New Hampshire Medicaid Care Management (MCM) Quality Strategy

Quality Strategy Revision #6
State Fiscal Year 2023

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

New Hampshire Medicaid Quality Strategy Version 6
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Preface

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

Please forward all comments about the NH MCM Quality Strategy with the phrase "Quality Strategy" in the subject line to: 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

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:

- Dental Benefits;

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

- 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
- Nursing Facility Services.

MCM Managed Care Organizations

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

Plan 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.

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.

B. New Hampshire Medicaid Care Management Quality Strategy

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

The Quality Strategy also represents the Department's effort to communicate with stakeholders the State's plans for assuring managed care organizations (MCOs) are:

- In compliance with the MCO contract;
- Have committed adequate resources to perform internal monitoring;
- Conduct ongoing quality improvement; and
- Actively contribute to health care improvement for the State's most vulnerable citizens.

The New Hampshire MCM Quality Strategy is publicly available at https://medicaidquality.nh.gov/care-management-quality-strategy and is promoted to stakeholders

and beneficiaries during public comment periods.

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

II Medicaid Managed Care Quality Program

A. DHHS Managed Care Quality Program Overview

Mission

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

Goals

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

1. Assure 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 contract compliance.
4. Assure the quality and validity of MCO 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 Bureau of Program Quality (BPQ) Medicaid Quality Program in partnership with:

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

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

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

External Quality Review Organization (EQRO)

The NH DHHS has contracted with 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. The Department has an option to renew 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);
- Validation of MCO quality performance measures;
- Preparation of an EQRO Technical Report for each Medicaid managed care plan; and
- Validation of MCO network adequacy (pending CMS guidance).

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

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

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

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

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

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

Data Sources and Systems

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

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

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

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

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

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

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

MCO Encounter Data

Medical and pharmacy encounter data is submitted by each MCO on an ongoing basis to the DHHS Medicaid Management Information System (MMIS) which adjudicates the encounters and

loads them into the MMIS reporting repository. Encounter data is used in a variety of ad hoc and ongoing applications for evaluation of the MCM program as well as individual MCO performance.

Medicaid Enrollment Data

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

MCO Plans, Reports and Data Tables

In addition to a robust set of performance measures, DHHS collects over 50 quantitative and qualitative plans, reports, and tables that are used for contract management by various DHHS business units to oversee the MCM program. A full list can be found at *Appendix C – MCO Plans, Tables, and Reports*.

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 MCOs to communicate key member details. The 834 file includes flags for members who receive long-term service and supports through one of the Department's Medicaid Waivers. In addition, special health care needs are identified through various eligibility categories, such as Aid to the Permanently and Totally Disabled. The 834 file includes but is not limited to the following information about each member:

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

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;
- Performance Based Auto Assignment Program;
- Quality Withhold and Incentive Program;
- Alternative Payment Models;

- Member Incentive Plans; and
- Liquidated Damages.

Performance Improvement Projects

The Department selects categories for each MCO to conduct performance improvement projects. Each of the MCOs is required to develop and conduct the following four (4) PIPs in consultation with the EQRO:

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

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

Performance Based Auto-Assignment Program

The Department administers a Performance Based Auto-Assignment Program where the MCOs' performance is evaluated for key performance indicators. 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.

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.

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

Alternative Payment Models

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

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

Member Incentive Programs

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

Liquidated Damages

The NH MCM program includes various provisions that when violated may result in liquidated damages. The categories of liquidated damages are tiered by four (4) levels representing varying severity. Included in the various violations are contract requirements connected to goals within the NH Medicaid Managed Care Quality Strategy.

See *Appendix E – Medicaid Care Management Services Contract Exhibit N: Liquidated Damages* for specific details.

MCO Quality Assurance and Improvement Programs

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

MCO Performance Improvement Projects (PIP)

The state requires each MCO 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 MCO PIP is conducted by New Hampshire's EQRO. See Objective 5.1. for more information about the current PIPs.

MCO Performance Measure Data

MCOs are required to collect and submit performance measure data using standard measures required by the Department.

See *Appendix B – MCO Performance Measures* for a full list of performance measures submitted to the Department.

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

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

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

The MCOs are required to submit annual plans that describe the MCO's annual organization-wide QAPI program structure and the annual goals and objectives for all quality activities. These activities include the MCOs 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 MCO 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; and
- Semi-annually reporting actions taken to address selected findings/recommendations identified by EQRO quality reports.

MCO 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.

MCO and DHHS Quarterly Quality Meetings

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

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*.

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 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 (goal 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;
- CMS Core Set/HEDIS (PPC) – Prenatal and Postpartum Care – Postpartum Care Rate; and

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

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
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 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		

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
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 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 MCO's network for time and distance standards that are established in the MCO contract. Standards developed in the MCO contract are compliant with requirements in 42 CFR 438.68(c). Networks are analyzed at the county level for each provider type. For provider types that do not meet time and distance standards, the MCO is required to submit a request for an exception to time and distance standards. The request must include:

- Annual member utilization of services provided by this provider type;
- Reasons for the unmet standards;
- MCO solution for deficiency;
- Progress on the solution if this was a previously requested exception; and
- Provider level detail.

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

- An insufficient number of qualified New Hampshire Medicaid and commercial providers or facilities are available to meet the geographic and timely access standards;
- The plan's failure to develop a provider network that is sufficient in number and type of providers to meet all of the standards in the Medicaid Care Management Contract (due to

the refusal of a provider to accept a reasonable rate, fee, term, or condition and that the health carrier has taken steps to effectively mitigate the detrimental impact on covered persons); and
- The required service can be obtained using telemedicine or telehealth from an in-network participating provider.

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

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 provider networks meet the 90% standard of time or distance for each New Hampshire County.		
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 2024)

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

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

On a quarterly basis, the MCM Quality Program reviews a selection of performance measures designed to evaluate beneficiary needs as well as service utilization. Measures include but are not limited to:
- Grievances and Appeals;
- Services utilization (i.e., emergency department, office/clinic visits);
- Emergency department visits for conditions treatable in primary care; and
- Beneficiary requests for primary care and specialist.

For each measure, control limits based on historical trends are employed in quarterly charts to provide a consistent indication of a potential access problem as each new quarter of data are available. Control limits will be set as three standard deviations (following conventional practice[2]) from the mean based on historical data. New quarterly rates that are three standard deviations from the mean will be considered a potential access issue that requires intensive analysis.

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

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

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

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

While the 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 access performance measures do not indicate an access issue**		
Percentage of monthly access performance measure reviews that are conducted to identify potential access issues.	100% (SFY 2021)	100% (SFY 2024)

*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 provide accurate information in their MCO 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 the MCOs' online provider directories found on the respective MCOs' web sites matched MCO 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 provide accurate information in their MCO provider		

directories.		
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

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. 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.		
Adult CAHPS - Getting care quickly: Getting needed care right away – Usually or Always	84.8% (CY 2020)	CY 2022 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 2022 National 50th Percentile
Adult CAHPS - Getting care quickly: Getting appointment with specialist as soon as needed	82.6% (CY 2020)	CY 2022 National 50th

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
		Percentile
Adult CAHPS - Getting needed care: Ease in getting care, tests and treatment	87.8% (CY 2020)	CY 2022 National 50th Percentile
Child CAHPS - Getting care quickly: Getting needed care right away – Usually or Always	95.1% (CY 2020)	CY 2022 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 2022 National 50th Percentile
Child CAHPS - Getting care quickly: Getting appointment with specialist as soon as needed	82.6% (CY 2020)	CY 2022 National 50th Percentile
Child CAHPS - Getting needed care: Ease in getting care, tests and treatment	89.5% (CY 2020)	CY 2022 National 50th Percentile

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 plans.

