New Hampshire Medicaid Care Management (MCM) Quality Strategy

State Fiscal Year 2020

Prepared by the Bureau of Quality Assurance and Improvement
NH Department of Health and Human Services (DHHS)
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The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence

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Preface

The New Hampshire Medicaid Care Management (MCM) Quality Strategy is a technical document required by the Code of Federal Regulations, CFR 438.340, and the Centers for Medicare and Medicaid Services (CMS) programs to ensure the delivery of quality health care by managed care organizations. This document is not intended to comprehensively describe all the activities that the State of New Hampshire's Department of Health and Human Services undertakes to ensure Medicaid program quality.

Please forward all comments about the NH MCM Quality Strategy with the phrase "Quality Strategy" in the subject line to: medicaidquality@dhhs.nh.gov. Please note, large font versions of this document are available upon request.

I Introduction

A. New Hampshire Medicaid Care Management (MCM) Program

The New Hampshire statewide Medicaid Care Management Program is the primary method of service delivery covering over 99%[1] of the NH Medicaid population. The following populations are enrolled in the MCM program.

- Aid to the Needy Blind Recipients;
- Aid to the Permanently and Totally Disabled Recipients;
- American Indians and Alaskan Natives;
- Auto Eligible and Assigned Newborns;
- Breast and Cervical Cancer Program Recipients;
- Children Enrolled in Special Medical Services/Partners in Health;
- Children with Supplemental Security Income;
- Foster Care/Adoption Subsidy Recipients;
- Granite Advantage (Medicaid Expansion Adults);
- Home Care for Children with Severe Disabilities (Katie Beckett);
- Medicaid Children Funded through the Children's Health Insurance Program;
- Medicaid for Employed Adults with Disabilities;
- Medicare Duals;
- Poverty Level Adults (Including Pregnant Women);
- Poverty Level Children; and
- Old Age Assistance Recipients.

The following eligibility groups are exempted from the MCM program and receive their benefits from the NH fee-for-service program.

- Family Planning Only Benefit Recipients;
- Health Insurance Premium Payment Recipients;
- In and Out Spend-Down Recipients;
- Recipients with Retroactive/Presumptive Eligibility Segments (Excluding Auto Eligible Newborns); and
- Veterans Affairs Benefit Recipients.

The MCM program covers all NH Medicaid services with the exception of the following services that are covered by the Medicaid fee-for-service program:

- Dental Benefits;
- Division for Children, Youth and Families Services (i.e. Non-EPSDT Child Health Support Services, Crisis Intervention, Home Based Therapy, Intensive Home and Community-Based Services, Placement Services, Private Non-Medical Institution for Children)
- Early Supports and Services;
- Glencliff Home Services;
- Home and Community Based Care Waiver Services (i.e. Acquired Brain Disorder Waiver,

[1] Figure is based on Medicaid Eligibility Data as of June 1, 2019.

Choices for Independence Waiver, In Home Support Waiver; Developmental Disabilities Waiver);
- Medicaid to Schools Services; and
- Nursing Facility Services.

New Hampshire has contracted with the following managed care organizations to provide statewide coverage for the NH MCM program:
- AmeriHealth Caritas New Hampshire;
- New Hampshire Healthy Families; and
- Well Sense Health Plan.

B. New Hampshire Medicaid Care Management Quality Strategy

Through this Quality Strategy for the NH MCM Program (Quality Strategy), NH coordinates services overseen by various DHHS business units and the MCM health plans into a single, unified approach with targeted goals and objectives.

The Quality Strategy also represents the Department's effort to communicate with stakeholders the State's plans for assuring managed care organizations (MCOs) are:
- In compliance with the MCO contract;
- Have committed adequate resources to perform internal monitoring;
- Conduct ongoing quality improvement; and
- Actively contribute to health care improvement for the State's most vulnerable citizens.

The New Hampshire MCM Quality Strategy is always publicly available at http://medicaidquality.nh.gov/ and is promoted to stakeholder and beneficiaries during public comment periods.

The State of New Hampshire's MCM Quality Strategy complies with the CMS regulations for Medicaid Managed Care Quality Strategy primarily found in 42 CFR 438.340 as demonstrated in the crosswalk found in *Appendix A*: *CMS Quality Strategy Requirements*.

II Medicaid Managed Care Quality Program

A. DHHS Managed Care Quality Program Overview

Mission

The New Hampshire Medicaid Quality Program supports the Department of Health and Human Services in improving the health and well-being of Medicaid beneficiaries through data driven oversight and development of policy and programs, while leading quality assurance and improvement activities.

Goals

The MCM Quality Program works to achieve the program mission based on the following 7 goals:

1. Assure the quality and appropriateness of care delivered to the NH Medicaid population enrolled in managed care.
2. Assure NH Medicaid members have access to care and a quality experience of care.
3. Assure MCO contract compliance.
4. Assure MCO quality program infrastructure.
5. Assure the quality and validity of MCO data.
6. Manage continuous performance improvement.
7. Conduct targeted population quality activities.

Organizational Structure

The MCM Quality Program is led by the DHHS Bureau of Quality Assurance and Improvement's (BQAI) Medicaid Quality Program in partnership with:

- DHHS BQAI Data Analytics and Reporting group;
- DHHS Bureau of Medicaid Care Management Operations;
- External Quality Review Organization (EQRO); and
- MCO Quality Assurance and Improvement (QAPI) programs.

DHHS BQAI Medicaid Quality Program

The Bureau is responsible for the implementation and coordination of all activities associated with the operation of the MCM Quality Program. This includes but is not limited to:

- Management of the EQRO contract;
- Management of the Performance Issue Tracking Log that identifies MCO performance issues for the NH Medicaid Director and various program managers;
- Distribution of MCO reports and plans to DHHS internal stakeholders;
- Creation of member materials that inform Medicaid beneficiaries of MCO performance;
- Regular public reporting on goals related to the MCM Quality Strategy; and
- Population-based analysis of the outcomes of MCO performance.

DHHS BQAI Data Analytics and Reporting Group

As part of the Quality program, the Data Analytics and Reporting group have oversight of data, analysis and reporting. The group currently functions to create routine and ad hoc reports to ensure

the delivery of quality care, the development of sound policy and for financial oversight of the Medicaid program. The group supports DHHS reporting on the NH MCM program.

DHHS Division for Medicaid Services, Bureau of Medicaid Care Management Operations

Direct DHHS oversight of MCO contract compliance is the primary responsibility of the Bureau of MCM Operations. The Bureau is overseen by the NH Medicaid Director and includes the NH MCM Account Management Team. The Account Managers act as liaisons between DHHS and the MCO Compliance Officer on all issues of MCO compliance. The NH MCM Account Managers work collaboratively with the Medicaid Quality Program and various cross-functioning program subject matter experts to assure MCO contract compliance.

External Quality Review Organization (EQRO)

The NH DHHS has contracted with an EQRO as required by 42 CFR 438 Subpart E. In order to comply with Federal regulations, 42 CFR 438.358(b), the federally mandatory EQRO's scope of work for the NH Medicaid EQRO includes:

- Validation of Performance Improvement Projects (PIP);
- Validation of MCO quality performance measures;
- Preparation of an EQRO Technical Report for each Medicaid managed care plan; and
- Validation of MCO network adequacy (pending CMS guidance).

Optional federal EQRO activities required in the NH Medicaid EQRO's scope of work include:

- Validation of MCO encounter data submissions;
- Validation of MCO consumer and provider surveys; and
- Additional focused quality studies, (i.e., health service delivery issues such as coordination, continuity, access and availability of needed services).

At this time, the NH MCM EQRO activities are not annually duplicated by activities associated with National Committee for Quality Assurance (NCQA) accreditation.

MCO Quality Assurance and Improvement (QAPI) programs.

In complement to the State's Quality Strategy, each MCO maintains and operates a QAPI program, as required by 42 CFR 438.330. The MCO QAPI is responsible for, but not limited to:

- Calculating performance measures required by the DHHS MCO contract;
- Conducting four (4) PIPs;
- Obtaining and maintaining NCQA health plan accreditation; and
- Fielding member experience of care surveys (i.e., Consumer Assessment of Healthcare Providers and Systems (CAHPS), behavioral health survey).

Additionally, the State conducts quarterly Quality Improvement meetings with the MCO Quality Leadership. These meetings routinely bring all of the MCOs together, take an agnostic perspective on the NH Medicaid program, and, to the greatest degree possible, harmonize the PIPs and other quality initiatives across the MCOs and the NH Medicaid program

Data Sources and Systems

Medicaid Quality Information System and MCO Performance Measures

DHHS collects over 200 performance measures from the MCOs, which are listed in A*ppendix B MCO Performance Measures*. The NH Medicaid program aggregates population-based measures to enhance the identification of program strengths and opportunities and makes all the performance measures in *Appendix B* publicly available on the NH Medicaid Quality website (https://medicaidquality.nh.gov/) which includes, but is not limited to:

- CMS Adult and Child Core set of measures;
- Agency for Healthcare Research and Quality's (AHRQ) CAHPS Member Experience of Care Survey for Adults, Children, and Children with Chronic Conditions; and
- NCQA Healthcare Effectiveness Data and Information Set (HEDIS).

The Medicaid Quality Indicators System (MQIS) is the primary system used by the MCM Quality program to efficiently manage over 200 MCO-generated performance measures. The system is used by:

- MCOs to directly submit all performance measure data;
- DHHS to automatically validate MCO data;
- DHHS to automatically flag data that should be reviewed by a Data Analyst;
- DHHS to conduct comprehensive data analysis for all performance measures; and
- DHHS to provide a public website of all published quality measures which allows any program or stakeholder to view measure results and create user defined, customized reporting.

NH also reviews data at the individual health plan level. Data are assessed by comparing health plan performance against the following (if appropriate):

- Contract standards;
- Other Medicaid health plans; and
- National and regional comparison data.

MCO Encounter Data

Medical and pharmacy encounter data is submitted by each MCO on an ongoing basis to the DHHS Medicaid Management Information System (MMIS) which adjudicates the encounters and loads them into the MMIS reporting repository. Encounter data is used in a variety of ad hoc and ongoing applications for evaluation of the MCM program as well as individual MCO performance.

Medicaid Enrollment Data

The New HEIGHTS system is DHHS's integrated eligibility systems for determining eligibility for Medicaid as well as other DHHS needs based programs. The system, managed by the Department's Division of Economic & Housing Stability. Data from the system is readily available in the DHHS data warehouse and in the MMIS reporting repository.

MCO Plans, Reports and Data Tables

In addition to a robust set of performance measures, DHHS collects over 50 quantitative and qualitative plans, reports, and tables that are used for contract management by various DHHS

business units to oversee the MCM program. A full list can be found at *Appendix C – MCO Plans, Tables, and Reports*.

Quality Initiatives and Programs

The NH MCM program includes the following initiatives and programs to support quality improvement in Medicaid population enrolled in Managed Care:

- Performance Improvement Projects;
- Quality Withhold and Incentive Program;
- Alternative Payment Models;
- Member Incentive Plans; and
- Liquidated Damages.

Performance Improvement Projects

Each of the MCOs is required to develop and conduct the following four (4) PIPs in consultation with the EQRO:

- Mental health PIP which will be focused on reducing Psychiatric Boarding in the emergency department;
- Substance use disorder PIP focused on improving service delivery;
- Clinical PIP focused on improving performance on an indicator that is below the national fiftieth (50^{th}) percentile; and
- Non-clinical PIP related to (1) addressing social determents of health; or, (2) integrating physical and behavioral health.

Quality Withhold and Incentive Program

The NH MCM program includes a withhold arrangement through which an actuarially sound percentage of the MCO's risk-adjusted capitation payment will be recouped from the MCO and distributed among the MCOs participating in the MCM program on the basis of meeting targets specified in the DHHS Withhold and Incentive Program. The program will focus on three categories:

- Care Management;
- Behavioral Health; and
- Quality Improvement.

The program will initially evaluate MCO performance on process measures beginning on January 1, 2020; and thereafter include performance measures that align with goals in the NH Medicaid Managed Care Quality strategy.

Alternative Payment Models

The NH MCM program requires that at least fifty percent (50%) of all MCO medical expenditures are in qualifying APMs, as defined by DHHS. Qualifying APMs at a minimum must achieve HCP-LAN APM Category 2-C or greater that assures a higher benchmark of linking quality and value. The MCO's APMs must address state priorities and evolving public health matters which will have connections to the NH Medicaid Managed Care Quality Strategy.

The NH MCM program requirements will be phased in to allow DHHS to finalize an APM strategy and MCOs to submit implementation plans that are reviewed and approved by DHHS.

Member Incentive Programs

The NH MCM program requires MCOs to create member incentive programs to encourage healthy behaviors. The incentives in the program will be connected to healthy behaviors in alignment with the MCO's QAPI and the NH Medicaid Managed Care Quality Strategy.

