New Hampshire Comprehensive Medicaid Quality Strategy

Quality Strategy #7
State Fiscal Year 2024

Prepared by the Bureau of Program Quality
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

Table of Contents

I Introduction 1
A. New Hampshire Medicaid Care Management (MCM) Program 1
History of MCM in New Hampshire 1
MCM Covered Populations 2
MCM Covered Services 2
MCM Managed Care Organizations 3
Children's Health Insurance Program (CHIP) 3
B. New Hampshire Comprehensive Medicaid Quality Strategy 3
II Medicaid Managed Care Quality Program 5
A. DHHS Managed Care Quality Program Overview 5
Mission 5
Goals 5
Organizational Structure 5
Data Sources and Systems 7
Quality Initiatives and Programs 9
MCO and DO Quality Assurance and Improvement Programs 10
Department Statewide MCM Transition of Care Policy [42 CFR 438.340(b)(5)] 12
Adoption of Evidence-Based Clinical Practice Guidelines [42 CFR 438.340(b)(1)] 12
B. Managed Care Quality Program Goals and Objectives 13
Goal 1 – Assure quality and appropriate care delivery to the NH Medicaid population enrolled in managed care. 13
Goal 2 – Assure members have access to care and a quality experience of care 15
Goal 3 – Assure MCO and DO contract compliance 20
Goal 4 – Assure the quality and validity of MCO and DO data 22
Goal 5 – Maintain Quality Performance Improvement Initiatives 23
Goal 6 – Conduct Key Population Health Quality Activities 28
Goal 7 – Achieve State Directed Payment Goals 35
III Review of Quality Strategy 38
A. Public Input 38
B. Quality Strategy Effectiveness Analysis 38
C. External Quality Review of Quality Strategy [42 CFR 340(c)(2)(iii)] 38
D. Significant Changes to the Quality Strategy 40
E. CMS Review 40
F. Strategy Assessment Timeline 40
Appendix A – CMS Quality Strategy Requirements 42
Appendix B – Medicaid Care Management and Dental Performance Measures 45

Appendix C – State Defined Network Adequacy and Availability of Service Standards 46
Appendix D – Medicaid Care Management Services Contracts Exhibit N – Liquidated Damages 49
Appendix E – 834 Categories of Eligibility 60
Appendix F – Public Comments on NH Comprehensive Medicaid Quality Strategy 62
Appendix G – Performance Improvement Projects 63
Appendix H – Quality Strategy Effectiveness Analysis 68

Preface

The New Hampshire Comprehensive Medicaid 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 Comprehensive Medicaid Quality Strategy with the phrase "Quality Strategy" in the subject line to: DHHS.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

History of MCM in New Hampshire

In 2011, the New Hampshire (NH) State Legislature directed the Commissioner of the Department of Health and Human Services (DHHS) to develop a comprehensive statewide managed care program for all Medicaid program enrollees. (Public Health, Chapter 126-A:5, Section XIX). The goals of the newly established Medicaid Care Management program were to offer "the best value, quality assurance, and efficiency, maximizing the potential for savings, and presenting the most innovative approach" to the provision of health services for the State's Medicaid beneficiaries.

The first phase of implementing the NH Medicaid Care Management (MCM) program included all State Plan Amendment services, with the exception of dental and 1915(c) waiver services (Choices for Independence, Acquired Brain Disorder, Developmental Disabilities, and In-Home Supports). The MCM program was mandatory for all NH Medicaid beneficiaries with the exception of: children in foster care, children receiving Supplemental Security Income (SSI) and Medicaid through Home Care for Children with Severe Disabilities, Native Americans, and those who were Medicare Dual Eligible could opt out of the program. This phase was fully implemented and coverage for enrolled Medicaid beneficiaries began on December 1, 2013.

The next phase in 2014 included Medicaid expansion populations created a result of NH's implementation of the Affordable Care Act, and subsequent Senate Bill 413 creating the NH Health Protection Program (NHHPP). The NHHPP expanded state supported health insurance through 1) mandatory participation and coverage for Medicaid eligible individuals that have access to but cannot afford, cost effective employer sponsored coverage; 2) a "Bridge to Marketplace," wherein newly eligible Medicaid beneficiaries were covered under the existing MCM health plans until 3) beginning January 1, 2016, newly eligible beneficiaries purchase insurance, with financial support from the federal government, on NH's Health Insurance Exchange. On July 10, 2018, the Governor signed into law SB 313 creating the Granite Advantage Health Program, transitioning the NHHPP population into the MCM program as of January 1, 2019.

On July 1, 2022, Governor Sununu signed into law an Adult Dental benefit. The legislation requires the DHHS to implement a comprehensive adult dental benefit by April 1, 2023. DHHS implemented the New Hampshire Smiles Adult Dental Program, a Dental Medicaid Care Management (DMCM) program. The benefit includes diagnostic, preventive, limited periodontics, restorative, and oral surgery services, as well as care management and transportation services. Individuals that participate in the 1915(c) waivers (such as Choices for Independence, Acquired Brain Disorder, Developmental Disabilities) and nursing facility residents have an additional removable partial and full denture benefit. The Children's Dental Benefit remains in the Fee-For-Service program and covers birth to 21 years.

As the NH Smiles Adult Dental Program is stood up and operationalized, it will be adding a new group of services to the existing NH MCM program, with all services managed through a separate Prepaid Ambulatory Health Plan (PAHP). As such, the NH MCM Quality Strategy SFY 23, last published on 6/30/22, is being updated to incorporate dental into the existing goals and objectives where applicable.

MCM Covered Populations

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 Medicaid 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.

MCM Covered Services

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:

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

[1] Figure is based on Medicaid Eligibility Data as of January 1, 2022.

- Nursing Facility Services.

MCM Managed Care Organizations

New Hampshire has one Medicaid Care Management plan and currently contracts with three Managed Care Organizations. New Hampshire has one Dental Medicaid Care Management plan and currently contracts with one Dental Organization. The term *Organizations* will refer to all four contracted plans.

New Hampshire has contracted with the following managed care and dental organizations to provide statewide coverage for the NH MCM program:

Organization Name	MCP Type	Authority	Populations Served
AmeriHealth Caritas New Hampshire	MCO	State Plan, & 1915(b)	All populations enrolled in NH Medicaid Care Management.
New Hampshire Healthy Families	MCO	State Plan, & 1915(b)	All populations enrolled in NH Medicaid Care Management.
Well Sense Health Plan	MCO	State Plan, & 1915(b)	All populations enrolled in NH Medicaid Care Management.
Northeast Delta Dental	DO	State Plan, 1915(b), 1915(c)	All populations enrolled in NH Adult Dental Medicaid Care Management.

Children's Health Insurance Program (CHIP)

New Hampshire operates CHIP as a Medicaid expansion program. The state provides CHIP benefits through managed care as administered by the three MCO health plans above. Dental benefits for children in the Medicaid program are administered by the State as fee-for-service benefits.

B. New Hampshire Comprehensive Medicaid 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) and dental organization (DO) are:

- In compliance with the MCO and DO 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 Comprehensive Medicaid Quality Strategy is publicly available at https://medicaidquality.nh.gov/care-management-quality-strategy-0 and is promoted to stakeholders and beneficiaries during public comment periods.

The State of New Hampshire's Comprehensive Medicaid 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 quality and appropriate care delivery to the NH Medicaid population enrolled in managed care.
2. Assure members have access to care and a quality experience of care.
3. Assure MCO and DO contract compliance.
4. Assure the quality and validity of MCO and DO data.
5. Maintain quality performance improvement initiatives.
6. Conduct targeted population health quality activities.
7. Achieve state directed payment goals.

Organizational Structure

The MCM Quality Program is led by the DHHS Division of Program Quality and Integrity, Bureau of Program Quality (BPQ) Medicaid Quality Program in partnership with:

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

DHHS BPQ 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 and DO performance issues for the NH Medicaid Director, the NH Medicaid Dental Director, and various program managers;
- Distribution of MCO and DO reports and plans to DHHS internal stakeholders;
- Creation of member materials that inform Medicaid beneficiaries of MCO and DO performance;
- Regular public reporting on goals related to the MCM Quality Strategy; and
- Population-based analysis of the outcomes of MCO and DO performance.

DHHS BPQ Data Analytics and Reporting

As part of the Quality program, Data Analytics and Reporting (DAR) unit oversees data, analysis and reporting. DAR 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. DAR supports DHHS reporting on the NH MCM program.

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

Direct DHHS oversight of MCO and DO 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 and DO contract compliance.

DHHS Division for Medicaid Services, Medicaid Dental Program

New Hampshire Medicaid provides dental services to children and youth up to age 21, in compliance with federal requirements to provide Early Periodic Screening Diagnosis and Treatment (EPSDT).

New Hampshire Medicaid provides diagnostic, preventive, restorative, limited periodontic, and oral surgery services to adults age 21 and older. A removable partial and full denture benefit is available for individuals included in the following three waiver categories: Acquired Brain Disorder (ABD), Developmental Disability (DD), and Choices for Independence (CFI), and nursing facility residents. All dental services for adults age 21 and older are administered through the Dental Organization in a Prepaid Ambulatory Health Plan.

The Dental Unit of the Division of Medicaid Services provides programmatic and clinical oversight of all dental services.

External Quality Review Organization (EQRO)

The NH DHHS has contracted with a single EQRO to meet the requirements of 42 CFR 438 Subpart E. The Department has contracted with Health Services Advisory Group (HSAG) Inc. to provide EQRO services from July 1, 2019 through June 30, 2024. In 2023, the HSAG contract was amended to include dental EQRO oversight. The Department has an option to renew EQRO MCO and DO services for an additional two years after 2024.

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) for MCOs and DO;
- Validation of MCO and DO quality performance measures;
- Preparation of EQRO Technical Reports; one report that includes each Medicaid managed care plan and a separate report that includes the dental organization; and
- Validation of MCO and DO network adequacy.

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

- Validation of MCO and DO encounter data submissions;
- Validation of MCO and DO consumer and provider surveys; and
- Additional focused quality studies, (i.e., health or dental 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) or Utilization Review Accreditation Commission accreditation (URAC) (DO).

As part of its annual process, the State's EQRO will continue to prepare Technical Reports as a compendium of each –Organization's (MCO and DO) 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 organization activities including:

- A description of the manner in which data was aggregated and analyzed;
- The conclusions drawn from the data on the quality, timeliness, and access to care provided by each organization; and
- For each Organization's activity reviewed, the EQRO addresses:
    - The objective of the 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 Organization's strengths and weaknesses with respect to the quality, timeliness, and access to health care or dental services furnished to Medicaid beneficiaries;
- Recommendations for improving the quality of health care services furnished by each Organization;
- Comparative information across the State's MCO and DO programs;
- Population-based aggregate measurement and analysis; and
- An assessment of the degree to which each Organization has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year.