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

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 customer service quality rates are equal to or higher than the national average for Medicaid managed care health plans		

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Adult CAHPS – Health plan customer service provided information or help – Usually or always	85.4% (CY 2020)	CY 2022 National 50th Percentile
Adult CAHPS - Health plan customer service treated member with courtesy and respect – Usually or always	95.0% (CY 2020)	CY 2022 National 50th Percentile
Child CAHPS – Health plan customer service provided information or help – Usually or always	82.2% (CY 2020)	CY 2022 National 50th Percentile
Child CAHPS - Health plan customer service treated caregiver with courtesy and respect – Usually or always	97.8% (CY 2020)	CY 2022 National 50th Percentile

Goal 3 – Assure MCO contract compliance

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

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

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

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

On a monthly basis, different units within the Bureau of Program Quality review 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 managed care 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 contract compliance.		
Objective 3.1 – Demonstrate contract compliance and identify quality issues through ongoing		

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
*MCO system wide performance measure evaluation.**		
Percentage of months the Department completed the Medicaid Director's Remedy report.	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 3.2 – Ensure annual EQRO contract compliance audit results demonstrate MCO contract standards are being met; and, for those standards that are not met, corrective action plans are approved.

The EQRO conducts an annual on-site compliance review at the offices of each MCO to ensure compliance with federal and State requirements including MCO contract requirements. After completing a comprehensive contract review in the first year of the MCM program, a new three-year cycle of reviewing one-third of all the elements contained in the compliance tool are implemented. For the review, a standard is created for each requirement. Requirements are reviewed to determine whether the standard has been: "Met," "Partially Met," or "Not Met." Standards that are "Partially Met" or "Not Met" require the health plan to submit a corrective action plan that must be approved by the EQRO. All standards that result in corrective action plans are re-examined during the following year's review.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 3: Assure MCO contract compliance.		
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.		
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 2024)

Goal 4 – Assure the quality and validity of MCO data

Objective 4.1 – Ensure the annual EQRO performance measure validation audit results verify the accuracy of MCO 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 have sufficient systems and processes in place to provide accurate and complete information for calculating valid performance measure rates according to the specifications required by the State.

On an annual basis, the EQRO validates performance measures submitted by the MCOs that are not audited by another entity (e.g., NCQA auditing of HEDIS data). Data are reviewed for various

standards (e.g., accurate data transfers, data repository best practices, and management of report production). Performance measure rates with data that is determined "Not Reportable" must be recalculated and resubmitted by the MCO. The EQRO then verifies the resubmitted rates.

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

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

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

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

** Professional and Institutional Claims Only
*** Professional, Institutional, and Pharmacy Claims

Goal 5 – Maintain Quality Performance Improvement Initiatives

Objective 5.1 – Maintain MCO performance improvement projects that are validated and align

with DHHS goals and objectives.

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

While the Department sets the broad direction of the PIPs based on the requirements above, the MCOs select the actual PIPs. The Department encourages the MCOs to select PIPs based on the same performance measures to maximize economies of scale. At the time of publication of the Quality Strategy, all three MCOs selected PIPs based on the same performance measures.

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 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 performance improvement projects that are validated and align with DHHS goals and objectives.**		
Percentage of MCO PIPs that are validated by the EQRO and align with DHHS goals and objectives.	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 5.2 – Ensure MCOs have acted upon each EQR recommendation/finding in the MCOs annual QAPI report.

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

- Violation of MCM 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 MCO is required to provide a written response in a semi-annual report provided to the Department. The MCO 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 have acted upon each EQR recommendation/finding in the MCOs annual QAPI report.**		
Percentage of EQRO recommendations/findings identified by the Department for follow up, that are acted upon by the MCOs.	TBD	100%

*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 MCM 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 of performance and in most cases reaching the threshold is required to receive the return of any withhold funding. 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 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 5.4 - 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 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 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 liquidated damages are in compliance with the minimum requirements in 42 CFR 438 Subpart I. The NH MCO Contract addresses remedies at the State's disposal to address MCO performance concerns. Liquidated damages may be enacted and the contract stratifies MCO violations into 4 levels, each with varying financial remedies. See *Appendix E – Medicaid Care Management Services Contract Exhibit N: Liquidated Damages* for specific details.

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.**		
Percentage of sanctions that are compliant with 42 CFR 438 Subpart I.	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 5.6 - 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 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 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, and provider solutions to the barriers.

The most recent forum was conducted in 2021 on the topic of 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

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 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).

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.

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	
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) - 30 Days	
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

Measure Name
Antidepressant Medication Management (AMM): Effective Acute Phase Treatment
Antidepressant Medication Management (AMM): Effective Continuation Phase Treatment
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

Measure Name
Follow-up After Emergency Department Visit for Mental Illness (FUM) Within 30 days by Age
Use of Opioids at High Dosage (HDO)
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

Measure Name
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 6:

- 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 period of MCM Quality Strategy version 6, 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.

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.**		

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Percentage of tasks associated with the health disparity plan that were 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 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 (Pending Approval).

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 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 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.

Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
Goal 6: Conduct Key Population Health Quality Activities		
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 2024)
Percentage of members who annually complete a health risk assessment.	14.4% (SFY 2021)	25% (SFY 2024)

Goal 7 – Achieve State Directed Payment Goals

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

In 2021, New Hampshire submitted a directed payment proposal for a Minimum Fee Schedule for Durable Medical Equipment (DME) to the CMS. Approval of the directed payment proposal is pending as of the submission date of this strategy.

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 2024)

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

Since 2018, the New Hampshire Department of Health and Human Services has been utilizing Directed Payments authorized by the Center 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.
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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.

In 2021, New Hampshire Department of Health and Human Services submitted a proposal for a Directed Payment for uniform dollar increase for inpatient discharges and outpatient visits to qualifying Critical Access Hospitals (CAH) for the rating period covering July 1, 2021, through

June 30, 2022. This evaluation represents the Department's review of the Directed Payment program proposed for rating period beginning July 1, 2021, and recommendations for the program beginning July 1, 2023.

During the period of the proposed Directed Payment, the Department partnered with the Foundation for Healthy Communities (FHC), which is an education and research organization for the NH Hospital Association (NHHA) tasked to evaluate the feasibility of a Value Based Payment program. The results of this evaluation support the VBP program that New Hampshire is proposing to CMS for July 1, 2022, through June 30, 2023.

The minimum fee schedule for CAHs is created to assure members maintain access to general acute care and maternity hospital services. The results of the evaluation support applying for the Directed Payment the Department is proposing to CMS for July 1, 2022, through June 30, 2023.

