State of New Hampshire
Department of Health and Human Services

State Fiscal Year 2025 Priority Populations Quality Study

August 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgements and Conflict of Interest Statement

The preparation of this report was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

Health Services Advisory Group, Inc. (HSAG) confirms that no one conducting the State Fiscal Year 2025 Priority Populations Quality Study activities had a conflict of interest with **AmeriHealth Caritas New Hampshire**, **New Hampshire Healthy Families**, or **WellSense Health Plan**.

1. Executive Summary

The New Hampshire Department of Health and Human Services (DHHS) asked Health Services Advisory Group, Inc. (HSAG), New Hampshire's external quality review organization, to conduct a quality study to better understand the priority population care management program. The study reviewed the number of members enrolled in the program, the process of enrollment (telephonic and/or in-person), the process used to discharge members, and the reasons members refused to participate in a care management program. HSAG reviewed the CAREMGT.49 Report for quarter four (Q4) 2024 and Q1 2025.

HSAG collected information for the study by sending questionnaires to the three Medicaid managed care organizations (MCOs) in New Hampshire: **AmeriHealth Caritas New Hampshire** (**ACNH**), **New Hampshire Healthy Families** (**NHHF**), and **WellSense Health Plan** (**WS**).

Methodology

To begin the study, HSAG reviewed the volume of members in a priority population and the process by which members are enrolled in care management. In addition, HSAG prepared a list of questions for the MCOs to answer regarding the process(es) the MCOs use to enroll and discharge members, and the reason(s) members declined to participate in a care management program. HSAG used an 11-step process to conduct the Priority Populations Quality Study that included the technical methods of information collection and analysis as shown in Appendix A. HSAG conducted the study from April through August 2025, and the process included a questionnaire and a follow-up virtual meeting whereby HSAG clarified the MCOs' responses with an additional questionnaire and/or virtual meetings to develop a summary of understanding. HSAG assigned this task to employees familiar with the New Hampshire Medicaid Care Management (MCM) Program who have worked on various external quality review (EQR) projects in the State. Appendix B includes the names and qualifications of the HSAG staff members assigned to the Service Authorization Quality Study.

Findings

HSAG investigated the information submitted in the CAREMGT.49 Report, noting the historical volume of members identified with needs and enrolled in care management. In October 2024, the beginning of state fiscal year (SFY) 2025, DHHS modified the contract (Contract 3.0) in which it required the MCOs to provide care management services to members who meet the criteria to be included in a DHHS-identified priority population. Contract 3.0 also requires the MCOs to oversee their participating primary care providers (PCPs) who provide care coordination to members who do not meet the criteria of a priority population. Therefore, MCO-delivered care management services focus on the priority populations identified by DHHS. Beginning in Q4 2024 through Q1 2025, **ACNH** and **WS** reported a decrease in the total number of members enrolled in care management; however, the members identified and engaged in the DHHS-defined priority populations increased. **NHHF** reported an increase

in the number of members enrolled in care management, but not for those who are part of the priority populations. Table 1-1 summarizes the MCOs' overall enrollment, the percentage of those enrolled in care management, and the percentage of those enrolled who are in a priority population.

Table 1-1—DHHS CAREMGT.49 Report Summary

	ACNH		NHHF		WS	
	Q4 2024	Q1 2025	Q4 2024	Q1 2025	Q4 2024	Q1 2025
Total Membership Enrolled in MCO	48,104	49,063	67,047	66,644	69,501	69,110
Total # of Members Enrolled in Care Management	1,665	1,416	843	881	2,262	1,796
Percentage of Total # of Members Enrolled in Care Management	3.46%	2.89%	1.26%	1.32%	3.25%	2.60%
Total # of Members in a Priority Population	318	492	203	170	366	548
Percentage of Priority Population Members Enrolled in Care Management	19.1%	34.7%	24.1%	19.3%	16.2%	30.5%

During the period of Q4 2024 and Q1 2025, the MCOs reported the total number of members enrolled in care management. During that period **NHHF** reported enrolling 843 (Q4 2024) and 881 (Q1 2025) members compared to **ACNH** and **WS**, who reported approximately double the number of members enrolled. **ACNH** and **WS** reported 1,665/2,262 (Q4 2024) and 1,416/1,796 (Q1 2025) members enrolled, respectively. During the same period, **ACNH** and **WS** reported a decrease, 3.46 percent to 2.89 percent (0.57 percentage points) and 3.25 percent to 2.6 percent (0.65 percentage points), respectively, in the percentage of total members enrolled in care management. **NHHF** reported a small increase during the same period in total members enrolled (0.06 percentage points) but also reported a decrease of 24.1 percent to 19.3 percent (4.8 percentage points) in members enrolled in care management who are attributed to a priority population. In addition, **ACNH** and **WS** reported an increase in the percentage of members enrolled in care management who were in a priority population; **ACNH** reported 19.1 percent in Q4 2024 and 34.7 percent in Q1 2025, an increase of 15.6 percentage points, and **WS** reported 16.2 percent in Q4 2024 and 30.5 percent in Q1 2025, an increase of 14.3 percentage points. **NHHF** reported a decrease from Q4 2024 (24.1 percent) to 19.3 percent in Q1 2025, a decrease of 4.8 percentage points.

The CAREMGT.49 Report also required the MCOs to submit detailed information regarding the number of adult and child members in a priority population eligible for care management. For the purposes of this report and ease of understanding, the priority populations are indicated as follows throughout the remainder of the report:

- Individuals who have required an inpatient admission for a behavioral health diagnosis within the previous 12 months—**Inpatient BH**

- All infants, children, and youth who are involved in the State's protective services and juvenile justice system, Division for Children, Youth and Families (DCYF), including those in foster care, and/or those who have elected voluntary supportive services—**DCYF**
- Infants diagnosed with low birth weight (LBW)—**LBW**
- Infants diagnosed with neonatal abstinence syndrome (NAS)—**NAS**
- Individuals with behavioral health needs (e.g., substance use disorder, mental health) who are incarcerated in the State's prisons and are eligible for participation in the Department's Community Reentry demonstration waiver, pending the Centers for Medicare & Medicaid Services' (CMS') approval—**Community Reentry**
- MCO-identified members who may benefit from the plan's care management services at the plan's option in accordance with the clinical care needs of the member—**Clinical Care Needs**

Table 1-2 outlines the number of MCO members per priority population identified for care management and enrolled in care management.

Table 1-2—CAREMGT.49 Report—Number of Members Enrolled by Priority Population

Priority Population Category	Adults						Children					
	ACNH		NHHF		WS		ACNH		NHHF		WS	
	Q4	Q1	Q4	Q1	Q4	Q1	Q4	Q1	Q4	Q1	Q4	Q1
	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025	2024	2025
Inpatient BH	132	169	35	42	102	122	17	34	32	26	11	21
DCYF	3	14	7	5	9	18	118	255	111	74	225	346
LBW	—	—	—	—	—	—	29	12	15	15	15	11
NAS	—	—	—	—	—	—	19	3	3	5	4	25
Community Reentry	0	5	0	3	0	7	—	—	—	—	—	—
Clinical Care Needs	1,155	804	488	478	1,399	965	192	120	152	233	497	283
Total Enrolled Members	1,290	992	530	528	1,510	1,112	375	424	313	353	752	686
Total Identified Members in a Priority Population	2,534	2,636	2,760	3,334	34,238	34,192	770	1,100	2,468	1,896	35,263	34,918

— Indicates that the adult or child population does not qualify for the priority population

Overall, each MCO reported enrolling more members in Q1 2025 than in Q4 2024. Exceptions include **NHHF**, which reported lower enrollment from Q4 2024 to Q1 2025 of child inpatient BH members, adult and child DCYF members, and adult members with clinical care needs. **ACNH** and **WS** reported decreased enrollment from Q4 2024 to Q1 2025 for adult and child members with clinical care needs. Additionally, **NHHF** reported enrolling less than half the number of adult inpatient BH members than **ACNH** and **WS**.

After reviewing the information concerning the CAREMGT.49 Report, HSAG investigated how each MCO enrolled members in care management, discharged members from care management, and collected information regarding the refusal of care management services. The process to obtain information from the MCOs included a questionnaire and individual meetings with each MCO, with the goal of defining the specifications used to compile the information submitted in the CAREMGT.49 Report. Appendix C includes the questionnaire sent to the MCOs and their responses. Appendix D contains the information from the virtual meetings and the MCOs' responses.

HSAG categorized the questionnaire into topics to mirror the CAREMGT.49 Report, which included the enrollment process, the discharge process, and the refusal process. Clarifications and discussions regarding the responses occurred within the virtual meetings. After compiling the information, HSAG identified consistencies and inconsistencies in the processes for enrollment and discharge within the information that the MCOs used to submit for the CAREMGT.49 Report. The MCOs indicated the following:

- Each MCO completed outreach to a member eligible for care management in a priority population, including multiple modalities and workflows to address the unique needs of the member. While telephonic outreach is the primary modality, an in-person process was available and used when appropriate.
- Each MCO categorized the status of a member's engagement in unique workflows for its organization. All three MCOs assessed the members; developed and assessed progress toward goals and needs; and discharged the members after 12 months of support, per contract, unless the member required ongoing support. Table 1-3 summarizes the unique categories identified.

Table 1-3—MCO System Categories for Member Status

Status in CAREMGT.49 Report	ACNH System Category	NHHF System Category	WS System Category
Identified for Priority Population (pre-enrollment)	Referral	Pending	Referral
Enrolled in Care Management	Monitoring, Inpatient, Active	Active, Monitoring	Open
Discharged From Care Management	Discharged	Closed—Successful	Closed—Graduated
Refused Care Management	Refused	Closed—Member Declines Services	Closed—Refused

- **NHHF** and **WS** agreed that if a member is unable to be reached despite multiple attempts, the case is closed after a period of at least three months. **ACNH** reported continuing outreach until the member is reached or declines services.
- Each MCO developed an organizational process to ensure that the members in a priority population could be identified and prioritized for outreach. **ACNH** reported a risk stratification system, **NHHF** developed workflow teams to complete outreach, and **WS** instituted team "pods" to address the unique needs of the population.
- When assessing for discharge, each MCO worked with the member to address his or her unique needs. If appropriate, the date of discharge was extended to continue support; however, at a minimum, each member in a priority population received a full 12 months of follow-up and confirmation that no new needs arose.
- The MCOs varied in the process to address the inability to reach a member after opening an episode. **ACNH** continued to outreach members monthly for a calendar year. **NHHF** kept the member in a monitoring status. **WS** discharged or closed the episode after three consecutive months of inactivity.

