS and New Hampshire Independent Care Management agencies. Usually a DHHS staff member...
attended these meetings to inform the group about statewide initiatives and to keep DHHS apprised of the group’s progress. Meeting topics included provider network strategies, care coordination during member coverage changes, NCQA long-term services and supports recommendations, CFI waiver program proposals, and care management models adopted by other states. The group is currently developing a project to improve care transition outcomes through improved communication with hospitals and with each other.

**Case Studies**

Several cases illustrate the positive impact of Well Sense’s care management initiatives on our members’ health.

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**Successful Case I**

A member was referred to a Well Sense Social Care Manager from Beacon following a hospitalization for mental health conditions. The member presented with paranoia, suicidal and homicidal ideation, extreme disorganization of thoughts, and trust issues. The member did not have established mental health providers, was dealing with a number of social barriers, living in an unsafe environment with family members who also had mental health issues and where domestic violence was common, and had no consistent form of communication. Additionally the member had no state or federal benefits other than Medicaid through the New Hampshire Health Protection Program.

Through Social Care Management outreach, Well Sense coordinated with multiple entities including the local police department, emergency room staff, and Beacon care management for re-admission to a psychiatric hospital to aid in stabilization. The social care manager and Beacon care manager co-managed the member while hospitalized to ensure a safe discharge plan. The discharge plan included supporting the member in leaving his unsafe living situation and going to a local shelter and providing the member with a Well Sense pre-programmed cell phone so he could keep in touch with his care providers, Well Sense and Beacon.

The social care manager reached out to the member with multiple face-to-face visits to assist with transition and stabilization after discharge. This included visiting the member at the shelter he was discharged to, attending his first appointment with his new mental health provider and assisting the member with intake and other paperwork. The care manager also helped the member in applying for public benefits through DHHS and in attaining Supplemental Security Income benefits. Additionally, the care manager provided support to the member by transferring him to a new PCP since his established PCP was retiring. The care manager engaged his existing PCP’s office to recommend a new provider that the member would be comfortable with and worked with the member through the PCP change process to ensure the member and provider were able to start a relationship built on trust.

The goals of this member’s case included co-managed social and behavioral health care coordination, discharge planning, and establishing a behavioral health provider and ongoing treatment. Among the positive outcomes of this case, the member has:

- attained stable housing
- received ongoing behavioral health care
- gained food stamps, cash assistance and Supplemental Security Income
- changed coverage from New Hampshire Health Protection Program to Standard Medicaid
- established a new and ongoing relationship with a care provider

Through these efforts, Well Sense made meaningful changes in a member’s health and well-being.
Successful Case 2

A 59 year old female was identified for the Well Sense Social Care Management Program through the Health Needs Assessment because of concerns that she could not afford housing. Upon assessment of the member, she was found to have decreasing neurological functioning, including memory deficits, gait instability, profound stuttering and reported weakness in her limbs. The member was undergoing an assessment for conversion disorder as the provider treatment team had not been able to locate an underlying reason for her loss of functioning. The member had co-occurring behavioral health conditions of post-traumatic stress disorder, anxiety and depression. The social care manager also learned the member had no consistent source of income. She had been living off a lump sum payment received from a workman’s compensation claim, and was unable to obtain additional cash benefits due to the unspent balance. Other social determinants revealed the member as being chronically under-housed for two years. She was periodically living as a guest with various family and friends and lacked social supports because her primary support was her son, who was busy with school and work and had limited time available to spend with the member.

The social care manager referred the member to Medical Care Management due to her deteriorated health issues and neurological problems. Well Sense worked with Beacon to locate a behavioral health provider. The care manager worked with Service Link to assist the member in applying for the Choices For Independence waiver and also provided assistance to the member in applying for cash and food benefits with the local DHHS office.

The medical care manager initiated referrals to neurology, a new PCP, orthopedics, physical therapy/speech therapy/occupational therapy services as well as neuropsych testing. The care manager also assisted the member in obtaining medical equipment (i.e., walker, leg brace). The medical care manager worked directly with provider offices and supplied guidance and support to the member in navigating physician appointments, and ensured that she received recommended screenings and vaccinations (i.e., mammogram, flu shot). The social care manager, medical care manager and Beacon worked closely to ensure continuity of care for the member at all levels, including joint face-to-face visits by the social and medical care managers, both initially to assess member functioning and for follow up needs to assist with transition and stabilization post discharge(s).

Among the positive outcomes were:

- Neurological problems have stabilized.
- Member became eligible for Choices for Independence waiver services to assist her with activities of daily living, maintaining her home, food preparation and nursing oversight.
- Member obtained Aid to the Permanently and Totally Disabled cash benefits and food stamps.
- Housing is more stable; member is able to pay rent in her current living situation and has applied for public housing assistance.
- Member now has a stable behavioral health team overseeing her behavioral health care.
- Member now has a stable medical team overseeing her medical care.