Liquidated Damages

The NH MCM program includes various provisions that when violated may result in liquidated damages. The categories of liquidated damages are tiered by four (4) levels representing varying severity. Included in the various violations are contract requirements connected to goals within the NH Medicaid Managed Care Quality Strategy. See *Appendix E – Medicaid Care Management Services Contract Exhibit N: Liquidated Damages* for specific details.

B. Managed Care Quality Program Goals and Objectives

The State's Quality Strategy has specific goals that connect to the program mission. Targeted objectives have been developed to measure progress towards achieving each goal. Objectives associated with each goal are a mix of performance standards and program activities. Meeting performance standards and completing program activities described in each objective is an indicator of the effectiveness of the NH MCM Quality Strategy in meeting the outlined goals.

Goal 1 – Assure the quality and appropriateness of care delivered to the NH Medicaid population enrolled in managed care.

Objective 1.1 – Ensure that by the end of State Fiscal Year 2022 annual preventive care measure rates are equal to or higher than the 75th percentile of National Medicaid managed care health plan rates.

The Medicaid Quality Program collects annual data on preventive care from each MCO. These indicators are a blend of clinical process and outcome measures related to the topic of prevention. The measure set is informed by the NCQA Quality Health Plan Ratings and includes measures from HEDIS as well as the CMS Adult and Child Core Sets.

Each measure is compared to NCQA Quality Compass 75th percentile of national Medicaid managed care health plans. An analysis is subsequently conducted to determine if the rates are equal to or higher than the national 75th percentile. Result are annually presented to internal stakeholders, the Medicaid Medical Care Advisory Council, included in the EQRO Technical Report, and publicly posted to https://medicaidquality.nh.gov.

Beginning with the NH Medicaid Care Management Quality Strategy effective September 1, 2019, NH will be transitioning from the prior Objective 1.1 of being equal to or higher than the national average. As the 75th percentile represents a higher benchmark, NH has identified the following measures previously below the benchmark in 2017 that will be targeted in achieving the objective:

- CMS Adult Core Set/HEDIS (IMA) – Immunizations for Adolescents Combination 1;

- CMS Adult Core Set/HEDIS (IMA) – Immunizations for Adolescents Combination 2 (goal will be the 90th percentile);
- CMS Adult Core Set/HEDIS (CHL) – Chlamydia Screening in Women; and
- CMS Adult Core Set/HEDIS (PPC) – Prenatal and Postpartum Care – Postpartum Care Rate.

Objective 1.2 – Ensure that by the end of State Fiscal Year 2022 annual treatment measure rates are equal to or higher than the 75th percentile of National Medicaid managed care health plan rates.

The Medicaid Quality Program collects annual data on treatment from each MCO. These indicators are a blend of clinical process and outcome measures related to the topic of treatment. The measure set is informed by the NCQA Quality Health Plan Ratings and includes measures from HEDIS as well as the CMS Adult and Child Core Sets.

Each measure is compared to NCQA Quality Compass 75th percentile of national Medicaid managed care health plans. An analysis is subsequently conducted to determine if the rates are equal to or higher than the national 75th percentile. Results are annually presented to internal stakeholders, the Medicaid Medical Care Advisory Council, included in the EQRO Technical Report, and publicly posted to https://medicaidquality.nh.gov.

Beginning with the NH Medicaid Care Management Quality Strategy effective September 1, 2019, NH will be transitioning from the prior Objective 1.1 of being equal to or higher than the national average. As the 75th percentile represents a higher benchmark, NH has identified the following measures previously below the benchmark in 2017 that will be targeted in achieving the objective:

- CMS Adult Core Set/HEDIS (SAA) – Adherence to Antipsychotic Medications for Individuals With Schizophrenia;
- CMS Adult Core Set/HEDIS (SSD) – Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications;
- CMS Adult Core Set/HEDIS (ADD) – Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance;
- CMS Adult Core Set/HEDIS (IET) – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment– Engagement of AOD Treatment - Total;
- CMS Adult Core Set/HEDIS (APP) – Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics; and
- HEDIS (LBP) -Use of Imaging Studies for Low Back Pain

CMS Adult Objective 1.3 – Ensure MCOs adopt of evidence-based clinical practice guidelines that meet the requirements of 42 CFR 438.340(b)(1).

The NH MCO Contract requires the MCOs to adopt evidence-based practice guidelines built upon high quality data and strong evidence. In addition to their standard practice guidelines, MCOs are required to develop additional guidelines to meet health needs of their members and address other opportunities for improvement identified in their QAPI programs. All MCO practice guidelines are subject to DHHS approval prior to the onset of a new program. All practice guidelines are available on the MCOs' online provider portals, and to providers, members and potential members upon request. MCO practice guidelines are used to inform coverage decisions, utilization

management, and member educational activities.

The MCM Quality Program has a two-prong approach to assuring compliance with this objective. First, every three years the MCO's adoption of evidence-based clinical practice guidelines is evaluated by NCQA for the purposes of health plan accreditation. Subsequently, once every three years the MCO's compliance with this MCO contract requirement is evaluated by the EQRO during a contract compliance review. The two reviews are coordinated to the extent possible so that the evaluation does not occur on the same year.

Examples of clinical practice guidelines include but are not limited to:

- *Bright Futures Pediatric Preventive Health Care from the American Academy of Pediatrics;* and
- *Immunization Coverage from the Centers for Disease Control and Prevention Vaccines for Children Program.*

Objective 1.4 - DHHS establishes a statewide transition of care policy that meets the requirements of 42 CFR 438.340(b)(5).

The Department's transition of care policy outlined in 438.62(b)(3) is described in the agreement between the Department and each of the MCOs. In general, Medicaid State Plan Services in place at the time a member transitions to an MCO will be honored for sixty (60) calendar days or until completion of a medical necessity review, whichever comes first.

In addition to the general provisions, the Department's policy describes transitions relative to:

- Continuity of care for pregnant women;
- Provider terminations;
- Prescription drug transitions;
- Transitional care after discharge;
- New Hampshire Hospital transitions after discharge; and,
- Prior authorization and transitions of care.

The most current policy in full can be found listed as *Transition of Care Policy* at: https://www.dhhs.nh.gov/ombp/caremgt/medicaid-recipients.htm

Goal 2 – Assure members have access to care and a quality experience of care

Objective 2.1 – Ensure that the MCO provider networks meet the 90% standard of time or distance for each New Hampshire County.

On a semi-annual basis, the MCM Quality Program evaluates each MCO's network for time and distance standards that are established in the MCO contract. Standards developed in the MCO contract are compliant with requirements in 42 CFR 438.68(c). Networks are analyzed at the county level for each provider type. For provider types that do not meet time and distance standards, the MCO is required to submit a request for an exception to time and distance standards. The request must include:

- Annual member utilization of services provided by this provider type;
- Reasons for the unmet standards;
- MCO solution for deficiency;

- Progress on the solution if this was a previously requested exception; and
- Provider level detail.

Exceptions are reviewed by a cross-functional group of Department staff to approve the MCO's requests for exceptions. Reasons for exception that are currently under consideration are:

- An insufficient number of qualified New Hampshire Medicaid and commercial providers or facilities are available to meet the geographic and timely access standards;
- The plan's failure to develop a provider network that is sufficient in number and type of providers to meet all of the standards in the Medicaid Care Management Contract (due to the refusal of a provider to accept a reasonable rate, fee, term, or condition and that the health carrier has taken steps to effectively mitigate the detrimental impact on covered persons); and
- The required service can be obtained using telemedicine or telehealth from an in-network participating provider.

See *Appendix D – State Defined Network Adequacy and Availability of Service Standards* for specific details.

Objective 2.2 – Ensure MCO access performance measures do not indicate an access issue

The MCO contract includes all requirements of 42 CFR 438.340 for assuring member access to care and availability of services. For monitoring member access to care and availability of services, the NH MCM Quality Program harmonizes with elements of NH's strategy for the CMS required Medicaid Fee for Service Access Report.

On a quarterly basis, the MCM Quality Program reviews a selection of performance measures designed to evaluate beneficiary needs as well as service utilization. Measures include but are not limited to:

- Grievances and Appeals;
- Services utilization (i.e., emergency department, office/clinic visits);
- Emergency department visits for conditions treatable in primary care;
- Beneficiary requests for primary care and specialist; and
- Member experience of care survey measures.

For each measure, control limits based on historical trends are employed in quarterly charts to provide a consistent indication of a potential access problem as each new quarter of data are available. Control limits will be set as three standard deviations (following conventional practice[2]) from the mean based on historical data. New quarterly rates that are three standard deviations from the mean will be considered a potential access issue that requires intensive analysis. For member experience of care survey measures, MCM rates will be evaluated to determine if they are at least equal to or better than the national average.

Annually, each MCO conducts a provider survey to determine compliance with the availability of services standards in the MCO contract.

Annually, the EQRO will conduct a secret shopper study for selected New Hampshire provider

[2] E.g., http://www.qualitydigest.com/aug/wheeler.html, http://www.isixsigma.com/dictionary/control-limits/

types. While each study will have a different focus, the core of the initiative will determine:

- New Hampshire providers accepting Medicaid;
- New Hampshire providers accepting Medicaid and accepting new patients; and
- Projected wait times for new appointments.

See *Appendix D – State Defined Network Adequacy and Availability of Service Standards* for specific details.

Objective 2.3 – Ensure that annual member experience of care survey rates are equal to or higher than the national average for Medicaid managed care health plans;

The MCM Quality Program collects annual data on beneficiaries' experience of care from each MCO. The measure set is informed by the NCQA Quality Health Plan Ratings and includes Adult and Child measures obtained through the CAHPS health plan survey.

Each measure is compared to NCQA Quality Compass national average of Medicaid managed care health plans. An analysis is subsequently conducted to determine if the rates are equal to or higher than the national average. Result are annually presented to the Medicaid Medical Care Advisory Council, included in the EQRO Technical Report, and publicly posted to https://medicaidquality.nh.gov.

Goal 3 – Assure MCO contract compliance

Objective 3.1 – Demonstrate contract compliance and identify quality issues through ongoing MCO system wide performance measure evaluation.

The NH MCM Program includes a robust list of required quality reports. These data are presented both as individual measures and aggregated into measure sets and reports to demonstrate the impact of specific programs and overall MCO impact in all domains of administrative and clinical quality.

On a monthly basis, the MCM Quality Program analyzes measures, plans, and reports for performance issues at the population and MCO level. The State reviews for:

- Performance that is concerning relative to contract standards;
- Continued trends over 3 measurement cycles; and
- Notable increases and decrease from the prior reporting period.

Performance issues are reviewed weekly by the State's contract mangers. Others may be enlisted to discuss specific quality measures, reports, or plans as needed based on concerns identified during data review. State contract managers then share the results with the MCOs for potential corrective action and performance improvement.

Objective 3.2 – Ensure annual EQRO contract compliance audit results demonstrate MCO contract standards are being met; and, for those standards that are not met, corrective action plans are approved;

The EQRO conducts an annual on-site compliance review at the offices of each MCO to ensure compliance with federal and State requirements including MCO contract requirements. After completing a comprehensive contract review in the first year of the MCM program, a new three-

year cycle of reviewing one-third of all the elements contained in the compliance tool are implemented. For the review, a standard is created for each requirement. Requirements are reviewed to determine whether the standard has been: "Met," "Partially Met," or "Not Met." Standards that are "Partially Met" or "Not Met" require the health plan to submit a corrective action plan that must be approved by the EQRO. All standards that result in corrective action plans are re-examined during the following year's review.

Goal 4 – Assure MCO quality program infrastructure

Objective 4.1 – Ensure that MCOs maintain accreditation from the National Committee for Quality Assurance of Health Plans (NCQA);

DHHS requires that the MCOs obtain and maintain NCQA accreditation. The maintenance of accreditation activities and the results will be reviewed and posted on the NH Medicaid Quality website.

Objective 4.2 – Ensure that MCOs annually maintain the operation of a QAPI programs that meets the requirements of 42 CFR 438.330;

In complement to the State's Medicaid Managed Care Quality Strategy, each MCO develops, maintains, and operates a QAPI program as required by 42 CFR 438.330, and the NH MCO Contract. The QAPI must be approved by the MCO's governing body and is subject to the approval by the State. Each MCO's QAPI describes the 4 MCO PIPs. All PIPs are monitored by the State's EQRO and adhere to CMS protocols for PIPs. PIPs are based on the MCO's initial assessments of their membership and in consultation with their consumer and provider advisory boards.

Additionally, the State conducts quarterly Quality Improvement meetings with the MCO Quality Leadership. These meetings routinely bring all of the MCOs together, take an agnostic perspective on the NH Medicaid program, and, to the greatest degree possible, harmonize the PIPs and other quality initiatives across the MCOs and the NH Medicaid program.

Finally, each MCO submits an annual report describing the effectiveness of their QAPI programs for review by DHHS. The review also includes how the MCO plans to address DHHS substantiated EQRO findings.

Goal 5 – Assure the quality and validity of MCO data

Objective 5.1 – Ensure the annual EQRO performance measure validation audit results verify the accuracy of MCO performance measures.