HSAG also investigated the MCOs' volume of refusals, processes, and reasons for refusal, if any. Table 1-4 summarizes the volume and percentage of members who refused care management, based on the number of members identified in a priority population.

Table 1-4—Summary of Members Who Refused Care Management

Members Refusing Care Management	ACNH		NHHF		WS	
	Q4 2024	Q1 2025	Q4 2024	Q1 2025	Q4 2024	Q1 2025
Total # of Adult Members Refusing	184	74	367	615	166	208
% of Adult Members Refusing	7.26%	2.81%	13.30%	18.45%	0.48%	0.61%
Total # of Child Members Refusing	31	25	117	167	72	93
% of Child Members Refusing	4.03%	2.27%	4.74%	8.81%	0.20%	0.27%

Each MCO reported the number of members who refused care management services. Calculating the percentage, based on the number of members identified in a priority population, **NHHF** noted the highest rate of refusal at 13.30 percent (Q4 2024) and 18.45 percent (Q1 2025) for adult members and 4.74 percent (Q4 2024) and 8.81 percent (Q1 2025) for child members.

- **ACNH** indicated that, generally, the reasons members refused care management included that the members did not have time or did not feel comfortable discussing their healthcare needs. The care manager, when documenting, could choose from a pre-populated list; however, **ACNH** did not track the information over time.
- **NHHF** reported that, generally, members felt they already had a lot of support, did not have time, or that it would not be beneficial to enroll in care management. The MCO collected the information during documentation; however, **NHHF** did not track the information over time.
- **WS** stated that, generally, members reported the ability to self-manage their care or already have a care manager assigned; therefore, **WS** did not track the reason for refusal.

Conclusions, Limitations, and Recommendations

Conclusions

HSAG identified the following findings for the priority populations quality study:

- The percentage of enrollment varied across the different priority populations for each MCO. Overall, the MCOs reported a low percentage of enrollment in each DHHS-defined priority population, excluding clinical care, at less than 50 percent, with few exceptions. **ACNH** noted greater than 50 percent enrollment for infants diagnosed with NAS and the community reentry members. **NHHF** also reported high enrollment with the community reentry population in Q1 2025 at 60 percent, and **WS** reported high enrollment in the community reentry members with 87.5 percent in Q1 2025.
- All three MCOs complete outreach to initially enroll the member using a variety of communication methods unique to the member, including in-person outreach, when necessary. In addition, the MCOs prioritize the needs of the member by specializing the team approach and workflow to ensure the appropriate members are prioritized.
- The MCOs take into consideration the needs of the member when concluding care management. If the member's goals have been met, all three MCOs monitor and support the member for a full 12 months, per contract. However, if the member's needs are not addressed or additional circumstances become a priority, the care management of the member continues.
- The MCOs do not track the reasons for member refusals of care management services. However, **ACNH** reported that it is able to document a reason for refusal if a member provides one.
- **ACNH** and **NHHF** kept a member who was enrolled then subsequently unable to reach in a monitoring status (i.e., continued outreach) for at least 12 months from the date of enrollment. If a member was enrolled then unable to reach, **WS** discharged the member after three consecutive months of unsuccessful attempts to reach the member. Therefore, **WS** could be discharging members prior to a full 12 months of enrollment in care management, per contract requirement for priority populations.
- Each MCO has a different time limitation regarding initial outreach to the member once identified. **ACNH** completes the first and second outreach within five business days, with a follow-up the next week. **NHHF** completes outreach within 30 days, continuing with multiple outreaches until the 30 days lapse. **WS** completes three phone attempts and a mailing outreach within 10 days.

Limitations

HSAG could not draw conclusions from the CAREMGT.40 (Members Enrolled in Care Management at Any Time During the Month) Report when in comparison to the CAREMGT.49 (MCO-Delivered Care Management Enrollment) Report. Information reported on the CAREMGT.40 Report concluded at the beginning of the 3.0 Contract, September 1, 2024. The goal of the study was to understand the volume of members in a priority population after the initiation of the 3.0 Contract; therefore, the comparison could not be made.

Recommendations

HSAG has the following recommendations for the MCOs:

- **ACNH** and **WS** should continue to outreach members who are identified as part of a priority population through at least 30 days from the identification of a priority population member to increase enrollment in the priority populations.
- The MCOs should continue to explore options to use community resources, community events, community organizations/health workers, or other community-level care coordinators to help locate members for outreach and care management enrollment of priority population members.
- The MCOs should continue to identify and prioritize the use of additional multi-modal methods of communication to outreach members, other than telephonic outreach, to increase the likelihood of successful contact.
- The MCOs should monitor and track the reasons members refuse care management services.
- The MCOs should constantly assess the number of staff devoted to care management needs to ensure that the MCOs have adequate staff with the credentials needed to support effective and efficient care management of members in priority populations.
- The MCOs could review their care management systems and continuously enhance their protocols and algorithms to evaluate and accommodate the needs of new populations (i.e., priority populations) served or additional services provided by the MCOs, including member incentives and/or rewards.
- The MCOs could implement processes to obtain member feedback regarding care management services, particularly the MCOs' methods of communication.

HSAG has the following recommendations for DHHS:

- DHHS should explicitly indicate in its contract when/if an MCO can discharge a member from a priority population after enrollment, but before the required 12 months of engagement, due to an inability to reach the member.
- DHHS could define potential categories of reasons members refuse care management and require the MCOs to report this information in the CAREMGT.49 Report. Future studies could include an assessment of the reasons members refuse care management services to determine if additional opportunities to improve enrollment and engagement exist.
- DHHS could further study the engagement of members in their care management and assessment of progress against the member's goals. Members who are consistently engaged in their care generally have better outcomes and a better understanding of their health status.

2. Overview and Methodology

Introduction

Since December 1, 2013, DHHS has operated the MCM Program, which is a statewide comprehensive risk-based capitated managed care program. Beneficiaries enrolled in the MCM Program receive services through one of three MCOs: **ACNH**, **NHHF**, or **WS**. All three MCOs coordinate and manage their members' care through dedicated staff and a network of qualified providers.

During SFY 2019–SFY 2024, the MCM Contract (Contract 2.0) required the MCOs to provide care coordination and care management services to all members. Beginning in SFY 2025, DHHS implemented a change to the MCM Contract (Contract 3.0) to require the MCOs to provide care management services to members who meet the criteria to be included in a DHHS-identified priority population. Contract 3.0 also requires the MCOs to oversee their participating PCPs, who provide care coordination to members who do not meet the criteria of a priority population. Therefore, MCO-delivered care management services focus on the DHHS-identified priority populations.

MCOs submit the quarterly CAREMGT.49 Report detailing the number of enrolled and discharged members from a care management program within a priority population. The report includes the following priority populations:

- Individuals who have required an inpatient admission for an inpatient BH diagnosis within the previous 12 months.
- All infants, children, and youth who are involved in the State's protective services and juvenile justice system, and the DCYF, including those in foster care and/or those who have elected voluntary supportive services.
- Infants diagnosed with LBW.
- Infants diagnosed with NAS.
- Individuals with behavioral health needs (e.g., substance use disorder, mental health) who are incarcerated in the State's prisons and eligible for participation in the Department's Community Reentry demonstration waiver pending CMS approval.
- MCO-identified members who may benefit from the MCO's care management services at the plan's option per the clinical care needs of the member.

DHHS met with HSAG to initiate a quality study to better understand the number of members in a priority population who are enrolled in a care management program. In addition, the study reviewed the process of enrollment (telephonic and/or in-person), the process used to discharge members, and the reasons members refused to participate in a care management program. HSAG reviewed the CAREMGT.49 Report for Q4 2024 and Q1 2025.

Goal of the Study

The goal of the study was to understand the volume of members in a priority population and the process by which members were enrolled in care management. In addition, the study incorporated a review of those members who declined participation in a care management program, noting the volume of refusals over time. HSAG used the quarterly New Hampshire CAREMGT.49 Report submitted by each MCO. HSAG also used the monthly quality measures reported to CAREMGT.39 (Members Enrolled in Care Management as of the Last Day of the Month) and CAREMGT.40 for reference.

HSAG followed the guidelines set forth in the CMS EQR *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity,* February 2023,[1] to create the process, tools, and interview questions used for the quality study. The review period covered SFY 2025. The goals of the study included the following:

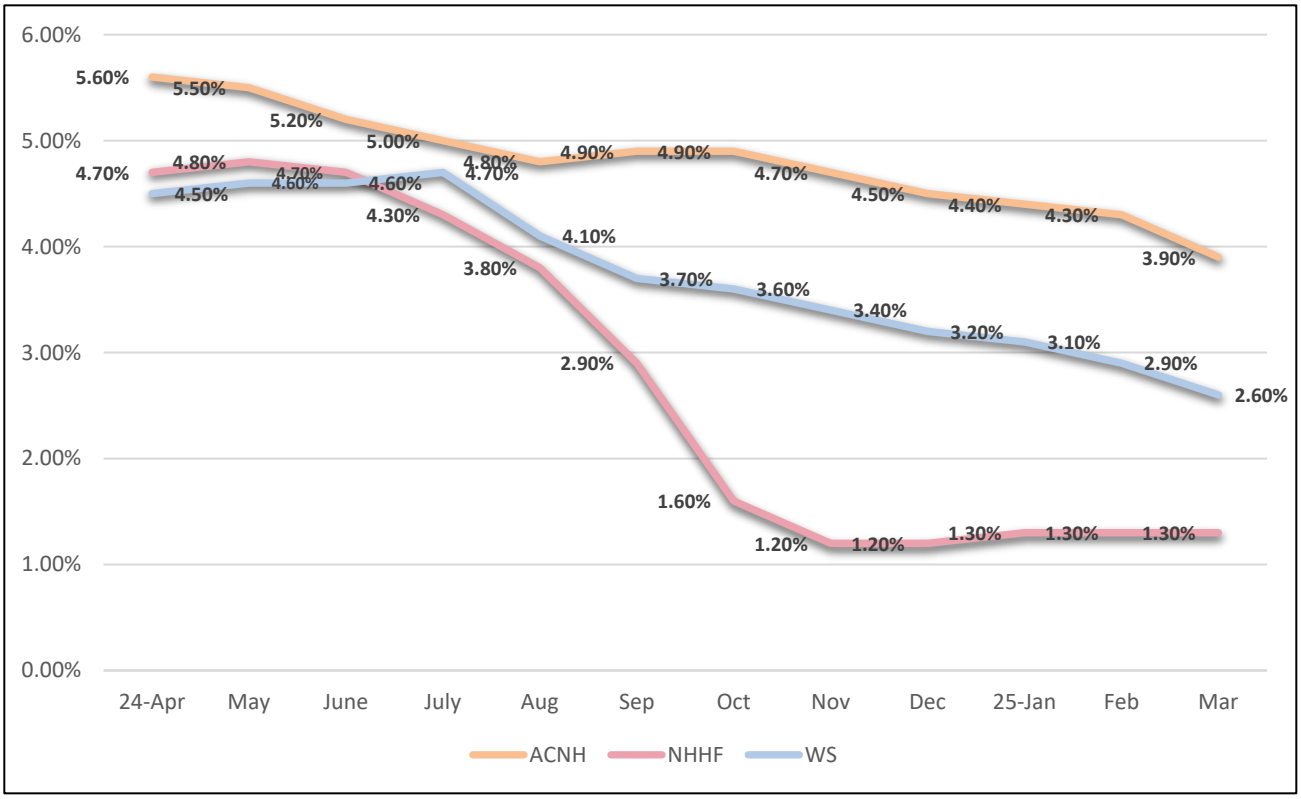
- Determine the process(es) each MCO used to enroll members
- Determine the process(es) each MCO used to discharge members
- Determine the reason(s) members declined to participate in a care management program
- Compare and contrast the care management program enrollment information (CAREMGT.39 and CAREMGT.40) prior to the implementation of the CAREMGT.49 Report