Data Sources and Systems

Medicaid Quality Information System and MCO Performance Measures [42 CFR 438.340(b)(3)(i)]

DHHS collects over 250 performance measures from the MCOs and DO, which are posted on the Medicaid Quality website *Medicaid Care Management Exhibit O Quality Deliverables (https://medicaidquality.nh.gov/medicaid-care-management-exhibit-o-quality-deliverables)*. 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) measures.

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

- MCOs and DOs to directly submit all performance measure data;
- DHHS to automatically validate MCO and DO 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 contracted MCM health plans; and
- National, regional, and commercial comparison data.

MCO and DO Encounter Data

Medical, pharmacy, and dental encounter data is submitted by each organization 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 organization 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 is managed by the Department's Division of Economic Supports. Data from the system is readily available in the DHHS data warehouse and in the MMIS reporting repository.

MCO and DO Plans, Reports and Data Tables

In addition to a robust set of performance measures, DHHS collects over 75 quantitative and qualitative plans, reports, and tables that are used for contract management by various DHHS business units to oversee the MCM and DMCM programs. A full list can be found at
https://medicaidquality.nh.gov/medicaid-care-management-exhibit-o-quality-deliverables

Identification of Members with Long-Term Services and Supports or Special Health Care Needs

DHHS uses the 834 eligibility file that is exchanged on a daily basis between the Department and the Organizations 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. 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 E – 834 Categories of Eligibility*).

Quality Initiatives and Programs

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

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

Performance Improvement Projects

The Department selects categories for each organization to conduct performance improvement projects. Each of the organizations is required to develop and conduct the following Department-approved PIPs in consultation with the EQRO:

- MCO: Mental health PIP;
- MCO: Substance use disorder PIP focused on improving service delivery;
- MCO Clinical PIP focused on improving performance on an indicator that is below the national fiftieth (50th) percentile; and
- MCO: Non-clinical PIP related to (1) addressing social determents of health; or, (2) integrating physical and behavioral health.
- DO: One (1) clinical PIP related to improving quality performance in an area that the DO performed lower than the national fiftieth (50th) percentile, as otherwise indicated by the Department.

See Objective 5.1 and *Appendix G: Performance Improvement Projects* for more details on the PIPs.

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 returned only on the basis of meeting targets specified in the DHHS Withhold and Incentive Program. The goal of the Withhold and Incentive Program is to incentivize organizations to meet performance standards in DHHS determined high-priority areas.

See Objective 5.3 for more details on the Withhold and Incentive Program.

Performance Based Auto-Assignment Program

The Department administers a Performance Based Auto-Assignment Program is designed to incentivize MCO performance on a variety of DHHS priorities such as process improvements; encounter data validation; and care management enrollment. Top performing MCOs are awarded additional member enrollment during the MCO member auto-assignment process.

See Objective 5.4 for more details on performance based auto-assignment program.

Alternative Payment Models

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

Over the past two years, the NH MCM APM program requirements have been phased in. The DO program requirements will be phased in to allow DHHS to finalize an APM strategy and DO to submit implementation plans that are reviewed and approved by DHHS. The DO's implementation of an APM strategy will develop on a separate timeline from the MCOs due to relative recentness of the program and distinct attributes of the provider network.

Member Incentive Programs

The NH MCM program requires MCOs and DO to create member incentive programs to encourage healthy behaviors. The incentives in the program are to be connected to healthy behaviors in alignment with the MCO's and DO'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 D – Medicaid Care Management Services Contract Exhibit N: Liquidated Damages* for specific details.

MCO and DO Quality Assurance and Improvement Programs

In complement to the State's Quality Strategy, each Organization maintains and operates a QAPI program, as required by 42 CFR 438.330.

MCO and DO Performance Improvement Projects (PIP)

The state requires each Organization to conduct performance improvement projects. The projects are designed to achieve significant improvement, sustained over time in health outcomes as documented in the CMS EQRO protocols. Each PIP includes:

- Measures related to categories required by the Department. Measure must use objective quality indicators;
- Interventions designed to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the intervention; and
- Planning and initiation of activities for increasing or sustaining improvement.

Validation of each PIP is conducted by New Hampshire's EQRO. See Objective 5.1 for more information about the current PIPs.

MCO and DO Performance Measure Data

MCOs and DOs are required to collect and submit performance measure data using standard measures required by the Department. Validation of performance measure data is conducted by the EQRO through detailed audits of source code, technical methods, and supporting documentation for a selection of metrics.

See comprehensive list of all MCO and DO Performance Measures submitted to the Department here: https://medicaidquality.nh.gov/medicaid-care-management-exhibit-o-quality-deliverables

Annual MCO and DO QAPI Review [42 CFR 438.330(b)(5)]

The annual review of each organization's QAPI programs is conducted through (1) the EQRO Technical Report and (2) the organization's annual QAPI plan and evaluation.

The State's EQRO Technical Report includes an assessment of each Organization'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 and/or dental services furnished by each organization, comparative information between the State's MCOs and DO, and an assessment of the degree to which each MCO and DO 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 or DO Contract amendments, additional MCO and DO 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.

The Organizations are required to submit annual plans that describe the organization-wide QAPI program structure and the annual goals and objectives for all quality activities. These activities include the organizations methods to:

- Detect under and over utilization [42 CFR 438.330(b)(3)]; and
- Assess quality and appropriateness of care for members with special health care need [42 CFR 438.330(b)(4)].

In addition, the Department requires the Organization to self-evaluate the impact and effectiveness of the individual QAPI programs by [42 CFR 438.330(e)(2)]:

- Annually assessing progress of activities outlined in the annual plan;
- Annual progress report of activities outlined in the QAPI Annual Plan; and
- Semi-annually reporting (EQRO.01) actions taken to address selected findings/recommendations identified by EQRO quality reports.

MCO and DO Health Plan Accreditation

DHHS requires that the MCOs obtain and maintain NCQA health plan accreditation, including the Medicaid Module. The maintenance of accreditation activities and the results are reviewed and posted on the NH Medicaid Quality website.

DHHS requires that DOs obtain and maintain URAC dental plan accreditation. The maintenance of accreditation activities and the results are reviewed and posted on the NH Medicaid Quality website.

MCO/DO and DHHS Quarterly Quality Meetings

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

Department Statewide MCM Transition of Care Policy [42 CFR 438.340(b)(5)]

The Department's transition of care policy, per the regulatory requirements outlined in in 42 CFR 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/programs-services/medicaid/medicaid-care-management

Adoption of Evidence-Based Clinical Practice Guidelines [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. In addition, 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*.

Adoption of Evidence-Based Clinical Practice Guidelines for Dental [42 CFR 438.236]

The NH DO Contract requires the DOs adopt evidence-based guidelines that are in compliance with CMS

and with URAC's requirements for health plan accreditation. The guidelines shall be based on valid and reasonable clinical evidence or a consensus of Providers in the particular field, shall consider the needs of Members, be adopted in consultation with Participating Providers, and be reviewed and updated periodically as appropriate.

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 quality and appropriate care delivery to the NH Medicaid population enrolled in managed care.

Objective 1.1 – Ensure that by the end of State Fiscal Year 2025 NH identified priority 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 (HMO). 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.

NH has identified the following measures previously below the benchmark in 2020 that will be targeted in achieving the objective:

- CMS Core Set/HEDIS (IMA) – Immunizations for Adolescents Combination 1;
- CMS Core Set/HEDIS (IMA) – Immunizations for Adolescents Combination 2 (objective is 90th percentile);
- CMS Core Set/HEDIS (WCC) – Weight Assessment and Counseling in Adolescents/Children – Body Mass Index.
- CMS Core Set/HEDIS (CHL) – Chlamydia Screening in Women;
- CMS Core Set/HEDIS (PPC) – Prenatal and Postpartum Care – Prenatal Care Rate; and
- CMS Core Set/HEDIS (PPC) – Prenatal and Postpartum Care – Postpartum Care Rate.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 1: Assure quality and appropriate care delivery to the NH Medicaid Managed Care population.		
Objective 1.1 – Ensure that by the end of State Fiscal Year 2025, annual preventive care measure rates are equal to or higher than 75th percentile of National Medicaid managed care health plan rates.		
Immunization for Adolescents Combination 1 -Without HPV (IMA)	74.3% (CY2020)	CY 2024 National 75th Percentile
Immunization for Adolescents Combination 2- Including HPV (IMA)	31.4% (CY2020)	CY 2024 National 75th Percentile
Weight Assessment and Counseling in Adolescents/Children – BMI (WCC)	63.9% (CY2020)	CY 2024 National 75th Percentile
Chlamydia Screening in Women (CHL)	46.5% (CY2020)	CY 2024 National 75th Percentile
Prenatal and Postpartum Care – Prenatal Care (PPC)	77.1% (CY2020)	CY 2024 National 75th Percentile
Prenatal and Postpartum Care – Postpartum Care (PPC)	73.1% (CY2020)	CY 2024 National 75th Percentile

Objective 1.2 – Ensure that by the end of State Fiscal Year 2025 NH identified priority 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 (HMO). 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.

NH has identified the following measures previously below the benchmark in 2020 that will be targeted in achieving the objective:

- CMS Core Set/HEDIS (ADD) – Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance;
- CMS Core Set/HEDIS (APP) – Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.

- CMS Core Set/HEDIS (HBD) – Comprehensive Diabetic Care Control <8%;
- CMS Core Set/HEDIS (CBP) – Controlling High Blood Pressure - Total; and
- HEDIS (POD) – Pharmacotherapy for Opioid Use Disorder.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 1: Assure quality and appropriate of care delivery to the NH Medicaid Managed Care population.		
Objective 1.2 – Ensure that by the end of State Fiscal Year 2025 annual treatment measure rates are equal to or higher than the 75th percentile of National Medicaid managed care health plan rates.		
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance (ADD)	53.6% (CY2020)	CY 2024 National 75th Percentile
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	62.4% (CY2020)	CY 2024 National 75th Percentile
Comprehensive Diabetic Care Control <8% (HBD)	42.8% (CY2020)	CY 2024 National 75th Percentile
Controlling High Blood Pressure – Total (CBP)	52.7% (CY2020)	CY 2024 National 75th Percentile
Pharmacotherapy for Opioid Use Disorder (POD)	28% (CY2020)	CY 2024 National 75th Percentile

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

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

On an annual basis, the MCM Quality Program evaluates each Organization’s network for time and distance standards that are established in the MCO and DO contract. Standards developed in the MCO and DO 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 organization 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;
- Organization’s 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 organization’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 C – State Defined Network Adequacy and Availability of Service Standards* for specific details.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 2: Assure that members have access to care and a quality experience of care.		
Objective 2.1 – Ensure that the MCO and DO provider networks meet the 90% standard of time or distance for each New Hampshire County.		
MCO Quality Measures		
Percent of NH counties in which all MCO provider networks assure that 90% of members meet time or distance standards OR have an exception request submitted to the Department.	100% (SFY 2021)	100% (SFY 2025)
DO Quality Measures		
Percent of NH counties in which all DO provider networks assure that 90% of members meet time or distance standards OR have an exception request submitted to the Department.	TBD	100% (SFY 2025)

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

The MCO and DO 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 aligns with elements of NH's strategy for the CMS required Medicaid Fee for Service Access Report.