Validation of performance measures is one of three mandatory EQRO activities required by CMS. The purpose of performance measure validation audit is to ensure that MCOs have sufficient systems and processes in place to provide accurate and complete information for calculating valid performance measure rates according to the specifications required by the State.

On an annual basis, the EQRO validates performance measures submitted by the MCOs that are not audited by another entity (e.g., NCQA auditing of HEDIS data). Data are reviewed for various standards (e.g., accurate data transfers, data repository best practices, and management of report

production). Performance measure rates with data that is determined "Not Reportable" must be recalculated and resubmitted by the MCO. The EQRO then verifies the resubmitted rates.

Objective 5.2 – Ensure that monthly EQRO encounter data validation results demonstrate MCO contract compliance for timeliness and accuracy of encounter data.

To ensure the integrity, reliability, and validity of the MCO encounter data, the State has contracted with its EQRO to audit and validate encounter data and to provide technical assistance to MCOs in collecting and submitting the requested information. On a monthly basis, the EQRO produces reporting that evaluates the MCOs compliance with submitting timely and accurate encounter data.

Goal 6 – Manage continuous performance improvement

Objective 6.1 – Ensure that MCO performance improvement projects demonstrate sustained improvement

Each MCO must implement four (4) rapid cycle PIPs which will include:

- Mental health PIP which will be focused on reducing Psychiatric Boarding in the emergency department;
- Substance use disorder PIP focused on improving service delivery;
- Clinical PIP focused on improving performance on an indicator that is below the national fiftieth (50^{th}) percentile; and
- Non-clinical PIP related to (1) addressing social determents of health; or, (2) integrating physical and behavioral health.

Each MCO will make an initial assessment of its membership and work in consultation with their consumer and provider advisory boards to determine the greatest potential for health care quality improvement opportunities.

The purpose of a PIP, as defined by 42 CFR §438.330(d) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. To ensure that such projects achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

Objective 6.2 – Ensure that the annual EQRO technical report includes MCO recommendations for performance improvement.

As part of its annual reporting, the State's EQRO will continue to prepare a Technical Report as a compendium of each MCOs' plan-specific activities, services and operations adherent to the CMS protocols found in 42 CFR 438.364 for external review quality reports. Specifically the EQRO Technical Report contains an overview of MCO activities including:

- A description of the manner in which MCO data was aggregated and analyzed;
- The conclusions drawn from the data on the quality, timeliness, and access to care provided by the MCO; and
- For each MCO activity reviewed, the EQRO addresses:
    - The objective of the MCO activity and the objective of the EQRO oversight function,

    - The technical methods of data collection and analysis,
    - A description of the data obtained, and
    - The conclusions drawn from the data;
- An assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO;
- Comparative information across the State's MCO programs;
- Population-based aggregate measurement and analysis; and
- An assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year.

Each EQRO Technical Report will also include information on trends in health plan enrollment and utilization; healthcare outcomes; statements of deficiencies and other on-site survey findings; the quality of the encounter data; and any requested EQRO measures or focused clinical study findings. The EQRO compiles a summary of each MCO, including strengths and weaknesses. The summary and full report is available on the NH Medicaid Quality website.

The State's EQRO Technical Report includes an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries. The report includes recommendations for improving the quality of health care services furnished by each MCO, comparative information about all of the State's MCOs, and an assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year. This information is used to identify the need for benefit changes, NH MCO Contract amendments, additional MCO quality improvement activities, sanctions or other program changes. Additionally, the EQRO report is used to inform the State of needed oversight or regulatory support to improve managed care health care delivery.

Objective 6.3 – Conduct quarterly Quality Assurance and Program Improvement meetings between the quality leadership of DHHS and the MCOs.

The State convenes quarterly meetings with the MCO quality leadership. These quarterly meetings routinely bring the State and MCO quality teams together, take a population perspective on the NH Medicaid program, and strive to harmonize quality initiatives across the NH Medicaid program.

Objective 6.4 – Ongoing appropriate use of MCO sanctions that are compliant with 42 CFR 438 Subpart I.

MCO liquidated damages are in compliance with the minimum requirements in 42 CFR 438 Subpart I. The NH MCO Contract addresses remedies at the State's disposal to address MCO performance concerns. Liquidated damages may be enacted and the contract stratifies MCO violations into 4 levels, each with varying financial remedies. See *Appendix E – Medicaid Care Management Services Contract Exhibit N: Liquidated Damages* for specific details.

Objective 6.5 – Ensure transparency by publicly reporting of over 200 MCM quality measures on

the NH Medicaid Quality website at https://medicaidquality.nh.gov/

A core value of the MCM Quality Program is transparency in reporting data around the performance and outcomes of the MCM program. As a result the public has access to over 200 MCM quality measures available on https://medicaidquality.nh.gov/

Goal 7 – Conduct Targeted population quality activities

Objective 7.1 – Conduct ongoing monitoring of the 1915b population to evaluate access to care, quality of care, and program impact.

The CMS Section 1915(b) waiver provides New Hampshire the legal authority to mandate the following groups of beneficiaries to enroll in a full risk managed care delivery system:

1. Beneficiaries who are also eligible for Medicare.
2. Indians as defined in §438.14(a), except as permitted under §438.14(d).
3. Children under 19 years of age who are:
    a. Eligible for SSI under Title XVI;
    b. Eligible under section 1902(e)(3) of the Act;
    c. In foster care or other out-of-home placement;
    d. Receiving foster care or adoption assistance; or
    e. Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.

For the beneficiaries in the 1915(b) population, the MCM Quality Program has developed a comprehensive monitoring plan with activities to assure access, quality and evaluate the program impact for the population. On a quarterly basis, data is evaluated for applicable monitoring activities, which include service utilization trends as well as grievances and appeals. In addition, annual data is compiled, such as a member focus group that is conducted by the EQRO to identify potential issues for the population that may not surface with other monitoring activities.

The monitoring plan includes an analysis for each activity to:

- Confirm that the activity was conducted;
- Summarize the results and findings;
- Identify problems found;
- Describe the plan/provider level corrective action plan to be administered; and
- Describe the system level program changes resulting from the monitoring findings.

The full monitoring plan can be found at:
https://www.dhhs.nh.gov/ombp/caremgt/documents/1915b-details-of-monitoring.pdf.

Objective 7.2 – Ensure there is an ongoing process to identify and inform the MCOs of members with long-term service and supports needs or persons with special health care needs.

DHHS uses the 834 eligibility file that is exchanged on a daily basis between the Department and the MCOs to communicate key member details. The 834 file includes flags for members who receive long-term service and supports through one of the Department's Medicaid Waivers. In

addition, special health care needs are identified through various eligibility categories, such as Aid to the Permanently and Totally Disabled. In addition the 834 file includes but is not limited to the following information about each member:

- Member level details (e.g., DOB, address);
- Claims history;
- Third party liability information;
- Race or Ethnicity;
- Language;
- Pregnancy Status;
- Division for Children, Youth and Families details;
- Nursing Facility and Home and Community Based Care details (e.g. Area agency);
- Members enrolled in Special Medical Services;
- Members receiving Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI); and
- Category of Eligibility (See *Appendix F – 834 Categories of Eligibility*).

Objective 7.3 – Ensure there is an ongoing process for the identification, evaluation, and reduction of health disparities.

The State currently obtains race (multiple categories), Hispanic ethnicity, and primary language spoken, during its eligibility and NH Medicaid enrollment process. This information, in addition to disability eligibility status, is shared with the MCOs as a part of daily eligibility data feeds through the 834 file.

Currently, the MCOs are required to implement Cultural Competency Plans that assure that providers, individuals, and systems within the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each.

To complement the activities associated with the Cultural Competency Plans, DHHS is working to formally include reducing health disparities as a unique activity to be administered by the MCO's QAPI programs.

Objective 7.4 –Conduct ongoing monitoring of access to care and quality care for members receiving services to treat mental health conditions.

The NH MCM quality program conducts targeted monitoring for members with mental health conditions. Monitoring of access to care and quality of care for this population follows the format of other goals and objectives within the NH MCM Quality Strategy. Activities include:

- Network Adequacy for Mental Health providers;
- Utilization monitoring;
- Treatment based quality of care measures;
- Mental health performance improvement projects; and
- Mental health member experience of care survey.

The NH MCM program requires the MCOs to work with DHHS and the NH Suicide Prevention Council to promote the "Zero Suicide Program," as well as well as other suicide prevention

programs. The NH MCM quality program monitors the MCOs' efforts to operationalize suicide prevention activities by evaluating the MCOs' "Zero Suicide Plan" that addresses how the MCO will:

- Incorporate standard suicide screening tools among providers;
- Assure psychiatric evaluations conducted by qualified professionals are available for members who present in provider offices;
- Implement their educational strategy to achieve systematic implementation of the Zero Suicide Model and comprehensive training for MCO staff and provider network;
- Incorporate the *Zero Suicide Consensus Guide* for Emergency Departments (ED) (Suicide Prevention Resource Center, "Care for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments," 2015);
- Ensure that all members who receive a mental health evaluation in the ED are also screened for suicide risk; and if indicated a comprehensive suicide risk assessment will be completed by a qualified professional.
- Partner with the hospitals to ensure suicide prevention interventions are delivered to patients prior to discharge; and
- Ensure that components of the guide are implemented for members during the discharge process (i.e., patient education, safety planning, follow-up calls).

NH DHHS received approval from CMS for a Uniform Dollar or Percentage Increases for Community Mental Health Programs for Assertive Community Treatment, Mobile Crisis Services, Same Day Access upon New Hampshire Hospital Discharge and Step Down Community Residence Beds for individuals dually diagnosed with Serious Mental Illness and Developmental Disabilities. The approval by CMS is linked to the NH Medicaid Care Management Quality Strategy and will be evaluated by determining the increase from the baseline period of the following measures:

- CMS Core Set: Follow-up after emergency department visit for mental illness: Within 7 Days of ED visit;
- CMS Core Set: Follow-up after emergency department visit for mental illness: Within 30 Days of ED visit;
- CMS Core Set: Follow-up after hospitalization for mental illness: Within 7 Days of discharge;
- CMS Core Set: Follow-up after hospitalization for mental illness: Within 30 Days of discharge; and
- Members receiving Community Mental Health Services who were discharged from New Hampshire Hospital (NHH) and readmitted within 30 calendar days.

Objective 7.5 – Conduct ongoing monitoring of access to care and quality care for members receiving services to treat substance use disorders.

The NH MCM quality program conducts targeted monitoring for members receiving services to treat substance use disorders. Monitoring of access to care and quality of care for this population follows the format of other goals and objectives within the NH MCM Quality Strategy. Activities include:

- Network adequacy for substance use disorder treatment providers;
- Substance use disorder performance improvement projects; and
- Treatment based quality of care measures.

Objective 7.6 – Improved care coordination.

The NH MCM quality program includes monitoring of two key MCO contract standards related to care coordination.

First, the Department is evaluating whether or not the MCOs achieve a standard of 15% of their population, defined as high risk / high need, and are enrolled in the MCOs care management program.

Second, the Department is evaluating whether or not the MCOs achieve a standard of 50% of their population enrolled in care management being managed by a Local Care Management Entity.

Failure to meet either of these contract standards may result in a corrective action plan or liquidated damages.

Objective 7.7 – Reduction in member gaps in eligibility.

The NH MCO contract includes two key requirements of the MCOs to support the Department's goal of reducing member gaps in eligibility.

First, the Department will require the MCOs to outreach to each member within 30 calendar days of the member recertification of eligibility for the Medicaid program. The MCOs are required to offer the member assistance with completing all the necessary paperwork for the recertification.

Second, the Department will require MCOs to conduct the following targeted activities to support Granite Advantage Health Care Plan members who are mandatory for the Community Engagement and work requirements:

- Targeted education to all Granite Advantage Health Care Plan members who contact the MCO;
- Outreach to offer assistance to all Granite Advantage Health Care Plan members who are out of compliance with the Community Engagement policy; and
- Assessing Granite Advantage Health Care Plan members using claims data and other means to determine if the member is potentially exempt from the Community Engagement and work requirement. In the event that the member is potentially medically exempt, the MCO will attempt to assist the member in completing the paperwork for the exemption.

The NH Medicaid Quality program will monitor compliance with these activities by evaluating the results of performance measures from Exhibit O and the EQRO's annual contract compliance review.

III Review of Quality Strategy

A. Public Input

With each update, the State distributes and publicly posts the draft Quality Strategy. Modifications to the Quality Strategy are made in response to public comments, stakeholder feedback, and any MCO contract amendments.

In addition to publicly posting the strategy, the draft is discussed with NH's Medicaid Medical Care Advisory Council, the quality leadership of the MCOs, and the MCOs' Member Advisory Council. All parties are provided the opportunity to comment on the Quality Strategy for a period of 30 days after public posting.