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 1, 2025.

Summary of Priority Populations Quality Study

The study began with a meeting attended by DHHS and HSAG. The purpose of the meeting was to discuss information submitted by the MCOs in the quarterly CAREMGT.49 Reports. During that meeting, HSAG learned that the MCOs report care management encounter data, including the number of adult and/or child members enrolled in a care management program, the number of members attributed to a priority population, the median number of days enrolled, the number of members discharged from care management, and the number of members who refused care management services. The MCOs also report the method of outreach (telephonic versus in-person). In order to better understand the impact of the change DHHS made to the MCM Contract (Contract 3.0), requiring the MCOs to prioritize care management services for members who met the criteria to be included in a DHHS-identified priority population, HSAG began with a review of the CAREMGT.39 Report. Figure 3-1 displays the CAREMGT.39 Report, which reports the percentage of the MCO's members who are enrolled in the care management program over a rolling 12-month period.

Figure 3-1—Percentage of MCO Members Enrolled in Care Management (CAREMGT.39)



Each month, each MCO reported the number of members identified as appropriate for care management services (denominator) and the number of members enrolled in care management (numerator). The

report did not require the MCOs to distinguish whether the member was an adult or a child, or for which priority population the member qualified. At the point of implementation of Contract 3.0, **ACNH** noted a decrease in overall care management enrollment from 4.9 percent in September 2024 to 3.9 percent in March 2025 (1.0 percentage point). **NHHF** noted a decrease from 2.9 percent to 1.3 percent (1.6 percentage points), and **WS** reported a decrease from 3.7 percent to 2.6 percent (1.1 percentage points) during the same period.

In comparison, the quarterly CAREMGT.49 Report required the MCOs to indicate the number of members enrolled in the MCO, the number of members (adult and child) identified as part of a priority population, the number of adult and/or child members enrolled in care management, and of those enrolled, the number of adult and child members who are enrolled in each priority population. Table 3-1 outlines the number of MCO members identified for and enrolled in care management. All MCOs reported a decrease in enrollment from Q4 2024 to Q1 2025 for members with clinical care needs except **NHHF**'s child members, for which there was an increase.

Table 3-1—CAREMGT.49 Report—Number of Members Enrolled by Priority Population

Priority Population Category	Adults						Children					
	ACNH		NHHF		WS		ACNH		NHHF		WS	
	Q4 2024	Q1 2025	Q4 2024	Q1 2025	Q4 2024	Q1 2025	Q4 2024	Q1 2025	Q4 2024	Q1 2025	Q4 2024	Q1 2025
Inpatient BH	132	169	35	42	102	122	17	34	32	26	11	21
DCYF	3	14	7	5	9	18	118	255	111	74	225	346
LBW	—	—	—	—	—	—	29	12	15	15	15	11
NAS	—	—	—	—	—	—	19	3	3	5	4	25
Community Reentry	0	5	0	3	0	7	—	—	—	—	—	—
Clinical Care Needs	1,155	804	488	478	1,399	965	192	120	152	233	497	283
Total Enrolled Members	1,290	992	530	528	1,510	1,112	375	424	313	353	752	686
Total Identified Members in a Priority Population	2,534	2,636	2,760	3,334	34,238	34,192	770	1,100	2,468	1,896	35,263	34,918

— Indicates that the adult or child population does not qualify for the priority population

ACNH reported approximately 300 fewer adult members and 70 fewer child members from Q4 2024 to Q1 2025 enrolled with clinical care needs. **WS** reported approximately 400 fewer adult members and 200 fewer child members from Q4 2024 to Q1 2025 with clinical care needs. **NHHF** reported 10 fewer adults and approximately 80 more children in this population from Q4 2024 to Q1 2025. Conversely, with a few exceptions, each MCO reported enrolling more DHHS-defined priority population members in Q1 2025 versus Q4 2024. For example, **ACNH** and **WS** reported an increase in enrollment of the DCYF adult and child members. **NHHF** reported lower enrollment from Q4 2024 to Q1 2025 for child inpatient BH members, adult and child DCYF members, and adult members with clinical care needs. **NHHF** also reported enrolling less than half the number of adult inpatient BH members than **ANCH** and **WS**.

In addition to the summary of members enrolled in care management, the CAREMGT.49 Report also included a breakdown of the enrolled members compared to the total number of members identified in a priority population. Table 3-2 demonstrates the number of members enrolled in a care management program by priority population and the percentage of enrollment based on the total number of eligible members in the priority population.

Table 3-2—CAREMGT.49 Report by Priority Population

	ACNH		NHHF		WS	
Priority Population Category	**Q4 2024**	**Q1 2025**	**Q4 2024**	**Q1 2025**	**Q4 2024**	**Q1 2025**
Inpatient BH						
Total # of Adult Members Enrolled in Care Management	16.50%	22.75%	7.99%	8.14%	17.09%	13.19%
	132/800	169/743	35/438	42/516	102/597	122/925
Total # of Child Members Enrolled in Care Management	18.89%	45.33%	16.08%	13.76%	8.40%	10.82%
	17/90	34/75	32/199	26/189	11/131	21/194
DCYF						
Total # of Adult Members Enrolled in Care Management	21.43%	10.29%	3.38%	2.59%	9.89%	9.94%
	3/14	14/136	7/207	5/193	9/91	18/181
Total # of Child Members Enrolled in Care Management	45.38%	33.07%	6.85%	7.65%	12.21%	14.99%
	118/260	255/771	111/1,621	74/967	225/1,843	346/2,308
LBW						
Total # of Adult Members Enrolled in Care Management	—	—	—	—	—	—
Total # of Child Members Enrolled in Care Management	25.00%	36.36%	19.48%	27.27%	37.50%	35.71%
	29/116	12/33	15/77	15/55	15/40	25/70
NAS						
Total # of Adult Members Enrolled in Care Management	—	—	—	—	—	—

	ACNH		NHHF		WS	
Priority Population Category	**Q4 2024**	**Q1 2025**	**Q4 2024**	**Q1 2025**	**Q4 2024**	**Q1 2025**
Total # of Child Members Enrolled in Care Management	51.35%	50.00%	16.67%	29.41%	26.67%	29.03%
	19/37	3/6	3/18	5/17	4/15	9/31
Community Reentry						
Total # of Adult Members Enrolled in Care Management	NA	55.56%	NA	60.00%	NA	87.50%
	0/0	5/9	0/0	3/5	0/0	7/8
Total # of Child Members Enrolled in Care Management	—	—	—	—	—	—
Clinical Care Needs						
Total # of Adult Members Enrolled in Care Management	67.15%	46.00%	23.07%	18.24%	4.17%	2.92%
	1,155/1,720	804/1,748	488/2,115	478/2,620	1,399/33,550	965/33,078
Total # of Child Members Enrolled in Care Management	71.91%	55.81%	27.49%	34.93%	1.50%	0.88%
	192/267	120/215	152/553	233/667	497/33,243	283/32,315

— Indicates that the adult or child population does not qualify for the priority population

NA indicates no data reported this quarter to calculate a percentage

Table 3-3 demonstrates a wide variation in the percentage of members enrolled in care management. **ACNH** enrolled over 67 percent of adult and child members in the clinical care needs priority population in Q4 2024. However, in Q1 2025, that percentage decreased to 46 percent. In addition, **ACNH** also reported high enrollment for child NAS members (51.35 percent in Q4 2024 and 50 percent in Q1 2025) and adult and child inpatient BH members (22.75 percent and 45.33 percent, respectively, in Q1 2025). **NHHF** reported consistent enrollment across all priority populations. The highest percentage of enrollment fell within the clinical care needs priority population, with enrollment rates for adults and children ranging from 18.24 percent to 34.93 percent; however, **NHHF** also engaged 60 percent of the adult community reentry members in Q4 2024, but it should be noted that there were only five members identified for this priority population. **WS** also reported high enrollment in the community reentry population in Q1 2025, with 87.5 percent of adult members enrolled in care management; however, there were only eight members identified in this population for **WS**. In addition, **WS** reported 37.5 percent in Q4 2024 and 35.71 percent in Q1 2025 of NAS child members enrolled in care management. **WS** also reported a decrease in the percentage of adult and child members within the clinical care needs priority population (4.17 percent in Q4 2024 to 2.92 percent in Q1 2025, and 1.5 percent in Q4 2024 to 0.88 percent in Q1 2025, respectively).

HSAG also analyzed the number of members refusing care management services. In the CAREMGT.49 Report, the MCOs reported the number of adult and child members within each priority population who refused care management. Table 3-3 summarizes the number of adult and child members within each priority population who refused care management and the related percentage of the identified priority population members who refused care management.