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.		
Ensure that the MCO provider networks meet the 90% standard of time or distance for each New Hampshire County.	100% (CY 2020)	100% (CY 2024)
Number of Critical Access Hospitals operating in the State	13 (CY 2020)	13 (CY 2024)
The State will evaluate payment models related to performance for future years.	100% (CY 2020)	100% (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 G – Public Comments on NH Medicaid Quality Strategy*

B. Quality Strategy Effectiveness Analysis

No less than every 3 years, DHHS conducts an effectiveness analysis of the current Quality Strategy. While the review is a stand-alone effort, it is 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 most recent 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

Recommendation/Findings	Status	Explanation
		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 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 program[3];
- Addition of a new group of services to the MCM program; or
- A change to the CMS regulations that impacts the NH Medicaid Quality Strategy.

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

[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#04 Posted Draft Quality Strategy to Comply with Revised CMS Regulations for Public Comment	April 2, 2018
QS#04 Presented Quality Strategy to the NH Medicaid Medical Care Advisory Committee	April 9, 2018
QS#04 Open Comment Period ends for Quality Strategy to Comply with Revised CMS Regulations.	May 2, 2018
QS#04 Post Final Updated Quality Strategy	June 26, 2018
QS#04 Monitor Quality Performance Results	Continuously
QS#05 Post Draft Quality Strategy to Comply with Revised CMS Regulations for Public Comment	July 1, 2019
QS#05 Presented Quality Strategy to the NH Medicaid Medical Care Advisory Committee	July 8, 2019
QS#05 Open Comment Period ends for Quality Strategy to Comply with Revised CMS Regulations	August 8, 2019
QS#05 Post Final Quality Strategy	August 31, 2019
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
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,	• II.B. Goal 6-Objective 6.1

CMS Regulation	NH MCM Quality Strategy
and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO, PIHP or PAHP at the time of enrollment. For purposes of this paragraph (b)(6), "disability status" means whether the individual qualified for Medicaid on the basis of a disability.	
438.340(b)(7) At a minimum, the State's Quality Strategy must include the following: For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.	• II.B. Goal 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	• III.

CMS Regulation	NH MCM Quality Strategy
review available on the Web site required under §438.10(c)(3).	
438.340(c)(2)(iii) Development, evaluation, and revision. Review and update the Quality Strategy as needed, but no less than once every 3 years. Updates to the Quality Strategy must take into consideration the recommendations provided pursuant to §438.364(a)(4).	• III.
438.340(c)(3)(i) Development, evaluation, and revision. Submit to CMS a copy of the initial strategy for CMS comment and feedback prior to adopting it in final.	• III.D.
438.340(c)(3)(ii) Development, evaluation, and revision. Submit to CMS the a copy of the revised strategy whenever significant changes, as defined in the state's Quality Strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.	• III.D.
438.340(d) Development, evaluation, and revision. Availability: the State must make the final Quality Strategy available on the Web site required under §438.10(c)(3).	• III.A.

Appendix B – MCO Performance Measures

Data detail as presented in the NH MCO Contract Defacto Exhibit O and as referenced. *Last Updated 11.24.21. Consult with the Department for any recent updates prior to use.*

Table B.1 MCM Performance Measures with Performance Targets

Measure Name	Reporting Reference ID	Measure Steward	Baseline Performance (year)	Performance Target (year)	Medicaid	CHIP
Adherence to Antipsychotics for Individuals with Schizophrenia	HEDIS_SAA	HEDIS/CMS Adult Core Set	72.6 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Antidepressant Medication Management	HEDIS_AMM_EFFECTIVE ACUTE PHASE	HEDIS	61 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Antidepressant Medication Management by Subpopulation	HEDIS_AMM_EFFECTIVE CONTINUATION PHASE	HEDIS	46.2 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Appropriate Testing for Pharyngitis	HEDIS_CWP	HEDIS	83.9 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Appropriate Treatment for Upper Respiratory Infection	HEDIS_URI	HEDIS	93.7 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Asthma Medication Ratio	HEDIS_AMR	HEDIS	60.8 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Average Pharmacy Claim Processing Time	CLAIM.17	NH DHHS	49 (SFY 2021)	>=National 75th percentile (CY 2023)	X	X
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	HEDIS_AAB	HEDIS	58.4 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Breast Cancer Screening	HEDIS_BCS	HEDIS/CMS Adult Core Set	52.5 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Cervical Cancer Screening	HEDIS_CCS	HEDIS	54 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Child and Adolescent Well-Care Visits	HEDIS_WCV_Age 3-11	HEDIS	62.7 (CY 2020)	>=National 75th percentile (CY 2023)	X	X

Measure Name	Reporting Reference ID	Measure Steward	Baseline Performance (year)	Performance Target (year)	Medicaid	CHIP
Child and Adolescent Well-Care Visits	HEDIS_WCV_Age 12-17	HEDIS	53.2 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Child and Adolescent Well-Care Visits	HEDIS_WCV_Age 18-21	HEDIS	31.7 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Childhood Immunization Status	HEDIS_CIS_Combo #10	HEDIS	41.3 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Chlamydia Screening in Women	HEDIS_CHL_TOTAL	HEDIS	46.5 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Claims Quality Assurance - Claims Payment Accuracy	CLAIM.25	NH DHHS	100% (SFY 2021)	97% (SFY 2023)	X	X
Claims Quality Assurance: Claims Financial Accuracy	CLAIM.26	NH DHHS	99.9% (SFY 2021)	99% (SFY 2023)	X	X
Claims Quality Assurance: Claims Processing Accuracy	CLAIM.27	NH DHHS	98.7% (SFY 2021)	97% (SFY 2023)	X	X
Comprehensive Diabetes Care	HEDIS_CDC_CONTROL < 8%	HEDIS	42.8 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Controlling High Blood Pressure	HEDIS_CBP	HEDIS/CMS Adult Core Set	52.7 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Diabetes Monitoring for People with Diabetes and Schizophrenia	HEDIS_SMD	HEDIS	59.6 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS_SSD	HEDIS/CMS Adult Core Set	76.1 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Family and Friends Program NEMT Rides	NEMT.22	NH DHHS	39.7% (SFY 2021)	50% (SFY 2023)	X	X
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	HEDIS_FUA_30 Day Total	HEDIS/CMS Adult Core Set	43.3 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	HEDIS_FUA_7 Day Total	HEDIS/CMS Adult Core Set	29.5 (CY 2020)	>=National 75th percentile (CY 2023)	X	X

Measure Name	Reporting Reference ID	Measure Steward	Baseline Performance (year)	Performance Target (year)	Medicaid	CHIP
Follow-Up After Emergency Department Visit for Mental Illness	HEDIS_FUM_30 Day Total	HEDIS	78.2 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Follow-Up After Emergency Department Visit for Mental Illness	HEDIS_FUM_7 Day Total	HEDIS	70.5 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Follow-Up After High Intensity Care for Substance Use Disorder	HEDIS_FUI_30 Day Total	HEDIS	66.2 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Follow-Up After High Intensity Care for Substance Use Disorder	HEDIS_FUI_7 Day Total	HEDIS	46.1 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Follow-Up After Hospitalization For Mental Illness	HEDIS_FUH_30 DAY FUP	HEDIS	74.1 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Follow-Up After Hospitalization For Mental Illness	HEDIS_FUH_7 DAY FUP	HEDIS	59 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Follow-Up Care for Children Prescribed ADHD Medication	HEDIS_ADD_CONTINUATION AND MAINTENANCE	HEDIS	53.6 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Follow-Up Care for Children Prescribed ADHD Medication	HEDIS_ADD_INITIATION	HEDIS	48.3 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Immunizations for Adolescents	HEDIS_IMA_Combo #1	HEDIS	74.3 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Immunizations for Adolescents	HEDIS_IMA_Combo 2	HEDIS	31.4 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	HEDIS_IET_TOTAL - ENGAGEMENT	HEDIS	22.9 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	HEDIS_IET_TOTAL - ENGAGEMENT	HEDIS/CMS Adult Core Set	22.9 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment by Subpopulation	HEDIS_IET_TOTAL - INITIATION	HEDIS	50.8 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Lead Screening in Children	HEDIS_LSC	HEDIS	76.5 (CY 2020)	>=National 75th percentile (CY 2023)	X	X