On a quarterly basis, the Division of Medicaid Services subject matter experts review 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; and
- Beneficiary requests for primary care and specialist.

For each measure, control limits based on historical trends are employed in quarterly charts to provide an 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

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

data. New quarterly rates that are three standard deviations from the mean will be considered a potential access issue that may require closer examination.

Annually, the EQRO will conduct a secret shopper or revealed caller study for selected New Hampshire provider 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.

While rates for each indicator are dependent on the provider type being evaluated, the Department also evaluates the same rate for a commercial payer in the state. Results are compared to better understand if any perceived access to care issues are unique to the Medicaid population.

While not included in this objective, each MCO conducts the adult and member Consumer Assessment of Healthcare and Provider Systems CAHPS survey. See how rates are evaluated in Object 2.4 and 2.5.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 2: Assure that members have access to care and a quality experience of care.		
*Objective 2.2 – Ensure MCO and DO access performance measures do not indicate an access issue**		
MCO Quality Measures		
Percentage of monthly MCO access performance measure reviews that are conducted to identify potential access issues.	100% (SFY 2021)	100% (SFY 2025)
DO Quality Measures		
Percentage of monthly DO access performance measure reviews that are conducted to identify potential access issues.	100% (SFY 2024)	100% (SFY 2025)

*Objective is based on conducting an operational process. Achievement of the objective is evaluated by a process measure instead of performance outcome measurement.

Objective 2.3 – Ensure that MCOs and DO provide accurate information in their provider directories.

Starting in calendar year 2022, the Department will validate the accuracy of the managed care network information supplied to Medicaid members through a provider network validation survey.

The goal of the survey conducted by the EQRO is to determine if the information in each Organizations' online provider directory found on the respective organizations' web sites matched MCO or DO provider data and could be confirmed by the sampled location through revealed shopper calls.

The survey involves a sample of primary care providers, specialists, and behavioral health providers. Baselines and statewide performance targets will be created after the initial survey is completed.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 2: Assure that members have access to care and a quality experience of care.		
Objective 2.3 – Ensure that MCOs and DO provide accurate information in their organization's provider directories.		
MCO Quality Measures		
Percentage of MCO audited primary care providers with exact matches between MCO data and provider directory. Baselines and targets TBD.	TBD	TBD
Percentage of MCO audited behavioral health providers with exact matches between MCO data and provider directory. Baselines and targets TBD.	TBD	TBD
Percentage of MCO audited specialist providers with exact matches between MCO data and provider directory. Baselines and targets TBD.	TBD	TBD
DO Quality Measures		
Percentage of DO audited dental providers with exact matches between DO data and provider directory. Baseline and targets TBD.	TBD	TBD

Objective 2.4 – Ensure that by the end of State Fiscal Year 2025 annual member experience of care survey access to care 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 and DO. 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.

While the CAHPS survey results are expansive, to monitor access to care the Department has selected four measures to evaluate the member experience. Results for these following four rates are compared to the NCQA Quality Compass 50th percentile of Medicaid managed care health plans:

- Adult/Child CAHPS - Getting care quickly: Getting needed care right away – Usually or Always
- Adult/Child CAHPS - Getting care quickly: Getting routine or check-up appointments as soon as they were needed – Usually or Always
- Adult/Child CAHPS - Getting care quickly: Getting appointment with specialist as soon as needed
- Adult/Child CAHPS - Getting needed care: Ease in getting care, tests and treatment

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 2: Assure that members have access to care and a quality experience of care.		
Objective 2.4 – Ensure that by the end of State Fiscal Year 2025, annual member experience of care survey access to care rates are equal to or higher than the national average for Medicaid managed care health plans.		
MCO Quality Measures		
Adult CAHPS - Getting care quickly: Getting needed care right away – Usually or Always	84.8% (CY 2020)	CY 2024 National 50th Percentile
Adult CAHPS - Getting care quickly: Getting routine or check-up appointments as soon as they were needed – Usually or Always	85.2% (CY 2020)	CY 2024 National 50th Percentile
Adult CAHPS - Getting care quickly: Getting appointment with specialist as soon as needed	82.6% (CY 2020)	CY 2024 National 50th Percentile
Adult CAHPS - Getting needed care: Ease in getting care, tests and treatment	87.8% (CY 2020)	CY 2024 National 50th Percentile
Child CAHPS - Getting care quickly: Getting needed care right away – Usually or Always	95.1% (CY 2020)	CY 2024 National 50th Percentile
Child CAHPS - Getting care quickly: Getting routine or check-up appointments as soon as they were needed – Usually or Always	89.5% (CY 2020)	CY 2024 National 50th Percentile
Child CAHPS - Getting care quickly: Getting appointment with specialist as soon as needed	82.6% (CY 2020)	CY 2024 National 50th Percentile
Child CAHPS - Getting needed care: Ease in getting care, tests and treatment	89.5% (CY 2020)	CY 2024 National 50th Percentile
DO Quality Measures		
Adult Dental CAHPS - Getting care quickly: Getting dental appointments as soon as they were wanted – Usually or Always	TBD	CY 2024 National 50th Percentile
Adult Dental CAHPS - Getting care quickly: Getting appointment with dental specialist as soon as it was wanted	TBD	CY 2024 National 50th Percentile
Adult Dental CAHPS - Getting needed care: Ease in getting emergency dental care appointment as soon as it was wanted	TBD	CY 2024 National 50th Percentile

Objective 2.5 – Ensure that annual member experience of care survey MCO and DO customer service quality 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 and DO. 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.

The Department has identified customer service quality to be a key indicator of a member's experience with a health plan. In addition, customer service quality is one of the most actionable indicators for improvement. The Department will compare the following two rates to the NCQA Quality Compass 50th percentile of Medicaid managed care health plans:

- Adult/Child CAHPS – Health plan customer service provided information or help – Usually or always
- Adult/Child CAHPS - Health plan customer service treated member/caregiver with courtesy and respect – Usually or always

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 2: Assure that members have access to care and a quality experience of care.		
Objective 2.5 – Ensure that annual member experience of care survey MCO and DO customer service quality rates are equal to or higher than the national average for Medicaid managed care health plans		
MCO Quality Measures		
Adult CAHPS – Health plan customer service provided information or help – Usually or always	85.4% (CY 2020)	CY 2024 National 50th Percentile
Adult CAHPS - Health plan customer service treated member with courtesy and respect – Usually or always	95.0% (CY 2020)	CY 2024 National 50th Percentile
Child CAHPS – Health plan customer service provided information or help – Usually or always	82.2% (CY 2020)	CY 2024 National 50th Percentile
Child CAHPS - Health plan customer service treated caregiver with courtesy and respect – Usually or always	97.8% (CY 2020)	CY 2024 National 50th Percentile
DO Quality Measures		
Adult Dental CAHPS – Dentist explained things in a way that was easy to understand – Usually or always	TBD	CY 2024 National 50th Percentile
Adult Dental CAHPS – Dentist treated member with courtesy and respect – Usually or always	TBD	CY 2024 National 50th Percentile

Goal 3 – Assure MCO and DO contract compliance

Objective 3.1 – Demonstrate contract compliance and identify quality issues through ongoing MCO and DO 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 organization 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 organization (MCO and DO) level. The State reviews for:

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

On a monthly basis, the Bureau of Program Quality reviews potential issues to determine whether escalation to the Medicaid Director is necessary. Confirmed issues are captured on the Monthly Medicaid Director's Remedy report. The report includes:

- Description of the issue;
- The name of the organization associated with the issue;
- Whether liquidated damages are recommended and the amount; and

- An indication if this is a new or re-occurring issue.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 3: Assure MCO and DO contract compliance.		
*Objective 3.1 – Demonstrate contract compliance and identify quality issues through ongoing MCO and DO system wide performance measure evaluation.**		
MCO Quality Measures		
Percentage of months the Department completed the Medicaid Director's Remedy report for MCO.	100% (SFY 2021)	100% (SFY 2025)
DO Quality Measures		
Percentage of months the Department completed the Medicaid Director's Remedy report for DO.	100% (SFY 2024)	100% (SFY 2025)

*Objective is based on conducting an operational process. Achievement of the objective is evaluated by process measurement(s) instead of performance outcome measurement(s).

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

The EQRO conducts an annual compliance review of each organization to ensure compliance with federal and State requirements including 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. The same process described above will be used for the DO beginning in SFY 2024 with a comprehensive contract review.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 3: Assure MCO and DO contract compliance.		
Objective 3.2 – Ensure annual EQRO contract compliance audit results demonstrate MCO and DO contract standards are being met; and, for those standards that are not met, corrective action plans are approved.		
MCO Quality Measures		
Percentage of MCO contract standards that are being met; and, for those standards that are not met, corrective action plans are approved.	100% (SFY 2021)	100% (SFY 2025)
DO Quality Measures		
Percentage of DO contract standards that are being met; and, for those standards that are not met, corrective action plans are approved.	100% (SFY 2024)	100% (SFY 2025)

Goal 4 – Assure the quality and validity of MCO and DO data

Objective 4.1 – Ensure the annual EQRO performance measure validation audit results verify the accuracy of MCO and DO performance measures.

Validation of performance measures is a mandatory EQRO activity required by CMS. The purpose of a performance measure validation audit is to ensure that MCOs and DOs 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 organizations 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 organization. The EQRO then verifies the resubmitted rates.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 4: Assure the quality and validity of MCO and DO data.		
Objective 4.1 – Ensure the annual EQRO performance measure validation audit results verify the accuracy of MCO and DO performance measures.		
MCO Quality Measures		
Percentage of MCO performance measures in the EQRO audit that are determined to be acceptable for reporting.	100% (SFY 2021)	100% (SFY 2025)
DO Quality Measures		
Percentage of DO performance measures in the EQRO audit that are determined to be acceptable for reporting.	100% (SFY 2024)	100% (SFY 2025)

Objective 4.2 – Ensure that monthly EQRO encounter data validation results demonstrate MCO and DO contract compliance for timeliness and accuracy of encounter data.

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

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 4: Assure the quality and validity of MCO and DO data.		
Objective 4.2 – Ensure that monthly EQRO encounter data validation results demonstrate MCO and DO contract compliance for timeliness and accuracy of encounter data.		
MCO Quality Measure		
X12 EDI Compliance Edits (P,I)	100% (SFY 2021)	98% (SFY 2025)
Validity of Member Identification Number (P, I, Rx)	99.6%-100% (SFY 2021)	100% (SFY 2025)
Validity of Billing Provider Information (P, I, Rx)	100% (SFY 2021)	98% (SFY 2025)
Validity of Servicing Provider Information (P,I)	100% (SFY 2021)	98% (SFY 2025)
Initial Submission Within 14 Days of Claim Payment (P, I, Rx)	85.5%-100% (SFY 2021)	100% (SFY 2025)
DO Quality Measures		
X12 EDI Compliance Edits	100% (SFY 2024)	98% (SFY 2025)
Validity of Member Identification Number	99.6%-100% (SFY 2024)	100% (SFY 2025)
Validity of Billing Provider Information	100% (SFY 2024)	98% (SFY 2025)
Validity of Servicing Provider Information	100% (SFY 2024)	98% (SFY 2025)
Initial Submission Within 14 Days of Claim Payment	85.5%-100% (SFY 2024)	100% (SFY 2025)

P – Professional, I – Institutional, Rx – Pharmacy

Goal 5 – Maintain Quality Performance Improvement Initiatives

Objective 5.1 – Maintain MCO and DO performance improvement projects that are validated and align with DHHS Medicaid Quality priority areas.