Again, Well Sense’s care management efforts significantly improved a member’s health and living conditions.
Behavioral Health and Substance Use Disorder Program

Through Beacon, our behavioral health partner, Well Sense manages our members’ behavioral health and substance use disorders. Beacon brings a unique approach to care management services through the Technical Assistant Clinician (TAC) model. In New Hampshire, a large number of members receive their services through community mental health centers (CMHCs). The TAC model provides systemic partnership with the community mental health system to ensure that all Well Sense members with behavioral health needs receive comprehensive and individualized treatment and crisis planning.

Beacon contracted with the CMHCs from July through August 2015 and from February 2016 through the present. During that time, the TACs have worked closely with the CMHCs through twice-a-month case rounding meetings, monthly onsite visits, medical record reviews and formulation of Quality Improvement (QI) plans. Quality improvement plans consist of goals and objectives that address access to care, collaboration with community providers and review of treatment planning processes. Members who are the most vulnerable – homeless, alone, fragile and in need of increased community support – are targeted for care management and a higher degree of collaboration. Step 2 members were transitioned to Well Sense with an intensive degree of collaborative care management through the High Touch Transition process developed by DHHS in collaboration with Well Sense and Beacon.

The established CMHC-TAC connection and High Touch has facilitated multi-faceted communication among Beacon, Well Sense medical care managers, medical and behavioral health providers, and DHHS. This collaboration has helped to identify members with medical issues such as asthma, diabetes and high blood pressure, in combination with mental health issues or substance use disorders, for comprehensive co-management and coordinated, synergistic treatment planning.

Applied Behavioral Analysis Services

During the 2015-2016 State fiscal year, a collaborative model of care developed by DHHS and implemented by Beacon was established to enhance Applied Behavioral Analysis (ABA) services. Through our partnership with DHHS and Beacon, and using ABA trained and experienced Beacon staff, children diagnosed with autism received comprehensive services required to address the symptoms of autism. In addition to the Beacon ABA specialists, the Beacon TACs assisted members and their families with coordination of services, identification of ABA specialty providers and education regarding the ABA service array.

Specialized Care Management

Members who do not receive their behavioral health services from a CMHC and who need care management or care coordination are assigned to the Beacon care manager. The care manager assists members in obtaining community resources, connecting to outpatient providers and finding more specialized care, as needed. Using a person-centered approach, the care manager maintains regular telephone contact with members, at a schedule agreed to by the members. This allows ongoing contact in a non-intrusive manner and facilitates stability. For example, members diagnosed with an eating disorder are referred to the care manager for care management and care coordination. The availability of specialized eating disorder services prompted increased requests for services and additional network enhancements, such as the use of telehealth. Finally, the care manager also is responsible for managing the care of members awaiting inpatient psychiatric placement in an emergency department. Emergency departments are contacted daily to address barriers to placement and examine alternative treatment options.

New Hampshire Hospital

Through our partnership with Beacon, we continue using its New Hampshire Hospital liaison. The liaison has helped reduce 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. Using a combination of member...
interaction and assessments, the liaison advocates for increased levels of CMHC services. In addition, the liaison facilitates member transition back to the community with tools such as transportation to follow-up appointments, and educating the member about the importance of medication adherence and follow-up appointments. As a result of these processes, 30-day hospital readmission rates were reduced from 13.27% in 2014 to 8.05% in 2015. The liaison and TACS also assist with the resolution of pharmacy matters, as needed, to obtain prescribed medication(s) for members.

**Whole-Person Care Management**

Through Beacon, Well Sense employs a whole-person approach to care management, incorporating clinical expertise and guidance from behavioral health, substance use disorder, medical, and psychosocial experts located in Well Sense’s Manchester office. There also is a Beacon clinical Substance Use Disorder (SUD) Coordinator who serves as a care manager and a resource to other care managers on co-management, education, provider access, and referral issues. The clinical team lead for Beacon 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.

**Behavioral Health Network Management**

Well Sense delegates management of behavioral health services to Beacon, which is an NCQA-accredited managed behavioral health organization. Beacon has its own policies and procedures that are approved by us as part of delegation oversight.

To help ensure that timely access to service delivery standards are met, through Beacon we monitor behavioral health and substance use disorder networks. We do not require prior authorization for the first 18 visits for an adult or the first 24 visits for a child at a contracted provider. Beacon’s care management team and the New Hampshire Hospital liaison collaborate so that members receive timely, appropriate and coordinated services when they are discharged. In addition, Beacon works directly with Well Sense care managers to integrate a member’s medical treatment needs with their behavioral health care.