Table 3-3—Number of Members Refusing Care Management

Priority Population Category	ACNH		NHHF		WS	
	Q4 2024	Q1 2025	Q4 2024	Q1 2025	Q4 2024	Q1 2025
Inpatient BH						
Total # of Adult Members	21	4	28	52	28	34
Adult Percentage of Refusal	2.63%	0.54%	6.39%	10.08%	4.69%	3.68%
Total # of Child Members	2	0	21	14	21	20
Child Percentage of Refusal	2.22%	0.00%	10.55%	7.41%	16.03%	10.31%
DCYF						
Total # of Adult Members	0	0	4	3	3	0
Adult Percentage of Refusal	0.00%	0.00%	1.93%	1.55%	3.30%	0.00%
Total # of Child Members	1	1	20	14	28	36
Child Percentage of Refusal	0.38%	0.13%	1.23%	1.45%	1.52%	1.56%
LBW						
Total # of Adult Members	—	—	—	—	—	—
Adult Percentage of Refusal	—	—	—	—	—	—
Total # of Child Members	1	0	1	0	2	4
Child Percentage of Refusal	0.86%	0.00%	1.30%	0.00%	5.00%	5.71%
NAS						
Total # of Adult Members	—	—	—	—	—	—
Adult Percentage of Refusal	—	—	—	—	—	—
Total # of Child Members	1	0	0	1	1	1
Child Percentage of Refusal	2.70%	0.00%	0.00%	5.88%	6.67%	3.23%
Community Reentry						
Total # of Adult Members	0	0	0	0	0	0
Adult Percentage of Refusal	NA	0	NA	0	NA	0
Total # of Child Members	—	—	—	—	—	—
Child Percentage of Refusal	—	—	—	—	—	—
Clinical Care Needs						
Total # of Adult Members	163	70	335	560	135	174
Adult Percentage of Refusal	9.48%	4.00%	15.84%	21.37%	0.40%	0.53%
Total # of Child Members	26	24	75	138	20	32
Child Percentage of Refusal	9.74%	11.16%	13.56%	20.69%	0.06%	0.10%

— Indicates that the adult or child population does not qualify for the priority population
NA indicates no data reported this quarter to calculate a percentage

All three MCOs reported a higher refusal rate for inpatient BH and clinical care needs members than the other priority populations. The MCOs also reported low refusal rates for the category of community reentry, NAS, and LBW.

HSAG also reviewed the CAREMGT.40 Report, a monthly report that measured members enrolled in care management and the percentage of members enrolled in care management at any point during the month. However, this report was discontinued at the end of Q3 2024 as the CAREMGT.49 Report began. HSAG could not draw conclusions or comparisons to the CAREMGT.49 Report as the data were not comparable to the data included in the CAREMGT.49 Report.

Summary of MCO Questionnaire Responses

On April 25, 2025, HSAG sent a questionnaire to the MCOs to obtain information concerning the processes to enroll, discharge, and define reasons for refusal of care management. Each MCO response, with full detail, is located in Appendix C.

Questions Regarding the Care Management Enrollment Process

How many times does the MCO attempt to outreach a member for enrollment in a care management program?

- All MCOs made at least three attempts to contact the member; however, **NHHF** reported no limit.
- During the virtual meeting follow-up, HSAG clarified the lack of time limit reported by **NHHF**, and **NHHF** reported that after multiple attempts and exhausting all modes of communication (e.g., alternative numbers, in-person visits, etc.), outreach was concluded.
- During the virtual meeting follow-up, HSAG also clarified the definition for high-risk members for **WS**, and **WS** reported that high-risk members are those members identified in the clinical care priority population on the CAREMGT.49 Report. Priority population and high-risk (i.e., clinical care needs) members may receive more persistent and multi-modal outreach.

What is the duration of time for attempting to reach the member?

- **ACNH** reported starting the telephonic outreach within five business days and making a final telephonic attempt within a week. **NHHF** completed outreach within 30 days, and **WS** completed three telephonic attempts within 10 days.

What categories, other than open, refused, and discharged, does the MCO use to distinguish the status of a member identified in a priority population? For example, does the MCO use pending, active, transition of care, inactive, closed, declined, etc.? If so, please provide the criteria for each phase of a care management program.

- The MCOs' enrollment categories of an open care management episode varied for a member identified in a priority population. In addition to the categories of open, discharged, and refused, **ACNH** also used monitoring and inpatient for episodes of inpatient/hospitalized members. **NHHF** used pending, active, monitoring, and closed (discharged). **WS** used the categories of referral, open, and closed (discharged).
- During the virtual meeting follow-up, HSAG requested that each MCO review its process for categorizing the status of a case from identification to closure. Each MCO clarified its categories of care management classification. HSAG summarized the responses in Table 3-4:

Table 3-4—Care Management Information System Status Categories by MCO

Status in CAREMGT.49	ACNH System Category	NHHF System Category	WS System Category
Identified for Priority Population (pre-enrollment)	Outreach	Pending	Referral
Enrolled in Care Management	Monitoring, IP, Active	Active, Monitoring	Open
Discharged From Care Management	Discharged	Closed—Successful	Closed—Graduated
Refused Care Management	Refused	Closed—Member Declines Services	Closed—Refused

If the member cannot be reached, does the MCO consider the encounter closed or refused?

- **ACNH** reported maintaining the member in a "supportive" state and completing outreach attempts monthly. **NHHF** and **WS** closed the encounter, documenting "unable to reach."
- During the virtual meeting follow-up, **ACNH** clarified that the members remain in a supportive (i.e., monitoring) category until they can be reached.

What methods is the MCO using to attempt to reach out to the member for enrollment in the care management program? Which method is the primary method?

- All three MCOs used telephonic outreach as the primary method for enrolling a member.

Does your MCO attempt to outreach members in person for enrollment in a care management program?

- **ACNH** and **NHHF** reported using the telephone as the method for outreach unless a member required other accommodations. **WS** noted care managers met members face-to-face for medical assessments within the hospital and community reentry members. **WS** would also use an alternative outreach method if a member required accommodations.

How does the MCO determine (criteria) if the member will receive telephonic or in-person outreach for enrollment?

- All MCOs prioritized telephonic outreach as the primary method for outreach; however, a face-to-face meeting with a member could be deployed, as needed. **NHHF** highlighted a location service program, whereby community health workers could attempt outreach at the last known physical location or within the local community, to offer care management services.

Does the MCO prioritize an order of outreach for the different priority populations?

- Each MCO used a unique process to prioritize outreach to the priority populations. **ACNH** prioritized its workflow by priority population and high-risk stratification. **NHHF** assigned care management team members to specific priority populations to whom they would outreach, and **WS** provided a different frequency/intensity of outreach for the community reentry and DCYF populations.
- During the virtual meeting and follow-up, **ACNH** reported that priority populations are flagged and prioritized for outreach in addition to those identified as high-risk (using a proprietary stratification system). **WS** reported that its care management teams organize into "pods" to provide focused outreach to the priority population(s) to which they are assigned. Each priority population has a workflow that addresses the unique needs of the priority population (i.e., DCYF, NAS, LBW, etc.).

If the member is discharged and re-enrolled within the defined period, are they counted twice in report?

- All MCOs agreed that the established criteria defined how to count members if identified within multiple populations.

If the member meets the criteria for multiple populations, is the member counted in each population?

- All three MCOs reported following the established criteria for measuring and reporting the number of members in each priority population.

Questions Regarding the Care Management Discharge Process

How does the MCO determine that the member is ready for discharge from a care management program?

- All MCOs agreed that if a member completed his or her goals or asked to be discharged, the MCO would discharge the member from the care management program.
- During the virtual meeting, **ACNH** clarified that if the member completed his or her goals, **ACNH** maintained the episode, checking to ensure new needs had not been identified for at least 12 months. **NHHF** also maintained the episode and updated the 12-month completion date to reflect updated circumstances, such as a new admission or need. **WS** also extended the closure date of the episode if the needs of the member required continued support unless the member requested to stop contact.

How frequently are the members evaluated for discharge?

- All three MCOs continued to support the member in a priority population for a full 12 months, following enrollment. **ACNH** and **NHHF** evaluated members for discharge (i.e., successful goal completion) at every contact, and **WS** evaluated the member at least quarterly.

Once enrolled, does the MCO discharge the member after "x" number of unsuccessful contacts?

- If a member did not respond to outreach (i.e., no response to telephone calls or other inquiries), each MCO varied in its approach to discharging the member. **ACNH** maintained the member in a supportive status with monthly outreach for 12 months, and **NHHF** did not close the episode until one year from the completed assessment (i.e., enrollment). **WS** discharged the member after three consecutive months of being unable to reach the member (unless communication continues with a community support, such as DCYF).

Questions Regarding the Care Management Refusal Process

What are the reasons a member declines a care management program?

- All three MCOs varied in their process to collect information regarding the reason a member refused to enroll in care management. For example, **ACNH** noted reasons such as not interested, nothing wrong, do not have the time, does not feel comfortable discussing healthcare need, and/or may have services already in place. **NHHF** also reported categories such as unable to reach the member, feeling they already have a lot of support, do not have time for monthly contacts, do not feel it would be beneficial for them, members don't trust health care systems, etc. **WS** reported members feel they do not need care management support or feel they can manage their own health, they already have a care manager at the community mental health center (CMHC), and/or feel overwhelmed with the amount of phone calls already received from multiple agencies.

Does the MCO track the reason a member declines a care management program?

- **ACNH** tracked reasons for refusing care management if the member provided a reason. **NHHF** did not track the reason a member refused care management services. **WS** tracked if a member declined care management services but did not document an exact reason for refusal.
- During the virtual meeting follow-up, **ACNH** acknowledged documenting from a list of reasons a member may decline. **NHHF** did not capture the reasons, nor track a list once the member declined. **WS** also did not track the reason a member declines care management.

If the member previously declined a care management program, but has been recently identified in a different priority population, does the MCO reach out to the member?

- **ACNH** completed outreach to all members in the priority population unless the member requested no contact. **NHHF** reported that there was a minimum of 30 days between outreach attempts, except for members discharging from an inpatient admission. **WS** noted completing outreach attempts after

three months of a documented refusal or status change. In addition, if a member declined care management upon outreach, each MCO would outreach the member again, if later identified in a different priority population. **NHHF** noted that they assured a minimum of 30 days between different priority population outreaches, and **WS** waited three months.

