New Hampshire Medicaid Care Management Quality Performance Report

Medicaid Care Management Quality Strategy Effectiveness Analysis – 2021

A Report Prepared by the Medicaid Quality Program
Division of Program Quality and Integrity
New Hampshire Department of Health and Human Services

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The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence

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Quality Strategy Effectiveness Analysis

The Department of Health and Human Services (Department) in compliance with 42 CFR 438.340(a) on August 31st, 2019 published an updated Medicaid Care Management quality strategy[1] to assess and improve the quality of health care services provided by Managed Care Organizations (MCO) in New Hampshire to Medicaid and Children's Health Insurance Program (CHIP) recipients.

On a periodic basis but no longer than every three years the Department conducts an effectiveness analysis of the current quality strategy. While the review is a stand-alone effort, it is primarily a compilation of separate quality activities and ongoing monitoring efforts that are conducted throughout the data period reviewed.

Background

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[2]. The review comprehensively evaluates 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*[3] to shape the analysis.

Methodology

Data Period

The evaluation primarily focuses on the 22 month performance period of 9/1/2019 – 6/30/2021. The beginning of the performance period marks the start of the newest MCO procurement and the end of the performance period marks 3 years from the last NH managed care quality strategy effectiveness analysis.

Goals and Objectives

The NH Medicaid managed care quality strategy identifies goals and objectives that focus on process as well as achieving outcomes. Goal 1 "Ensure Quality and Appropriateness of Care Delivered" is an example of an outcome. Goal 4 "Assure MCO quality program infrastructure" is an example of a process measure. NH has determined that both are essential to operating an effective Medicaid quality program.

"The *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality*

[1] https://medicaidquality.nh.gov/sites/default/files/MCM%202.0%20Quality%20Strategy%20SFY%202020_0.pdf
[2] https://medicaidquality.nh.gov/care-management-quality-strategy
[3] https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf

Strategy Toolkit emphasizes the importance of goals and objectives that achieve outcomes. Sample tools are provided in the guidance for states to display outcomes in their respective quality strategies. While NH will continue to evaluate goals and objectives that focus on both process and outcomes, *Appendix A: Outcome Goals and Objectives* provides the CMS recommended table that isolates outcome measures.

Evaluation Process

The table below outlines the criteria used to evaluate the effectiveness of each objective. While the review is a stand-alone effort, it is primarily a compilation of separate quality activities and ongoing monitoring efforts that are conducted throughout the data period reviewed.

Review Criteria	**Description**
Activity Conducted	The criteria verifies whether the process outlined in the objective was conducted.
Baseline Data (Outcome Only)	The criteria provides initial data for outcome objectives prior to the establishment of performance goals.
Current Results	The criteria provides point in time information about the Department's results in achieving the objective.
Progress on Objective (Met/Made Progress/Not Met)	The criteria provides a score to evaluate the Department's progress in meeting the objective. Met = Objective was fully achieved. Made Progress = Objective was not fully achieved, but the evaluation identified progress towards achieving the objective. Not Met = Objective was not fully achieved and the evaluation does not identify progress towards achieving the objective.
Plans for plan/provider level corrective action	The criteria identifies specific activities that will be conducted by individual health plans or providers to better meet the objective.
Plans for system-level changes	The criteria identifies specific activities that will be conducted by the Department to better meet the objective.
Revisions based on evaluation (if any)	The criteria identifies revisions that will be made to the objective in the next version of the quality strategy based on the effectiveness evaluation.

Alignment with CMS Adult and Child Core Set Measures

The CMS Quality Strategy Toolkit encourages states to review performance on the Adult and Child Core Set of measures relative to other states and use the quality strategies to prioritize and articulate quality improvement goals in those areas where performance can improve.

New Hampshire has included the following CMS core set measures in the NH Medicaid Care

Management Quality strategy based on opportunities for improvement identified by comparing NH rates to the national 75th percentile of Medicaid health plans:

- CMS Adult Core Set (PPC-AD) – Prenatal and Postpartum Care: Postpartum Care;
- CMS Adult Core Set (SAA-AD) – Adherence to Antipsychotic Medications for Individuals With Schizophrenia;
- CMS Adult Core Set (SSD-AD) – Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications;
- CMS Adult Core Set (IET-AD) – Engagement of Alcohol & Other Drug Abuse or Dependence Treatment;
- CMS Adult and Child Core Set (CHL-CH) (CHL-AD) – Chlamydia Screening in Women;
- CMS Child Core Set (ADD-CH) – Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance;
- CMS Child Core Set (IMA-CH) – Immunizations for Adolescents Combination 1;
- CMS Child Core Set (IMA-CH) – Immunizations for Adolescents Combination 2; and
- CMS Child Core Set (APP-CH) – Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.