Measure Name	Reporting Reference ID	Measure Steward	Baseline Performance (year)	Performance Target (year)	Medicaid	CHIP
MCO Contacts and Contact Attempts Following ED Discharges for SUD	SUD.42	NH DHHS	52.2% (SFY 2021)	95% (SFY 2023)	X	X
Medical Service, Equipment and Supply Post-Delivery Service Authorization Timely Determination Rate	SERVICEAUTH.13	NH DHHS	99.6% (SFY 2021)	100% (SFY 2023)	X	X
Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	SERVICEAUTH.01	NH DHHS	99.6% (SFY 2021)	100% (SFY 2023)	X	X
Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests	SERVICEAUTH.03	NH DHHS	99.2% (SFY 2021)	95% (SFY 2023)	X	X
Member Communications: Calls Abandoned	MEMCOMM.03	NH DHHS	1.0% (SFY 2021)	>5% (SFY 2023)	X	X
Member Communications: Speed to Answer Within 30 Seconds	MEMCOMM.01	NH DHHS	94.4% (SFY 2021)	80% (SFY 2023)	X	X
Member Communications: Calls Returned by the Next Business Day	MEMCOMM.24	NH DHHS	98.8% (SFY 2021)	100% (SFY 2023)	X	X
Members Enrolled in Care Management	CAREMGT.39	NH DHHS	1.9% (SFY 2021)	>=3.0 (SFY 2023)	X	X
Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS_APM_ Blood Glucose and Cholesterol Testing (Total)	HEDIS	31.3 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS_APM_ Cholesterol Testing (Total)	HEDIS	31.3 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
NH Hospital Discharges - Discharge Plan Provided to Aftercare Provider Within 7 Calendar Days of Member Discharge	NHHDISCHARGE.13	NH DHHS	99.4% (SFY 2021)	98% (SFY 2023)	X	X
NH Hospital Discharges - MCO Contacts and Contact Attempts	NHHDISCHARGE.17	NH DHHS	97.6%(SFY 2021)	100% (SFY 2023)	X	X

Measure Name	Reporting Reference ID	Measure Steward	Baseline Performance (year)	Performance Target (year)	Medicaid	CHIP
NH Hospital Discharges - Member Received Discharge Instruction Sheet	NHHDISCHARGE.01	NH DHHS	99.4% (SFY 2021)	98% (SFY 2023)	X	X
Pharmacotherapy for Opioid Use Disorder	HEDIS_POD	HEDIS	28 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Pharmacotherapy Management of COPD Exacerbation	HEDIS_PCE_BRONCHODIALTOR	HEDIS	84.5 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Pharmacotherapy Management of COPD Exacerbation	HEDIS_PCE_SYSTEMICCORTICOSTERIOD	HEDIS	74.9 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Pharmacotherapy Management of COPD Exacerbation by Subpopulation	HEDIS_PCE_SYSTEMICCORTICOSTERIOD	HEDIS	74.9 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Pharmacy Service Authorization Timely Determination Rate	SERVICEAUTH.04	NH DHHS	99.6% (SFY 2021)	98% (SFY 2023)	X	X
Prenatal and Postpartum Care	HEDIS_PPC_POSTPARTUM CARE	HEDIS	73.1 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Prenatal and Postpartum Care	HEDIS_PPC_TIMELINESSOF PRENATAL CARE	HEDIS	77.1 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Provider Communications: Calls Abandoned	PROVCOMM.03	NH DHHS	1.3% (SFY 2021)	<5% (SFY 2023)	X	X
Provider Communications: Speed to Answer Within 30 Seconds	PROVCOMM.01	NH DHHS	88.5% (SFY 2021)	80% (SFY 2023)	X	X
Provider Communications: Calls Returned by Next Business Day	PROVCOMM.08	NH DHHS	95.4% (SFY 2021)	90% (SFY 2023)	X	X
Resolution of Expedited Appeals Within 72 Hours	APPEALS.03	NH DHHS	99.5% (SFY 2021)	100% (SFY 2023)	X	X
Resolution of Standard Appeals Within 30 Calendar Days	APPEALS.01	NH DHHS	99.9% (SFY 2021)	100% (SFY 2023)	X	X
Risk of Chronic Opioid Use (COU)	HEDIS_COU	HEDIS	9.3 (CY 2020)	>=National 75th percentile (CY 2023)	X	X

Measure Name	Reporting Reference ID	Measure Steward	Baseline Performance (year)	Performance Target (year)	Medicaid	CHIP
Scheduled NEMT Trips Delivered On Time	NEMT.24	NH DHHS	92.7% (SFY 2021)	>=95.0 (SFY 2023)	X	X
Statin Therapy for Patients with Cardiovascular Disease	HEDIS_SPC_80%	HEDIS	79.2 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Statin Therapy for Patients with Diabetes	HEDIS_SPD	HEDIS	76.1 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Successful Completion of MCO Health Risk Assessment	HRA.08	NH DHHS	14.4% (SFY 2021)	25% (SFY 2023)	X	X
Timely Processing of All Clean Provider Claims: Ninety Days of Receipt	CLAIM.24	NH DHHS	100% (SFY 2021)	99% (SFY 2023)	X	X
Timely Processing of All Clean Provider Claims: Thirty Days of Receipt	CLAIM.23	NH DHHS	99.6% (SFY 2021)	95% (SFY 2023)	X	X
Timely Processing of Non-Electronic Provider Claims: Thirty Days of Receipt	CLAIM.22	NH DHHS	99.5% (SFY 2021)	95% (SFY 2023)	X	X
Timely Provider Credentialing - PCPs	TIMELYCRED.01	NH DHHS	95.7% (SFY 2021)	100% (SFY 2023)	X	X
Timely Provider Credentialing - Specialty Providers	TIMELYCRED.02	NH DHHS	99.0% (SFY 2021)	100% (SFY 2023)	X	X
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	HEDIS_APP_TOTAL	HEDIS	62.4 (CY 2020)	>=National 75th percentile (CY 2023)	X	X
Use of Imaging Studies for Low Back Pain	HEDIS_LBP	HEDIS	76.5 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Use of Opioids at High Dosage	HEDIS_HDO	HEDIS	11.4 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Use of Opioids from Multiple Providers	HEDIS_UOP	HEDIS	2.3 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Weight Assessment and Counseling	HEDIS_WCC_BMI	HEDIS	63.9 (CY 2020)	>=National 75th percentile (CY 2023)	X	