Beacon has a team of TACs dedicated to working with the CMHCs to ensure that they are fully trained and prepared to offer services to our members. Substance use disorder (SUD) training has been incorporated into the training plan. For example, the Beacon SUD coordinator recently conducted training at New Hampshire Hospital on American Society of Addiction Medicine criteria. The TACs also provide information to CMHCs regarding upcoming trainings provided in the community. Beacon TACs work closely with the CMHCs to ensure a smooth transition for members who discharge from higher levels of care to aftercare with CMHCs, and coordination of care between CMHCs providing care to medically complex members and Well Sense care managers. Beacon educates all newly credentialed providers on its provider manual, which supplies information regarding operations and authorization requirements, as well as details on appointment standards and hours of operation. Providers are required to contact Beacon if they are temporarily or permanently unable to meet these standards, and are contractually obligated to provide notification of practice change and appointment access limitations.

Beacon also annually reaches out to 10% of network providers in an effort to ensure adequate access and availability. Discrepancies identified during these calls are addressed with the individual providers. Additionally, the calls serve to identify recruitment opportunities, which help ensure appropriate access and availability for all Well Sense members.

Beacon analyzes and reports on member requests for assistance in accessing providers, emergency department utilization, inpatient utilization, and annual HEDIS & CAHPS measures, all of which are categorized by metropolitan and non-metropolitan counties.
Through Beacon, Well Sense assesses compliance with access requirements by looking at whether providers offer: 1) 24/7 access for medically necessary requests, and 2) hours of operation are no less than hours offered to commercial or Medicaid fee-for-service enrollees. We also require providers to furnish this information during the onboarding process, including information on 24/7 coverage for clinical and psychopharmacological services and detailed information on office hours.

In addition, our ombudspersons and appeals coordinators log grievances and appeals to identify trends. If trends are identified in the access or availability category, the ombudspersons or appeals coordinators work with the appropriate team to address barriers. Beacon sends quarterly reports to the State containing the categories and results of all Well Sense grievances and appeals. Since contract initiation, Beacon has not identified any trending issues with access or availability for Well Sense members.

Pharmacy

Well Sense Health Plan’s pharmacy benefit continues to provide comprehensive coverage for cost-effective medications to members, including generic drug alternatives when clinically appropriate. Additionally, we have incorporated coverage of many new specialty drugs following clinical review of data to assess their efficacy and safety in comparison to other available treatment options. We also make formulary changes, including additions, on an ongoing basis throughout the year to ensure members have access to the most current and relevant treatment options.

Percent of Utilizing Members (children < 18 years of age and adults ≥18 years of age for Well Sense Health Plan: July 1, 2015 – March 31, 2016.

The graph below illustrates the percentage of Well Sense members who actively use the pharmacy benefit, broken out by children and adults. The trend for all ages demonstrates an increase in the members who may benefit from Well Sense coverage for medically necessary medications.

Generic Substitution Rate: July 1, 2015 – March 31, 2016

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. The following graph shows that we continue to increase generic utilization for drugs that have brand-name versions available.
Generic vs. Brand Name Utilization Rate: July 1, 2015 – March 31, 2016

This rate demonstrates the percentage of our prescription claims that are for generic drugs compared to all prescription claims. The graph below illustrates that we have increased our generic utilization rate.

Top Prescribed Drugs by Cost to the Plan: July 1, 2015 – March 31, 2016

For this reporting period, Well Sense’s top 10 drugs by cost are listed below.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Suboxone</td>
</tr>
<tr>
<td>2</td>
<td>Harvoni</td>
</tr>
<tr>
<td>3</td>
<td>Methylphenidate tabs</td>
</tr>
<tr>
<td>4</td>
<td>Vyvanse</td>
</tr>
<tr>
<td>5</td>
<td>Novolog</td>
</tr>
<tr>
<td>6</td>
<td>Aripiprazole tabs</td>
</tr>
<tr>
<td>7</td>
<td>Humira</td>
</tr>
<tr>
<td>8</td>
<td>Sovaldi</td>
</tr>
<tr>
<td>9</td>
<td>Advair</td>
</tr>
<tr>
<td>10</td>
<td>Amphetamine</td>
</tr>
</tbody>
</table>
Prior Authorization Volume: July 1, 2015 – March 31, 2016

Well Sense constantly monitors the volume and quality of our formulary management programs. A key component of our formulary management program includes prior authorization requests. The chart below illustrates the changes in volume of prior authorization requests received by Well Sense for coverage of drugs. There has been a decline in the number of prior authorization requests submitted to Well Sense as a result of the formulary transition that occurred October 1, 2015 when we implemented our formulary.