Each MCO must implement four (4) rapid cycle PIPs over the 5 year MCO contract cycle. PIPs must include the following categories that align with the Department's goals and objectives:

- Mental health;
- Substance use disorder focused on improving service delivery;
- Clinical focused on improving performance on an indicator that is below the national fiftieth (50th) percentile; and
- Non-clinical related to (1) addressing social determents of health; or, (2) integrating physical and behavioral health.

The DO must implement one (1) PIP over the first 2 year DO contract cycle. The PIP will be developed in collaboration with DHHS.

While the Department sets the broad direction of the PIPs based on the requirements above, the organizations select the actual PIPs. The Department encourages the organizations to select PIPs based on the same performance measures to maximize economies of scale. DHHS strategy is to encourage the MCOs to select the same measures for their PIPs.

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.

The Department utilizes the EQRO to validate the MCOs and DOs administration of the PIPs following the CMS EQRO protocols.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 5: Maintain Quality Performance Improvement Initiatives.		
*Objective 5.1 – Maintain MCO and DO performance improvement projects that are validated and align with DHHS goals and objectives.**		
MCO Quality Measures		
Percentage of MCO PIPs that are validated by the EQRO and align with DHHS goals and objectives.	100% (SFY 2021)	100% (SFY 2025)
DO Quality Measures		
Percentage of DO PIP that is validated by the EQRO and align with DHHS goals and objectives.	TBD	100% (SFY 2025)

*Objective is based on conducting an operational process. Achievement of the objective is evaluated by process measurement(s) instead of performance outcome measurement(s).

Objective 5.2 – Ensure MCOs and DOs have acted upon each EQR recommendation/finding in the Organization's annual QAPI report or the semi-annual EQRO.01 report.

Each EQRO report findings and recommendations for improvements are evaluated to determine if there is:

- Violation of contract standards;
- Impact to NH Medicaid quality improvement priorities;
- Impact to NH Medicaid members' access to care; and/or
- Impact to NH Medicaid members' quality of care.

In the event that a finding and/or recommendation meets any of the conditions listed above, the organization is required to provide a written response in a semi-annual (EQRO.01) report provided to the Department. The organization will continue to report progress on the issue in subsequent semi-annual reports until the Department considers the issue to be resolved.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 5: Maintain Quality Performance Improvement Initiatives.		
*Objective 5.2 – Ensure MCOs and DOs have acted upon each EQR recommendation/finding in the organization's annual QAPI report or semi-annual EQRO.01 report.**		
MCO Quality Measures		
Percentage of EQRO recommendations/findings identified by the Department for MCO follow up, that are acted upon by the organization.	100% (SFY 2022)	100% (SFY 2025)
DO Quality Measures		
Percentage of EQRO recommendations/findings identified by the Department for DO follow up, that are acted upon by the organization.	TBD	100% (SFY 2025)

*Objective is based on conducting an operational process. Achievement of the objective is evaluated by process measurement(s) instead of performance outcome measurement(s).

Objective 5.3 - Maintain Quality Withhold and Incentive Program.

Starting on July 1, 2020, the Department implemented a Quality Withhold and Incentive Program. The program is an arrangement through which an actuarially sound percentage of the MCO's risk-adjusted capitation payment will be recouped from the MCO and returned on the basis of meeting specific performance targets. Withhold dollars that are not earned back by an MCO are used to fund an incentive pool that can award high performing MCOs.

Note: Withholding capitation payments from the MCOs is a retrospective process that is determined at the end of the annual program.

The program includes specific performance measures that align with Department goals and objectives including but not limited to metrics outlined in Objective 1.1 and 1.2 of the NH Comprehensive Medicaid Quality Strategy. Each MCOs' performance is evaluated based on their individual metric rates. Each performance measure has a minimum threshold and an annual goal. The minimum threshold is typically the MCOs' prior year performance and in most cases reaching the threshold is required to earn back the withhold. The annual goal is typically the Department's goal of 75th percentile of National Medicaid health plans, and in most cases reaching the annual goal is required to receive a full return of withhold funding.

The Withhold and Incentive program is implemented based on the following stages associated with the program:

- Performance measures and targets selected;
- Approval of targets by the Department's contracted actuaries;
- Collection of performance measure data; and
- Final withhold calculations.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 5: Maintain Quality Performance Improvement Initiatives.		
*Objective 5.3 – Maintain Quality Withhold and Incentive Program.**		
Annual percentage of withhold and incentive program stages that are completed	100% (SFY 2021)	100% (SFY 2025)

*Objective is based on conducting an operational process. Achievement of the objective is evaluated by process measurement(s) instead of performance outcome measurement(s).

Objective 5.4 - Maintain Quality Performance Based Auto Assignment Program.

The Department administers a Performance Based Auto-Assignment Program where each MCO's performance is evaluated on a selection of key process performance indicators. Top performing MCOs are awarded additional member enrollment during the MCO member auto-assignment process.

To date, programs have included:

- MCO membership enrollment in care management;
- MCO membership with a completed health risk assessment;
- Follow up with a member after receiving substance use disorder services at an emergency department;
- Reducing psychiatric boarding; and
- Quality, timeliness, and accuracy of MCO encounter data.

The auto-assignment program is implemented based on the following stages associated with the program:

- Methods and performance measures are established;
- Collection of performance measure data;
- Final auto-assignment program calculations; and
- Changes made to the DHHS Medicaid Eligibility auto-assignment software.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 5: Maintain Quality Performance Improvement Initiatives.		
*Objective 5.4 – Maintain Quality Performance Based Auto-Assignment Program.**		
Annual percentage of performance based auto-assignment program stages that are completed	100% (SFY 2021)	100% (SFY 2024)

*Objective is based on conducting an operational process. Achievement of the objective is evaluated by process measurement(s) instead of performance outcome measurement(s).

Objective 5.5 – Maintain liquidated damages program that includes sanctions that are compliant with 42 CFR 438 Subpart I.

MCO and DO liquidated damages are in compliance with the minimum requirements in 42 CFR 438 Subpart I. The NH MCO and DO Contract addresses remedies at the State's disposal to address MCO and

DO performance concerns. Liquidated damages may be enacted and the contract stratifies violations into 4 levels, each with varying financial remedies. See *Appendix D – Medicaid Care Management Services Contracts Exhibit N: Liquidated Damages* for specific details.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 5: Maintain Quality Performance Improvement Initiatives.		
*Objective 5.5 – Maintain liquidated damages program that includes sanctions that are compliant with 42 CFR 438 Subpart I.**		
MCO Quality Measures		
Percentage of MCO sanctions that are compliant with 42 CFR 438 Subpart I.	100% (SFY 2021)	100% (SFY 2025)
DO Quality Measures		
Percentage of DO sanctions that are compliant with 42 CFR 438 Subpart I.	100% (SFY 2024)	100% (SFY 2025)

*Objective is based on conducting an operational process. Achievement of the objective is evaluated by process measurement(s) instead of performance outcome measurement(s).

Objective 5.6 - Conduct a multi-stakeholder quality forum to identify barriers and solutions to improve key performance indicators.

Periodically, the Department selects one quality measure that (1) presents an opportunity for improvement and (2) reflects a priority issue for the Department. The measure then becomes the focus of a multi-stakeholder quality forum. The measure selected is most often included in Objective 1.1 or Objective 1.2.

Once a quality measure is selected, the Department conducts a deep analysis of the most current performance rate to determine:

- Individual MCO or DO specific rates;
- Individual provider rates;
- Individual New Hampshire regional rates;
- Comparisons to New Hampshire commercial payer rates; and
- Comparisons to National benchmarks.

The analysis is conducted to determine variables (e.g. MCOs, providers, NH regions) that could be positive or negative drivers of the rate.

After the analysis is conducted, the Department begins a statewide recruiting process for the quality forum to identify professionals in New Hampshire that are direct stakeholders who affect the performance rate. Recruitment is inclusive of Department staff, MCO or DO staff, NH providers, community agencies, advocacy agencies, and NH Medicaid recipients or families members who are utilizers of the service being discussed. In addition to direct stakeholders, the Department also recruits national experts that can introduce best practices and/or summarize the most current research on the topic.

After analysis and recruitment is completed, with assistance from the EQRO, the Department schedules

the quality forum. The objectives of the quality forum are to (1) reach consensus on barriers affecting the NH Medicaid rate for the performance measure and (2) brainstorm potential Department, MCO or DO, and provider solutions to the barriers.

The 2021 quality forum topic was increasing follow-up visits after seeking substance use treatment in the emergency department. The full report of the meeting can be found at:
https://medicaidquality.nh.gov/sites/default/files/NH_Annual_Meeting_Sept_29_2021_F1.pdf

The 2023 quality forum topic was increasing chlamydia screening rates in women. The full report is pending.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 5: Maintain Quality Performance Improvement Initiatives.		
*Objective 5.6 – Conduct a multi-stakeholder quality forum to identify barriers and solutions to improve key performance indicators.**		
The Department conducts multi-stakeholder quality forums that identify barriers and solutions to improve key performance indicators.	100% (SFY 2021)	100% (SFY 2025)

*Objective is based on conducting an operational process. Achievement of the objective is evaluated by process measurement(s) instead of performance outcome measurement(s).

Goal 6 – Conduct Key Population Health Quality Activities.

Objective 6.1 – Identify, evaluate and to the extent possible reduce health disparities. [42 CFR 438.340(b)(6)].

In compliance with 42 CFR 438.340(b)(6), the Department has implemented the New Hampshire Medicaid Managed Care Health Disparities Plan. The plan involves the following two phases:

- Phase 1: Identification and evaluation of NH Medicaid health disparities; and
- Phase 2: Initiatives to reduce NH Medicaid health disparities.

Phase 1: Identification and Evaluation of NH Medicaid Health Disparities

The Department receives member level data from selected performance measures (i.e., HEDIS and/or CMS Core Set) that are calculated by the MCOs. The member level data indicates:

- Member identification number;
- Whether the member met the measure's numerator requirement;
- Event dates (if applicable); and
- Measurement year.