Measure Name	Reporting Reference ID	Measure Steward	Baseline Performance (year)	Performance Target (year)	Medicaid	CHIP
Weight Assessment and Counseling	HEDIS_WCC_Counseling for nutrition	HEDIS	65.9 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Weight Assessment and Counseling	HEDIS_WCC_Counseling for physical activity	HEDIS	60.3 (CY 2020)	>=National 75th percentile (CY 2023)	X	
Well-Child Visits in the first 30 Months of Life	HEDIS_W30_Well-Child Visits in the First 30 Months	HEDIS	54.9 (CY 2020)	>=National 75th percentile (CY 2023)	X	X

Table 1.2 MCM Performance Measures: Reporting Only

Measure Name	Reporting Reference ID	Measure Steward	Medicaid	CHIP
Access to Preventive/ Ambulatory Health Services for Adult Medicaid Members with SUD	SUD_CMS.32_CY	CMS	X	
Adult and Youth CMHP Eligible Members: Smoking Status	MHTOBACCO.01	NH DHHS	X	X
Adult CAHPS	CAHPS_A_SUP	CAHPS	X	
Adult CMHP Assertive Community Treatment (ACT) Service Utilization	MHACT.01	NH DHHS	X	
Asthma in Younger Adults Admission Rate per 100,000 Enrollee Months	CMS_A_INP_PQI15	CMS Adult Core Set	X	X
Average Length Of Stay In An IMD For SUD	SUD_CMS.36	NH DHHS, CMS	X	X
Care Management Comprehensive Assessment Results within 14 Calendar Days	CAREMGT.25	NH DHHS	X	X
Care Management Comprehensive Assessments Completed by Subcontractor Entity	CAREMGT.23	NH DHHS	X	X
Care Management Outreach to High-Risk/High-Need Members	CAREMGT.29	NH DHHS	X	X

Measure Name	Reporting Reference ID	Measure Steward	Medicaid	CHIP
Care Management: Comprehensive Assessment Attempts Completed Within 30 Days	CAREMGT.24	NH DHHS	X	X
Child CAHPS	CAHPS_CCC_SUP	CAHPS	X	X
Comprehensive Diabetes Care: Hemoglobin A1C Poor Control (>9.0%)	CMS_A_HPC	CMS Adult Core Set	X	
Concurrent Use of Opioids and Benzodiazepines	CMS_A_CUOB	CMS Adult Core Set	X	
Continuity of Pharmacotherapy for Opioid Use Disorder	SUD_CMS.22	NH DHHS	X	
Contraceptive Care – All Women Ages 15 – 44: Long-Acting Reversible Method of Contraception (LARC)	CMS_CCW.02	CMS Adult and Child Core Sets	X	X
Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception	CMS_CCW.01	CMS Adult and Child Core Sets	X	X
Contraceptive Care – Postpartum Women	CMS_A_CCP	CMS Adult Core Set	X	
Developmental Screening in the First Three Years of Life	CMS_CH_DEV	CMS Child Core Set	X	X
Diabetes Short-Term Complications Admission Rate per 100,000 Member Months	CMS_A_INP_PQI01	CMS Adult Core Set	X	
ED Visits for Mental Health Preceded by NH Hospital Stay in Past 30 Days	NHHREADMIT.15	NH DHHS	X	X
Emergency Department Visits - Mental Health Conditions	AMBCARE.13	NH DHHS	X	X
Emergency Department Visits - Potentially Treatable in Primary Care	AMBCARE.12	NH DHHS	X	X
Emergency Department Visits - Substance Use Disorder and Substance Misuse Related Conditions	AMBCARE.14	NH DHHS	X	X
Emergency Department Visits for Any Condition	AMBCARE.20	NH DHHS	X	X

Measure Name	Reporting Reference ID	Measure Steward	Medicaid	CHIP
Emergency Department Visits for Physical Health Conditions	AMBCARE.11	NH DHHS	X	X
Follow-up Visit after Community Hospital or APRT Discharge for Mental Health-Related Conditions - Within 30 Days of Discharge	MHDISCHARGE.02	NH DHHS	X	X
Follow-up Visit after Community Hospital or APRT Discharge for Mental Health-Related Conditions - Within 7 Days of Discharge	MHDISCHARGE.01	NH DHHS	X	X
Follow-up Visit after Discharge from NH Hospital - Within 30 Days of Discharge	NHHDISCHARGE.19	NH DHHS	X	X
Follow-up Visit after Discharge from NH Hospital - Within 7 Days of Discharge	NHHDISCHARGE.18	NH DHHS	X	X
Frequent Emergency Department Use	AMBCARE.18	NH DHHS	X	X
Heart Failure Admission Rate per 100,000 Enrollee Months	CMS_A_INP_PQI08	CMS Adult Core Set	X	
Inpatient Hospital Utilization - Ambulatory Care Sensitive Conditions	INPASC.04	NH DHHS	X	X
Interest on Late Paid Claims	CLAIM.08	NH DHHS	X	X
Member Access to SUD Services following SUD Assessment and Diagnosis	SUD.51	NH DHHS	X	X
Member Appeals Received	APPEALS.19	NH DHHS	X	X
Member Cancellations of Scheduled NEMT Trips by Reason for Member Cancellation	NEMT.23	NH DHHS	X	X
Member Communications: Reasons for Telephone Inquiries	MEMCOMM.06	NH DHHS	X	X
Member Grievances Received	GRIEVANCE.03	NH DHHS	X	X
Member Referrals to DHHS's Tobacco Cessation Programs	TOBACCO.03	NH DHHS	X	X

Measure Name	Reporting Reference ID	Measure Steward	Medicaid	CHIP
Members Enrolled in Care Management at Any Time During the Month	CAREMGT.40	NH DHHS	X	X
Members Identified as High-Risk/High-Need Receiving Care Management	CAREMGT.42	NH DHHS	X	X
Members Receiving Care Management by Geographic Region	CAREMGT.43	NH DHHS	X	X
Members Receiving Face-to-Face Local Care Management	CAREMGT.32	NH DHHS	X	X
Members Receiving Local Care Management by Geographic Region	CAREMGT.41	NH DHHS	X	X
NEMT Requests Delivered by Type of Medical Service	NEMT.15	NH DHHS	X	X
Neonatal Abstinence Syndrome Engagement in Care Management	CARECOORD.04	NH DHHS	X	X
Neonatal Abstinence Syndrome Referrals to Care Management	CARECOORD.03	NH DHHS	X	X
NH Hospital Discharges - New CMHC Patient Had Intake Appointment with CMHC within 7 Calendar Days of Discharge	NHHDISCHARGE.16	NH DHHS	X	X
Pharmacy Utilization Management: Generic Drug Substitution	PHARMUTLMGT.03	NH DHHS	X	X
Pharmacy Utilization Management: Generic Drug Utilization	PHARMUTLMGT.04	NH DHHS	X	X
Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	PHARMUTLMGT.02	NH DHHS	X	X
Physician/APRN/Clinic Visits	AMBCARE.10	NH DHHS	X	X
Polypharmacy Monitoring: Adults With 5 or More Prescriptions in 60 Consecutive Days	POLYPHARM.06	NH DHHS	X	
Polypharmacy Monitoring: Children with 4 or More Prescriptions for 60 Consecutive Days	POLYPHARM.04	NH DHHS	X	X