External Quality Review Organization's Recommendations in the Quality Strategy

The CMS Quality Strategy Toolkit recommends states consider whether the state has acted on external quality review recommendations in the state quality strategy.

The NH Medicaid Care Management Quality Strategy includes process objective 6.2 "Ensure that the annual EQRO technical report includes MCO recommendations for performance improvement." The objective was an initial process objective to assure that recommendations were being provided. As this objective has been achieved, the Department will further evolve the objective to include external quality review recommendations in the next version of the quality strategy.

Results

Summary Results

Quality Strategy Objective	Process / Outcome Objective	Results (Met / Made Progress / Did Not Meet)
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	Outcome	Made progress.

Medicaid managed care health plan rates.		
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
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
Objective 1.4 - DHHS establishes a statewide transition of care policy that meets the requirements of 42 CFR 438.340(b)(5).	Process	Met
Objective 2.1 – Ensure that the MCO provider networks meet the 90% standard of time or distance for each New Hampshire County.	Process	Met
Objective 2.2 – Ensure MCO access performance measures do not indicate an access issue	Process	Met
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
Objective 3.1 – Demonstrate contract compliance and identify quality issues through ongoing MCO system wide performance measure evaluation.	Process	Met
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
Objective 4.1 - Ensure that MCOs maintain accreditation from the National Committee for Quality Assurance of Health Plans (NCQA).	Process	Met
Objective 4.2 – Ensure that MCOs annually maintain the operation of a QAPI programs that meets the requirements of 42 CFR	Process	Met

438.330.		
Objective 5.1 – Ensure the annual EQRO performance measure validation audit results verify the accuracy of MCO performance measures.	Process	Met
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
Objective 5.1 – Ensure the annual EQRO performance measure validation audit results verify the accuracy of MCO performance measures.	Process	Met
Objective 5.2 – Ensure that monthly EQRO encounter data validation results demonstrate MCO contract compliance for timeliness and accuracy of encounter data.	Process	Partially Met
Objective 6.1 – Ensure that MCO performance improvement projects demonstrate sustained improvement	Process	N/A
Objective 6.2 – Ensure that the annual EQRO technical report includes MCO recommendations for performance improvement.	Process	Met
Objective 6.3 – Conduct quarterly Quality Assurance and Program Improvement meetings between the quality leadership of DHHS and the MCOs.	Process	Met
Objective 6.4 – Ongoing appropriate use of MCO sanctions that are compliant with 42 CFR 438 Subpart I.	Process	Met
Objective 6.5 – Ensure transparency by publicly reporting of over 200 MCM quality measures on http://medicaidquality.nh.gov/	Process	Met
Objective 7.1 – Conduct ongoing monitoring of the 1915b population to evaluate access to care, quality of care, and program impact.	Process	Met
Objective 7.2 – Ensure there is an ongoing process to identify and inform the MCOs of members with long-term service and	Process	Met

supports needs or persons with special health care needs.		
Objective 7.3 – Ensure there is an ongoing process for the identification, evaluation, and reduction of health disparities.	Process	Partially Met
Objective 7.4 – Conduct ongoing monitoring of access to care and quality care for members receiving services to treat mental health conditions.	Process	Met
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
Objective 7.5 – Conduct ongoing monitoring of access to care and quality care for members receiving services to substance use disorders.	Process	Met
Objective 7.6 – Improved care coordination.	Process	Made progress
Objective 7.7 – Reduction in member gaps in eligibility.	Process	N/A