In addition to input from these committees, the draft Quality Strategy, final Quality Strategy and supporting reports and documents are available for public review and comments at the NH Medicaid Quality website at https://medicaidquality.nh.gov/care-management-quality-strategy

Comments and DHHS responses can be found in *Appendix G – Public Comments on NH Medicaid Quality Strategy*

B. Quality Strategy Effectiveness Analysis

No less than every 3 years DHHS conducts an effectiveness analysis of the current Quality Strategy. While the review is a stand-alone effort, it is primarily a compilation of a variety of completed quality studies that are conducted throughout the year. The next effectiveness analysis will be completed prior to the end of SFY 2021.

C. Significant Changes to the Quality Strategy

In addition to the triannual update, the Quality Strategy is updated when there is a significant change to the NH MCM Program. A significant change is defined when at least one of the following actions occurs:

- Re-procurement of the MCO contract;
- Addition of a new population to the MCM program[3];
- Addition of a new group of services to the MCM program; or
- A change to the CMS regulations that impacts the NH Medicaid Quality Strategy.

D. CMS Review

Following public input, the final Quality Strategy is submitted to CMS for feedback prior to finalizing.

[3] The addition of new populations to the MCO contract will not trigger a new quality strategy when the existing quality strategy activities sufficiently monitor the new populations, and additional substantive monitoring activities are unnecessary.

E. Strategy Assessment Timeline

Triennially, NH DHHS will comprehensively assess the Quality Strategy, MMIS Reporting Repository database, the MCO Annual Report, the NCQA accreditation process, HEDIS and CAHPS surveys, and other data collected by NH Medicaid. Other data includes the Comprehensive Healthcare Information System database (all payer claims database, managed by NH DHHS), the findings from the EQRO's *Technical Report Evaluation of Improvement Initiatives and the Strengths and Opportunities for Improvement*.

Timeline for Quality Strategy for the NH Medicaid Managed Care Program – Assessment of Objectives

Quality Strategy Activity	Date Completed
QS#01 Post Draft Quality Strategy for Step One for Public Comment	July 15, 2012
QS#01 Post Final Quality Strategy	October 1, 2013
QS#01 Monitor Quality Performance Results	Continuously
QS#02 Post Draft of Quality Strategy for Step Three for Public Comments	July 15, 2014
QS#02 Post Final Quality Strategy	September 1, 2014
QS#03 Post Draft of Quality Strategy for Step Two Phase 1 for Public Comments	August 3, 2015
QS#03 Post Final Quality Strategy	September 1, 2015
QS#04 Posted Draft Quality Strategy to Comply with Revised CMS Regulations for Public Comment	April 2, 2018
QS#04 Presented Quality Strategy to the NH Medicaid Medical Care Advisory Committee	April 9, 2018
QS#04 Open Comment Period ends for Quality Strategy to Comply with Revised CMS Regulations.	May 2, 2018
QS#04 Post Final Updated Quality Strategy	June 26, 2018
QS#04 Monitor Quality Performance Results	Continuously
QS#05 Post Draft Quality Strategy to Comply with Revised CMS Regulations for Public Comment	July 1, 2019
QS#05 Presented Quality Strategy to the NH Medicaid Medical Care Advisory Committee	July 8, 2019
QS#05 Open Comment Period ends for Quality Strategy to Comply with Revised CMS Regulations	August 8, 2019
QS#05 Post Final Quality Strategy	August 31, 2019 (Scheduled)

Post Triennial Update Draft Quality Strategy for Public Comment	60 days prior to Agreement Year

Appendix A – CMS Quality Strategy Requirements

CMS Regulation	NH MCM Quality Strategy
438.340(a) General rule. Each State contracting with an MCO, PIHP, or PAHP as defined in §438.2 or with a PCCM entity as described in §438.310(c)(2) must draft and implement a written Quality Strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP or PCCM entity.	• All Sections
438.340(b)(1) At a minimum, the State's Quality Strategy must include the following: (1) The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by §§438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.	• II.B.Goal 2-Objective 2.1 • II.B.Goal 2-Objective 2.2 • II.B.Goal 1-Objective 1.4
438.340(b)(2) At a minimum, the State's Quality Strategy must include the following (2) The State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP.	• II.A. • II.B.
438.340(b)(3)(i) At a minimum, the State's Quality Strategy must include the following: (3) A description of—(i) The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with §438.330(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the Web site required under §438.10(c)(3); and,	• II.A.Data and Systems • II.B.Goal 3 –Objective 3.1
438.340(b)(3)(ii) At a minimum, the State's Quality Strategy must include the following: (ii) The performance improvement projects to be implemented in accordance with §438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP.	• II.B.Goal 6 –Objective 6.1
438.340(b)(4) At a minimum, the State's Quality Strategy must include the following: (4) Arrangements for annual, external independent reviews, in accordance with §438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP, PAHP, and PCCM entity (described in §438.310(c)(2)) contract.	• II.A. Organizational Structure – EQRO
438.340(b)(5) At a minimum, the State's Quality Strategy must include the following: A description of the State's transition of care policy required under §438.62(b)(3).	• II.B.Goal 1-Objective 1.5
438.340(b)(6) At a minimum, the State's Quality Strategy must include the following: The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on	• II.B.Goal 7-Objective 7.3

CMS Regulation	NH MCM Quality Strategy
age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO, PIHP or PAHP at the time of enrollment. For purposes of this paragraph (b)(6), "disability status" means whether the individual qualified for Medicaid on the basis of a disability.	
438.340(b)(7) At a minimum, the State's Quality Strategy must include the following: For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.	• II.B.Goal 6-Objective 6.4
438.340(b)(8) At a minimum, the State's Quality Strategy must include the following: A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity described in §438.310(c)(2).	• N/A
438.340(b)(9) At a minimum, the State's Quality Strategy must include the following: The mechanisms implemented by the State to comply with §438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).	• II.B.Goal 7-Objective 7.2
438.340(b)(10) At a minimum, the State's Quality Strategy must include the following: (10) The information required under §438.360(c) (relating to non-duplication of EQR activities)	• II.A. Organizational Structure – EQRO
438.340(b)(11) At a minimum, the State's Quality Strategy must include the following: The State's definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section.	• III.C.
438.340(c)(1)(i) Development, evaluation, and revision. In drafting or revising its Quality Strategy, the State must: Make the strategy available for public comment before submitting the strategy to CMS for review, including obtaining input from the Medical Care Advisory Committee (established by §431.12 of this chapter), beneficiaries, and other stakeholders.	• III.A.
438.340(c)(1)(ii) Development, evaluation, and revision. In drafting or revising its Quality Strategy, the State must make the strategy available for public comment before submitting the strategy to CMS for review, including if the State enrolls Indians in the MCO, PIHP, or PAHP, consulting with Tribes in accordance with the State's Tribal consultation policy.	• III.A. • III.D.
438.340(c)(2)(i) Development, evaluation, and revision. Review and update the Quality Strategy as needed, but no less than once every 3 years. This review must include an evaluation of the effectiveness of the Quality Strategy conducted within the previous 3 years.	• N/A - effectiveness analysis was conducted in 2018. The next analysis will be conducted prior to the end of SFY 2021.
438.340(c)(2)(ii) Development, evaluation, and revision. Review and update the Quality Strategy as needed, but no less than once every 3 years. The State must make the results of the review available on the Web site required under §438.10(c)(3).	• III.
438.340(c)(2)(iii) Development, evaluation, and revision.	• III.

CMS Regulation	NH MCM Quality Strategy
Review and update the Quality Strategy as needed, but no less than once every 3 years. Updates to the Quality Strategy must take into consideration the recommendations provided pursuant to §438.364(a)(4).	
438.340(c)(3)(i) Development, evaluation, and revision. Submit to CMS a copy of the initial strategy for CMS comment and feedback prior to adopting it in final.	• III.D.
438.340(c)(3)(ii) Development, evaluation, and revision. Submit to CMS the a copy of the revised strategy whenever significant changes, as defined in the state's Quality Strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.	• III.D.
438.340(d) Development, evaluation, and revision. Availability: the State must make the final Quality Strategy available on the Web site required under §438.10(c)(3).	• III.A.

Appendix B – MCO Performance Measures

Data detail as presented in the NH MCO Contract Defacto Exhibit O and as referenced. *Last Updated 3.9.18. Consult with the Department for any recent updates prior to use.*