With the transition from New Hampshire DHHS’ preferred drug list to the Well Sense formulary, there was potential for some members to be impacted where a drug now required authorization. As a result, Well Sense proactively approved authorizations for impacted members to continue on their previously prescribed therapies for six months after the effective date of the transition. This action ensured that any potential disruption in therapies would be minimized during the transition phase.

Specialty Drugs: July 1, 2015 – March 31, 2016

Well Sense has a Specialty Pharmacy Program under which members treated with complex conditions and receiving certain medications are given special attention and management to ensure that their drug treatments are effective and that any side effects are minimized. We work with Envision Pharmacies, formerly known as Orchard, a specialty pharmacy that offers proactive and focused care to members using these drugs.

The chart below details the volume of specialty drugs that are dispensed to Well Sense members each quarter.
Among all of the specialty drugs that are included within the Well Sense Specialty Pharmacy Program, the top five therapeutic categories of treatments for our members are:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Therapeutic Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hepatitis C</td>
</tr>
<tr>
<td>2</td>
<td>Inflammatory Conditions</td>
</tr>
<tr>
<td>3</td>
<td>Growth Hormone</td>
</tr>
<tr>
<td>4</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>5</td>
<td>Hemophilia</td>
</tr>
</tbody>
</table>

The two graphs below detail the number of members using specialty drugs and the total prescription fills per quarter as well as the cost of these drugs.

Adherence is an important factor for members taking these medications. The Specialty Pharmacy Program promotes adherence to ensure members continue to experience effective treatment of their chronic and complex conditions. The following chart demonstrates that adherence rates for the top 5 specialty drug therapies are consistently above the 80% threshold.
As a subject matter expert, the role of our Substance Use Disorder (SUD) Coordinator is two-fold. First, the SUD Coordinator provides care management services for members who have any degree of substance use difficulty. The SUD Coordinator participates with care management to support members with issues related to substance use disorders, access to treatment and referral to resources. Members receive care management through consultation with a behavioral health or medical care manager. The SUD Coordinator engages members identified by the Well Sense Lock-In Program and those with a diagnosis of opioid or alcohol dependence in care management. The SUD Coordinator also collaborates with SUD treatment facilities to oversee treatment delivery and assist in transition of care to the community. This allows members to work toward sobriety since they receive treatment through a continuum of care.

As an integral part of our care model, SUD care management focuses on prevention, detection, education and treatment. The SUD Coordinator works with SUD programs and providers throughout New Hampshire to assure that Well Sense standards of care are met.

The Clinical SUD Coordinator also works with key stakeholder groups, such as the New Hampshire Providers Association and the Bureau of Drug and Alcohol Services. In addition, the SUD Coordinator attends community forums to better understand member needs in their struggles with substance use disorder. Our Beacon New Hampshire Medical Director and SUD specialists work closely with the SUD Coordinator to integrate core SUD principles and concepts into all of our clinical activities.

* Diseases within the Inflammatory Conditions specialty drug therapy category
Section 5: Member Services

General
Well Sense provides services to our members through multiple channels.

Call Center
Our Call Center representatives are available to ensure that members receive the excellent service they deserve. The representatives help our members understand their benefits and answer questions they may have about their coverage and the services we provide. From July 1, 2015 through May 31, 2016, the Well Sense Call Center answered 51,853 calls from members.

Our dedicated Member Service Call Center celebrated its first anniversary July 1, 2016. We currently have a 14 person team composed of a supervisor and 13 Member Service representatives. They are available 8 a.m. – 8 p.m. Monday, Tuesday and Wednesday, and 8 a.m. – 6 p.m. Thursday and Friday.

Community Outreach
Well Sense Health Plan’s Community Outreach team travels throughout the state to establish relationships with many non-profit organizations that can help support our members too. Between July 1, 2015 and June 30, 2016, our Community Outreach representatives attended 161 events in communities across New Hampshire. We also developed and sustained close partnerships with a number of human service agencies, health centers and community-focused groups that are advancing resources for New Hampshire’s low-income population. Examples of these partnerships include:

- Child and Family Services (statewide)
- Families in Transition (Manchester, Concord, Dover)
- Granite United Way & the United Way of the Greater Seacoast
- NH Food Bank (Manchester)
- Families First Health & Support Services (Portsmouth)
- Whole Village Agency Council (Plymouth)
- Strafford County Prevention Board (Dover)
- Community Resource Network (Rockingham County)
- Community Network Team (Keene)

Member Advisory Board
Well Sense Health Plan’s Member Advisory Board encourages participating members to provide feedback on their managed care experience. We use their recommendations to help us identify barriers to care and make quality improvements. To ensure that board members can attend the in-person meetings, we arrange transportation or provide transportation reimbursement. We also offer a call-in option for those members who are unable to attend in person. For the 2015/2016 year, we conducted four meetings, held in August, October, March and May, at our Manchester office. This year we added several new members, including the parent of a disabled adult, and a disabled adult who is able to participate via phone.