Detailed Results

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

Objective 1.1 – Ensure that by the end of State Fiscal Year 2022 annual preventive care measure rates are equal to or higher than the 75th percentile of National Medicaid managed care health plan rates.	
Confirm activity was conducted	See report: *NH Medicaid Care Management Quality Improvement Priority Update – SFY 2021* - https://medicaidquality.nh.gov/sites/default/files/SFY%202021%20NH%20 MCM%20Quality%20Improvement%20Priority%20Update%20F3.pdf. The report provides analysis of the annual data collected from the three MCOs for the 4 prevention measures selected as performance improvement priorities. The Medicaid Quality Program collects annual data on preventive care from each MCO. These indicators are a blend of clinical process and outcome measures related to the topic of prevention. The measure set is informed by the NCQA Quality Health Plan Ratings and includes measures from HEDIS as well as the CMS Adult and Child Core Sets. Each measure is compared to NCQA Quality Compass 75th percentile of national Medicaid managed care health plans. An analysis is subsequently conducted to determine if the rates are equal to or higher than the national 75th percentile. Result are annually presented to internal stakeholders, the Medicaid Medical Care Advisory Council, included in the EQRO Technical Report, and publicly posted to https://medicaidquality.nh.gov.
Baseline Data	Calendar Year 2018 – 4 out of 4 measures did not meet the goal.
Current Results	Calendar Year 2019 – • 3 out of 4 measures made progress meeting the goal; and • 1 out of 4 measures did not make progress or meet the goal. The measure that did not meet the goal was Immunizations for Adolescents Combination Including HPV Vaccinations (IMA-CH).
Progress on Objective (Met/Made	Made progress.

Progress/Not Met)	
Describe plan/provider-level corrective action (if any)	To incentivize improvement, the Department has included Adolescent Well Child Visits (WCV-CH) in the SFY 2021 NH Medicaid Care Management Withhold and Incentive Program.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
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.	
Confirm activity was conducted	See report: *NH Medicaid Care Management Quality Improvement Priority Update – SFY 2021* - https://medicaidquality.nh.gov/sites/default/files/SFY%202021%20NH%20 MCM%20Quality%20Improvement%20Priority%20Update%20F3.pdf. The report provide analysis of the 6 treatment measures that were selected as performance improvement priorities. The Medicaid Quality Program collects annual data on treatment from each MCO. These indicators are a blend of clinical process and outcome measures related to the topic of treatment. The measure set is informed by the NCQA Quality Health Plan Ratings and includes measures from HEDIS as well as the CMS Adult and Child Core Sets. Each measure is compared to NCQA Quality Compass 75th percentile of national Medicaid managed care health plans. An analysis is subsequently conducted to determine if the rates are equal to or higher than the national 75th percentile. Results are annually presented to internal stakeholders, the Medicaid Medical Care Advisory Council, included in the EQRO Technical Report, and publicly posted to https://medicaidquality.nh.gov.
Baseline Data	Calendar Year 2018 – 5 out of 6 measures did not meet the goal.
Current Results	Calendar Year 2019 –

	• 4 out of 6 measures met the goal; • 1 out of 6 measures made progress meeting the goal; and • 1 out of 6 measures did not make progress or meet the goal. The measure was Continuation of Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medications (ADD-CH).
Progress on Objective	Made progress.
Describe plan/provider-level corrective action (if any)	The measure not making progress is Continuation of Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medications (ADD-CH). To incentivize improvement, the measure is being added to the SFY 2022 NH Medicaid Care Management Withhold and Incentive Program.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 1.3 – Ensure MCOs adopt of evidence-based clinical practice guidelines that meet the requirements of 42 CFR 438.340(b)(1).	
Confirm activity was conducted	Confirmed for SFY 2021 The MCM Quality Program has a two-prong approach to assuring compliance with this objective. First, every three years the MCO's adoption of evidence-based clinical practice guidelines is evaluated by NCQA for the purposes of health plan accreditation. Subsequently, once every three years the MCO's compliance with this MCO contract requirement is evaluated by the EQRO during a contract compliance review. The two reviews are coordinated to the extent possible so that the evaluation does not occur on the same year.
Baseline Data	N/A

Current Results	• All MCOs determined to be in compliance with federal regulation via the EQRO contract compliance audit (i.e. SFY 2018 and SFY 2020 reviews). • All MCOs met the standard during NCQA accreditation review.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 1.4 - DHHS establishes a statewide transition of care policy that meets the requirements of 42 CFR 438.340(b)(5).	
Confirm activity was conducted	Confirmed. The Department's transition of care policy outlined in 438.62(b)(3) is described in the agreement between the Department and each of the MCOs. In general, Medicaid State Plan Services in place at the time a member transitions to an MCO will be honored for sixty (60) calendar days or until completion of a medical necessity review, whichever comes first.
Baseline Data	N/A
Current Results	The state has meet the following requirements as outlined in 42 CFR438.340(b)(5) by including elements required in 42 CFR 438.62(b)(3) as demonstrated below the transition of care policy: 1. Is publicly available at: https://www.dhhs.nh.gov/ombp/caremgt/documents/transition-of-care.pdf 2. Provides instructions to members and potential members on how to access continued services upon transition 3. Is described in the quality strategy under Objective 1.4.