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
ACCESSREQ.05	Member Requests for Assistance Accessing MCO Designated Primary Care Providers per Average Members by County	**Measure**	**Quarter**
ACCESSREQ.06	Member Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated Primary Care) Providers per Average Members by County	**Measure**	**Quarter**
AMBCARE.10	Physician/APRN/Clinic Visits by Subpopulation	**Measure**	**Quarter**
AMBCARE.11	Emergency Department Visits for Medical Health Conditions by Subpopulation	**Measure**	**Quarter**
AMBCARE.12	Emergency Department Visits Potentially Treatable in Primary Care by Subpopulation	**Measure**	**Quarter**
AMBCARE.13	Emergency Department Visits for Mental Health Conditions by Subpopulation	**Measure**	**Quarter**
AMBCARE.14	Emergency Department Visits for Substance Use Related (Chronic or Acute) Conditions by Subpopulation	**Measure**	**Quarter**
AMBCARE.18	Frequent (4+ per year) Emergency Department Use by Subpopulation	**Measure**	**Quarter**
AMBCARE.20	Emergency Department Visits for Any Condition by Subpopulation	**Measure**	**Quarter**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
AMBCARE.28	ED Visits for Mental Health Preceded by NH Hospital Stay in Past 30 Days	**Measure**	**Quarter**
APPEALS.01	Appeals Resolution: Resolution of Standard Appeals Within 30 Calendar Days	**Measure**	**Quarter**
APPEALS.02	Appeals Resolution: Resolution of Extended Standard Appeals Within 44 Calendar Days	**Measure**	**Quarter**
APPEALS.03	Appeals Resolution: Resolution of Expedited Appeals Within 72 Hours	**Measure**	**Quarter**
APPEALS.04	Appeals Resolution: Resolution of All Appeals Within 45 Calendar Days	**Measure**	**Quarter**
APPEALS.05	Appeals Resolution: Resolution of Appeals by Disposition Type	**Measure**	**Quarter**
APPEALS.18	Appeals Reversed: Service Authorized Within 72 Hours Following Reversed Appeal	**Measure**	**Quarter**
APPEALS.19	Appeals Received: Member Initiated	**Measure**	**Quarter**
BHDISCHARGE.01	Community Hospital Discharges for Mental Health Conditions: Member Had Visit With Mental Health Practitioner within 07 Calendar Days of Discharge by Subpopulation	**Measure**	**Quarter**
BHDISCHARGE.02	Community Hospital Discharges for Mental Health Conditions: Member Had Visit With Mental Health Practitioner within 30 Calendar Days of Discharge by Subpopulation	**Measure**	**Quarter**
BHREADMIT.05	Community Hospital Readmissions for Mental Health Conditions: at 30 days by Subpopulation	**Measure**	**Quarter**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
BHREADMIT.06	Community Hospital Readmissions for Mental Health Conditions: at 180 days by Subpopulation	**Measure**	**Quarter**
CAHPS_A_SUP	Adult CAHPS: Supplemental Questions	**Measure**	**Standard HEDIS schedule**
CAHPS_CCC_SUP	Child CAHPS: Supplemental Questions	**Measure**	**Standard HEDIS schedule**
CARECOORD.03	Neonatal Abstinence Syndrome Referrals to Care Management	**Measure**	**Quarter**
CARECOORD.04	Neonatal Abstinence Syndrome Engagement in Care Management	**Measure**	**Quarter**
CAREMGT.22	Care Management Comprehensive Assessments Completed within 30 Days	**Measure**	**Quarter**
CAREMGT.23	Care Management Comprehensive Assessments Completed by Local Care Management Entity	**Measure**	**Quarter**
CAREMGT.24	Care Management: Comprehensive Assessment Attempts Completed Within 30 Days	**Measure**	**Quarter**
CAREMGT.25	Care Management Care Plans Disseminated within 14 Calendar Days	**Measure**	**Quarter**
CAREMGT.27	Members Identified as High-Risk/High-Need Receiving Care Management	**Measure**	**Quarter**
CAREMGT.29	Care Management Outreach to High-Risk/High-Need Members	**Measure**	**Quarter**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
CAREMGT.30	Members Receiving Local Care Management by IDN	**Measure**	**Quarter**
CAREMGT.31	Median Days Members Enrolled in Local Care Management	**Measure**	**Quarter**
CAREMGT.32	Members Receiving Face-to-Face Local Care Management	**Measure**	**Quarter**
CAREMGT.33	Care Management - Members Receiving Local Care Management who are High Risk Members	**Measure**	
CAREMGT.34	Members Enrolled in Care Management	**Measure**	**Quarter**
CAREMGT.35	Care Management: Member Referrals to DHHS's Tobacco Cessation Programs	**Measure**	**Quarter**
CAREMGT.36	Median Days Members Enrolled In Plan Care Management	**Measure**	**Quarter**
CLAIM.05	Claims: Processing Accuracy	**Measure**	
CLAIM.06	Claims: Payment Accuracy	**Measure**	
CLAIM.07	Claims: Financial Accuracy	**Measure**	
CLAIM.08	Claims: Interest on Late Paid Claims	**Measure**	**Month**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
CLAIM.09	Claims: Timely Processing: Sixty Days of Receipt for Professional and Facility Medical Claims	**Measure**	
CLAIM.11	Claims: Processing Results for Professional and Facility Medical Claims - Paid, Suspended, Denied	**Measure**	**Month**
CLAIM.17	Claims: Timely Processing for Pharmacy Claims	**Measure**	**Month**
CLAIM.21	Claims: Timely Processing for Electronic Professional and Facility Medical Claims	**Measure**	**Month**
CLAIM.22	Claims: Timely Processing for Non-Electronic Professional and Facility Medical Claims	**Measure**	**Month**
CLAIM.23	Timely Professional and Facility Medical Claim Processing – All Clean Claims	**Measure**	**Month**
CLAIM.24	Claims: Timely Processing: Ninety Days of Receipt for Professional and Facility Medical Claims	**Measure**	**Month**
CLAIM.25	Claims: Payment Accuracy	**Measure**	**Month**
CLAIM.26	Claims: Financial Accuracy	**Measure**	**Month**
CLAIM.27	Claims: Processing Accuracy	**Measure**	**Month**
CMS_A_ABA	Adult BMI Assessment	**Measure**	**Calendar Year**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
CMS_A_AMM	Antidepressant Medication Management	**Measure**	**May 1 of year prior to measurement year to Oct 31 of measurement year.**
CMS_A_AMR	Asthma Medication Ratio	**Measure**	**Calendar Year**
CMS_A_BCS	Breast Cancer Screening	**Measure**	**2 Calendar Years**
CMS_A_CBP	Controlling High Blood Pressure	**Measure**	**Calendar Year**
CMS_A_CCP	Contraceptive Care – Postpartum Women	**Measure**	**Calendar Year**
CMS_A_CDF	Screening for Clinical Depression and Follow-up Plan	**Measure**	**Calendar Year**
CMS_A_CHL	Chlamydia Screening in Women	**Measure**	**Calendar Year**
CMS_A_CUOB	Concurrent Use of Opioids and Benzodiazepines	**Measure**	**Calendar Year**
CMS_A_FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	**Measure**	**Calendar Year**
CMS_A_FUAFUM	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence	**Measure**	
CMS_A_FUM	Follow-Up After Emergency Department Visit for Mental Illness	**Measure**	**Calendar Year**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
CMS_A_HA1C	Comprehensive Diabetes Care: Hemoglobin A1c Testing	**Measure**	**Calendar Year**
CMS_A_HPC	Comprehensive Diabetes Care: Hemoglobin A1C Poor Control (>9.0%)	**Measure**	**Calendar Year**
CMS_A_HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%)	**Measure**	**Calendar Year**
CMS_A_IET	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	**Measure**	**Calendar Year**
CMS_A_INP_PQI01	Diabetes Short-Term Complications Admission Rate per 100,000 Member Months	**Measure**	**Calendar Year**
CMS_A_INP_PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months	**Measure**	**Calendar Year**
CMS_A_INP_PQI08	Heart Failure Admission Rate per 100,000 Enrollee Months	**Measure**	**Calendar Year**
CMS_A_INP_PQI15	Asthma in Younger Adults Admission Rate per 100,000 Enrollee Months	**Measure**	**Calendar Year**
CMS_A_MPM	Annual Monitoring for Patients on Persistent Medications	**Measure**	**Calendar Year**
CMS_A_MSC.01	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	**Measure**	**Calendar Year**
CMS_A_MSC.02	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications	**Measure**	**Calendar Year**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
CMS_A_MSC.03	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	**Measure**	**Calendar Year**
CMS_A_OHD	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage	**Measure**	**Calendar Year**
CMS_A_PCR	Plan All-Cause Readmissions	**Measure**	**Calendar Year**
CMS_A_SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	**Measure**	**Calendar Year**
CMS_A_SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	**Measure**	**Calendar Year**
CMS_CCW.01	Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception	**Measure**	**Calendar Year**
CMS_CCW.02	Contraceptive Care – All Women Ages 15 – 44: Long-Acting Reversible Method of Contraception (LARC)	**Measure**	**Calendar Year**
CMS_CH_DEV	Developmental Screening in the First Three Years of Life	**Measure**	**Calendar Year**
EPSDT.01-EPSDT.0X	Delivery of Applied Behavioral Analysis Services Under Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Benefit	**Measure**	
GRIEVANCE.03	Grievances: Received from Member	**Measure**	**Quarter**
GRIEVANCE.04	Grievances: Timely Processing of All Grievances	**Measure**	**Quarter**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
GRNT_ADV.01	Granite Advantage: Members who Received Outreach and Education	**Measure**	**Prior 12 Months**
GRNT_ADV.02	Preventive Care and Screening: Tobacco Use Screening and Cessation Intervention	**Measure**	**Calendar Year**
HEDIS_AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	**Measure**	**Calendar Year**
HEDIS_ABA	Adult BMI Assessment	**Measure**	**Calendar Year**
HEDIS_ADD	Follow-Up Care for Children Prescribed ADHD Medication	**Measure**	**One year starting March 1 of year prior to measurement year to February 28 of measurement year.**
HEDIS_ADD_SUB	Follow-Up Care for Children Prescribed ADHD Medication by Subpopulation	**Measure**	**One year starting March 1 of year prior to measurement year to February 28 of measurement year.**
HEDIS_AMB	Outpatient and Emergency Dept. Visits/1000 Member Months	**Measure**	**Calendar Year**
HEDIS_AMM	Antidepressant Medication Management	**Measure**	**May 1 of year prior to measurement year to Oct 31 of measurement year.**
HEDIS_AMM_SUB	Antidepressant Medication Management by Subpopulation	**Measure**	**May 1 of year prior to measurement year to Oct 31 of measurement year.**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
HEDIS_AMR	Asthma Medication Ratio	**Measure**	**Calendar Year**
HEDIS_APC	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	**Measure**	**Calendar Year**
HEDIS_APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	**Measure**	**Calendar Year**
HEDIS_APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	**Measure**	**Calendar Year**
HEDIS_APP_SUB	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics by Subpopulation	**Measure**	**Calendar Year**
HEDIS_ASF	Unhealthy Alcohol Use Screening and Follow-Up	**Measure**	**Calendar Year**
HEDIS_AWC	Adolescent Well Care Visits	**Measure**	**Calendar Year**
HEDIS_BCS	Breast Cancer Screening	**Measure**	**2 Calendar Years**
HEDIS_BCS_SUB	Breast Cancer Screening - Age 50-74 by Subpopulation	**Measure**	**2 Calendar Years**
HEDIS_CAP	Children and Adolescents' Access To Primary Care Practitioners	**Measure**	**Calendar Year**
HEDIS_CBP	Controlling High Blood Pressure	**Measure**	**Calendar Year**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
HEDIS_CCS	Cervical Cancer Screening	**Measure**	**3 Calendar Years**
HEDIS_CDC	Comprehensive Diabetes Care	**Measure**	**Calendar Year**
HEDIS_CHL	Chlamydia Screening in Women	**Measure**	**Calendar Year**
HEDIS_CIS	Childhood Immunization Status	**Measure**	**Calendar Year**
HEDIS_COU	Risk of Chronic Opioid Use (COU)	**Measure**	**Calendar Year**
HEDIS_CWP	Appropriate Testing for Children With Pharyngitis	**Measure**	**One year starting July 1 of year prior to measurement year to June 30 of measurement year.**
HEDIS_DSF	Depression Screening and Follow-up for Adolescents and Adults	**Measure**	**Calendar Year**
HEDIS_FMC	Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions	**Measure**	**January 1 to December 24 of measurement year**
HEDIS_FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	**Measure**	**Calendar Year**
HEDIS_FUH	Follow-Up After Hospitalization For Mental Illness	**Measure**	**January 1 to December 1 of measurement year**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
HEDIS_FUM	Follow-Up After Emergency Department Visit for Mental Illness	**Measure**	**Calendar Year**
HEDIS_HFS	Hospitalization Following Discharge from a Skilled Nursing Facility (within 30 Days of the ED visit)	**Measure**	**Calendar Year**
HEDIS_IET	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	**Measure**	**Calendar Year**
HEDIS_IET_SUB	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment by Subpopulation	**Measure**	**Calendar Year**
HEDIS_IMA	Immunizations for Adolescents	**Measure**	**Calendar Year**
HEDIS_LBP	Use of Imaging Studies for Low Back Pain	**Measure**	**Calendar Year**
HEDIS_LSC	Lead Screening in Children	**Measure**	**Calendar Year**
HEDIS_MMA	Medication Management for People with Asthma	**Measure**	**Calendar Year**
HEDIS_MPM	Annual Monitoring for Patients on Persistent Medications	**Measure**	**Calendar Year**
HEDIS_MPM_SUB	Annual Monitoring for Patients on Persistent Medications by Subpopulation	**Measure**	**Calendar Year**
HEDIS_PCE	Pharmacotherapy Management of COPD Exacerbation	**Measure**	**Calendar Year**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
HEDIS_PCE_SUB	Pharmacotherapy Management of COPD Exacerbation by Subpopulation	**Measure**	**Calendar Year**
HEDIS_PPC	Prenatal and Postpartum Care	**Measure**	**Calendar Year**
HEDIS_SAA	Adherence to Antipsychotics for Individuals with Schizophrenia	**Measure**	**Calendar Year**
HEDIS_SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	**Measure**	**Calendar Year**
HEDIS_SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	**Measure**	**Calendar Year**
HEDIS_SPC	Statin Therapy for Patients with Cardiovascular Disease	**Measure**	**Calendar Year**
HEDIS_SPD	Statin Therapy for Patients with Diabetes	**Measure**	**Calendar Year**
HEDIS_SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	**Measure**	**Calendar Year**
HEDIS_UOD	Use of Opioids at High Dosage	**Measure**	**Calendar Year**
HEDIS_UOP	Use of Opioids from Multiple Providers	**Measure**	**Calendar Year**
HEDIS_URI	Appropriate Treatment for Children With Upper Respiratory Infection	**Measure**	**One year starting July 1 of year prior to measurement**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
			year to June 30 of measurement year.
HEDIS_W15	Well-Child Visits in the first 15 Months of Life	**Measure**	**Calendar Year**
HEDIS_W34	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	**Measure**	**Calendar Year**
HEDIS_WCC	Weight Assessment and Counseling	**Measure**	**Calendar Year**
HOSP_INP.01	Risk Adjusted Readmission to Any Hospital for Any Cause by Adult Behavioral Health and Non-Behavioral Health Population within 30 Days	**Measure**	
HRA.04	Health Risk Assessment: Best Effort to Have New Member Conduct MCO's Health Needs Self-Assessment	**Measure**	**Quarter**
HRA.05	Health Risk Assessment: New Member Successfully Completed MCO's Health Needs Self-Assessment	**Measure**	**Quarter**
INPASC.04	Inpatient Hospital Utilization: Ambulatory Care Sensitive Conditions by Adult Subpopulation	**Measure**	**Agreement Year**
INPUTIL.02	Inpatient Hospital Utilization: All Conditions Excluding Maternity/Newborns by Subpopulation	**Measure**	**Quarter**
MEMCOMM.01	Member Communications: Speed to Answer Within 30 Seconds	**Measure**	**Month**
MEMCOMM.03	Member Communications: Calls Abandoned	**Measure**	**Month**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
MEMCOMM.06	Member Communications: Reasons for Telephone Inquiries	**Measure**	
MEMCOMM.21	Behavioral Health Crisis Call Results	**Measure**	**Month**
MEMCOMM.22	Granite Advantage Outreach: Members Identified by MCO as Potentially Exempt	**Measure**	**Month**
MEMCOMM.23	Granite Advantage Outreach: Members Identified by DHHS as Mandatory and Non-compliant	**Measure**	**Month**
MEMCOMM.24	Member Communications: Messages Returned by the Next Business Day	**Measure**	**Month**
MEMCOMM.25	Member Communications: Reasons for Telephone Inquiries	**Measure**	**Month**
MEMCOMM.26	Granite Advantage Outreach: GAHCP Members Who Call the MCO Call Center and Receive All Required Education and Support	**Measure**	**Month**
MHACT.01	Adult CMHP Assertive Community Treatment (ACT) Service Utilization	**Measure**	**Quarter**
MHACT.02	Adult CMHP Assertive Community Treatment (ACT) Service Recipients who had a Visit with a Community Mental Health Program (CMHP) within 24 Hours of Discharge from New Hampshire Hospital	**Measure**	**Quarter**
MHEBSE.01	Adult CMHP Eligible Members Engaged in Evidence Based Supportive Employment (EBSE) Services	**Measure**	**Quarter**
MHEBSE.02	Adult CMHP Eligible Members with Updated Employment Status	**Measure**	**Quarter**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
MHREADMIT.01	Readmissions for Mental Health Conditions: Within 30 Days by Subpopulation	**Measure**	**Quarter**
MHREADMIT.02	Readmissions for Mental Health Conditions: Within 180 Days by Subpopulation	**Measure**	**Quarter**
MHTOBACCO.01	Adult and Youth CMHP Eligible Members: Smoking Status	**Measure**	**Agreement Year**
NEMT.12	Non-Emergent Medical Transportation: Services Delivered by Mode of Transportation	**Measure**	**Quarter**
NEMT.13	Non-Emergent Medical Transportation: Request Authorization Approvals by Mode of Transportation	**Measure**	**Quarter**
NEMT.15	Non-Emergent Medical Transportation: Services Delivered by Type of Medical Service	**Measure**	**Quarter**
NEMT.17	Non-Emergent Medical Transportation: Member Cancellations for Scheduled Trips by Reason	**Measure**	**Quarter**
NEMT.18	Non-Emergent Medical Transportation: Contracted Transportation & Wheelchair Van Provider Scheduled Trip Results by Outcome	**Measure**	**Quarter**
NEMT.21	Non-Emergent Medical Transportation: Contracted Transportation & Wheelchair Van Provider Scheduled Trips Timeliness	**Measure**	**Quarter**
NEMT.22	Non-Emergent Medical Transportation: Family and Friends Program Rides	**Measure**	**Quarter**
NHHDISCHARGE.01	New Hampshire Hospital: Discharges Where Members Received Discharge Instruction Sheet	**Measure**	**Quarter**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
NHHDISCHARGE.10	New Hampshire Hospital Discharges: Patient Had Visit With Mental Health Practitioner within 07 Calendar Days of Discharge by Subpopulation	**Measure**	**Quarter**
NHHDISCHARGE.12	New Hampshire Hospital Discharges: Patient Had Visit With Mental Health Practitioner within 30 Calendar Days of Discharge by Subpopulation	**Measure**	**Quarter**
NHHDISCHARGE.13	New Hampshire Hospital Discharges: Discharge Plan Provided to Aftercare Provider within 07 Days of Member Discharge	**Measure**	**Quarter**
NHHDISCHARGE.16	New Hampshire Hospital Discharges: New CMHP Patient Had CMHP Intake Appointment within 7 Calendar Days of Discharge	**Measure**	**Quarter**
NHHDISCHARGE.17	New Hampshire Hospital Discharges: MCO Contacts and Contact Attempts	**Measure**	**Quarter**
NHHREADMIT.10	New Hampshire Hospital Readmissions: at 30 days by Subpopulation	**Measure**	**Quarter**
NHHREADMIT.11	New Hampshire Hospital Readmissions: at 180 days by Subpopulation	**Measure**	**Quarter**
NHHREADMIT.12	ED Visits for Mental Health Preceded by NH Hospital Stay in Past 30 Days	**Measure**	**Quarter**
PDN.04	Private Duty Nursing: RN-Level Hours Delivered and Billed	**Measure**	**Quarter**
PDN.05	Private Duty Nursing: LPN-Level Hours Delivered and Billed	**Measure**	**Quarter**
PHARM_PDC	Proportion of Days Covered (PDC):	**Measure**	**Calendar Year**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
PHARMQI.09	Safety Monitoring: Prior Authorized Fills for Opioid Prescriptions with Dosage over 100 mg Morphine Equivalent Dosing (MED)	**Measure**	**Quarter**
PHARMQI.17	Annual Comprehensive Medication Review and Counseling: Completion Rate	**Measure**	**Prior 12 months**
PHARMQI.18	Annual Comprehensive Medication Review and Counseling: Impact of Review	**Measure**	**Prior 12 months**
PHARMUTLMGT.02	Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	**Measure**	**Quarter**
PHARMUTLMGT.03	Pharmacy Utilization Management: Generic Drug Substitution	**Measure**	**Quarter**
PHARMUTLMGT.04	Pharmacy Utilization Management: Generic Drug Utilization	**Measure**	**Quarter**
POLYPHARM.04	Polypharmacy Monitoring: Children With 4 or More Prescriptions	**Measure**	**Quarter**
POLYPHARM.06	Polypharmacy Monitoring: Adults With 5 or More Prescriptions in 60 Consecutive Days	**Measure**	**Quarter**
PROVAPPEAL.01	Resolution of Provider Appeals Within 30 Calendar Days	**Measure**	**Quarter**
PROVCOMM.01	Provider Communications: Speed to Answer Within 30 Seconds	**Measure**	**Month**
PROVCOMM.03	Provider Communications: Calls Abandoned	**Measure**	**Month**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
PROVCOMM.06	Provider Communications: Reasons for Telephone Inquiries	**Measure**	
PROVCOMM.07	Provider Communications: Reasons for Telephone Inquiries	**Measure**	**Month**
PROVCOMM.08	Provider Communications: Messages Returned by the Next Business Day	**Measure**	**Month**
PROVCOMM.21	Provider Communications: Messages Returned by the Next Business Day	**Measure**	
SDH.XX	Social Determinants of Health	**Measure**	**TBD**
SERVICEAUTH.01	Service Authorizations: Timely Determinations for Urgent Medical Service, Equipment and Supply Requests	**Measure**	**Quarter**
SERVICEAUTH.03	Service Authorizations: Timely (14 Day) Determinations for New Routine Medical Service, Equipment and Supply Requests (excludes NEMT and Complex Diagnostic Radiology)	**Measure**	**Quarter**
SERVICEAUTH.04	Service Authorizations: Timely Determinations for Pharmacy	**Measure**	**Quarter**
SERVICEAUTH.09	Service Authorizations: Pharmacy Prior Authorizations Stratified by Behavioral Health and Other Drugs	**Measure**	
SERVICEAUTH.13	Service Authorizations: Post-Delivery Timely (30 Day) Determinations for Medical Service, Equipment and Supply Requests	**Measure**	**Quarter**
SERVICEAUTH.14	Service Authorizations: Denials by Waiver Population	**Measure**	**Quarter**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
SERVICEAUTH.15	Service Authorizations: Physical, Occupational and Speech Therapy Service Authorization Denials by Waiver and Non-Waiver Populations	**Measure**	**Quarter**
SERVICEAUTH.16	Service Authorizations: Pharmacy Prior Authorizations Stratified by Behavioral Health and Other Drugs	**Measure**	**Quarter**
SUD.25	Substance Use Disorder: Continuity of Pharmacotherapy for Opioid Use Disorder	**Measure**	**Calendar Year**
SUD.26	Substance Use Disorder: Member Access to SUD Services After Initial Positive Screening	**Measure**	**Calendar Year**
SUD.27	Substance Use Disorder: Member Access to Clinically Appropriate Services as Identified by ASAM Level of Care Determination	**Measure**	**Calendar Year**
SUD.28	Substance Use Disorder: Members Completing SUD Treatment	**Measure**	**Calendar Year**
SUD.29	Substance Use Disorder: Members with a SUD Diagnosis	**Measure**	**Month**
SUD.30	Substance Use Disorder: Emergency Department Utilization for SUD	**Measure**	
SUD.31	Substance Use Disorder: Members Receiving Early Intervention Services	**Measure**	**Month**
SUD.32	Substance Use Disorder: Members Receiving Outpatient Services (ASAM level 1)	**Measure**	**Month**
SUD.33	Substance Use Disorder: Members Receiving Intensive Outpatient and Partial Hospitalization Services	**Measure**	**Month**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
SUD.34	Substance Use Disorder: Members Receiving Residential and Inpatient Services	**Measure**	**Month**
SUD.35	Substance Use Disorder: Members Receiving Medically Managed Intensive Inpatient Services (ASAM level 4)	**Measure**	**Month**
SUD.37	Substance Use Disorder: Members Receiving Pharmacy-based Medication Assisted Treatment and Other Treatment	**Measure**	**Month**
SUD.38	Substance Use Disorder: Withdrawal Management	**Measure**	**Month**
SUD.42	Inpatient Hospital Discharges for SUD MCO Contacts and Contact Attempts	**Measure**	**Quarter**
SUD.44	Substance Use Disorder: Any SUD Treatment	**Measure**	**Quarter**
SUD.45	Substance Use Disorder: SUD Diagnosis Treated in an IMD	**Measure**	**Agreement Year**
SUD.46	Substance Use Disorder: Average Length of Stay in IMDs	**Measure**	**Agreement Year**
SUD.47	Substance Use Disorder: Inpatient Stays for SUD	**Measure**	**Month**
SUD.48	Substance Use Disorder: Readmissions among Members with SUD	**Measure**	**Agreement Year**
SUD.49	Substance Use Disorder: Access to Preventive/ Ambulatory Health Services for Adult Medicaid Members with SUD	**Measure**	**Agreement Year**