Measure Name	Reporting Reference ID	Measure Steward	Medicaid	CHIP
Private Duty Nursing: Authorized Hours for Adults Delivered and Billed by Quarter	PDN.05	NH DHHS	X	
Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter	PDN.04	NH DHHS	X	X
Professional and Facility Medical Claim Processing Results	CLAIM.11	NH DHHS	X	X
Proportion of Days Covered (PDC):	PHARM_PDC	NH DHHS	X	X
Provider Communications: Reasons for Telephone Inquiries	PROVCOMM.07	NH DHHS	X	X
Readmissions among Members with SUD by Subpopulation	SUD_CMS.25	CMS	X	X
Readmissions for Mental Health Conditions within 180 Days of Discharge	MHREADMIT.07	NH DHHS	X	X
Readmissions for Mental Health Conditions within 180 days of Discharge - Community Hospital or APRT Facilities	MHREADMIT.05	NH DHHS	X	X
Readmissions for Mental Health Conditions within 30 Days of Discharge	MHREADMIT.06	NH DHHS	X	X
Readmissions for Mental Health Conditions within 30 Days of Discharge - Community Hospital or APRT Facilities	MHREADMIT.04	NH DHHS	X	X
Readmissions to NH Hospital - Within 180 Days of Discharge	NHHREADMIT.14	NH DHHS	X	X
Readmissions to NH Hospital - Within 30 Days of Discharge	NHHREADMIT.13	NH DHHS	X	X
Requests for Assistance Accessing MCO Designated Primary Care Providers by County	ACCESSREQ.05	NH DHHS	X	X
Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County	ACCESSREQ.06	NH DHHS	X	X
Resolution of All Appeals Within 45 Calendar Days	APPEALS.04	NH DHHS	X	X

Measure Name	Reporting Reference ID	Measure Steward	Medicaid	CHIP
Resolution of Appeals by Disposition Type	APPEALS.05	NH DHHS	X	X
Resolution of Extended Standard Appeals Within 44 Calendar Days	APPEALS.02	NH DHHS	X	X
Resolution of Provider Appeals Within 30 Calendar Days	PROVAPPEAL.01	NH DHHS	X	X
Results of Scheduled NEMT Trips by Outcome	NEMT.18	NH DHHS	X	X
Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	PHARMQI.09	NH DHHS	X	X
Service Authorization Denials for Waiver & Non-HCBC Waiver Populations	SERVICEAUTH.14	NH DHHS	X	X
Service Authorizations: Physical, Occupational & Speech Therapy Service Authorization Denials by Waiver & Non-HCBC Waiver Populations	SERVICEAUTH.15	NH DHHS	X	X
Services Authorized within 72 Hours Following a Reversed Appeal	APPEALS.18	NH DHHS	X	X
SUD Diagnosis Treated in an IMD by Subpopulation	SUD_CMS.05	CMS	X	X
Timely Processing of All Grievances	GRIEVANCE.05	NH DHHS	X	X
Timely Processing of Electronic Provider Claims: Fifteen Days of Receipt	CLAIM.21	NH DHHS	X	X
Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage	CMS_A_OHD	CMS Adult Core Set	X	

Appendix C – MCO Plans, Tables and Reports

Data detail as presented in the NH MCO Contract Defacto Exhibit O and as referenced. *Last Updated 11.24.21. Consult with the Department for any recent updates prior to use.*

Reporting Reference ID	Report Name	Data Type	Measure Data Period
ANNUALRPT.01	Medicaid Care Management Program Comprehensive Annual Report	Narrative Report	Agreement Year
APM.01	Alternative Payment Model Plan	Plan	Varies
APM.02	Alternative Payment Model Quarterly Update	Table	Varies
APM.03	Alternative Payment Model Completed HCP-LAN Assessment Results	Narrative Report	Varies
APPEALS.16	Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population	Table	Quarter
APPEALS.17	Pharmacy Appeals by Type of Resolution and Therapeutic Drug Class by State Plan, 1915B Waiver, and Total Population	Table	Quarter
BHDRUG.01	Severe Mental Illness Drug Prior Authorization Report	Table	Quarter
BHPARITY.01	Behavioral Health Parity Attestation	Table	Calendar Year
BHSTRATEGY.01	Behavioral Health Strategy Plan and Report	Plan	Agreement Year
BHSURVEY.01	Behavioral Health Satisfaction Survey Annual Report	Table	Calendar Year
CAREMGT.01	Care Management Plan Including Plan to Assess and Report on the Quality and Appropriateness of Care Furnished to Members With Special Health Care Needs	Plan	Agreement Year
CAREMGT.26	Care Management Resources - Unmet Needs	Table	Quarter

Reporting Reference ID	Report Name	Data Type	Measure Data Period
CAREMGT.28	Care Management: Members Receiving Care Management by Priority Population	Table	Quarter
CULTURALCOMP.01	Cultural Competency Strategic Plan	Plan	N/A
DUR.01	Drug Utilization Review (DUR) Annual Report	Narrative Report	Federal Fiscal Year
EMERGENCYRESPONSE.01	Emergency Response Plan	Plan	Agreement Year
EPSDT.01	Delivery of Applied Behavioral Analysis Services Under Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Benefit	Table	Quarter
EPSDT.20	Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Plan	Plan	Agreement Year
EQRO.01	MCO Follow-up on EQRO Recommendations	Narrative Report	Semi-annual
FINANCIALSTMT.01	MCO Annual Financial Statements	Narrative Report	MCO Financial Period
FWA.02	Fraud Waste and Abuse Log: FWA Related to Providers	Table	Month
FWA.04	Fraud Waste and Abuse Log: Date of Death Report	Table	Month
FWA.05	Fraud Waste and Abuse Log: Explanation Of Medical Benefit Report	Table	Quarter
FWA.06	Fraud Waste and Abuse Log: Waste Recovery Report	Table	Quarter
FWA.20	Comprehensive Annual Prevention of Fraud Waste and Abuse Summary Report	Narrative Report	Agreement Year
GRIEVANCE.02	Grievance Log Including State Plan / 1915B Waiver Flag	Table	Quarter

Reporting Reference ID	Report Name	Data Type	Measure Data Period
HEDISMEMBER.01	HEDIS Member Level Data	Table	Calendar Year
HRA.09	Health Risk Assessment Narrative Report	Narrative Report	Quarter
INLIEUOF.01	In Lieu of Services Report	Narrative Report	Agreement Year
INTEGRITY.01	Program Integrity Plan	Plan	Agreement Year
LOCKIN.01	Pharmacy Lock-in Member Enrollment Log	Table	Month
LOCKIN.03	Pharmacy Lock-in Activity Summary	Table	Month
MCISPLANS.01	Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	Plan	Agreement Year
MEMINCENTIVE.01	Member Incentive Table	Table	Quarter
MEMINCENTIVE.02	Member Incentive Plan	Plan	Agreement Year
MHEDBRD.01	Emergency Department Psychiatric Boarding Table	Table	Month
MHREADMIT.03	Mental Health Readmissions: Service Utilization Prior to Readmission	Table	Quarter
MHSUICIDE.01	Zero Suicide Plan	Plan	Agreement Year
MLR.01	Medical Loss Ratio Report	Table	Quarter
MONTHLYOPS.01	Monthly Operations Report	Table	Month
MSQ.01	Medical Services Inquiry Letter	Table	Month