	4. Is explained to individuals in the MCO member handbook
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.

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.	
Confirm activity was conducted	Confirmed for the annual period 1/1/2020-12/31/2020. On a semi-annual basis, the MCM Quality Program evaluates each MCO's network for time and distance standards that are established in the MCO contract. Standards developed in the MCO contract are compliant with requirements in 42 CFR 438.68(c). Networks are analyzed at the county level for each provider type. For provider types that do not meet time and distance standards, the MCO is required to submit a request for an exception to time and distance standards. The request must include: • Annual member utilization of services provided by this provider type; • Reasons for the unmet standards; • MCO solution for deficiency; • Progress on the solution if this was a previously requested exception; and • Provider level detail. Exceptions are reviewed by a cross-functional group of Department staff to approve the MCO's requests for exceptions. Reasons for exception that are currently under consideration

<table>
<tr><td></td><td>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.</td></tr>
<tr><td>Current Results</td><td>Of the 601 county and provider combinations that were evaluated, there were 81 instances, listed below, where at least one plan did not meet 90% of either the time or distance standards. In most instances the reason was a lack of the provider type in the county. In all instances the MCO had a plan for members in the county to access services.
Adult Medical Day Care (Coos, Grafton)
Allergist (Coos)
Developmental Behavioral Health Pediatrician (Belknap, Carroll, Cheshire, Coos, Grafton, Stafford)
General Inpatient Psychiatric Facilities (Coos)
Hospital – Diagnostic Cardiac Catheterization (Cheshire, Coos)
Hospital – Therapeutic Radiation (Cheshire, Coos)
Licensed Renal Dialysis (Coos, Grafton)
Methadone Clinic (Coos, Carroll, Grafton)
Ophthalmologist and Optometrist (Coos)
Pediatric Specialist: Allergist/Immunologist, Ophthalmologist, Orthopedic Surgeon, Otolaryngologist, Plastic Surgeon (All Counties)</td></tr>
</table>

	• Plastic Surgeon (Coos, Carroll, Grafton) • Short-Term Care Facility for Inpatient Psychiatric (Carroll, Cheshire, Coos, Grafton) • Short-Term Facility for Inpatient Medical Rehabilitation Services (Carroll, Cheshire, Coos, Grafton) • Thoracic Surgery (Coos, Grafton) Exception to network adequacy in 2020 are consistent with previous exceptions. All exceptions to network adequacy have MCO plans about how members will access services. The greatest number of exceptions are for providers in Carroll, Coos, and Grafton counties. Pediatric specialties represent the only provider type with statewide exceptions to network adequacy.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	DHHS will continue to monitor the MCOs networks on an annual basis and member access to care related to these services.
Revisions based on evaluation (if any)	None at this time.
Objective 2.2 – Ensure MCO access performance measures do not indicate an access issue	
Confirm activity was conducted	Confirmed, see report *NH Medicaid Care Management Network & Access Monitoring June 2021*: https://medicaidquality.nh.gov/sites/default/files/MCM%20Network%20Adequacy%20and%20Access%20to%20Care%202021-07%20Final.pdf 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.

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

For each measure, control limits based on historical trends are employed in quarterly charts to provide a consistent indication of a potential access problem as each new quarter of data are available. Control limits will be set as three standard deviations (following conventional practice[4]) from the mean based on historical data. New quarterly rates that are three standard deviations from the mean will be considered a potential access issue that requires intensive analysis. For member experience of care survey measures, MCM rates will be evaluated to determine if they are at least equal to or better than the national average.