Predictor variables (i.e., demographic and other categorical indicators) using a Veera Construct, are then cleansed, organized, and linked with the member level performance measure data. The result is a member level record showing predictor variables and individual results on performance metrics. Predictor variables include:

- Age;
- Gender (male or female);

- Ethnicity (Hispanic or Non-Hispanic);
- Race (White or Non-White);
- Metro County/Non-Metro County;
- Tri City (Manchester, Nashua, or Concord);
- 10 NH counties;
- Community Mental Health Center Client (CMHC);
- 1915(c) Home and Community Based Waiver Status;
- Foster care; and
- Disability status.

Member race is primarily captured during the determination of Medicaid eligibility using Office of Management and Budget categories. While data exists on a variety of racial categories, New Hampshire's total population was 93.7% "white alone" or "white in combination" in 2020 US Census data. With such a significant percentage of the population reported as white, the individual non-white categories are too small to use statistical modeling described below or implement meaningful quality improvement activities. To assure that the Department is identifying and evaluating potential health disparities based on race, the predictor variable Non-White was created to assure sufficient volume for analysis.

The Department defines disability status in the variable as required by 42 CFR 438.340(b)(6) based on categories of eligibility including: aid to permanently and totally disabled, needy blind, disabled employed adults, and children with severe disabilities in home care programs.

Upon the completion of matching predictor variables and performance measure results, generalized linear regression modeling is conducted for each measure. The objective of the process is to determine whether predictor variables are considered significant predictors for the numerator requirement. Results were considered statistically significant if the p-value was <0.05.

Race is not a required data element that is captured during Medicaid eligibility and as a result, 21% of members included in the regression modeling had a null value for this element. The process of multiple imputation attempted to correct for that by averaging the non-null values several times and assignment values to nulls based on the average spread of data in the non-nulls. Over the time frame covered by MCM Quality Strategy version 6, the Department will explore different opportunities for addressing null values in race inclusive of methods introduced by CMS, NCQA, and the National Quality Forum:

- Direct methods of training Medicaid eligibility workers in effective methods of capturing member race data; or
- Indirect methods such as:
    - Assigning race categories based on community-level data (e.g. census, zip code) to attribute characteristics to a patient who resides in that location; or
    - Bayesian surname methodology to attribute race.

Primary language is also not a required data element that is captured during Medicaid eligibility and as a result, has a significant proportion of member data reporting null for this element. Additionally, language data does not distinguish between primary written, spoken, or signed language(s) according to national best practices. NH DHHS is undergoing a large data collection project to overhaul how demographic data is captured in our data and eligibility systems, language is part of this project but will not be fully in place for several more years. NH has participated in the National Academy of State Health Policy (NASHP) Learning Lab (technical assistance) program to learn from other states who are leaders in this topic. For these reasons, primary language has been excluded from this analysis, but will be added in the future.

Initial results of the linear regression modeling using Calendar Year 2020 data can be found in the table below.

HEDIS/CMS Core Set Measure	Significant Predictors for Numerator (p-value <0.05), CY 2020
Follow-up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions (FMC) - 7 Days	Age, Female, Hillsborough County, Rockingham County, CMHC Client, Disabled
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 7 Days	None
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 30 Days	None
Follow-up After Hospitalization for Mental Illness (FUH) - 7 Days	Age, Hillsborough County, Rockingham County, CMHC Client,
Follow-up After Hospitalization for Mental Illness (FUH) - 30 Days	Age, Female, CMHC Client, White*
Follow-up After High-Intensity Care for Substance Use Disorder (FUI) - 7 Days	Age, Tri City
Follow-up After High-Intensity Care for Substance Use Disorder (FUI) - 30 Days	Age, White
Follow-up After Emergency Department Visit for Mental Illness (FUM) - 7 Days	Age, Tri City, Carroll County, Hillsborough County, Rockingham County, CMHC Client
Follow-up After Emergency Department Visit for Mental Illness (FUM) - 30 Days	Age, Female, Hispanic, Hillsborough County, Rockingham County, CMHC Client, White
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (Engagement)	Age, CMHC Client, Disabled
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (Initiation)	Tri City

*White race was found to be statistically significant in 3/11 measures but, because this field was heavily imputed, and with the non-null race values in the dataset being overwhelmingly White, these results should be interpreted with caution.

Calendar year 2021 data represents an expansion of performance measures that will be included in the identification and evaluation process. The full list of measures to be included are in the table below.

Measure Name
Follow-Up Care for Children Prescribed ADHD Medication (ADD): Initiation Phase
Follow-Up Care for Children Prescribed ADHD Medication (ADD): Continuation and Maintenance Phase
Antidepressant Medication Management (AMM): Effective Acute Phase Treatment
Antidepressant Medication Management (AMM): Effective Continuation Phase Treatment

Measure Name
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) - Blood Glucose Testing
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) - Cholesterol Testing
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) - Blood Glucose and Cholesterol Testing
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
Breast Cancer Screening (BCS)
Controlling High Blood Pressure (CBP)
Cervical Cancer Screening (CCS)
Comprehensive Diabetes Care (CDC): HbA1c Poor Control (>9.0%)
Comprehensive Diabetes Care (CDC): HbA1c Control (<8.0%)
Chlamydia Screening in Women (CHL)
Childhood Immunization Status (CIS): Combination 10
Risk of Continued Opioid Use >= 15 Days by Age
Risk of Continued Opioid Use >= 30 Days by Age
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) within 7 days
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) Within 30 days
Follow-Up After Hospitalization for Mental Illness (FUH) within 7 Days by Age
Follow-Up After Hospitalization for Mental Illness (FUH) within 30 Days by Age
Follow-Up after High-Intensity Care for Substance Use Disorder (FUI) within 7 Days
Follow-Up after High-Intensity Care for Substance Use Disorder (FUI) within 30 Days
Follow-up After Emergency Department Visit for Mental Illness (FUM) Within 7 days by Age
Follow-up After Emergency Department Visit for Mental Illness (FUM) Within 30 days by Age
Use of Opioids at High Dosage (HDO)

Measure Name
Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (Total)
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (Total)
Initiation of Alcohol Abuse or Dependence Treatment (IET)
Engagement of Alcohol Abuse or Dependence Treatment (IET)
Initiation of Opioid Abuse or Dependence Treatment (IET)
Engagement of Opioid Abuse or Dependence Treatment (IET)
Initiation of Other Drug Abuse or Dependence Treatment (IET)
Engagement of Other Drug Abuse or Dependence Treatment (IET)
Immunizations for Adolescents (IMA): Combination 2
Lead Screening
Pharmacotherapy for Opioid Use Disorder
Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care
Prenatal and Postpartum Care (PPC): Postpartum Care
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
Well-Child Visits in the First 30 Months of Life (W30) - Visits in the First 15 Months
Well-Child Visits in the First 30 Months of Life (W30) - Visits for Age 15 Months-30 Months
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): Evidence of BMI Percentile Documentation
Child and Adolescent Well-Care Visits (WCV)

To achieve objective 6.1 of the Quality Strategy related to the identification and evaluation of disparities, the Department will conduct the following tasks throughout the period of MCM Quality Strategy version

SFY 2023:

- Collect member level HEDIS/Core Set data from the MCOs;
- Match member level data with predictor variables;
- Conduct linear regression modeling on each measure to determine significant predictor variables;
- Conduct linear regression modeling to determine significant predictor variables that negatively impact numerator events; and
- Explore additional initiatives to reduce null values for member race data.

Phase 2: Reduce Health Disparities to the Extent Possible

Over the three-year period of MCM Quality Strategy SFY 2023 to SFY 2025, the Department plans to explore different quality activities that could be leveraged to reduce health disparities. At a minimum, the Department will share the results with the MCOs QAPI programs to support focused quality improvement interventions.

Additionally the Department will explore the following activities:

- Withhold and Incentive Program to determine if the program could be adjusted to incorporate improvement on quality measures in a specific populations with significant predictor variable(s) associated with the measure;
- Performance Based-Auto Assignment Program to determine if a method could be included that focuses on improvement on a quality measure in a specific population with significant predictor variable(s) associated with the measure;
- Liquidated Damages to determine if MCO contract standards could be developed that focus on minimum performance on a quality measure in a specific population with significant predictor variable(s) associated with the measure;
- Multi-Stakeholder Quality Forums to determine if the selected performance measure evaluated in the forum should include discussions related to specific populations with significant predictor variable(s) associated with the measure; and
- Performance Improvement Projects to determine if the EQRO's validation process should include MCO exploration of improvement efforts in a specific population with significant predictor variable(s) associated with the measure.
- MCOs and DOs are required to have a Cultural Competency Plan and must be responsive to any identified population-specific needs.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 6: Conduct Key Population Health Quality Activities.		
*Objective 6.1 – Identify, evaluate, and to the extent possible reduce health disparities.**		
Percentage of tasks associated with the health disparity plan that were completed.	100% (SFY 2021)	100% (SFY 2025)

*Objective is based on conducting an operational process. Achievement of the objective is evaluated by process measurement(s) instead of performance outcome measurement(s).

Objective 6.2 – Identify, evaluate and to the extent possible reduce health disparities in the behavioral

health population.

The Department has multiple initiatives related to the behavioral health population receiving Medicaid services. The population includes members with mental health conditions and members receiving services for the treatment of substance use. Current Medicaid initiatives include but are not limited to:

- Community Mental Health Center Directed Payment;
- Community Mental Health Agreement;
- CMS 1115 Demonstration Institution for Mental Disease Waiver for Substance Use Disorder; and
- CMS 1115 Demonstration Institution for Mental Disease Waiver for Severe and Mental Illness.

With considerable attention on supporting this population, the Department will assure the activities included in objective 6.1 are conducted specifically for the behavioral health population.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 6: Conduct Key Population Health Quality Activities.		
*Objective 6.2 – Identify, evaluate, and to the extent possible reduce health disparities in the behavioral health population.**		
Percentage of tasks associated with the health disparity plan that were completed for the behavioral health population.	100% (SFY 2021)	100% (SFY 2025)

*Objective is based on conducting an operational process. Achievement of the objective is evaluated by process measurement(s) instead of performance outcome measurement(s).

Objective 6.3 – Increase care coordination in the Managed Care Population.

The NH MCM quality program includes monitoring of two key MCO contract standards related to care coordination. The Department's goals for the program is to expand the use of MCO care management beyond those members with high risk to those members who have emerging risk.

First, the Department is evaluating whether or not the MCOs achieve a standard of 3% of their population and are enrolled in the MCOs care management program.

Second, the Department is evaluating whether or not the MCOs achieve a standard of 25% of their population completing an annual health risk assessment.

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

The Department also promotes the use of a dental risk assessment and plans to obtain baseline data.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 6: Conduct Key Population Health Quality Activities		

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Objective 6.3 – Increase care coordination in the Managed Care Population.		
Percentage of members enrolled in an MCO who are enrolled in care management.	1.9% (SFY 2021)	3% (SFY 2025)
Percentage of members who annually complete a health risk assessment.	14.4% (SFY 2021)	25% (SFY 2025)
Percentage of dental members who complete a dental risk assessment.	TBD	25% (SFY 2025)

Goal 7 – Achieve State Directed Payment Goals

Objective 7.1 – Ensure state meets goals of the Durable Medical Equipment directed payment.