Reporting Reference ID	Performance Measure Name	Data Type	Measure Data Period
TIMELYCRED.01	Timely Provider Credentialing - PCPs	**Measure**	**Quarter**
TIMELYCRED.02	Timely Provider Credentialing - Specialty Providers	**Measure**	**Quarter**

Appendix C – MCO Plans, Tables and Reports

Data detail as presented in the NH MCO Contract Defacto Exhibit O and as referenced. *Last Updated 3.9.18. Consult with the Department for any recent updates prior to use.*

Reporting Reference ID	Name	Data Type	Measure Data Period
ANNUALRPT.01	Medicaid Care Management Program Comprehensive Annual Report	**Narrative Report**	**Agreement Year**
APM.01	Alternative Payment Model Plan	**Plan**	**Varies**
APM.02	Alternative Payment Model Quarterly Update	**Table**	**Varies**
APM.03	Alternative Payment Model Completed HCP-LAN Assessment Results	**Narrative Report**	**Varies**
APPEALS.16	Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population	**Table**	**Quarter**
APPEALS.17	Pharmacy Appeals by Type of Resolution and Therapeutic Drug Class by State Plan, 1915B Waiver, and Total Population	**Table**	**Quarter**
BHDRUG.01	Severe Mental Illness Drug Preauthorization Report	**Table**	**Month**
BHPARITY.01	Behavioral Health Parity Attestation	**Table**	**Calendar Year**
BHPARITY.02	Behavioral Health Parity Analysis Tool	**Table**	**Semi-Annual**

Reporting Reference ID	Name	Data Type	Measure Data Period
BHSTRATEGY.01	Behavioral Health Strategy Plan and Report	**Plan**	**Agreement Year**
CAREMGT.01	Care Management Plan Including Plan to Assess and Report on the Quality and Appropriateness of Care Furnished to Members With Special Health Care Needs	**Plan**	**N/A**
CAREMGT.26	Care Management: Local Care Management Resources - Unmet Needs	**Table**	**Quarter**
CAREMGT.28	Care Management: Members Receiving Care Management by Priority Population	**Table**	**Quarter**
CULTURALCOMP.01	Cultural Competency Strategic Plan	**Plan**	**N/A**
DSH.01	Disproportionate Hospital Claims Report	**Table**	**Hospital Fiscal Year**
DUR.01	Drug Utilization Review (DUR) Annual Report	**Narrative Report**	**Federal Fiscal Year**
EMERGENCYRESPONSE.01	Emergency Response Plan	**Plan**	**N/A**
EPSDT.01	Delivery of Applied Behavioral Analysis Services Under Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Benefit	**Table**	**Quarter**
EPSDT.20	Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Plan	**Plan**	**N/A**
FINANCIALSTMT.01	MCO Annual Financial Statements	**Narrative Report**	**MCO Financial Period**

Reporting Reference ID	Name	Data Type	Measure Data Period
FWA.02	Fraud Waste and Abuse Log: FWA Related to Providers	**Table**	**Month**
FWA.04	Fraud Waste and Abuse Log: Date of Death Report	**Table**	**Month**
FWA.05	Fraud Waste and Abuse Log: Explanation Of Medical Benefit Report	**Table**	**Quarter**
FWA.20	Comprehensive Annual Prevention of Fraud Waste and Abuse Summary Report	**Narrative Report**	**Agreement Year**
FWA.22	Subrogation Report	**Table**	**Month**
GRIEVANCE.02	Grievance Log Including State Plan / 1915B Waiver Flag	**Table**	**Quarter**
INLIEUOF.01	In Lieu of Services Report	**Narrative Report**	**Agreement Year**
INTEGRITY.01	Program Integrity Plan	**Plan**	**N/A**
LOCKIN.01	Pharmacy Lock-in Member Enrollment Log	**Table**	**Month**
LOCKIN.03	Pharmacy Lock-in Activity Summary	**Table**	**Month**
MCISPLANS.01	Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	**Plan**	**N/A**

Reporting Reference ID	Name	Data Type	Measure Data Period
MEMINCENTIVE.01	Member Incentive Table	**Table**	**Quarter**
MEMINCENTIVE.02	Member Incentive Plan	**Plan**	**Point-in-Time**
MHEDBRD.01	Emergency Department Psychiatric Boarding Table	**Table**	**Month**
MHREADMIT.03	Mental Health Readmissions: Service Utilization Prior to Readmission	**Table**	**Quarter**
MHSUICIDE.01	Zero Suicide Plan	**Plan**	**Agreement Year**
MHSURVEY.01	Mental Health Satisfaction Survey Annual Report	**Narrative Report**	**Calendar Year**
MLR.01	Medical Loss Ratio Report	**Table**	**Quarter**
MONTHLYOPS.01	Monthly Operations Report	**Table**	**Month**
MSQ.01	Medical Services Inquiry Letter	**Table**	**Month**
NETWORK.01	Comprehensive Provider Network and Equal and Timely Access Semi-Annual Filing	**Narrative Report**	**Semi-Annual**
NETWORK.03	Plan to Recruit and Maintain Sufficient Networks of SUD Service Providers and Member Access	**Plan**	