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

Annually, the EQRO will conduct a secret shopper study for selected New Hampshire provider 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.</td></tr>
<tr><td>Baseline Data</td><td>N/A</td></tr>
<tr><td>Current Results</td><td>Utilization measures are within historical control limits suggesting no significant changes in member’s accessing care.</td></tr>
</table>

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

	All utilization measures showed a decrease in the 2nd quarter of calendar year 2020 followed by a return to historical utilization levels in the 3rd quarter. The decrease is likely attributable to the COVID-19 pandemic. Increases in requests for specialist providers are likely driven by members enrolled in the new MCO AmeriHealth Caritas.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
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	
Confirm activity was conducted	Confirmed see report *NH Medicaid Care Management Network & Access Monitoring June 2021*: https://medicaidquality.nh.gov/sites/default/files/MCM% 20Network%20Adequacy%20and%20Access%20to%20Care%202021-07%20Final.pdf The MCM Quality Program collects annual data on beneficiaries' experience of care from each MCO. The measure set is informed by the NCQA Quality Health Plan Ratings and includes Adult and Child measures obtained through the CAHPS health plan survey. Each measure is compared to NCQA Quality Compass national average of Medicaid managed care health plans. An analysis is subsequently conducted to determine if the rates are equal to or higher than the national average. Result are annually presented to the Medicaid Medical Care Advisory Council, included in the EQRO Technical Report, and publicly posted to https://medicaidquality.nh.gov.
Baseline Data	All measures for the MCM program rate met the standard in 2019.

Current Results	All measures evaluated for the MCM program rate met the standard in 2020.
Progress on Objective	Met
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	The next version of the Quality Strategy will identify which specific CAHPS measures will be evaluated. Priority will be placed on CAHPS measures that produce data that are actionable. For example, measures reflecting member perceptions on the ease of accessing services can be further evaluated by reviewing other access to care data. Measures reflecting overall satisfaction with a health plan are not easily actionable because there is no data describing the reasons a member was or was not satisfied.

Goal 3 – Assure MCO contract compliance

Objective 3.1 – Demonstrate contract compliance and identify quality issues through ongoing MCO system wide performance measure evaluation.	
Confirm activity was conducted	Confirmed. The NH MCM Program includes a robust list of required quality reports. These data are presented both as individual measures and aggregated into measure sets and reports to demonstrate the impact of specific programs and overall MCO impact in all domains of administrative and clinical quality. On a monthly basis, the MCM Quality Program analyzes measures, plans, and reports for performance issues at the population and MCO level. The State reviews for: • Performance that is concerning relative to contract standards; • Continued trends over 3 measurement cycles; and • Notable increases and decrease from the prior reporting period. Performance issues are reviewed weekly by the State's contract mangers. Others may be enlisted to discuss specific quality measures, reports, or plans as needed based on concerns

	identified during data review. State contract managers then share the results with the MCOs for potential corrective action and performance improvement.
Baseline Data	N/A
Current Results	In March 2020 the Department implemented a robust system of issue identification and escalation. From March 2020 – June 2021 the Department identified 115 instances where performance data indicated an MCO was out of compliance with a contract performance threshold. The most frequently cited performance indicators include: • Enrollment in MCO care management; • Timely provider credentialing; • Timely processing of service authorizations; and • Follow up contacts to members after discharge from inpatient psychiatric facilities.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	For performance periods on or after April 1, 2021 the Department will begin exercising contractual authority to impose liquidated damages. Between April 1, 2021 and June 30, 2021 the Department has imposed $4,000 in liquidated damages to health plans that are out of compliance with specific provisions of the MCO contract.
Revisions based on evaluation (if any)	None at this time.
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;	
Confirm activity was conducted	Confirmed. The EQRO conducted an onsite compliance review at each MCO. See report *2020 New Hampshire External Quality Review Technical Report February 2021*: https://medicaidquality.nh.gov/sites/default/files/NH%20 EQRO%20Technical%20Report%20SFY%202020_0.pdf

	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.
Baseline Data	N/A
Current Results	The SFY 2020 overall compliance review scores are: • 86.9% AmerihealthCaritas New Hampshire; • 94.3% New Hampshire Healthy Families; and • 94.5% Well Sense Health Plan. While the scores demonstrate some contract standards are not being met, 100% of all not met standards had an EQRO approved corrective action plan.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.