Since 2021, the Department has been utilizing directed payments authorized by the Centers for Medicare and Medicaid Services to provide a Minimum Fee Schedule for Durable Medical Equipment (DME). These directed payments are designed to advance goals associated with improving access.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 7: Achieve State Directed Payment Goals.		
Objective 7.1 – Ensure state meets goals of the Durable Medical Equipment directed payment.		
Percent of NH counties in which all MCO provider networks assure that 90% of members meet time or distance standards for DME providers.	100% (SFY 2021)	100% (SFY 2025)

Objective 7.2 - Ensure state meets goals of the Community Mental Health Program directed payment.

Since 2018, the Department has been utilizing Directed Payments authorized by the Centers for Medicare and Medicaid Services to provide uniform dollar increases for targeted Community Mental Health Services. These directed payments are designed to advance goals associated with improving access to quality care that are contained within the New Hampshire Medicaid Managed Care Quality Strategy.

In 2021, New Hampshire submitted a proposal for directed payment of a uniform dollar increase for:

- Community mental health programs fidelity to Assertive Community Treatment (ACT) services;
- Same day/next day access upon hospital/designated receiving facility discharges and weekly thereafter for up to 90 days post-discharge;
- Step down community residence beds for individuals dually diagnosed with serious mental illness and development disabilities;
- Timely Prescriber Referral after Intake; and
- Consistent Illness Management and Recovery (IMR) services for at least 10 weeks.

The proposal was continued from the prior year for the ACT fidelity directed payment, the community

residential beds for co-occurring diagnosis, and the same day/next day follow-up directed payments. Directed payments for mobile crisis and increase in ACT enrollment were removed. New directed payments for SFY2022 included the Timely Prescriber and IMR services.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 7: Achieve State Directed Payment Goals.		
Objective 7.2 – Ensure state meets goals of the Community Mental Health Program directed payment.		
Members receiving Community Mental Health Services who were discharged from New Hampshire Hospital or Designated Receiving Facility and readmitted within 30 calendar days****	6.4% (CY 2019)	4.4% (CY 2024)
Members receiving Community Mental Health Services who were discharged from New Hampshire Hospital or Designated Receiving Facility and readmitted within 90 calendar days****	15.5% (CY 2019)	13.5% (CY 2024)
Follow-up after hospitalization for mental illness: 7 Days of discharge	56.1% (CY 2019)	National 75th Percentile (CY 2024)
Follow-up after hospitalization for mental illness: 30 Days of discharge	74% (CY 2019)	National 75th Percentile (CY 2024)
Emergency Department Visits for Mental Health Conditions for Adult Members' receiving Community Mental Health Services. ****	19.3 Visits (CY 2019)	18.9 Visits (CY 2024)

****Lower Performance is desired.

Objective 7.3 - Ensure state meets goals of the Critical Access Hospital directed payment.

Since 2021, the Centers for Medicare and Medicaid Services has authorized the Department to utilize Directed Payment for uniform dollar increase for inpatient discharges and outpatient visits to qualifying Critical Access Hospitals (CAH).

The minimum fee schedule for CAHs is created to assure members maintain access to general acute care and maternity hospital services.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 7: Achieve State Directed Payment Goals.		
Objective 7.3 – Ensure state meets goals of the Critical Access Hospital directed payment.		
Admission rate for the following three measures: diabetes short-term complications; heart failure admission rates; chronic obstructive pulmonary disorder or asthma in older adults.	8.8 admissions per 100,000 member months (CY 2021)	8.3 admissions per 100,000 member months (CY 2024)
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse	57% (CY 2020)	58% (CY 2024)
Follow-Up After Emergency Department Visit for Mental Illness	76% (CY 2020)	73% (CY 2024)

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 F – 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 a compilation of quality studies conducted throughout the year.

The most recent effectiveness analysis was conducted in June 2021 and can be found at: https://medicaidquality.nh.gov/care-management-quality-strategy. Summary of results and adjustment made to Quality Strategy 6 can be found in *Appendix I – Quality Strategy Effectiveness Analysis.*

The next effectiveness analysis will be completed prior to July 2024.

C. External Quality Review of Quality Strategy [42 CFR 340(c)(2)(iii)]

Annually the EQRO reviews the Department's Quality Strategy to provide recommendations about how the state can target goals and objectives to better support improvement in the quality, timeliness and access to health care services provided to the NH Medicaid population. This review is included in the annual EQRO technical report. The table below provides:

- Recommendations from the 2021 EQRO technical report;
- Status indicating whether the Department amended Quality Strategy 6 to incorporate the recommendations; and
- Explanation about how the Department amended Quality Strategy 6 or why no change was made at this time.

Recommendation/Findings	Status	Explanation
Create new or revise existing objectives in the MCM Quality Strategy to require MCOs to conduct a barrier analysis to improve preventive care rates.	Adopted	Objective 5.6 was added to the Quality Strategy to address this recommendation. The objective states: "Conduct a multi-stakeholder quality forum to identify barriers and solutions to improve key performance indicators." Each quality forum focuses on one key performance indicator, but is not exclusively limited to preventive care rates. Forum attendees consist of a diverse group of stakeholders such as medical providers, patients/family members, community organizations, MCO quality staff, and DHHS staff. Approximately half of the forum is spent conducting a barrier analysis and identifying potential solutions/recommendations. The forum concludes with a voting exercise to identify the top barriers and their potential solutions/recommendations. Forum outputs are shared with DHHS leadership.
Continue to include postpartum care visits as a measure in Objective 1.1 in the MCM Quality Strategy.	Adopted	This recommendation continues to be addressed in Objective 1.1: "Ensure that by the end of State Fiscal Year 2025, annual preventive care measure rates are equal to or higher than the 75th percentile of National Medicaid managed care health plan rates."
Create new or revise existing objectives in the MCM Quality Strategy to require MCOs to redistribute Clinical Practice Guidelines to all PCPs and pediatricians.	Not Adopted	This recommendation was not adopted because the MCM contract requires MCOs to disseminate Practice Guidelines to DHHS and all affected Providers and make Practice Guidelines available, including but not limited to the MCO's website, and upon request, to Members and potential Members (4.8.2.5). The EQRO monitors compliance through its Contract Compliance Audits (Standard VII, Member Service and Standard XIII, Quality Management).
Create new or revise existing objectives in the MCM Quality Strategy to require MCOs to improve the quality of information on the provider directories.	Adopted	Objective 2.3 was added to the Quality Strategy to address this recommendation. The objective states: "Ensure the MCOs provide accurate information in their MCO provider directories." Monitoring will be conducted through various Quality studies. For example, this is included in the SFY22 Secret Shopper/Network Adequacy Quality Study.
Continue to include objectives in the MCM Quality Strategy related to the MCOs' Performance Improvement Projects.	Adopted	This recommendation continues to be addressed in Objective 5.1: "Maintain MCO performance improvement projects that are validated and align with DHHS goals and objectives." The current rapid PIP cycle will conclude on June 30, 2022 and a new

Recommendation/Findings	Status	Explanation
		PIP cycle will begin 7/1/2022.

D. 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 program3;
- 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.

E. CMS Review

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

F. Strategy Assessment Timeline

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

[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.

Quality Strategy Activity	Date Completed
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
QS#06 NH Medicaid Medical Care Advisory Committee Quality Strategy Presentation #1	April 11, 2022
QS#06 Post Draft Quality Strategy to Comply with Revised CMS Regulations for Public Comment	May 2, 2022
QS#06 NH Medicaid Medical Care Advisory Committee Quality Strategy Presentation #2	May 9, 2022
QS#06 Open Comment Period ends for Quality Strategy to Comply with Revised CMS Regulations	June 2, 2022
QS#06 NH Medicaid Medical Care Advisory Committee Quality Strategy Presentation #3	June 13, 2022
QS#06 Post Final Quality Strategy	June 30, 2022
QS#7 Post Draft Quality Strategy to Comply with Revised CMS Regulations for Public Comment	March 12, 2024
QS#7 NH Medicaid Medical Care Advisory Committee Quality Strategy Presentation to MCAC	April 8, 2024
QS#7 Open Comment Period ends for Quality Strategy to Comply with Revised CMS Regulations	April 12, 2024
QS#7 Post Final Quality Strategy	April 17, 2024
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.A. Appendix D.
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).	• II.A. Data Sources & Systems • Appendix B. • Appendix C.
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.A. Quality Initiatives & Programs. • II.B. Goal 5-Objective 5.1 • Appendix H.
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.A. Department Statewide MCM Transition of Care Policy
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 age, race, ethnicity, sex, primary language, and disability status. States	• II.B. Goal 6-Objective 6.1

CMS Regulation	NH MCM Quality Strategy
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 5-Objective 5.5
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.A. Data Sources and Systems • Appendix F
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. • Appendix G.
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.	• III.B. • Appendix I.
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. Review and update the Quality Strategy as needed, but no less than once	• III.

CMS Regulation	NH MCM Quality Strategy
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 – Medicaid Care Management and Dental Performance Measures

A comprehensive list of current MCO and DO Performance Measures with Performance targets, Plans, Tables, and Narrative Reports can be accessed through publically posted NH MCO and DO Contract Defacto Exhibit O at the following link:

https://medicaidquality.nh.gov/medicaid-care-management-exhibit-o-quality-deliverables

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

Table C.1 MCM Contract Network Adequacy 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
OB/GYN	One (1) within sixty (60) driving minutes or forty-five (45) 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

Table C.2 MCM Contract Availability of Service Standards

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.
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 of medical signs or symptoms not requiring immediate attention.
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.

Availability of Service Standards	
MCO Contract Section	**Standard**
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	Emergency medical and behavioral health care shall be available twenty-four (24) hours a day, seven (7) days a week. Behavioral health care shall be available, and the MCO shall have in its network the capacity to ensure that waiting times for 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 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 days from the date the ASAM level of Care Assessment was completed.

Availability of Service Standards	
MCO Contract Section	Standard
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, the MCO shall: Assist the pregnant woman with identifying alternative Providers and with accessing services with these Providers. This assistance shall include actively reaching out to identify Providers on the behalf of the Member. Provide interim services until the appropriate level of care becomes available at either the agency or an alternative Provider. Interim services shall include: at least one (1) sixty (60) minute individual or group outpatient session per week; recovery support services as needed by the Member; and daily calls to the Member to assess and respond to any emergent needs.