- During the virtual meeting and email follow-up, **NHHF** clarified that a waiting period of 30 days could be changed if the clinical staff judgment or provider request indicated the member required outreach sooner. **ACNH** noted follow-up, including multiple multi-modal attempts, occurred over a 30-day time period.

4. Conclusions, Limitations, and Recommendations

DHHS asked HSAG to conduct a quality study to understand the volume of members in a priority population and the process by which members were enrolled in care management, as submitted in the quarterly New Hampshire CAREMGT.49 Report. In addition, HSAG determined the process(es) each MCO used to enroll members, discharge members, and decline care management participation, and completed an analysis of the reported information in comparison to the CAREMGT.39 Report.

Conclusions

HSAG identified the following findings for the priority populations quality study:

- The percentage of enrollment varied across the different priority populations for each MCO. Overall, the MCOs reported a low percentage of enrollment in each DHHS-defined priority population, excluding clinical care, at less than 50 percent, with few exceptions. **ACNH** noted greater than 50 percent enrollment for infants diagnosed with NAS and the community reentry members. **NHHF** also reported high enrollment with the community reentry population in Q1 2025 at 60 percent, and **WS** reported high enrollment in the community reentry members with 87.5 percent in Q1 2025.
- All three MCOs complete outreach to initially enroll the member using a variety of communication methods unique to the member, including in-person outreach, when necessary. In addition, the MCOs prioritize the needs of the member by specializing the team approach and workflow to ensure the appropriate members are prioritized.
- The MCOs take into consideration the needs of the member when concluding care management. If the member's goals have been met, all three MCOs monitor and support the member for a full 12 months, per contract. However, if the member's needs are not addressed or additional circumstances become a priority, the care of the member continues.
- The MCOs do not track the reasons for member refusals of care management services. However, **ACNH** reported that it is able to document a reason for refusal if a member provides one.
- **ACNH** and **NHHF** kept a member who was enrolled, then subsequently unable to be reached, in a monitoring status (i.e., continued outreach) for at least 12 months from the date of enrollment. If a member was enrolled and then unable to be reached, **WS** discharged the member after three consecutive months of unsuccessful attempts to reach the member. Therefore, **WS** could be discharging members prior to a full 12 months of enrollment in care management, per contract requirement for priority populations.
- Each MCO has a different time limitation regarding initial outreach to the member once identified. **ACNH** completes the first and second outreach within five business days, with a follow-up the next week. **NHHF** completes outreach within 30 days, continuing with multiple outreaches until the 30 days lapse. **WS** completes three phone attempts and a mailing outreach within 10 days.

Limitations

- HSAG could not draw conclusions from the CAREMGT.40 Report when in comparison to the CAREMGT.49 Report. Information reported on the CAREMGT.40 Report concluded at the beginning of the 3.0 Contract, September 1, 2024. The goal of the study was to understand the volume of members in a priority population after the initiation of the 3.0 Contract; therefore, the comparison could not be made.

Recommendations

HSAG has the following recommendations for the MCOs:

- **ACNH** and **WS** should continue to outreach members who are identified as part of a priority population through at least 30 days from the identification of a priority population member to increase enrollment in the priority populations.
- The MCOs should continue to explore options to use community resources, community events, community organizations/health workers, or other community-level care coordinators to help locate members for outreach and care management enrollment of priority population members.
- The MCOs should continue to identify and prioritize the use of additional multi-modal methods of communication to outreach members, other than telephonic outreach, to increase the likelihood of successful contact.
- The MCOs should monitor and track the reasons members refuse care management services.
- The MCOs should constantly assess the number of staff devoted to care management needs to ensure that the MCOs have adequate staff with the credentials needed to support effective and efficient care management of members in priority populations.
- The MCOs could review their care management systems and continuously enhance their protocols and algorithms to evaluate and accommodate the needs of new populations (i.e., priority populations) served or additional services provided by the MCOs, including member incentives and/or rewards.
- The MCOs could implement processes to obtain member feedback regarding care management services, particularly the MCOs' methods of communication.

HSAG has the following recommendations for DHHS:

- DHHS should explicitly indicate in its contract when/if an MCO can discharge a member from a priority population after enrollment, but before the required 12 months of engagement, due to an inability to reach the member.
- DHHS could define potential categories of reasons members refuse care management and require the MCOs to report this information in the CAREMGT.49 Report. Future studies could include an assessment of the reasons members refuse care management services to determine if additional opportunities to improve enrollment and engagement exist.

- DHHS could further study the engagement of members in their care management and assessment of progress against the member's goals. Members who are consistently engaged in their care generally have better outcomes and a better understanding of their health status.

Appendix A. Technical Methods of Collection of Information and Analysis

HSAG used an 11-step process to conduct the MCO Priority Populations Quality Study, which uses the technical methods of information collection and analysis as defined in Table A-1.

Table A-1—Process to Conduct the Priority Populations Quality Study

Step 1:	**Meet with DHHS**
	HSAG will meet with DHHS to define the study parameters.
Step 2:	**Send a questionnaire to the MCOs**
	HSAG will work with DHHS to develop a questionnaire for the MCOs to respond to the study parameters and goals.
Step 3:	**Receive and review questionnaire responses from the MCOs**
	Once the MCOs return the questionnaire, HSAG will review the document to ensure that the MCO sufficiently answered all the questions on the form.
Step 4:	**Compile the MCO's responses**
	HSAG will evaluate the responses and determine if the MCOs submitted answers adequately to address the volume of members in a priority population and the process by which members are enrolled and discharged from a care management program.
Step 5:	**Meet with DHHS to review responses from the questionnaire**
	HSAG will meet with DHHS to review the information submitted by the MCOs on the questionnaire and determine if additional clarification will be needed concerning the responses.
Step 6:	**Determine if a second questionnaire or meeting is needed**
	If additional information is needed from the MCOs, HSAG and DHHS will determine if the MCOs should send written responses or if a meeting with the MCOs to obtain the necessary information for the study is sufficient.
Step 7:	**Continue gathering information until complete information is obtained from the MCOs**
	HSAG will continue to work with DHHS and the MCOs until complete information is obtained from the MCOs concerning the volume of members in a priority population and the process by which members are enrolled and discharged from a care management program.
Step 8:	**Compile information received from the MCOs concerning the volume of members in a priority population and the process by which members are enrolled and discharged from a care management program**
	HSAG will compile and collate the information received from the MCOs.
Step 9:	**Prepare a final document with all responses from the MCOs**
	After receiving the final responses from the MCOs, HSAG will prepare a document showing all responses received from the MCOs. The summary will clarify the volume of members in a priority population and the process by which members are enrolled and discharged from a care management program.

Step 10:	Write the report
	HSAG will prepare a report providing details of the information obtained during the study. The report will include an evaluation of the study goals.
Step 11:	**Receive DHHS approval of the draft report**
	HSAG will send a draft report to DHHS for approval. After approval of the information contained in the draft report, HSAG will send a finalized version of the report to DHHS.

Appendix B. Quality Study Review Team

HSAG assembled a Quality Study Review Team based on the full complement of skills required for the Priority Populations Quality Study activity. Table B-1 lists the Quality Study Review Team members, their roles, and relevant skills and expertise.

Table B-1—Quality Study Review Team

Name/Role	Skills and Expertise
Sara Landes, MHA, CPHQ *Director, State & Corporate Services*	Ms. Landes has over 13 years of experience as a project leader in healthcare quality improvement, and she is proficient in federal, National Committee for Quality Assurance (NCQA), and other regulatory compliance guidelines as well as in data analysis, evaluation, and research/resolution capabilities. Ms. Landes joined HSAG in 2021.
Christina Cebriak, RN, MSN-CCM *Project Manager II*	Ms. Cebriak has over 30 years of healthcare industry experience, including clinical nursing, regulatory compliance, performance improvement, care management, and utilization review. Ms. Cebriak has a Master of Science in Nursing degree with an emphasis in organizational leadership and is currently certified in care management. Ms. Cebriak joined HSAG in early 2024.

Appendix C. MCO Questionnaire and Responses

HSAG sent a questionnaire to the MCOs to gather information about how the MCOs enroll and discharge members in care management and their processes for documenting refusals of care management services. Table C-1 through Table C-3 include the MCOs' responses to the questionnaire.

Table C-1—Questions Regarding the Care Management Enrollment Process

How many times does the MCO attempt to outreach a member for enrollment in a care management program?	
ACNH	**ACNH** will make three attempts to contact the member to enroll in care management. After the three attempts are made, we send an Unable to Contact (UTC) letter by mail.
NHHF	There is no limit, unless a member specifically opts out of Care Management outreach.
WS	**WS** attempts at minimum to make three telephonic outreach calls and send one Unable to Reach letter for enrollment into Care Management Programs. High-risk and priority population members may receive more persistent and multi-modal outreach (e.g., up to 6+ attempts).
HSAG's Comparison of Answers	All three MCOs attempt outreach to the member at least three times. **NHHF** did not have a limit of outreach.
What is the duration of time for attempting to reach the member?	
ACNH	**ACNH** makes the first and second outreach call within five business days of notification or referral. The third call is made the following week, and the UTC letter is sent by mail if the third call is unsuccessful.
NHHF	All attempts are made within 30 days of identification.
WS	The first three phone attempts and mailing outreach are completed within the first 10 days of referral. High Risk or Priority Population members may receive additional outreach attempts spread out over the following weeks.
HSAG's Comparison of Answers	Each MCO completed outreach within different time frames. **ACNH** attempted outreach within approximately two weeks, **NHHF** attempted outreach within 30 days, and **WS** attempted outreach within 10 days.