The Member Advisory Board also includes representatives from departments across our organization, including:

- Director of Operations (Board Chair)
- Appeals and Grievances
- Claims
- Care Management
- Public Partnerships
- Marketing
- Pharmacy
- Enrollment
- Provider Relations
In addition, Well Sense hosts two regional meetings each year in the community and invites members from those areas to share their experiences and ask questions. This past year we conducted meetings at Ammonoosuc Community Health Center in Littleton and Harbor Homes in Nashua.

**Member Grievances**

Members or their authorized representatives have the right to file a grievance. They can file grievances if they are not satisfied with any aspect of Well Sense operations or the care and services they receive as a member.

Grievances must be filed with our Member Services Call Center in writing, by phone, or in person at our offices. Well Sense reviews and responds to all grievances – in writing – as the member’s condition warrants, but no later than 30 calendar days from the day we receive the grievance unless we ask for an extension. Our Grievance Department investigates all administrative grievances. These can include issues related to dissatisfaction with Well Sense policies, procedures and areas of operations, and the service of staff in provider offices and facilities. The department staff documents the member’s concerns and outreaches to other departments or providers to relay and investigate the member’s dissatisfaction issues. Once we gather all findings, a written response is sent to the member.

Grievances related to quality of care, which involve dissatisfaction regarding health care or health care discussions, are reviewed by nurses and/or medical directors depending on the severity of the grievance.

Grievances are grouped into five categories. We received the following total number of grievances from June 1, 2015 through May 31, 2016:

<table>
<thead>
<tr>
<th>Grievance Type</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>3</td>
</tr>
<tr>
<td>Attitude/Services</td>
<td>43</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>11</td>
</tr>
<tr>
<td>Billing/Financial</td>
<td>3</td>
</tr>
<tr>
<td>Quality of Practitioner Office Site</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
</tr>
</tbody>
</table>

We continue to review grievance data on an ongoing basis to determine potential patterns of causes and identify opportunities for appropriate intervention. It is important to note that the number of behavioral health related grievances continues to be low, and no trends have been identified.

**Cultural Competency**

In an effort to provide culturally competent services, we strive to collect demographic information from each of our members on their race, ethnicity, and preferred spoken and written language. We collect this through the Health Risk Assessment forms that members are required to complete. To date, we have successfully received information for 40% of our members. This data, together with details pertaining to prevalent health conditions, supports our efforts to meet members’ individual needs. It also helps us identify possible disparities and opportunities for improvement based on HEDIS® and utilization measures.

Our Care Management staff also considers demographic information when contacting members to better assist those members with coordinating and navigating the health care system. When conducting an initial member assessment for care management, Care Management staff asks members to identify whether any cultural and/or religious beliefs should inform their care plans. When care management concludes, staff checks with members to ensure that their needs were met.
For language assistance we continue to use Language Line, which offers interpreters in over 170 languages, as well as Lutheran Social Services, which offers in-person interpreter services that providers can access for members who have language interpreter needs. We also develop member educational and marketing materials in additional languages and distribute them to appropriate community agencies throughout the state.

We ensure that our providers are aware of cultural competency requirements. Our newly contracted providers receive a welcome kit and attend a provider orientation, which includes an overview of cultural competency. Our online Provider Manual also outlines cultural competency requirements. During the past year our Provider Relations team conducted 397 face-to-face visits to our provider community.

The member services functions we have in place allow us to answer our members’ questions and address their concerns. Through these channels we can help ensure that our members are satisfied with the services that we and our network of health care providers deliver.

**Section 6: Utilization Management and Appeals**

**General/Utilization Management**

Well Sense conducts utilization management (UM) to evaluate medical necessity, appropriateness and efficiency of health care services in order to ensure that members have access to the right care in the right setting at the right time. At Well Sense, this starts by bringing together the member and his or her primary care provider (PCP) to create a high quality plan of care, which may include referrals to specialists, hospital inpatient care, home health services, equipment, or prescription medications.

We administer UM by reviewing requests for services to ensure they are medically necessary for the health care needs of the member. This process is known as authorization. Most services do not require authorization from Well Sense, but some do, as described below.