Reporting Reference ID	Report Name	Data Type	Measure Data Period
NETWORK.01	Comprehensive Provider Network and Equal and Timely Access Annual Filing	Table	Calendar Year
NETWORK.10	Corrective Action Plan to Restore Provider Network Adequacy	Table	Calendar Year
NETWORK.11	Access to Care Provider Survey	Table	Agreement Year
PDN.07	Private Duty Nursing: Individual Detail for Members Receiving Private Duty Nursing Services	Table	Quarter
PDN.08	Private Duty Nursing: Network Adequacy Report	Table	Quarter
PHARMQI.10	Child Psychotropic Medication Monitoring Report	Table	Quarter
PMP.01	Program Management Plan	Plan	Agreement Year
PROVAPPEAL.02	Provider Appeals Log	Table	Quarter
PROVCOMPLAINT.01	Provider Complaint and Appeals Log	Table	Quarter
PROVPREVENT.01	Hospital-Acquired and Provider-Preventable Condition Table	Table	Annual
PROVPRIV.01	Behavioral Health Written Consent Report	Narrative Report	Agreement Year
PROVTERM.01	Provider Termination Log	Table	As Needed or Weekly
PROVTERM.02	Provider Termination Report	Table	Month
QAPI.01	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	Plan	Calendar Year
QAPI.02	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	Narrative Report	Calendar Year

Reporting Reference ID	Report Name	Data Type	Measure Data Period
SERVICEAUTH.05	Service Authorization Determination Summary by Service Category by State Plan, 1915B Waiver, and Total Population	Table	Quarter
SUBROGATION.01	Subrogation Report	Table	Month
SUD.27	Member Access to Clinically Appropriate Services as Identified by ASAM Level of Care Determination Table	Table	Calendar Year
SUD.39	High Opioid Prescribing Provider Monitoring Report	Narrative Report	Agreement Year
SUDAUDIT.01	SUD Record Audits	Narrative Report	6 Months
SUDAUDIT.02	SUD Record Audit Provider Level Summaries	Table	6 Months
TOBACCO.01	Annual Report of MCO Tobacco Cessation Program Offerings, Operations, and Utilization	Narrative Report	Agreement Year
TOBACCO.02	Semi-Annual Report of MCO Tobacco Cessation Utilization	Narrative Report	Agreement Year
TOBACCO.04	Tobacco Cessation Activity Report	Report or Table	Quarter
TPLCOB.01	Coordination of Benefits: Costs Avoided Summary Report	Table	Quarter
TPLCOB.02	Coordination of Benefits: Medical Costs Recovered Claim Log	Table	Quarter
TPLCOB.03	Coordination of Benefits: Pharmacy Costs Recovered Claim Log	Table	Quarter
UMSUMMARY.03	Medical Management Committee	Narrative Report	Agreement Year

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

Network Adequacy Standards	
Provider/Service Type	**Time and Distance Standard**
PCPs (adult & pediatric)	Two (2) within forty (40) minutes or fifteen (15) driving miles
Adult Specialists	One (1) within sixty (60) minutes or forty-five (45) driving miles
Pediatric Specialists	One (1) within one hundred twenty (120) minutes or eighty (80) driving miles
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

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.

Availability of Service Standards	
MCO Contract Section	**Standard**
4.7.5.6.4	Urgent, Symptomatic Office Visits shall be available from the Member's PCP or another Provider within forty-eight (48) hours. An Urgent, Symptomatic Office Visit is associated with the presentation of medical signs or symptoms that require immediate attention, but are not life threatening and do not meet the definition of Emergency Medical Condition.
4.7.5.6.5	Transitional Health Care shall be available from a primary care or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a Substance Use Disorder treatment program.
4.7.5.6.6	Transitional Home Care shall be available with a home care nurse, licensed counselor, and/or therapist (physical therapist or occupational therapist) within two (2) calendar days of discharge from inpatient or institutional care for physical or mental health disorders, if ordered by the Member's PCP or Specialty Care Provider or as part of the discharge plan.
4.7.5.17.1	The MCO shall have in its network the capacity to ensure that Transitional Health Care by a Provider shall be available from a primary or specialty Provider for clinical assessment and care planning within two (2) business days of discharge from inpatient or institutional care for physical or mental health disorders or discharge from a Substance Use Disorder treatment program.
4.7.5.17.2	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

Availability of Service Standards	
MCO Contract Section	**Standard**
	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.
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.

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

Information as presented in this Exhibit is current as of the January 1, 2021, NH MCO contract that was presented to NH Governor and Executive Council on January 22, 2021. Consult with the Department for any recent updates prior to use.

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
LEVEL 1 MCO action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of member(s); reduces members' access to care; and/or the integrity of the managed care program	1.1 Failure to substantially provide medically necessary covered services	$25,000 per each failure
	1.2 Discriminating among members on the basis of their health status or need for health care services	$100,000 per violation
	1.3 Imposing arbitrary utilization management criteria, quantitative coverage limits, or prior authorization requirements prohibited in the contract	$25,000 per violation
	1.4 Imposing on members premiums or charges that are in excess of the premiums or charges permitted by DHHS	$10,000 per violation (DHHS will return the overcharge to the member)
	1.5 Continuing failure to meet minimum care management, care coordination and transition of care policy requirements	$25,000 per week of violation
	1.6 Continuing failure to meet minimum behavioral health (mental health and substance use disorder) requirements, including regarding the full continuum of care for members with substance use disorders	$25,000 per week of violation
	1.7 Continuing failure to meet or failure to require their network providers to meet the network adequacy standards established by DHHS (without an approved exception) or timely member access to care standards in Section 4.7.5.	$1,000 per day per occurrence until correction of the failure or approval by DHHS of a Corrective Action Plan $100,000 per day for failure to meet the requirements of the approved Corrective Action Plan
	1.8 Misrepresenting or falsifying information furnished to CMS or to DHHS or a member	$25,000 per violation

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

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	1.18 Failure to notify a member of DHHS senior management within twelve (12) hours of a report by the Member, Member's relative, guardian or authorized representative of an allegation of a serious criminal offense against the Member by any employee of the MCO, its Subcontractor or a Provider	$50,000 per violation
	1.19 Two or more Level 1 violations within a contract year	$75,000 per occurrence
LEVEL 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

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	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
	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	$5,000 per delayed application and $1,000 per each day the application is delayed
	2.15 Failure to meet performance standards in the contract which include care management measures (Sections 4.10.2.12, 4.10.6.2 and 4.10.8.3), claims processing (Sections 4.4.4.1.2, 4.18.1.5, 4.18.1.6, 4.18.4.2 and 4.18.5.2), call center performance (Sections 4.4.4.3.3.1, 4.4.4.3.3.2, 4.13.4.1.3.1, 4.3.4.1.3.2 and 4.13.4.1.3.3), non-emergency medical transportation (Section 4.1.9.8), and 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

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	2.18 Failure to comply with subrogation timeframes established in RSA 167:14-a	$15,000 per occurrence
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