What categories, other than open, refused, and discharged, does the MCO use to distinguish the status of a member identified in a priority population? For example, does the MCO use pending, active, transition of care, inactive, closed, declined, etc.? If so, please provide the criteria for each phase of a care management program.	
ACNH	ACNH uses the listed categories along with monitoring and inpatient (IP) and closed. The monitoring cases are those that remain in care management and are outreached either monthly or quarterly to ensure needs are met and IP is for those episodes that are inpatient members. Cases that are closed can be reopened and outreached if they have not refused contact from the health plan.
NHHF	Pending–Member is identified and outreach to complete assessments and enroll in care management is being done. Active–Member agrees to care management, completed assessment, and has active care plan with goals actively being worked on by care management and member. Monitoring–Member agrees to care management, completed assessment, and has monitoring care plan to outreach monthly to check in for any new needs. Closed–Member was not able to reach, completed all goals successfully, unable to reach after enrollment, deceased, ineligible with health plan, member declines care management services after enrollment.
WS	WS utilizes three categories to identify member status in a priority population care management program. 1. Referral–Once member is identified. 2. Open–Once member has verbally consented to enroll in care management. 3. Closed–When the status is "closed" additional details for closure outcomes and reasons are: Declines Intervention, Loss of Coverage, Lost Contact, Graduated, Patient Expired, Unable to Reach, or Triaged Out.
HSAG's Comparison of Answers	Each MCO provided categories unique to its organization. Additional clarification is needed.
If the member cannot be reached, does the MCO consider the encounter closed or refused?	
ACNH	If the member is part of the priority population, we continue to outreach to that member monthly and keep the episode in a supportive state. Bright Start cases are also held and outreached either quarterly or monthly depending on acuity. All other episodes are closed.
NHHF	The encounter is considered closed as unable to reach.
WS	If the member cannot be reached the encounter is Closed. "Unable to reach" is documented as outcome reason.
HSAG's Comparison of Answers	Each MCO provided information unique to its organization. Additional clarification is needed.

What methods is the MCO using to attempt to reach out to the member for enrollment in the care management program? Which method is the primary method?	
ACNH	**ACNH** uses telephonic outreach as its primary means of outreach; however, we utilize texting, email, regular mail, face-to-face meeting and virtual visits as alternative methods as needed.
NHHF	Telephonic is the primary method utilized. **NHHF** also can complete visits for enrollment virtually through Zoom or Teams meetings, in person, through email, through USPS mail or via text message (available 5/20/25).
WS	Telephonic, Mailings, Emails for DCYF & Community Reentry, in-person face-to-face. Telephonic is primary.
HSAG's Comparison of Answers	All three MCOs use telephonic outreach as their primary means of outreach.
Does your MCO attempt to outreach members in person for enrollment in a care management program?	
ACNH	**ACNH** does not do in-person enrollment unless needed for a reason or accommodation.
NHHF	Yes
WS	Yes, **WS** Care Managers will meet members face-to-face for medical within the hospital and for community reentry members in person upon release. MCH & DCYF priority population care managers will also meet members in person per request or if there is an identified barrier for telephonic engagement.
HSAG's Comparison of Answers	All three MCOs utilize in-person enrollment, as needed.
How does the MCO determine (criteria) if the member will receive telephonic or in-person outreach for enrollment?	
ACNH	**ACNH** uses telephonic outreach unless member requests face-to-face visit or due to an accommodation.
NHHF	All members are initially attempted to be contacted telephonically. A member is asked once reached telephonically if they would prefer to have the visit/complete assessment in person. If they answer "yes", then an in-person meeting is arranged. If a member is part of the priority population and does not respond to telephonic outreach, **NHHF** initiates location services, where our community health workers go to the member's last known address/address on file to engage the member in person and offer Care Management Services.
WS	Telephonic at first, if barrier, or request by member/team in-person face-to-face can be scheduled.
HSAG's Comparison of Answers	All three MCOs utilize telephonic outreach as the primary method; however, face-to-face or in-person outreach is possible when requested by the member. In addition, **NHHF** may utilize a member's last known physical address if the member does not respond to telephonic outreach.

Does the MCO prioritize an order of outreach for the different priority populations?	
ACNH	Outreach is prioritized by priority populations per contract and risk stratification. **ACNH** uses Predictive Intervention and Care Management Success to identify and to break the members into priority populations with high, medium, and low risk scores. All members in the priority populations are outreached, we use the risk score to determine order outreaching high risk first, medium risk next, and then low risk.
NHHF	Each category of Priority Population Members has specific teams that complete outreach and are focused on their one population.
WS	**WS** does prioritize outreach differently based on the designated priority populations. Individuals designated to the Community Reentry demonstration program are prioritized for a scheduled meeting between the member (inmate), community reentry Care Manager and the **WS** Care Manager within one business day of notification of a community reentry member coming onto the plan. For outreach to members in the DCYF identified priority population, Care Management attempts to reach out to the member's guardians/case head, DCYF district office registered nurses (RNs) and Certified Peer Support Workers/Juvenile Parole and Probation Officers (CPSWs/JPPOs), primary care providers (PCPs), and foster parents in an attempt to enroll members. Care Managers will exceed the traditional three outreach attempts and instead make six outreach attempts in order to accommodate outreaching providers and DCYF.
HSAG's Comparison of Answers	Each MCO completes outreach to the priority populations; however, the method is unique to each MCO. **ACNH** uses risk stratification, **NHHF** outreaches by population, and **WS** increases the minimum time frame or increases the number of outreaches, based on the population complexity.
If a member is discharged and re-enrolled within the defined period, are they counted twice in the report?	
ACNH	We count only unique member ID, and those are only counted once in a defined period.
NHHF	Yes, for CAREMGT.49, but only newly enrolled column and discharged column. It does not impact the rate of total members enrolled on the last day of the measurement period.
WS	**WS** does not count members in multiple populations, criteria has been established for hierarchy in determination of which priority population a member will be counted toward.
HSAG's Comparison of Answers	**ACNH** reported counting members once within a defined period. **NHHF** confirmed the information is reported within the appropriate field once during the defined period, and **WS** confirmed following the required hierarchy, counting each member only once in the defined period.

<table>
<tr><th colspan="2">If the member meets the criteria for multiple populations, is the member counted in each population?</th></tr>
<tr><td>ACNH</td><td>This question is not applicable for CAREMGT.39. The CAREMGT.39 measure does not contain priority population breakouts. For CAREMGT.49, we follow the Priority Population Hierarchy provided on the report template. If a member meets the criteria for more than one population, then they will only be counted once, as outlined in the Priority Population Hierarchy.</td></tr>
<tr><td>NHHF</td><td>Not for CAREMGT.49 and CAREMGT.39 reports. However, they are counted on the other Priority Population Care Management reports multiple times as instructed in the specifications (e.g., CAREMGT.51, CAREMGT.52, CAREMGT.53, etc.)</td></tr>
<tr><td>WS</td><td>WS does not count members in multiple populations, criteria has been established for hierarchy in determination of which priority population a member will be counted toward.

The member will be counted only once in the first priority category they meet based on the hierarchy below.
<table>
<tr><th colspan="2">Adults 18 + Years of Age</th></tr>
<tr><td>1</td><td>Individuals who have required an inpatient admission for a behavioral health diagnosis within the previous twelve (12) months.</td></tr>
<tr><td>2</td><td>Individuals with behavioral health needs (e.g., substance use disorder, mental health) who are incarcerated in the State’s prisons and eligible for participation in the Department’s Community Reentry demonstration waiver.</td></tr>
<tr><td>3</td><td>All young adults who are involved in the State’s protective services and juvenile justice system, Division for Children, Youth and Families (DCYF), including those in foster care, and/or those who have elected voluntary supportive services.</td></tr>
<tr><td>4</td><td>MCO identified members who may benefit from the plan’s care management services at the plan’s option in accordance with the clinical care needs of the member.</td></tr>
</table></td></tr>
</table>

If the member meets the criteria for multiple populations, is the member counted in each population?	
	Children < 18 years of Age 1 Infants diagnosed with neonatal abstinence syndrome (NAS). 2 Infants diagnosed with low birth weight**. 3 Individuals who have required an inpatient admission for a behavioral health diagnosis within the previous twelve (12) months. 4 All infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care, and/or those who have elected voluntary supportive services. 5 MCO identified members who may benefit from the plan's care management services at the plan's option in accordance with the clinical care needs of the member. *Incarcerated refers to 45 days prior to release through one year of being released from the State's prison. **Low birth weight is defined as a weight of less than or equal to 2,499 grams or 5.51 lbs.
HSAG's Comparison of Answers	All three MCOs confirmed members are counted only once in the defined period based on the priority population hierarchy.

Table C-2—Questions Regarding the Care Management Discharge Process

How does the MCO determine that the member is ready for discharge from a care management program?	
ACNH	The member will be discharged from the care management program when the member has completed all the goals and/or asks to be discharged from the care management program. If the member is a priority population member, they will be placed in a supportive status and outreached monthly for an entire year from enrollment.
NHHF	If a member successfully accomplishes their goals, has no other identified needs or gaps in care, or member requests to close. If a member is in the priority populations, member will remain open with a completed up-to-date Comprehensive Assessment for outreach monthly for minimum of identification date to check in and see if member has any new identified goals or issues that care management can assist with.
WS	WS determines that a member is ready for discharge when goals are met and they have been engaged in care management for at least 12 months for priority populations.
HSAG's Comparison of Answers	Each MCO responded with unique workflows within their organization. Additional clarification is needed.
How frequently are the members evaluated for discharge?	
ACNH	Members are evaluated for discharge at every outreach from the time of enrollment.
NHHF	Members are evaluated with every successful contact for discharge. It is a member-driven decision to participate in the program.
WS	Discharge planning is ongoing and evaluation of progress towards goals are reviewed with the member at least quarterly. Ongoing care management support is offered to priority population members at a minimum of 12 months.
HSAG's Comparison of Answers	Each MCO reported evaluating for discharge upon outreach and successful contact.
Once enrolled, does the MCO discharge the member after "x" number of unsuccessful contacts?	
ACNH	Members in Priority Populations remain in supportive status with outreach monthly until designated contractual 12-month period from initial contact. Members that are not in the Priority Populations are closed after three unsuccessful attempts to contact.
NHHF	Members in Priority Populations do not get closed until their Comprehensive Assessment has lapsed one year from completion. We continue to make outreach to these members monthly and also send out location services to try to re-engage in care management. Members not in the Priority Population are closed after three or more unsuccessful outreach attempts.
WS	WS discharges members after three consecutive months of being unable to reach, unless communication continues with community supports (e.g., DCYF, Waiver Care Managers).
HSAG's Comparison of Answers	Each MCO reported workflows unique to their organization. Additional clarification needed.