Well Sense received 50,344 requests for authorization between July 1, 2015 and May 31, 2016. We approved 46,727 (93%) of these requests and denied 3,617 (7%). The majority of requests we received were for outpatient services. We approved 92% of the outpatient requests and 96% of the inpatient requests.
During spring 2016, more than 5,000 new members joined Well Sense. Many of these new members require complex care or ongoing services in the outpatient or home setting to support their independence in the community. In anticipation of these members joining Well Sense, we updated certain medical policies related to their unique needs and streamlined our authorization review processes. Our UM staff participated in joint “High Touch” conference calls between DHHS and our Care Management Department, reviewing case studies of the most fragile members to anticipate authorization requirements related to their service needs. We also used DHHS-supplied information regarding existing authorizations and claims history to proactively identify members requiring authorization for continuation of pre-existing services from the time of enrollment. These authorizations remained in place for up to 60 days during which time we worked with providers to help anticipate the clinical documentation requirements that would apply to future authorization requests. In many cases we negotiated directly with providers to implement interim processes for clinical data submissions that resulted in rapid medical necessity review and subsequent UM decision. We educated our providers about our medical necessity criteria and authorization processes by telephone, email, and at in-person meetings.
As noted above, certain services described in the Member Handbook require prior authorization before the service is provided. These include, but are not limited to, specific elective procedures, elective inpatient admissions, services provided in the home setting, and those services rendered by a provider that is not in our network. Providers contact Well Sense directly to obtain authorizations. The PCP or requesting provider assists in the review process by providing key information about why the service is medically necessary, based on the member’s medical history and health needs. Prior authorization is never required for emergency care, urgent care performed outside our service area, or for family planning services.

In addition to our focus on assuring that our members’ medically necessary care needs are met, we regularly evaluate our UM processes and procedures. In late-2016 we removed the authorization requirement for short-term observation in an outpatient facility. Since these services were commonly provided in the post-emergency department stabilization period or following certain outpatient procedures, eliminating the authorization requirement reduced providers administrative burdens without negatively impacting care.

Well Sense approves the vast majority of authorization requests for care and services. If a request for coverage is denied, members can appeal the decision.

**Member Appeals**

Members or their authorized representatives may file an appeal with us when a request for a service, supply or medication is denied. The information on the appeals process appears in the denial letter that is mailed to the member and his or her provider, and can also be found in the Member Handbook, and on our website. Providers who wish to appeal on a member’s behalf can find the appeals process in our online Provider Manual. Well Sense strives to ensure that the appeals process is fair, thorough and consistent for all our members.
In the past year:

- The highest percentage of member appeals we received was for pharmacy related services (72%).
- The highest percentage of dismissed appeals also was pharmacy related (34%).
- The number of behavioral health related appeals continues to be small; we have not identified any patterns.

We dismiss some appeals for administrative reasons. This is the case specifically when a provider files an appeal on behalf of a member but we are unable to obtain required permission from the member authorizing the provider to act as the member’s authorized representative during the appeals process. In these instances we must dismiss the appeal. The Appeals Department attempts to contact members either by telephone and written correspondence, but is not always successful. We also may approve a request and dismiss an appeal if the provider immediately sends additional information to the Appeals Department showing the member meets the clinical coverage criteria. Members and providers have 30 calendar days from the date of the initial denial letter to file a standard member appeal. The appeal is dismissed, barring good cause, if we receive it after that timeframe.

Information for prior authorization review

We regularly remind providers of the importance of submitting all required clinical information for a prior authorization review. This helps reduce the administrative burden on provider office staff having to coordinate and file an appeal on behalf of a member. Our clinical coverage criteria are available on our website, wellsense.org, so providers can identify the clinical information necessary for the initial submission to Well Sense. Our Provider Services Department also is available to assist providers with questions on prior authorization and member appeals submissions.

Successful utilization management requires collaboration among the health plan, the providers and the members. At Well Sense we strive to ensure that effective communication leads to a utilization management program where the members’ health care needs are the primary focus.

Section 7: Provider Relations & Services

Well Sense Health Plan’s dedicated, Manchester-based Provider Relations team is the primary liaison to our statewide provider network. Provider Relations consultants ensure that we maintain effective channels of communication by educating providers at orientations and regular office visits, assisting them to more efficiently navigate our systems, sharing our policies and procedures and listening to their concerns and recommendations. In addition, Well Sense sends and posts to our website all Network Notifications that describe changes in policies or processes.