Reporting Reference ID	Name	Data Type	Measure Data Period
NETWORK.10	Corrective Action Plan to Restore Provider Network Adequacy	**Plan**	**Point-in-time**
NETWORK.11	Access to Care Provider Survey	**Table**	**Agreement Year**
NHHREADMIT.09	Mental Health Readmissions: Service Utilization Prior to Readmission	**Table**	
PDN.07	Private Duty Nursing: Individual Detail for Members Receiving Private Duty Nursing Services	**Table**	**Quarter**
PHARMQI.10	Child Psychotropic Medication Monitoring Report	**Table**	**Quarter**
PMP.01	Program Management Plan	**Plan**	**N/A**
PROVAPPEAL.02	Provider Appeals Log	**Table**	**Quarter**
PROVCOMPLAINT.01	Provider Complaint and Appeals Log	**Table**	**Quarter**
PROVPREVENT.01	Hospital-Acquired and Provider-Preventable Condition Table	**Table**	**Annual**
PROVPRIV.01	Behavioral Health Written Consent Report	**Narrative Report**	**Agreement Year**
PROVTERM.01	Provider Termination Log	**Table**	**As Needed or Weekly**

Reporting Reference ID	Name	Data Type	Measure Data Period
PROVTERM.02	Provider Termination Report	**Table**	**Month**
QAPI.01	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	**Plan**	**Agreement Year**
SERVICEAUTH.05	Service Authorization Determination Summary by Service Category by State Plan, 1915B Waiver, and Total Population	**Table**	**Quarter**
SUD.39	High Opioid Prescribing Provider Monitoring Report	**Narrative Report**	**Agreement Year**
TPLCOB.01	Coordination of Benefits: Costs Avoided Summary Report	**Table**	**Quarter**
TPLCOB.02	Coordination of Benefits: Medical Costs Recovered Claim Log	**Table**	**Quarter**
TPLCOB.03	Coordination of Benefits: Pharmacy Costs Recovered Claim Log	**Table**	**Quarter**
UMSUMMARY.03	Medical Management Committee	**Narrative Report**	**Agreement Year**
CAHPS_A_ALL	CAHPS 5.0H Core Survey - Adults	**Reports, Files**	**Standard HEDIS schedule**
CAHPS_CCC_ALL	CAHPS 5.0H Survey - Children with Chronic Conditions	**Reports, Files**	**Standard HEDIS schedule**
CMS_A_FUA_GA	Member Detail for CMS_A_FUA	**File**	**Calendar Year**

Reporting Reference ID	Name	Data Type	Measure Data Period
CMS_A_FUM_GA	Member Detail for CMS_A_FUM	**File**	**Calendar Year**
CMS_A_IET_GA	Member Detail for CMS_A_IET	**File**	**Calendar Year**
CMS_A_INP_PQI01_GA	Member Detail for CMS_A_INP_PQI01	**File**	**Calendar Year**
CMS_A_INP_PQI05_GA	Member Detail for CMS_A_INP_PQI05	**File**	**Calendar Year**
CMS_A_INP_PQI08_GA	Member Detail for CMS_A_INP_PQI08	**File**	**Calendar Year**
CMS_A_INP_PQI15_GA	Member Detail for CMS_A_INP_PQI15	**File**	**Calendar Year**
CMS_A_MSC.01_GA	Member Detail for CMS_A_MSC.01_GA	**File**	**Calendar Year**
CMS_A_MSC.02_GA	Member Detail for CMS_A_MSC.02_GA	**File**	**Calendar Year**
CMS_A_MSC.03_GA	Member Detail for CMS_A_MSC.03_GA	**File**	**Calendar Year**
HEDIS_Deliverables	HEDIS Deliverables generated for submission to NCQA	**Reports, Files**	**Standard HEDIS schedule**

Appendix D – State Defined Network Adequacy and Availability of Service Standards

Network Adequacy Standards	
Provider/Service Type	**Time and Distance Standard**
PCPs (adult & pediatric)	Two (2) within forty (40) minutes or fifteen (15) driving miles
Adult Specialists	One (1) within sixty (60) minutes or forty-five (45) driving miles
Pediatric Specialists	One (1) within one hundred twenty (120) minutes or eighty (80) driving miles
Hospitals	One (1) within sixty (60) minutes or forty-five (45) driving miles
Mental Health Providers (adult & pediatric)	One (1) within forty-five (45) minutes or twenty-five (25) driving miles
Pharmacies	One (1) within forty-five (45) minutes or fifteen (15) driving miles
Tertiary or Specialized services (Trauma, Neonatal, etc.)	One (1) within one hundred twenty (120) minutes or eighty (80) driving miles
Individual/Group MLADCs	One (1) within forty-five (45) minutes or fifteen (15) driving miles
SUD Programs	One (1) within sixty (60) minutes or forty-five (45) driving miles
Adult Medical Day Care	One (1) within sixty (60) minutes or forty-five (45) driving miles
Hospice	One (1) within sixty (60) minutes or forty-five (45) driving miles
Office-Based Physical Therapy/Occupational Therapy/Speech Therapy	One (1) within sixty (60) minutes or forty-five (45) driving miles

Availability of Service Standards	
MCO Contract Section	Standard
4.7.5.6.1	Non-Symptomatic Office Visits (i.e., preventive care) shall be available from the Member's PCP or another Provider within forty-five (45) calendar days.

Availability of Service Standards	
MCO Contract Section	Standard
4.7.5.6.3	Non-Urgent, Symptomatic Office Visits (i.e., routine care) shall be available from the Member's PCP or another Provider within ten (10) calendar days. A Non-Urgent, Symptomatic Office Visit is associated with the presentation
4.7.5.6.4	Urgent, Symptomatic Office Visits shall be available from the Member's PCP or another Provider within forty-eight (48) hours. An Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.
4.7.5.6.5	Transitional Health Care shall be available from a primary care or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a Substance Use Disorder treatment program.
4.7.5.6.6	Transitional Home Care shall be available with a home care nurse, licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or Specialty Care Provider or as part of the discharge plan.
4.7.5.17.1	The MCO shall have in its network the capacity to ensure that Transitional Health Care by a Provider shall be available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.
4.7.5.17.2	Waiting times for [Behavioral Health] appointments and/or service availability do not exceed the following: • Within six (6) hours for a non-life threatening emergency; • Within forty-eight (48) hours for urgent care; and • Within ten (10) business days for a routine office visit appointment.
4.7.5.18	The MCO shall ensure that Providers under contract to provide Substance Use Disorder services shall respond to inquiries for Substance Use Disorder services from Members or referring agencies as soon as possible and no later than two (2) business days following the day the call was first received. The Substance Use Disorder Provider is required to conduct an initial eligibility screening for services as soon as possible, ideally at the time of first contact (face-to-face communication by meeting in person or electronically or by telephone conversation) with the Member or referring agency, but not later than two (2) business days following the date of first contact.
4.7.5.19	The MCO shall ensure that Members who have screened positive for Substance Use Disorder services shall receive an ASAM Level of Care Assessment within two (2) business days of the initial eligibility screening and a clinical evaluation as soon as possible following the ASAM Level of Care Assessment and no later than (3) business days after admission.
4.7.5.20	The MCO shall ensure that Members identified for withdrawal management, outpatient or intensive outpatient services shall start receiving services within seven (7) business days from the date ASAM Level of Care Assessment was completed until such a time that the Member is accepted and starts receiving services by the receiving agency. Members identified for partial hospitalization or

Availability of Service Standards	
MCO Contract Section	Standard
	rehabilitative residential services shall start receiving interim services (services at a lower level of care than that identified by the ASAM Level of Care Assessment) or the identified service type within seven (7) business days from the date the ASAM Level of Care Assessment was completed and start receiving the identified level of care no later than fourteen (14) business d
4.7.5.23	The MCO shall ensure that pregnant women are admitted to the identified level of care within twenty-four (24) hours of the ASAM Level of Care Assessment. If the MCO is unable to admit a pregnant woman for the needed level of care within twenty-four (24) hours

Appendix E – Medicaid Care Management Services Contract Exhibit N – Liquidated Damages

Information as presented in this Exhibit is current as of the February 15, 2019 NH MCO contract that was presented to NH Governor and Council on February 20, 2019. Consult with the Department for any recent updates prior to use.

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
1. LEVEL 1 MCO action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of member(s); reduces members' access to care; and/or the integrity of the managed care program	1.1 Failure to substantially provide medically necessary covered services	$25,000 per each failure
	1.2 Discriminating among members on the basis of their health status or need for health care services	$100,000 per violation
	1.3 Imposing arbitrary utilization management criteria, quantitative coverage limits, or prior authorization requirements prohibited in the contract	$25,000 per violation
	1.4 Imposing on members premiums or charges that are in excess of the premiums or charges permitted by DHHS	$10,000 per violation (DHHS will return the overcharge to the member)
	1.5 Continuing failure to meet minimum care management, care coordination and transition of care policy requirements	$25,000 per week of violation
	1.6 Continuing failure to meet minimum behavioral health (mental health and substance use disorder) requirements, including regarding the full continuum of care for members with substance use disorders	$25,000 per week of violation
	1.7 Continuing failure to meet or failure to require their network providers to meet the network adequacy standards established by DHHS (without an approved exception) or timely member access to care standards in Section 4.7.5.	$1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan $100,000 per day for failure to meet the requirements of the approved Corrective Action Plan
	1.8 Misrepresenting or falsifying information furnished to CMS or to DHHS or a member	$25,000 per violation
	1.9 Failure to comply with the requirements of Section 5.3 (Program Integrity) of the contract	$10,000 per month of violation (for each month that DHHS determines that the MCO is not substantially in compliance)
	1.10 Continuing failure to resolve member appeals and grievances within specified timeframes	$25,000 per violation

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	1.11 Failure to submit timely, accurate, and/or complete encounter data submission in the required file format. *(For submissions more than 30 calendar days late, DHHS reserves the right to withhold 5% of the aggregate capitation payments made to the MCO in that month until such time as the required submission is made)*	$5,000 per day the submission is late
	1.12 Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness)	$25,000 per violation
	1.13 Failure to adhere to the Preferred Drug List requirements	$25,000 per violation
	1.14 Continued noncompliance and failure to comply with previously imposed remedial actions and/or intermediate sanctions from a Level 2 violation	$25,000 per violation
	1.15 Continued failure to comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 CFR part 438, subpart K, which prohibits discrimination in the delivery of mental health and substance use disorder services and in the treatment of members with, at risk for, or recovering from a mental health or substance use disorder	$50,000 per violation for continuing failure
	1.16 Continued failure to meet the requirements for minimizing psychiatric boarding	$5,000 per day for continuing failure
	1.17 In-network provider not enrolled with NH Medicaid	$1,000 per provider not enrolled, $500 per additional day provider is not suspended once MCO is notified of non-enrollment, unless good cause is determined at the discretion of DHHS
	1.18 Failure to notify a member of DHHS senior management within twelve (12) hours of a report by the Member, Member's relative, guardian or authorized representative of an allegation of a serious criminal offense against the Member by any employee of the MCO, its Subcontractor or a Provider	$50,000 per violation
	1.19 Two or more Level 1 violations within a contract year	$75,000 per occurrence

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
2. LEVEL 2 MCO action(s) or inaction(s) that jeopardize the integrity of the managed care program, but does not necessarily jeopardize member(s) health, safety, and welfare or access to care.	2.1 Failure to meet readiness review timeframes or address readiness deficiencies in a timely manner as required under the Agreement	$5,000 per violation (DHHS reserves the right to suspend enrollment of members into the MCO until deficiencies in the MCO's readiness activities are rectified)
	2.2 Failure to maintain the privacy and/or security of data containing protected health information (PHI) which results in a breach of the security of such information and/or timely report violations in the access, use, and disclosure of PHI	$100,000 per violation
	2.3 Failure to meet prompt payment requirements and standards	$25,000 per violation
	2.4 Failure to cost avoid, inclusive of private insurance, Medicare or subrogation, at least 1% of paid claims in the first year of the contract, 1.2% in the second year, and 1.5% in contract years 3, 4, and 5; or failure to provide adequate information to determine cost avoidance percentage as determined by DHHS	$50,000 per violation
	2.5 Failure to cost avoid claims of known third party liability (TPL)	$250 per member and total claim amount paid that should have been cost avoided
	2.6 Failure to collect overpayments for waste and abuse in the amount of 0.06% of paid claim amounts in the first year of the contract, 0.08% in the second year, and 0.10% in years 3, 4, and 5	$50,000 per violation
	2.7 Failure to refer at least 20 potential instances of subcontractor or provider fraud, waste, or abuse to DHHS annually	$10,000 unless good cause determined by Program Integrity
	2.8 EQR audit reports with "not met" findings that have been substantiated by DHHS	$10,000 per violation
	2.9 Using unapproved beneficiary notices, educational materials, and handbooks and marketing materials, or materials that contain false or materially misleading information	$5,000 per violation
	2.10 Failure to comply with member services requirements (including hours of operation, call center, and online portal)	$5,000 per day of violation