Table C.3 Dental Contract Geographic Network Adequacy Standards

Geographic Access Standards	
Location	**Requirement**
Urban counties, including Strafford, Hillsborough, and Rockingham counties:	a. Ten miles or 15 minutes driving time for core services; b. Twenty miles or 30 minutes driving time for common services; and
Middle counties, including Merrimack, Belknap, Cheshire, Grafton, Carroll, and Sullivan counties:	a. Twenty miles or 40 minutes driving time for core services; b. Forty miles or 80 minutes driving time for common services; and
Rural counties, including Coos county:	a. Thirty miles or one hour driving time for core services; b. Eighty miles or 2 hours driving time for common services; and
• Core services: Dental diagnostic services; Dental preventive services; Dental restorative services • Common Services: Dental adjunctive general services; Dental oral and maxillofacial surgery; Dental periodontics (limited coverage in NH Medicaid); Dental prosthodontics which are removable	

Appendix D – Medicaid Care Management Services Contracts Exhibit N – Liquidated Damages

Table D.1 MCO Contract Liquidated Damages

Information as presented in this Exhibit is current as of the January 1, 2023, NH MCO contract that was presented to NH Governor and Executive Council on December 21, 2022. 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 (Section 4.10), care coordination (Section 4.10), and transition of care (Section 4.10.9) 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

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	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
	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	$50,000 per violation

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	against the Member by any employee of the MCO, its Subcontractor or a Provider	
	1.19 Two or more Level 1 violations within a contract year	$75,000 per occurrence
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 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

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	2.10 Failure to comply with member services requirements (including hours of operation, call center, and online portal)	$5,000 per day of violation
	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 timely process 98% of clean and complete provider credentialing applications	$1,000 per delayed application
	2.15 Failure to meet performance standards in the contract which include: 2.15.1 Care management measures (Sections 4.10.2.12, 4.10.6.2, and 4.10.8.3); 2.15.2 Claims processing (Sections 4.2.4.1.2, 4.18.1.5, 4.18.1.6, 4.18.4.2, and 4.18.5.2); 2.15.3 Call center performance (Sections 4.4.4.3.3.1, 4.4.4.3.3.2, 4.13.4.1.3.1, 4.13.4.1.3.2, and 4.13.4.1.3.3); 2.15.4 Non-emergency medical transportation (Section 4.1.9.8); and 2.15.5 Service authorization processing (Sections 4.2.3.7.1, 4.8.4.2.1.1, 4.8.4.2.1.5, and 4.8.4.3.1)	$1,000 per violation
	2.16 Failure to meet 98% of claims financial accuracy requirements (Section 4.18.3), and 95% of post service authorization processing requirements (Section 4.8.4.3.5)	$1,000 per violation
	2.17 Two or more Level 2 violations within a contract year	$50,000 per occurrence
	2.18 Failure to comply with subrogation timeframes established in RSA 167:14-a	$15,000 per occurrence

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
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 Alternative Payment Model requirements	$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
	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

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
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, measure, report or deliverable (excludes encounter data and other financial reports). The violation shall apply to resubmissions that occur in contract years following the initial submission due date.	$1,000 for each of the first ten occurrences each contract year, $5,000 for each additional occurrence in same contract year. The number of occurrences in a contract year shall be the aggregate of all issues subject to liquidated damages in this Section 4.1.
	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

Table D.2 Dental Contract Liquidated Damages

Information as presented in this Exhibit is current as of the April 1, 2023, NH DO contract that was presented to NH Governor and Executive Council on November 2, 2022. Consult with the Department for any recent updates prior to use.

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
5. LEVEL 1 DO action(s) or inaction(s) that seriously	1.1 Failure to substantially provide medically necessary covered services	$5,000 per each failure
	1.2 Discriminating among members on the basis of their health status or need for health care services	Up to $20,000 per violation

jeopardize the health, safety, and welfare of member(s); reduces members' access to care; and/or the integrity of the managed care program.	1.3 Imposing arbitrary utilization management criteria, quantitative coverage limits, or prior authorization requirements prohibited in the contract	$5,000 per violation
	1.4 Imposing on members premiums or charges that are in excess of the premiums or charges permitted by DHHS	$2,000 per violation up to a maximum of $25,000 or double the amount of the excess charges (whichever is greater) (DHHS will return the overcharge to the Member)
	1.5 Failure to meet minimum care management and care coordination requirements (Section 4.10).-	$5,000 per week of violation
	1.6 Failure to meet the Agreement's Time and Distance Standards and Timely Access to Service Delivery Standards (without an approved exception) at Program Start and/or through the contract term (without an approved exception)	$1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan $20,000 per day for failure to meet the requirements of the approved Corrective Action Plan
	1.7 Misrepresenting or falsifying information furnished to CMS or to DHHS or a member	$25,000 per violation
	1.8 Failure to comply with the requirements of Section 5.3 (Program Integrity) of the contract	$2,000 per month of violation (for each month that DHHS determines that the DO is not substantially in compliance)
	1.10 Continuing failure to resolve individual member appeals and grievances within specified timeframes	$1,000 per appeal or grievance that continues to not meet specified timeframes; per month
	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 DO in that month until such time as the required submission is made)*	$1,000 per day the submission is late
	1.12 Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness)	$5,000 per violation
	1.13 Continued noncompliance and failure to comply with previously imposed remedial actions and/or intermediate sanctions from a Level 2 violation	$5,000 per violation
	1.14 In-network provider not enrolled with NH Medicaid	$1,000 per provider not enrolled, $500 per additional day provider is not suspended once DO is notified of non-

		enrollment, unless good cause is determined at the discretion of DHHS
	1.15 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 DO, its Subcontractor or a Provider	$10,000 per violation
	1.16 Two or more Level 1 violations within a contract year	$15,000 per occurrence
6. LEVEL 2 DO 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 DO until deficiencies in the DO'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	$20,000 per violation
	2.3 Failure to meet prompt payment requirements and standards	$5,000 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	$10,000 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	$10,000 per violation
	2.7 Failure to refer at least 20 potential instances of subcontractor or provider fraud, waste, or abuse to DHHS annually	$2,000 unless good cause determined by Program Integrity
	2.8 Using unapproved beneficiary notices, educational materials, and handbooks and marketing materials, or materials that contain false or materially misleading information	$5,000 per violation

	2.9 Failure to comply with member services requirements (including hours of operation, call center, and online portal)	$5,000 per day of violation
	2.10 Continued noncompliance and failure to comply with previously imposed remedial actions and/or intermediate sanctions from a Level 3 violation	$5,000 per week of violation
	2.11 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
	2.12 Failure to timely process 98% of clean and complete provider credentialing applications	$1,000 per delayed application
	2.13 Failure to meet performance standards in the contract which include, but are not limited to: 2.13.1 Care management measures (Sections 4.10.2.8, 4.10.2.10, and 4.10.2.11); 2.13.2 Claims processing (Sections 4.17.1.5, 4.17.1.6, 4.17.2.3, 4.17.2.4, 4.17.3.2, 4.17.4.2, and 4.17.5.2; 2.13.3 Call center performance (Sections 4.3.1.9.3.1, 4.3.1.9.4.2, 4.12.4.1.11.1, 4.12.4.1.11.2, 4.12.4.1.11.3, and 4.12.4.1.14.); 2.13.4 Non-emergency medical transportation (Section 4.1.12.3); and 2.13.5 Service authorization processing (Sections 4.8.1.4.2 - 4.8.1.4.8, 4.8.7.3.4, and 4.16.1.3.7)	$1,000 per violation
	2.14 Failure to meet 97% of claims financial accuracy requirements (Section 4.17.4.2), and 95% of post service authorization processing requirements (Section 4.8.7.3.4)	$1,000 per violation
	2.15 Two or more Level 2 violations within a contract year	$10,000 per occurrence
	2.16 Failure to comply with subrogation timeframes established in RSA 167:14-a	$3,000 per occurrence
7. LEVEL 3 DO action(s) or inaction(s) that diminish the effective oversight	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	$2,000 per violation
	3.2 Failure to submit to DHHS within the specified timeframes all required plans, documentation, and reporting related to the implementation of Alternative	$2,000 per week of violation

and administration of the managed care program.	Payment Model requirements	
	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)	$2,000 per violation
	3.5 Failure to report subrogation settlements that are under 80% of the total liability (lien amount)	$2,000 per violation
	3.6 Failure to enforce material provisions under its agreements with Subcontractor	$5,000 per violation
	3.7 Failure to submit and obtain DHHS review and approval for applicable Subcontracts	$5,000 per violation
	3.8 Failure to comply with ownership disclosure requirements	$2,000 per violation
	3.9 Continued noncompliance and failure to comply with previously imposed remedial actions and/or intermediate sanctions from a Level 4 violation	$5,000 per week of violation
	3.10 Two or more Level 3 violations within a contract year	$20,000 per occurrence
8. LEVEL 4 DO action(s) or inaction(s) that inhibit the efficient operation the managed care program.	4.1 Submission of a late, incorrect, or incomplete, measure, report or deliverable (excludes encounter data and other financial reports). The violation shall apply to resubmissions that occur in contract years following the initial submission due date.	$1,000 for each of the first ten occurrences each contract year, $5,000 for each additional occurrence in same contract year. The number of occurrences in a contract year shall be the aggregate of all issues subject to liquidated damages in this Section 4.1.
	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	$2,000 per violation

Appendix E – 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	-----
Children’s Medicaid	-----
Expanded Children	-----
Former Foster Care	-----
NH Health Protection Program--Medically Frail	-----
Newborn	-----
Parents Caretaker	-----
Pregnant Woman	-----

Category of Eligibility Description	Additional Identifier
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 F – Public Comments on NH Comprehensive Medicaid Quality Strategy

#	Page #	Draft Excerpt	Author	Comment	DHHS Response

Appendix G – Performance Improvement Projects

***PIP #1: Diabetes Screening for People (18-64 years) with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (*SSD*)**

MCO	AIM Statement	Intervention
ACNH	By June 30, 2021,* increase the percentage of adult members 18 to 64 years of age residing in Hillsborough County, New Hampshire, who receive diabetic screening while on antipsychotic medications for schizophrenia or bipolar disorder. Diabetic screening is a glucose or hemoglobin A1c (HbA1c) test. Increase from 67.4% to goal of 88.0%.	1. ACNH will conduct telephonic outreach to prescribing providers to schedule or complete the metabolic screening test (blood glucose or HbA1c).
NHHF	By June 30, 2021*, NHHF aims to increase the percentage of members 18–64 years of age, who reside in Hillsborough County, New Hampshire, and are diagnosed with schizophrenia, schizoaffective, or bipolar disorder; dispensed an antipsychotic medication; and are screened for diabetes, utilizing a glucose or HbA1c test, during the measurement period from 80.8% to 90.0%.	1. NHHF will conduct targeted reminder calls to prescribing providers for members to remind them to order lab work to screen for diabetes while their patient is taking antipsychotic medication. 2. NHHF will work with Care Management staff to follow-up with members taking antipsychotic medications who were non-compliant for diabetes screening. Follow up will include live telephonic outreach followed by a mailed reminder. 3. NHHF will conduct telephonic outreach to noncompliant members to provide education on the importance of diabetes screening and to remind them about the lab work required to monitor for diabetes while on antipsychotic medication.
WS	By June 30, 2021*, WS aims to increase the percentage of members, 18–64 years of age, with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication, assigned to	1. WS will deliver provider education on the use of care gap reports to identify members taking antipsychotic medications who need diabetes screening and encouraged providers to use the care gap reports for member outreach to schedule the

MCO	AIM Statement	Intervention
	selected PHOs [physician-hospital organizations], and had a diabetes screening (a glucose or HbA1c test) from 78.57% to 92.85%.	necessary diabetes screening. 2. WS will mail a cobranded educational letter to members that prompts them to contact the provider for an appointment, attend the appointment, and complete the needed HbA1c screening within 30 days of receiving the letter. 3. WS will implement a Provider Focused Alternative Payment Model (APM) Member Outreach and Testing

* In April 2021, DHHS determined that due to coronavirus disease 2019 (COVID-19), the SMART Aim end date for the current PIPs will be extended until June 30, 2022.