We strive to create a positive provider experience and limit providers’ administrative burdens. To help with this goal, the Provider Relations team promotes the importance of online support tools, including our website and how it supports their daily operations. For example, providers are able to electronically verify member eligibility through the New Hampshire MMIS Portal, our own secure website portal, or HIPAA standard 270/271 transactions. To make the user experience easier, Provider Relations reviews and revises online provider materials for ease of navigation.
The Well Sense provider experience involves a multi-faceted communications approach that includes:

- Local and regional onsite provider forums that furnish comprehensive information and education on Well Sense operations, including administrative updates, programs, policies and procedures
- Provider Relations consultants who regularly visit provider offices
- Welcome kits that include welcome letters, quick reference guides and all materials necessary to conduct business with us
- New-provider orientations
- Quarterly provider e-newsletter
- Office staff meetings and trainings as required or requested by the provider
- Provider Advisory Council that meets four times per year
- Electronic notifications on all Well Sense updates and programs
- Comprehensive website that houses Well Sense policies and reports, which are available via a secure provider portal

We continue to expand the diversity of the Provider Advisory Committee. Historically, committee members have been almost exclusively physicians, but in the last few months we have added three new Home and Community-Based providers to the committee. The insight gained and shared from committee members adds tremendous value in assisting us to understand the whole continuum of care for our members.

Timely access and use of care

A comprehensive network of primary care providers, specialists, and behavioral health providers furnishes care and services to our members. Our ongoing contracting efforts allow us to enhance our provider network. In addition, we comply with standards for member access and availability of services. The few exceptions that have been granted are for specialties in remote areas of the state.

Our Quality Improvement Committee reviews network data, including access survey results. Network Management evaluates the data and collaborates with providers on areas where opportunities for improvement are identified. On an ongoing basis, Network Management reviews the following:

- Practitioner self-reported data that is collected during onsite visits by Provider Relations consultants availability
- Telephone survey data based on a random sample of provider offices
- Grievances and appeals submitted by members related to access and availability
- Electronic notifications on all Well Sense updates and programs

Well Sense also conducted two Lead Time Surveys during the reporting period to help monitor provider access. The surveys involved outreach to primary, specialty and home health care providers to assess wait times for a first-available appointment. We measured providers against the following standards:

<table>
<thead>
<tr>
<th>Appointment Time</th>
<th>Primary Care</th>
<th>Specialty Care</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>48 hours</td>
<td>48 hours</td>
<td>n/a</td>
</tr>
<tr>
<td>Non-urgent symptomatic</td>
<td>10 calendar days</td>
<td>10 calendar days</td>
<td>n/a</td>
</tr>
<tr>
<td>Non-symptomatic (preventative care)</td>
<td>30 days</td>
<td>30 days</td>
<td>n/a</td>
</tr>
<tr>
<td>Transitional Healthcare</td>
<td>7 calendar days of a member discharge from in-patient or institutional care</td>
<td>7 calendar days of a member discharge from in-patient or institutional care</td>
<td>2 calendar days of a member discharge from in-patient or institutional care</td>
</tr>
</tbody>
</table>
We executed our first Lead Time Survey of approximately 2,100 providers in November 2015. For specialists, we completed evaluations among the top five high volume providers in neurology, cardiology, otolaryngology, orthopedics, ophthalmology, and obstetrics/gynecology. Additionally, we evaluated age-specific appointments (adult vs. pediatric).

Primary care and specialty care offices were in full compliance with wait time standards across all appointment types evaluated. Home health care agencies also were found to be in full compliance with the standards – being able to schedule a visit with a member within two days of the member being discharged from an inpatient facility. We believe that the education and support we offered to providers throughout the year has been a key factor in the rise of compliance with the standards.

The second Lead Time Survey was conducted by an external vendor and concluded on May 31, 2016. The summary results of this survey were provided in Well Sense Health Plan's response to Network.01 submitted in August 2016.

**Behavioral Health Services**

Our service model includes the delegation of managing behavioral health services to our partner, Beacon Health Strategies (Beacon). Under this agreement, Beacon approves policies and procedures.

Through Beacon, Well Sense monitors the behavioral health and substance use disorder networks to ensure that they meet the following minimum timely access standards:

<table>
<thead>
<tr>
<th>Appointment Time</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Life Threatening Emergency</td>
<td>6 hours</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>48 hours</td>
</tr>
<tr>
<td>Routine Appointment</td>
<td>10 days</td>
</tr>
</tbody>
</table>

When contracted providers see members, we do not require a prior authorization for the first 18 visits for an adult or 24 visits for a child. Beacon’s Care Management team and the liaison to New Hampshire Hospital collaborate to ensure members receive timely, appropriate and coordinated services upon discharge. Beacon also works directly with Well Sense Care Management staff to integrate a member's behavioral health care with his or her medical and social needs.

Beacon's Provider Manual contains information about operations, authorizations, appointment standards and hours of operation. That is why Beacon educates all newly credentialed providers about the manual's importance. Providers must contact Beacon if they are temporarily or permanently unable to meet the standards described in the manual, and are contractually obligated to notify Beacon of any practice changes and appointment access limitations.