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	2.11 Member in pharmacy "lock-in" program not locked into a pharmacy and no documentation as to waiver or other excuse for not being locked in	$500 per member per occurrence and total pharmacy claims amount paid while not locked-in
	2.12 Continued noncompliance and failure to comply with previously imposed remedial actions and/or intermediate sanctions from a Level 3 violation	$25,000 per week of violation
	2.13 Failure to suspend or terminate providers in which it has been determined by DHHS that the provider has committed a violation or is under fraud investigation by MFCU when instructed by DHHS	$500 per day of violation
	2.14 Failure to process a provider credentialing clean and complete application timely	$5,000 per delayed application and $1,000 per each day the application is delayed
	2.15 Failure to meet performance standards in the contract which include case management measures (Section 4.10.2.6, 4.10.6.2, 4.10.8.2), claims processing (Section 4.15.8.2, 4.18.1.3, 4.18.2.2, 4.18.3-4.18.5), call center performance (Section 4.4.4.2.3.1 & 4.13.4.1.2), transportation rides (Section 4.1.9.3 & 4.1.9.7), and service authorization processing (Section 4.2.3.7.1 & 4.8.4.1)	$1,000 per violation
	2.16 Two or more Level 2 violations within a contract year	$50,000 per occurrence
	2.17 Failure to comply with subrogation timeframes established in RSA 167:14-a	$15,000 per occurrence
3. LEVEL 3 MCO action(s) or inaction(s) that diminish the effective oversight and administration of the managed care program.	3.1 Failure to submit to DHHS within the specified timeframes any documentation, policies, notices, materials, handbooks, provider directories, provider agreements, etc. requiring DHHS review and/or approval or as requested by an audit	$10,000 per violation
	3.2 Failure to submit to DHHS within the specified timeframes all required plans, documentation, and reporting related to the implementation of	$10,000 per week of violation
	3.3 Failure to implement and maintain required policies, plans, and programs	$500 per every one-week delay
	3.4 Failure to comply with provider relations requirements (including hours of operation, call center, and online portal)	$10,000 per violation
	3.5 Failure to report subrogation settlements that are under 80% of the total liability (lien amount)	$10,000 per violation

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	3.6 Failure to enforce material provisions under its agreements with Subcontractor	$25,000 per violation
	3.7 Failure to submit and obtain DHHS review and approval for applicable Subcontracts	$25,000 per violation
	3.8 Failure to comply with ownership disclosure requirements	$10,000 per violation
	3.9 Continued noncompliance and failure to comply with previously imposed remedial actions and/or intermediate sanctions from a Level 4 violation	$25,000 per week of violation
	3.10 Failure to meet minimum social services and community care requirements, as described in Section 4.10.10 (Coordination and Integration with Social Services and Community Care) of the contract, with respect to unmet resource needs of members	$10,000 per violation
	3.11 Failure to ensure that clinicians conducting or contributing to a comprehensive assessment are certified in the use of New Hampshire's CANS and ANSA, or an alternative evidenced based assessment tool approved by DHHS within the specified timeframe	$10,000 per violation
	3.12 Two or more Level 3 violations within a contract year	$100,000 per occurrence
4. LEVEL 4 MCO action(s) or inaction(s) that inhibit the efficient operation the managed care program.	4.1 Submission of a late, incorrect, or incomplete report or deliverable (excludes encounter data and other financial reports)	$500 per day of violation
	4.2 Failure to comply with timeframes for distributing (or providing access to) beneficiary handbooks, identification cards, provider directories, and educational materials to beneficiaries (or potential members)	$5,000 per violation
	4.3 Failure to meet minimum requirements requiring coordination and cooperation with external entities (e.g., the New Hampshire Medicaid Fraud Control Unit, Office of the Inspector General) as described in the contract	$5,000 per violation
	4.4 Failure to comply with program audit remediation plans within required timeframes	$5,000 per occurrence
	4.5 Failure to meet staffing requirements	$5,000 per violation
	4.6 Failure to ensure provider agreements include all required provisions	$10,000 per violation

Appendix F – 834 Categories of Eligibility

Category of Eligibility Description	Additional Identifier
Old Age Assistance	Old Age Assistance
Aid to the Needy Blind	-----
Aid to the Permanently and totally Disabled	Disabled Adult
Families with Older Children (FWOC)	TANF
Transitional Assessment Planning Program (TAP)	TANF
New Hampshire Employment Program (NHEP)	TANF
Interim Disabled Parent Program (IDP)	TANF
Unemployed Parent (UP)	TANF
Family Assistance Program (FAP)	TANF
Unemployed Parent	TANF
Breast and Cervical Cancer Program	BCCP
Old Age Assistance (Cat Needy)	Old Age Assistance
Aid to the Needy Blind (Cat Needy)	-----
Aid to the Permanently and totally Disabled (Cat Needy)	Disabled Adult
Children w/Severe Disabilities (Cat Needy)	-----
NHEP-Related Regular or Absent Parent (Cat Needy)	TANF-related MA
NHEP-Related Unemployed Parent (Cat Needy)	TANF-related MA
FAP-Related Regular or Absent Parent (Cat Needy)	TANF-related MA
FAP-Related Unemployed Parent (Cat Needy)	TANF-related MA
Home Care-Children w/Severe Disabilities (Cat Needy)	Katie-Beckett
Children's Expanded	-----
Newborn	-----
Adoption Subsidy IV-E (Cat Needy)	Adoption Subsidy
Adoption Subsidy Non IV-E (Cat Needy)	Adoption Subsidy
Foster Care IV-E (Cat Needy)	Foster Care
Foster Care Non IV-E (Cat Needy)	Foster Care
Refugee Medical Assistance Adult (Cat Needy)	-----
Refugee Medical Assistance Family (Cat Needy)	-----
Extended 12 Month	-----
Extended 4 Month	-----
Medicaid for Employed Adults	Disabled Adult
NH Health Protection Program	-----

Category of Eligibility Description	Additional Identifier
Children's Medicaid	-----
Expanded Children	-----
Former Foster Care	-----
NH Health Protection Program--Medically Frail	-----
Newborn	-----
Parents Caretaker	-----
Pregnant Woman	-----
Old Age Assistance (Med Needy)	Old Age Assistance
Aid to the Needy Blind (Med Needy)	-----
Aid to the Permanently and totally Disabled (Med Needy)	Disabled Adult
Children w/Severe Disability (Med Needy)	-----
NHEP-Related Regular or Absent Parent (Med Needy)	TANF-related MA
NHEP-Related Unemployed Parent (Med Needy)	TANF-related MA
FAP-Related Regular or Absent Parent (Med Needy)	TANF-related MA
FAP-Related Unemployed Parent (Med Needy)	TANF-related MA
HC-CSD (Med Needy)	Katie-Beckett
Adoption Subsidy Non IV-E (Med Needy)	Adoption Subsidy
Foster Care Non IV-E (Med Needy)	Foster care
Refugee Medical Assistance Adult (Med Needy)	-----
Refugee Medical Assistance Family (Med Needy)	-----
Poverty Level Child	-----
Poverty Level Pregnant Woman / Postpartum	-----
Children's Medical Assistance	-----
Qualified Pregnant Woman / Postpartum	-----
Protected MA - 1619(A) / 1619(B)	-----
Protected MA – Pickle	-----

Appendix G – Public Comments on NH Medicaid Quality Strategy

#	Page #	Draft Excerpt	Author	Comment	DHHS Response
1	8	As the 75th percentile represents a higher benchmark, NH has identified the following measures previously below the benchmark in 2017 that will be targeted in achieving the objective:	MCO Quality Managers	The list of measures that are no longer included in NCQA's Quality Ratings of Health Plans for Medicaid.	DHHS revised the list to be inclusive of measures included in NCQA's Quality Ratings of Health Plans for Medicaid.
2	14	Objective 6.3 – Conduct quarterly Quality Assurance and Program Improvement meetings between the quality leadership of DHHS and the MCOs.	NH Developmental Services Quality Council	We strongly believe that people with developmental disabilities and traumatic brain injuries should be the focus of one of these meetings each year and request that a representative of the Quality Council attends this meeting. Any reports or other data regarding the health of people with developmental disabilities and traumatic brain injuries compiled in advance of or after the meetings should be shared with the Council.	The Council's first request is for one of the quarterly quality meetings between the Department and the Managed Care Organizations focus on people with developmental disabilities and traumatic brain injuries. Unfortunately, the referenced quarterly meeting is an operational based technical meeting that does not focus on a single population. However, the Department would be willing to attend a Council meeting in the future and present available NH Managed Care data related to the 1915(c) populations.
3	15	Objective 7.2 – Ensure there is an ongoing process to identify and inform the MCOs of members with long-term service and supports needs or persons with special health care needs.	NH Developmental Services Quality Council	MCOs must track specific health indicators for people with developmental disabilities and traumatic brain injuries. As indicated on Page 15 of the NH Medicaid Quality Care Management report, "DHHS uses the 834 eligibility file that is exchanged on a daily basis between the Department and	Regarding the pharmacy measures, the majority of the measures would likely be impacted by polypharmacy. In the new MCM contract the Department has included enhancements to manage polypharmacy which includes requiring the MCO to manage an annual medication counseling program. The Department will share results of this program with the Council. In addition, the Department collects pharmacy data for waiver populations related to: antidepressant medication adherence,

#	Page #	Draft Excerpt	Author	Comment	DHHS Response
				the MCOs to communicate key member details. The 834 file includes flags for members who receive long-term service and supports through one of the Department's Medicaid Waivers." As DHHS already provides this information to the MCOs, it should not be difficult to track specific health outcomes for this population.	ADHD medication follow up visits with a physician, and use of first line psychosocial care for children receiving antipsychotics. The following indicators require a medical record review and would not be available without an amendment to the MCM contract: • Proportion of people who reported to have had a hearing test in the past year; • Proportion of people in each BMI category; and • Proportion of people who were reported to engage in regular physical activity (at least 30 minutes 3 time a week.) The following indicators are collected via survey and detail regarding waiver populations are not available: • Proportion of people who were reported to have had a flu vaccine in the past year; and • Proportion of people who were reported to use nicotine or tobacco products. The last indicator related to dental exams represents services that are not required in the MCM program and data from the MCOs are not available.
4	15	Objective 7.2 – Ensure there is an ongoing process to identify and inform the MCOs of members with long-term service and supports needs or persons with special health care needs.	NH Developmental Services Quality Council	In addition to the categories above, DHHS must track and report on the following: • Emergency room visits, • Service authorization denials by provider type, • Service authorization denials for medications, • Grievances filed and	The Council's third request is for the Department to track Emergency Department Visits, Service Authorizations, Grievances, and Appeals for specific populations. At this time the Department tracks Grievances, ED visits and other utilization specifically for the 1915(c) waiver population. In addition, based on comments from members of the Council on the Department's contract with the MCOs, the Department will be tracking service authorization

#	Page #	Draft Excerpt	Author	Comment	DHHS Response
				outcomes, and • Appeals filed and outcomes by level.	denials for Physical Therapy, Occupational Therapy, and Speech Therapy broken out by 1915(c) waiver. The Department will consider collecting Appeals specific to 1915(c) waiver populations; however, this may require contract amendment.
5	7-8	(1) Objective 1.1 – Ensure that by the end of State Fiscal Year 2022 annual preventive care measure rates are equal to or higher than the 75th percentile of National Medicaid managed care health plan rates. (2) Objective 1.2 – Ensure that by the end of State Fiscal Year 2022 annual treatment measure rates are equal to or higher than the 75th percentile of National Medicaid managed care health plan rates.	NH Developmental Services	In addition to comments above regarding specific health outcomes for people with developmental disability and traumatic brain injuries, it is very important that New Hampshire sets a high bar for the general performance of our Managed Care Organizations (MCOs) as they are a critical part of the health of NH residents on Medicaid. As such, we are disappointed that the general standards are so low for many of the indicators, the 75% percentile in some cases. We are also disappointed that the companies' performances are being compared to the US average, not the NE average. As we all know, people in the New England area are generally healthier than the total US and the MCOs should be expected to produce results which are at least as high as the results in our sister states, not the lower US average.	The Council's final comment was regarding NH's selection of the National 75th percentile as a goal for Prevention and Treatment performance measures. NH has increased the goal from exceeding the national average to the 75th percentile. If achieved, performance rates would be better than 75% of all other National Medicaid Health Plans. The National comparison was selected because the New England Average represents states that have had managed care far longer than New Hampshire. As the New Hampshire program continues to mature, the Department will evaluate whether the New England Average represents a valid comparison. DHHS is happy to further discuss this element in further detail.