Level	Noncompliant Behavior and/or Practices (Non-Exhaustive List)	Liquidated Damages Range
	3.12 Two or more Level 3 violations within a contract year	$100,000 per occurrence
LEVEL 4 MCO action(s) or inaction(s) that inhibit the efficient operation the managed care program.	4.1 Submission of a late, incorrect, or incomplete report or deliverable (excludes encounter data and other financial reports). The violation shall apply to resubmissions that occur in contract years following the initial submission due date	$1,000 for each of the first 10 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 4.1.1 $500 per day of violation
	4.2 Failure to comply with timeframes for distributing (or providing access to) beneficiary handbooks, identification cards, provider directories, and educational materials to beneficiaries (or potential members)	$5,000 per violation
	4.3 Failure to meet minimum requirements requiring coordination and cooperation with external entities (e.g., the New Hampshire Medicaid Fraud Control Unit, Office of the Inspector General) as described in the contract	$5,000 per violation
	4.4 Failure to comply with program audit remediation plans within required timeframes	$5,000 per occurrence
	4.5 Failure to meet staffing requirements	$5,000 per violation
	4.6 Failure to ensure provider agreements include all required provisions	$10,000 per violation

Appendix F – 834 Categories of Eligibility

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

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

Appendix G – Public Comments on NH Medicaid Quality Strategy

#	Page #	Draft Excerpt	Author	Comment	DHHS Response
1	13-14	Table in objective 1.2	MCO Employee	Verbal Comments – The New Hampshire Medicaid rates in the table do not align with the aggregate data in the tables on https://medicaidquality.nh.gov/.	In calculating HEDIS measures using a sample of members, the Department uses a weight in calculating the statewide rates to adjust for variation in the size of each MCOs population.
2	15	Control limits will be set as three standard deviations (following conventional practice) from the mean based on historical data.	MCAC Member	Verbal Comment – Is three standard deviations too great of a tolerance for monitoring?	Previously the Department used two standard deviations, but changed the process to three because of a high number of false positive results. It was determined that two standard deviations was too sensitive to identify true variations.
3	26	The objective of the process is to determine whether predictor variables are considered significant predictors for the numerator requirement.	MCO Employee	Verbal Comment – Would the data be more meaningful to indicate predictor variables for negative numerator events? For example, would it be better to identify when a specific population is less likely to perform well on a quality measure?	The Department agrees with the comment and will conduct linear regression modeling to determine predictor variables for a negative numerator events.

Appendix H – 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.

MCO	AIM Statement	Intervention
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 selected PHOs [physician-hospital organizations], and had a diabetes screening (a glucose or HbA1c test) from 78.57% to 92.85%.	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 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	1. NHHF will test the use of a notification of alcohol and other drug (AOD) diagnosis and/or referral (NDR) form to

MCO	AIM Statement	Intervention
	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%.	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 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.

MCO	AIM Statement	Intervention
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%.	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.

*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.

Appendix I – 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 #5 Objective	Process / Outcome Objective	Results (Met / Made Progress / Did Not Meet)	Quality Strategy Version #6 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	Key performance indicators updated.
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	Key performance indicators updated.
Objective 1.3 – Ensure MCOs adopt of evidence-based clinical practice guidelines that meet the requirements of 42 CFR 438.340(b)(1).	Process	Met	No findings/recommendations.
Objective 1.4 - DHHS establishes a statewide transition of care policy that meets the	Process	Met	No findings/recommendations.

Quality Strategy Version #5 Objective	Process / Outcome Objective	Results (Met / Made Progress / Did Not Meet)	Quality Strategy Version #6 Revisions Based on Analysis Findings/Recommendations
requirements of 42 CFR 438.340(b)(5).			
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.
Objective 2.2 – Ensure MCO access performance measures do not indicate an access issue	Process	Met	No findings/recommendations.
Objective 2.3 – Ensure that annual member experience of care survey rates are equal to or higher than the national average for Medicaid managed care health plans	Outcome	Met	Specific key performance indicators have been selected for the experience of care objective.
Objective 3.1 – Demonstrate contract compliance and identify quality issues through ongoing MCO system wide performance measure evaluation.	Process	Met	No findings/recommendations.
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.
Objective 4.1 - Ensure that MCOs maintain accreditation from the National Committee for Quality Assurance of Health Plans (NCQA).	Process	Met	No findings/recommendations.
Objective 4.2 – Ensure that MCOs annually maintain the operation of a QAPI programs that meets the requirements of 42 CFR 438.330.	Process	Met	No findings/recommendations.
Objective 5.1 – Ensure the annual EQRO performance measure validation audit results verify the accuracy of MCO performance measures.	Process	Met	No findings/recommendations.
Objective 5.2 – Ensure that monthly EQRO	Process	Partially Met	Added encounter data validation key

Quality Strategy Version #5 Objective	Process / Outcome Objective	Results (Met / Made Progress / Did Not Meet)	Quality Strategy Version #6 Revisions Based on Analysis Findings/Recommendations
encounter data validation results demonstrate MCO contract compliance for timeliness and accuracy of encounter data.			performance indicators to the Performance Based Auto-Assignment Program.
Objective 6.1 – Ensure that MCO performance improvement projects demonstrate sustained improvement	Process	N/A – In Progress	No findings/recommendations.
Objective 6.2 – Ensure that the annual EQRO technical report includes MCO recommendations for performance improvement.	Process	Met	Revised component of the quality strategy to provide a section about Department actions in response to EQR evaluation of the Department's Quality Strategy.
Objective 6.3 – Conduct quarterly Quality Assurance and Program Improvement meetings between the quality leadership of DHHS and the MCOs.	Process	Met	Objective removed and relocated to the description of the MCOs QAPI programs.
Objective 6.4 – Ongoing appropriate use of MCO sanctions that are compliant with 42 CFR 438 Subpart I.	Process	Met	No findings/recommendations.
Objective 6.5 – Ensure transparency by publicly reporting of over 200 MCM quality measures on http://medicaidquality.nh.gov/	Process	Met	No findings/recommendations.
Objective 7.1 – Conduct ongoing monitoring of the 1915b population to evaluate access to care, quality of care, and program impact.	Process	Met	No findings/recommendations.
Objective 7.2 – Ensure there is an ongoing process to identify and inform the MCOs of members with long-term service and supports needs or persons with special health care needs.	Process	Met	No findings/recommendations.
Objective 7.3 – Ensure there is an ongoing process for the identification, evaluation, and reduction of health disparities.	Process	Partially Met	New health disparities objective.

Quality Strategy Version #5 Objective	Process / Outcome Objective	Results (Met / Made Progress / Did Not Meet)	Quality Strategy Version #6 Revisions Based on Analysis Findings/Recommendations
Objective 7.4 – Conduct ongoing monitoring of access to care and quality care for members receiving services to treat mental health conditions.	Process	Met	No findings/recommendations.
Objective 7.4.a – Conduct ongoing monitoring of access to care and quality care for members receiving services to treat mental health conditions. Associated with NH's CMS Directed Payment	Outcome	Not Met	Adjustments made to the directed payment and revised key performance indicators identified.
Objective 7.5 – Conduct ongoing monitoring of access to care and quality care for members receiving services to substance use disorders.	Process	Met	No findings/recommendations.
Objective 7.6 – Improved care coordination.	Process	Made progress	Added care coordination key performance indicators to the Performance Based Auto-Assignment Program.
Objective 7.7 – Reduction in member gaps in eligibility.	Process	N/A	No findings/recommendations.