Beacon analyzes and reports on member requests for assistance in accessing providers, emergency department utilization, inpatient utilization, and annual HEDIS and CAHPS measures. The information is segmented by metropolitan and non-metropolitan counties.

There are processes in place to review access compliance based on providers offering 24/7 access for medically necessary requests and the hours of operation being no less than hours offered to commercial or Medicaid fee for service enrollees. As part of the provider onboarding process, Beacon collects information on 24/7 coverage for clinical and psychopharmacological services, and detailed information on office hours.

As part of the administrative process, Beacon logs all grievances and appeals to identify trends. If Beacon identifies trends in the access or availability category, its 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.

**Provider Call Center**

The Well Sense Provider Services Call Center responds to inquiries from providers, both in-network and out-of-network. Issues can include member benefits, and eligibility and claims payment status. Our Member/Provider Service representatives are cross trained in the New Hampshire Call Center to be able to assist both providers and members. From July 1, 2015 through May 31, 2016, the Well Sense Call Center received 41,339 calls from providers.

By providing the necessary services and support to our medical and behavioral health providers, we can ensure that they deliver the best care to our members.

**Section 8: Fraud, Waste and Abuse**

Well Sense Health Plan’s Compliance and Privacy Officer oversees our program integrity initiatives, including those relating to fraud, waste and abuse (FWA). Provider and member FWA Operations are delegated to the Vice President of Provider Audit and Special Investigations. The Manager of the Special Investigations Unit (SIU) coordinates day-to-day operations of the unit, as well as serving as the New Hampshire Fraud and Abuse Coordinator. The SIU staff includes several investigators, a data analyst and an administrative assistant. With credentials ranging from Juris Doctorate to certified fraud examiner/investigator and certified coder, the staff remains abreast of the latest FWA issues and trends through regular continuing education. The Well Sense SIU collaborates with the Department of Health and Human Services Program Integrity Unit (DHHS PIU), Special Investigations Unit (DHHS SIU), and the State’s Medicaid Fraud Control Unit to address suspected FWA and to identify new trends and outliers.

**Preventing and Detecting Fraud, Waste and Abuse during Fiscal Year 2016**

We make every effort to prevent FWA by educating providers, members and employees through a number of different methods. These include:

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

In addition, we have implemented a number of approaches 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
- Managing pharmacy system controls such as the Controlled Substance Management Program
- Applying medical claim controls, including pre-payment application of NCCI and OCE edits
- External sources

• Conducting random samplings of members to verify that services billed were provided, and returning calls of members who contact us questioning these services

• Leveraging data warehouse claims querying tools

• 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

Investigating Fraud, Waste and Abuse during Fiscal Year 2016

Well Sense receives provider or member-related FWA referrals from various sources, including our clinical vendors. These referrals, along with outliers and trends identified through data mining, are triaged by SIU staff. The SIU conducts a preliminary evaluation and either submits an MCO Request to Open Investigation or an MCO Fraud Referral to the DHHS PIU or DHHS SIU, refers the issue to Well Sense Provider Audit or other department, or closes it. A comprehensive review follows DHHS’ approval of a Request to Open Investigation. If we suspect FWA during an investigation, we suspend further action and submit an MCO Fraud Referral to the DHHS PIU or DHHS SIU. Upon their approval, the Well Sense SIU will remediate identified errors.

Summary of Results during Fiscal Year 2016

In FY16, Well Sense received 252 referrals related to member eligibility; 43 members were referred to the DHHS SIU for eligibility determinations. Including cases carried over from FY15, a total of 49 cases were referred to the State during FY16.

Our SIU received and evaluated 67 referrals related to suspected FWA in FY16. We are currently evaluating five, while 37 were closed. These were either triaged to another functional area, the appropriate information was provided to the requesting agency, or they were found not to be FWA related. We opened SIU cases for 25 of the FY16 referrals. Including cases carried over from FY15, we managed an active suspected FWA caseload of 47 cases during FY16.

Well Sense closed 23 cases, 15 of which resulted in identified overpayments. Of the 24 cases that remain open, seven involve identified overpayments. The total value of claims reviewed for these open cases was $1,149,688.39, with recoverable overpayments of $79,180.78 based on settlement agreements/agreed-upon audit findings. As of June 30, 2016, we collected $58,620.67, $7,500 of which was collected in the prior fiscal year related to a settlement agreement spanning multiple fiscal years.

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

The results above demonstrate that Well Sense has a robust SIU that is actively engaged in fighting health care fraud and committed to serving the New Hampshire Care Management Program.