Table C-3—Questions Regarding the Care Management Refusal Process

What are the reasons a member declines a care management program?	
ACNH	Typical reasons given are not interested, nothing wrong, do not have the time, does not feel comfortable discussing healthcare need, may have services already in place.
NHHF	• Unable to reach member • Members feel they already have a lot of supports • Members don't have time for monthly contacts • Members don't feel it would be beneficial for them • Members don't trust health care systems • Member lack of understanding of MCO Care Management program
WS	Members report they do not need care management support or feel they can manage their own health. Members will report they already have a care manager at the community mental health center (CMHC) or already have a CPSW. Members feel overwhelmed with the amount of phone calls already received from multiple agencies. Some members decline care management due to mistrust of the system or privacy concerns.
HSAG's Comparison of Answers	Each MCO reported a variation in their processes for categorizing the reason(s) a member declined a care management program. Additional clarification is needed.
Does the MCO track the reason a member declines a care management program?	
ACNH	Yes
NHHF	No
WS	**WS** tracks members that decline or opt out of care management but not the exact reason.
HSAG's Comparison of Answers	Each MCO varied in its response. Additional clarification is needed.
If the member previously declined a care management program, but has been recently identified in a different priority population, does the MCO reach out to the member?	
ACNH	The MCO will reach out to all members in the priority population (PP) unless member has stated they do not want any contact from the MCO for any reason and that is documented as a sensitive note.

If the member previously declined a care management program, but has been recently identified in a different priority population, does the MCO reach out to the member?	
NHHF	Yes, if it has been 30 days since the previous outreach attempt to enroll in Care Management. The only circumstance in which a member would not be outreached again is if the member requested to opt out of all Care Management communication. This would be identified in our Clinical Documentation system, TruCare. If outreach occurred in the past 30 days, we would not reattempt due to the recency and wait until the member had 30 days since the previous attempt. The only exception for more frequent outreach attempts is for members discharging from an inpatient admission. An attempt to complete the transition of care with the member is made for every inpatient discharge.
WS	Yes, **WS** will attempt outreach after three months of a documented refusal or a status has changed for the member.
HSAG's Comparison of Answers	Each MCO varied in its response. Additional clarification is needed.

Appendix D. Virtual Meeting Follow-Up

After HSAG reviewed and compiled the MCOs' responses to the questionnaire, HSAG conducted a follow-up virtual meeting with each MCO. HSAG asked specific questions to each MCO to gain additional clarity regarding their processes for care management enrollment, discharge, and refusal information. HSAG followed up each meeting with a summary email including all questions and MCO responses to ensure HSAG captured the information accurately. HSAG also asked some additional questions via email, and the MCOs responded. Table D-1 includes the follow-up questions and MCO responses.

Table D-1—MCO Responses to Follow-Up Questions

How many times does the MCO attempt to outreach a member for enrollment in a care management program?	
Initial ACNH Response	**ACNH** will make three attempts to contact the member to enroll in care management. After the three attempts are made, we send a UTC letter by mail.
Initial NHHF Response	There is no limit, unless a member specifically opts out of Care Management outreach.
Initial WS Response	**WS** attempts at minimum to make three telephonic outreach calls and send one Unable to Reach letter for enrollment into Care Management Programs. High-risk and priority population members may receive more persistent and multi-modal outreach (e.g., up to 6+ attempts).
Virtual Meeting Question (NHHF)	HSAG requested the MCO clarify that there was no limit to the number of outreach attempts.
Virtual Meeting Response	**NHHF Response:** After exhausting attempts, including alternative numbers and other contact methods, **NHHF** ceases outreach to members identified as the priority population. However, if after 30 days the member is still identified as a priority population and/or triggers for care management for other needs, **NHHF** would initiate outreach to complete the Comprehensive Assessment and offer care management services again until successful enrollment is achieved or member decline is received.
Virtual Meeting Question (WS)	HSAG requested clarification of the definitions for high-risk members.
Virtual Meeting Response	**WS Response:** Priority populations are the DHHS-defined members within the assigned groups (DCYF, NAS, LBW, etc.). Those members identified as high-risk risk that would not fall into the designated priority population groups are captured in the clinical care category on the CAREMGT.49 Report, along with other lower-risk members, that would still benefit from care management.

What categories, other than open, refused, and discharged, does the MCO use to distinguish the status of a member identified in a priority population? For example, does the MCO use pending, active, transition of care, inactive, closed, declined, etc.? If so, please provide the criteria for each phase of a care management program.	
Initial ACNH Response	ACNH uses the listed categories along with monitoring and inpatient (IP) and closed. The monitoring cases are those that remain in care management and are outreached either monthly or quarterly to ensure needs are met and IP is for those episodes that are inpatient members. Cases that are closed can be reopened and outreached if they have not refused contact from the health plan.
Initial NHHF Response	Pending–Member is identified and outreach to complete assessments and enroll in care management is being done. Active–Member agrees to care management, completed assessment, and has active care plan with goals actively being worked on by care management and member. Monitoring–Member agrees to care management, completed assessment, and has monitoring care plan to outreach monthly to check in for any new needs. Closed–Member was not able to reach, completed all goals successfully, unable to reach after enrollment, deceased, ineligible with health plan, member declines care management services after enrollment.
Initial WS Response	WS utilizes three categories to identify member status in a priority population care management program. 1. Referral–Once member is identified. 2. Open–Once member has verbally consented to enroll in care management. 3. Closed–When the status is "closed" additional details for closure outcomes and reasons are: Declines Intervention, Loss of Coverage, Lost Contact, Graduated, Patient Expired, Unable to Reach, or Triaged Out.
Virtual Meeting Question (All MCOs)	HSAG requested clarification from all three MCOs on the categories of a member's status while enrolled in care management.
Virtual Meeting Response	**ACNH Response:** Once ACNH identifies the member, outreach begins. The episode is considered active until goals are completed or the member does not believe additional follow-up is needed. The case is placed in monitoring status, and contact moves to once per month. **NHHF Response:** Once the member is identified as part of the priority population, outreach is initiated (pending category). If a member agrees to an assessment but does not accept care management, the

What categories, other than open, refused, and discharged, does the MCO use to distinguish the status of a member identified in a priority population? For example, does the MCO use pending, active, transition of care, inactive, closed, declined, etc.? If so, please provide the criteria for each phase of a care management program.	
	episode is moved to closed. Active status implies that the member has completed an assessment, goals are being addressed, and the care plan is being implemented. Once the initial needs are met and the care management team addresses the needs, the status changes to monitoring, which allows for a less frequent (monthly) basis. Closed is used as noted above—Member was not able to reach, completed all goals successfully, unable to reach after enrollment, deceased, ineligible with health plan, member declines care management services after enrollment. **WS Response:** Once the member has been identified, the member is placed in referral status. Once consent is obtained, the episode is moved to open status and the team begins work on the assessment, the interventions, and goals. The episode is closed if the member declines further support, has loss of coverage, loss of contact, graduates, expires, is unable to reach, or it is determined that the member did not have needs to address. If the member graduates, the member is considered discharged. If a member cannot be reached, the case is closed after three consecutive months of not being able to be reached.
If the member cannot be reached, does the MCO consider the encounter closed or refused?	
Initial ACNH Response	If the member is part of the priority population, we continue to outreach to that member monthly and keep the episode in a supportive state. Bright Start cases are also held and outreached either quarterly or monthly depending on acuity. All other episodes are closed.
Initial NHHF Response	The encounter is considered closed as unable to reach.
Initial WS Response	If the member cannot be reached the encounter is Closed. “Unable to reach” is documented as outcome reason.
Virtual Meeting Question (ACNH)	HSAG requested confirmation that “supportive state” means monitoring.
Virtual Meeting Response	**ACNH Response:** Correct, yes, supportive state means monitoring. If the member cannot be reached after the case is opened, the status remains supportive until they can be reached.

Does the MCO prioritize an order of outreach for the different priority populations?	
Initial ACNH Response	Outreach is prioritized by priority populations per contract and risk stratification. **ACNH** uses Predictive Intervention and Care Management Success to identify and to break the members into priority populations with high, medium, and low risk scores. All members in the priority populations are outreached, we use the risk score to determine order outreaching high risk first, medium risk next, and then low risk.
Initial NHHF Response	Each category of Priority Population Members has specific teams that complete outreach and are focused on their one population.
Initial WS Response	**WS** does prioritize outreach differently based on the designated priority populations. Individuals designated to the Community Reentry (CRE) demonstration program are prioritized for a scheduled meeting between the member (inmate), CRE Care Manager and the **WS** Care Manager within one business day of notification of a CRE member coming onto the plan. For outreach to members in the DCYF identified priority population, Care Management attempts to reach out to the member's guardians/case head, DCYF district office registered nurses (RNs) and Certified Peer Support Workers/Juvenile Parole and Probation Officers (CPSWs/JPPOs), primary care providers (PCPs), and foster parents in an attempt to enroll members. Care Managers will exceed the traditional three outreach attempts and instead make six outreach attempts in order to accommodate outreaching providers and DCYF.
Virtual Meeting Question (ACNH and WS)	HSAG asked **ACNH** and **WS** to describe how risk stratification and the priority populations are coordinated.
Virtual Meeting Response	**ACNH Response:** Priority populations are included and flagged for the care management team to address. Risk stratification identifies the top percentiles of expected needs from the **ACNH** membership. Care managers prioritize the outreach based on the stratification; however, the priority population members are considered a first priority or highest risk. **WS Response:** The care management team organizes into "pods" which provide focused outreach to the group assigned. Each priority population is uniquely addressed with the appropriate outreach time frame, workflow, and type of process to complete outreach.

How does the MCO determine that the member is ready for discharge from a care management program?	
Initial ACNH Response	The member will be discharged from the care management program when the member has completed all the goals and/or asks to be discharged from the care management program. If the member is a priority population member, they will be placed in a supportive status and outreached monthly for an entire year from enrollment.
Initial NHHF Response	If a member successfully accomplishes their goals, has no other identified needs or gaps in care, or member requests to close. If a member is in the priority populations, member will remain open with a completed up-to-date Comprehensive Assessment for outreach monthly for minimum of identification date to check in and see if member has any new identified goals or issues that care management can assist with.
Initial WS Response	**WS** determines that a member is ready for discharge when goals are met and they have been engaged in care management for at least 12 months for priority populations.
Virtual Meeting Question (All MCOs)	HSAG asked the MCOs, if a member in a priority population met their goals, did the MCO continue to outreach the member?
Virtual Meeting Responses	**ACNH Response:** If a member of a priority population has reached their goal, **ACNH** follows the look-back period of one year and also extends the completion date, based on the member's needs, and maintains in a supportive state. **NHHF Response:** If a member completes their goals they are moved to a monitoring status. **NHHF** noted the ending date for monitoring varies based on the population. The date may be extended based on the unique needs of the member and could be considered rolling. For example, an inpatient BH admission, then readmission, moves the beginning date forward, thereby extending the start date by which the member is monitored for a year. **WS Response:** Yes, outreach does continue; however, if a member requests the outreach stop, the case is closed and documented. **WS** does extend the closure of the case date, if appropriate, and the needs of the member continue. For example, multiple admissions, continued needs, etc. The date can be considered ongoing and active.
HSAG Follow-up Question for ACNH via Email	Could **ACNH** clarify if a member is experiencing multiple admissions or needs, does **ACNH** push the starting date for the required year forward to allow more time for engagement? In addition, what is the duration and frequency (rare, sometimes, and frequently) the episode extension may occur?