PIP #2: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment— (IET-Engagement)

MCO	AIM Statement	Intervention
ACNH	By June 30, 2021,* increase the percentage of adult members 18 years and older having two or more additional alcohol and other drug (AOD) services or medication treatment within 34 days after discharge during the measurement period among adult members 18 years and older discharged from an acute inpatient stay with any diagnosis of substance use disorder (SUD) during the measurement period, from 26.5% to 42.6%.	1. ACNH will facilitate timely communication between the ACNH transition of care coordinator (TOC) and the hospital discharge planner to increase the number of targeted inpatient members who had the follow-up visit scheduled prior to being discharged.
NHHF	By June 30, 2021*, NHHF will increase the percentage of engagement of AOD treatment among members, ages 13 years or older, who had a new episode of AOD abuse or dependence, who already initiated treatment, who were engaged in ongoing AOD treatment within 34 days of the initiation visit and reside in Rockingham County, New Hampshire, from 13.45% to 20.0%.	1. NHHF will test the use of a notification of alcohol and other drug (AOD) diagnosis and/or referral (NDR) form to increase in the number of providers completing and submitting the NDR form within 48 hours of diagnosis. 2. NHHF will test MCO faxed outreach to primary care providers (PCPs) after the member's acute care admission/discharge/transfer for AOD dependence diagnosis to support treatment engagement to increase the number of

MCO	AIM Statement	Intervention
		targeted members engaged in treatment following an acute care event that included AOD diagnoses. 3. NHHF will email education related to smoking cessation and its connection to substance misuse disorder to members who are in the denominator for the measure. The intervention will encourage members to outreach to providers for substance misuse treatment or substance misuse disorder as well as smoking cessation and includes health plan phone contact information to call for assistance and program information. 4. NHHF will provide education to providers at Community Mental Health Clinics (CMHC's) in Rockingham County for members who are certified with that facility. Education will include a letter explaining the IET measure, common scenarios of non-adherent members, SAMSHA flyer related to co-occurring diagnosis, details about assessing and coding Substance Use Disorder. This outreach will encourages providers to assess, code and follow up appropriately for those with a co-occurring diagnosis of behavioral health and substance use disorders.
WS	By June 30, 2021*, WS aims to increase the percentage of members, 18 years of age or older, newly diagnosed with opioid dependency who engaged in ongoing treatment within 34 days of the initiation visit from 35.6% to 41.0%.	1. WS will test Project ECHO which is opioid use disorder provider education. 2. WS will test a redesigned provider education for treatment adherence among Medication-Assisted Treatment (MAT) Providers.

*In April 2021, DHHS determined that due to coronavirus disease 2019 (COVID-19), the SMART Aim end date for the current PIPs will be extended until June 30, 2022.

PIP #3: HPV Vaccine

MCO	AIM Statement	Intervention
ACNH	By December 31, 2023, ACNH will use key driver diagram interventions to increase the completed HPV vaccine series percentage, per HEDIS IMA specifications, among eligible adolescent members who turn 13 years of age during the measurement period from 9.3% to 16.5%.	1. ACNH will send early birthday cards with reminder to complete the HPV vaccine series for members turning 13 years of age during calendar year 2023. 2. ACNH will conduct targeted provider outreach to reinforce HPV vaccination information and how to close gaps in care for completion of vaccination series
NHHF	By 12/31/2023, use key driver diagram interventions to increase the administrative data rate of eligible members meeting HEDIS measure for HPV vaccines during MY2023, from 26.26% to 28.9%.	1. NHHF will send educational emails to parents/guardians of members 9 to 12 years of age who are eligible for the HPV vaccine and have not yet received two doses. 2. NHHF will conduct provider HPV vaccine education through a breakout session showing the film “Someone You Love”.
WS	By 12/31/2023, use key driver diagram interventions to increase the percentage of HPV vaccines among adolescents turning 13 years of age, from 27.63% to 30.16% ($p < 0.05$).	1. WS will conduct a targeted text message campaign to parents with eligible adolescents who have not yet received the HPV vaccine. 2. WS will conduct a targeted provider education through an educational video and telephone and/or email communications.

PIP #3: Health Risk Assessment

MCO	AIM Statement	Intervention
ACNH	By December 31, 2023, ACNH will use key driver diagram interventions to increase the percentage of completed health risk assessments (HRA) among the eligible members from 14.53% to 15.0%.	1. ACNH will conduct telephonic outreach to members requesting child car seats and assist members with completion of the HRA.
NHHF	By Dec. 31, 2023, use key driver diagram interventions to increase the percentage of HRA completed among the NH Healthy Families Medicaid membership from 27.07% to	1. NHHF will redesign the reminder telephone message to offer a way to request after hours assistance with the completion of the HRA.

MCO	AIM Statement	Intervention
	27.5%.	2. NHHF conduct member outreach through a postcard with a QR code for the member to scan that takes them to the HRA to complete the assessment.
WS	By December 31st, 2023, use key driver diagram interventions to increase the percentage of annual Health Risk Assessments performed among the eligible Medicaid population, from 9.8% to 10.04% ($p < 0.05$).	1. WS will conduct a text message outreach to members prompting them to complete the HRA via their smart phone. 2. WS will conduct an incentive program through a text message campaign where the member will receive a monetary incentive for completing the HRA.

Appendix H – Quality Strategy Effectiveness Analysis

The analysis, required by 42 CFR 438.340(c), evaluates the effectiveness of the quality strategy and is publicly available on the NH Medicaid Quality website at:
https://medicaidquality.nh.gov/sites/default/files/Quality%20Strategy%20Effectiveness%20Analysis%20June%202021%20F1.pdf

The review comprehensively evaluated MCM Quality Strategy Version #5 including the 25 objectives contained within 7 goals to determine whether progress has been made since the Quality Strategy was published. In addition, the review evaluates whether the state is continuing or revising goals and objectives based on the findings of the review. While there is no formal structure federally required by the regulation, the Department has utilized the CMS guidance from the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit to shape the analysis.

The table below provides a summary of the results and actions taken by the Department to incorporate the findings in MCM Quality Strategy Version #6.

Quality Strategy Version #6 Objective	Process / Outcome Objective	Results (Met / Made Progress / Did Not Meet)	Quality Strategy Version #7 Revisions Based on Analysis Findings/Recommendations
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.	Outcome	Made progress	Continue to monitor.
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.	Outcome	Made progress	Continue to monitor.
Objective 2.1 – Ensure that the MCO provider networks meet the 90% standard of time or distance for each New Hampshire County.	Process	Met	No findings/recommendations. Added DO to objective.
Objective 2.2 – Ensure MCO access performance measures do not indicate an access issue	Process	Met	No findings/recommendations. Added DO to objective.
Objective 2.3 – Ensure that annual member experience of care survey rates are equal to or higher than the national average for Medicaid	Outcome	Met	Specific key performance indicators have been selected for the experience of care objective. Added DO to objective.

Quality Strategy Version #6 Objective	Process / Outcome Objective	Results (Met / Made Progress / Did Not Meet)	Quality Strategy Version #7 Revisions Based on Analysis Findings/Recommendations
managed care health plans			
Objective 2.4 – Ensure that by the end of State Fiscal Year 2025 annual member experience of care survey access to care rates are equal to or higher than the national average for Medicaid managed care health plans.	Outcome	N/A – In Process	Continue to monitor. Added dental member experience survey questions to objective.
Objective 2.5 – Ensure that annual member experience of care survey MCO customer service quality rates are equal to or higher than the national average for Medicaid managed care health	Outcome	N/A – In Process	Continue to monitor. Added dental member experience survey questions to objective.
Objective 3.1 – Demonstrate contract compliance and identify quality issues through ongoing MCO system wide performance measure evaluation.	Process	Met	No findings/recommendations. Added DO to objective.
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;	Process	Met	No findings/recommendations. Added DO to objective.
Objective 4.1 – Ensure the annual EQRO performance measure validation audit results verify the accuracy of MCO performance measures.	Process	Met	No findings/recommendations. Added DO to objective.
Objective 4.2 – Ensure that monthly EQRO encounter data validation results demonstrate MCO contract compliance for timeliness and accuracy of encounter data.	Process	Met	No findings/recommendations. Added DO to objective.
Objective 5.1 – Maintain MCO performance improvement projects that are validated and align with DHHS goals and objectives.	Process	Met	No findings/recommendations. Added DO to objective and clarified alignment with Medicaid Quality priority areas.
Objective 5.2 – Ensure MCOs have acted upon each EQR recommendation/finding in the Organization’s annual QAPI report.	Process	Met	No findings/recommendations. Added DO to objective.
Objective 5.3 - Maintain Quality Withhold and	Process	N/A – In Process	No findings/recommendations.

Quality Strategy Version #6 Objective	Process / Outcome Objective	Results (Met / Made Progress / Did Not Meet)	Quality Strategy Version #7 Revisions Based on Analysis Findings/Recommendations
Incentive Program.			
Objective 5.4 - Maintain Quality Performance Based Auto Assignment Program.	Process	N/A – In Process	No findings/recommendations.
Objective 5.5 – Maintain liquidated damages program that includes sanctions that are compliant with 42 CFR 438 Subpart I.	Process	N/A – In Process	No findings/recommendations. Added DO to liquidated damage matrix.
Objective 5.6 - Conduct a multi-stakeholder quality forum to identify barriers and solutions to improve key performance indicators.	Process	N/A – In Process	Continue to plan and monitor.
Objective 6.1 – Identify, evaluate and to the extent possible reduce health disparities. [42 CFR 438.340(b)(6)].	Process	N/A – In Process	Continue to monitor.
Objective 6.2 – Identify, evaluate and to the extent possible reduce health disparities in the behavioral health population.	Process	N/A – In Process	Continue to include behavioral health indicator in health disparity analysis.
Objective 6.3 – Increase care coordination in the Managed Care Population.	Process	N/A – In process	Added completion of dental risk assessment to objective.
Objective 7.1 – Ensure state meets goals of the Durable Medical Equipment directed payment.	Process	Met	No findings/recommendations.
Objective 7.2 - Ensure state meets goals of the Community Mental Health Program directed payment.	Process	Partially Met	Continue to monitor program.
Objective 7.3 - Ensure state meets goals of the Critical Access Hospital directed payment.	Process	Partially Met	Continue to monitor program