How does the MCO determine that the member is ready for discharge from a care management program?	
ACNH Email Response	Every time a member has an admission, the start date is changed to that admission. If the start date is April and the member has an admission in October, the 12 months begins again in October. In theory if there are multiple admissions they could remain in care management for a long period of time. Usually this is rare; however, we see multiple readmissions more frequently with the Priority Population of Behavioral Health. The rest of the Priority Populations are relatively rare for readmissions once they are set up by care management with community services and supports.
HSAG Follow-up Question for NHHF via Email	Could **NHHF** clarify for which population(s) the ending date of monitoring may be extended. In addition, what is the duration and frequency (rare, sometimes, and frequently) the episode extension may occur?
NHHF Email Response	Clarification on "extended" date - this does not apply to case status, but during discussion was meant to apply to priority population status. The example of BH Discharge was used to show that the latest "trigger date" per priority population definition is used to determine the 12 month +1 day post-occurrence timeframe as outlined by the Contract and CAREMGT.49 definitions for minimum length of time a member would be consider as part of that priority population. Case status is driven member, clinical need, etc. and a member may stay in active or monitoring status for as long as indicated by such.
HSAG Follow-up Question for WS via Email	Yes, outreach does continue; however, if a member requests the outreach stop, the case is closed and documented. **WS** does extend the closure of the case date, if appropriate and the needs of the member continue. For example, multiple admissions, continued needs, etc. The date can be considered ongoing and active.
WS Email Response	Clarification on "extended" date–this does not apply to case status, but during discussion was meant to apply to priority population status. The example of an inpatient BH Discharge was used to show that the latest "trigger date" per priority population definition is used to determine the 12 month +1 day post-occurrence time frame as outlined by the Contract and CAREMGT.49 definitions for minimum length of time a member would be considered as part of that priority population. Case status is member-driven, clinical need, etc. and a member may stay in active or monitoring status for as long as indicated by such.
What are the reasons a member declines a care management program?	
Initial ACNH Response	Typical reasons given are not interested, nothing wrong, do not have the time, does not feel comfortable discussing healthcare need, may have services already in place.
Initial NHHF Response	• Unable to reach member • Members feel they already have a lot of supports

What are the reasons a member declines a care management program?	
	• Members don't have time for monthly contacts • Members don't feel it would be beneficial for them • Members don't trust health care systems • Member lack of understanding of MCO Care Management program
Initial WS Response	Members report they do not need care management support or feel they can manage their own health. Members will report they already have a care manager at the community mental health center (CMHC) or already have a CPSW. Members feel overwhelmed with the amount of phone calls already received from multiple agencies. Some members decline care management due to mistrust of the system or privacy concerns.
Virtual Meeting Question (All MCOs)	HSAG clarified the MCO's ability to track the reason(s) a member may refuse care management.
Virtual Meeting Response	**ACNH Response:** **ACNH** has a list of reasons the care manager can document, if refusing services. **ACNH** works to educate members on the benefit of care management. **ACNH** does track the reasons for refusal. **NHHF Response**: From a general category/anecdotal perspective, members decline for the reasons listed; however, **NHHF** does not follow a report or capture the reasons specifically within the care management system. **WS Response:** **WS** does not track the reason a member refuses care management.
Does the MCO track the reason a member declines a care management program?	
Initial ACNH Response	Yes
Initial NHHF Response	No
Initial WS Response	**WS** tracks members that decline or opt out of care management but not the exact reason.
Virtual Meeting Question (WS)	HSAG clarified the information and asked if **WS** could confirm it tracked the reason a member declined or refused care management.
Virtual Meeting Response	**WS Response:** **WS** does not track the reason a member refuses care management.

If the member previously declined a care management program, but has been recently identified in a different priority population, does the MCO reach out to the member?	
Initial ACNH Response	The MCO will reach out to all members in the priority population (PP) unless member has stated they do not want any contact from the MCO for any reason and that is documented as a sensitive note.
Initial NHHF Response	Yes, if it has been 30 days since the previous outreach attempt to enroll in Care Management. The only circumstance in which a member would not be outreached again is if the member requested to opt out of all Care Management communication. This would be identified in our Clinical Documentation system, TruCare. If outreach occurred in the past 30 days, we would not reattempt due to the recency and wait until the member had 30 days since the previous attempt. The only exception for more frequent outreach attempts is for members discharging from an inpatient admission. An attempt to complete the transition of care with the member is made for every inpatient discharge.
Initial WS Response	Yes, **WS** will attempt outreach after three months of a documented refusal or a status has changed for the member.
Virtual Meeting Question (NHHF)	HSAG clarified the time frame for the initiation of a new outreach if a member is identified in a new priority population.
Virtual Meeting Response	**NHHF Response: NHHF** will wait 30 days prior to starting outreach again; however, the clinical judgment of the care management staff or a request from a provider may move the outreach sooner. **NHHF** noted outreach prior to 30 days is typically an isolated event.
Email Follow-Up Question (ACNH)	HSAG clarified **ACNH**'s response, requesting **ACNH** confirm the following: Is there a timeframe associated with the process of outreach either between identification of the new population referral or the length of time in which the MCO attempts outreach prior to closing the new referral?
Email Follow-Up Response	**ACNH** follows standard guidelines for outreach to PP. We attempt outreach to newly identified members within 48 hours and if UTC we attempt two more times plus a UTC letter is sent to the member. This all takes place within 30 days.

Appendix E. Recommendations for the EQRO.01 Report

Appendix E contains specific recommendations generated by the study for each MCO to include in the EQRO.01 Report.

Table E-1—Recommendations for ACNH

Number	Recommendation
ACNH-2025-EQRO.01-QS-PP-01	**ACNH** should continue to outreach members who are identified as part of a priority population through at least 30 days from the identification of a priority population member to increase enrollment in the priority populations.
ACNH-2025-EQRO.01-QS-PP-02	**ACNH** should continue to explore options to use community resources, community events, community organizations/health workers, or other community-level care coordinators to help locate members for outreach and care management enrollment of priority population members.
ACNH-2025-EQRO.01-QS-PP-03	**ACNH** should continue to identify and prioritize the use of additional multi-modal methods of communication to outreach members, other than telephonic outreach, to increase the likelihood of successful contact.
ACNH-2025-EQRO.01-QS-PP-04	**ACNH** should monitor and track the reasons members refuse care management services.
ACNH-2025-EQRO.01-QS-PP-05	**ACNH** should constantly assess the number of staff devoted to care management needs to ensure that the MCOs have adequate staff with the credentials needed to support effective and efficient care management of members in priority populations.
ACNH-2025-EQRO.01-QS-PP-06	**ACNH** could review their care management systems and continuously enhance their protocols and algorithms to evaluate and accommodate the needs of new populations (i.e., priority populations) served or additional services provided by the MCOs, including member incentives and/or rewards.
ACNH-2025-EQRO.01-QS-PP-07	**ACNH** could implement processes to obtain member feedback regarding care management services, particularly **ACNH**'s methods of communication.

Table E-2—Recommendations for NHHF

Number	Recommendation
NHHF-2025-EQRO.01-QS-PP-01	**NHHF** should continue to explore options to use community resources, community events, community organizations/health workers, or other community-level care coordinators to help locate members for outreach and care management enrollment of priority population members.
NHHF-2025-EQRO.01-QS-PP-02	**NHHF** should continue to identify and prioritize the use of additional multi-modal methods of communication to outreach members, other than telephonic outreach, to increase the likelihood of successful contact.
NHHF-2025-EQRO.01-QS-PP-03	**NHHF** should monitor and track the reasons members refuse care management services.
NHHF-2025-EQRO.01-QS-PP-04	**NHHF** should constantly assess the number of staff devoted to care management needs to ensure that the MCOs have adequate staff with the credentials needed to support effective and efficient care management of members in priority populations.
NHHF-2025-EQRO.01-QS-PP-05	**NHHF** could review their care management systems and continuously enhance their protocols and algorithms to evaluate and accommodate the needs of new populations (i.e., priority populations) served or additional services provided by the MCOs, including member incentives and/or rewards.
NHHF-2025-EQRO.01-QS-PP-06	**NHHF** could implement processes to obtain member feedback regarding care management services, particularly **NHHF**'s methods of communication.

Table E-3—Recommendations for WS

Number	Recommendation
WS-2025-EQRO.01-QS-PP-01	**WS** should continue to outreach members who are identified as part of a priority population through at least 30 days from the identification of a priority population member to increase enrollment in the priority populations.
WS-2025-EQRO.01-QS-PP-02	**WS** should continue to explore options to use community resources, community events, community organizations/health workers, or other community-level care coordinators to help locate members for outreach and care management enrollment of priority population members.
WS-2025-EQRO.01-QS-PP-03	**WS** should continue to identify and prioritize the use of additional multi-modal methods of communication to outreach members, other than telephonic outreach, to increase the likelihood of successful contact.

Number	Recommendation
WS-2025-EQRO.01-QS-PP-04	**WS** should monitor and track the reasons members refuse care management services.
WS-2025-EQRO.01-QS-PP-05	**WS** should constantly assess the number of staff devoted to care management needs to ensure that the MCOs have adequate staff with the credentials needed to support effective and efficient care management of members in priority populations.
WS-2025-EQRO.01-QS-PP-06	**WS** could review their care management systems and continuously enhance their protocols and algorithms to evaluate and accommodate the needs of new populations (i.e., priority populations) served or additional services provided by the MCOs, including member incentives and/or rewards.
WS-2025-EQRO.01-QS-PP-07	**WS** could implement processes to obtain member feedback regarding care management services, particularly **WS**'s methods of communication.