Goal 4 – Assure MCO quality program infrastructure

Objective 4.1 - Ensure that MCOs maintain accreditation from the National Committee for Quality Assurance of Health Plans (NCQA).	
Confirm activity was conducted	Confirmed. See report *MCO Accreditation Report.* https://medicaidquality.nh.gov/member-enrollment-guide-quality-nh-medicaid-plans DHHS requires that the MCOs obtain and maintain NCQA accreditation. The maintenance of accreditation activities and the results will be reviewed and posted on the NH Medicaid Quality website.
Baseline Data	N/A
Current Results	All 3 MCOs have achieved accreditation from NCQA.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 4.2 – Ensure that MCOs annually maintain the operation of a QAPI programs that meets the requirements of 42 CFR 438.330.	
Confirm activity was conducted	Confirmed for SFY 2021. In complement to the State's Medicaid Managed Care Quality Strategy, each MCO develops, maintains, and operates a QAPI program as required by 42 CFR 438.330, and the NH MCO Contract. The QAPI must be approved by the MCO's governing body and is subject to the approval by the State. Each MCO's QAPI describes the 4 MCO PIPs. All PIPs are monitored

	by the State's EQRO and adhere to CMS protocols for PIPs. PIPs are based on the MCO's initial assessments of their membership and in consultation with their consumer and provider advisory boards. Additionally, the State conducts quarterly Quality Improvement meetings with the MCO Quality Leadership. These meetings routinely bring all of the MCOs together, take an agnostic perspective on the NH Medicaid program, and, to the greatest degree possible, harmonize the PIPs and other quality initiatives across the MCOs and the NH Medicaid program. Finally, each MCO submits an annual report describing the effectiveness of their QAPI programs for review by DHHS. The review also includes how the MCO plans to address DHHS substantiated EQRO findings.
Baseline Data	N/A
Current Results	• All MCOs have been determined to be in compliance with federal regulation via the EQRO contract compliance audit (i.e. SFY 2019 and SFY 2020 reviews). • All MCOs met the standard during their most recent NCQA accreditation review.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time

Goal 5 – Assure the quality and validity of MCO data

Objective 5.1 – Ensure the annual EQRO performance measure validation audit results verify the accuracy of MCO performance measures.	
Confirm activity was conducted	Confirmed. See report *2020 New Hampshire External Quality Review Technical Report*

	February 2021: https://medicaidquality.nh.gov/sites/default/files/NH%20 EQRO%20Technical%20Report%20SFY%202020_0.pdf 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.
Baseline Data	N/A
Current Results	All MCO audit elements in the SFY 2020 Performance Measure Validation audit were met.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 5.2 – Ensure that monthly EQRO encounter data validation results demonstrate MCO contract compliance for timeliness and accuracy of encounter data.	
Confirm activity was conducted	Confirmed. See report *2020 New Hampshire External Quality Review Technical Report February 2021*: https://medicaidquality.nh.gov/sites/default/files/NH%20 EQRO%20Technical%20Report%20SFY%202020_0.pdf 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.
Baseline	N/A
Current Results	The following elements did not meet encounter data submission and quality standards: • Validity of Member Identification Number and Billing Provider Information in Pharmacy Encounters (Well Sense); • Timeliness of Professional Encounters Submitted (AmeriHealth, New Hampshire Healthy Families); • Timeliness of Institutional Encounters Submitted (AmeriHealth); and • Timeliness of Pharmacy Encounters Submitted (AmeriHealth, New Hampshire Healthy Families).
Progress on Objective	Partially Met
Describe plan/provider-level corrective action (if any)	Well Sense has received four (4) notifications and New Hampshire Healthy Families has receive one (1) notification from the Department to correct identified encounter data quality issues. Both MCOs are meeting with the Department on a monthly basis to correct these issues.
Describe system-level program changes made as a result of monitoring findings (if any)	The Department is conducting several new encounter data studies in SFY 2021. First, the Department will conduct a comparative analysis to determine whether encounters submitted to DHHS by the MCOs are complete and accurate based on data stored in the MCOs system. Second the department is conducting a medical record review to compare the accuracy of the MCOs records with the provider's file. Beginning April 1, 2021 the Department plans to begin exercising contractual authority to impose liquidated damages for encounter data issues.
Revisions based on evaluation (if any)	None at this time.

Goal 6 – Manage continuous performance improvement

Objective 6.1 – Ensure that MCO performance improvement projects demonstrate sustained improvement	
Confirm activity was conducted	Partially confirmed. To evaluate sustained improvement, performance improvement projects must progress through all four stages of the PIP cycle. By the end of SFY 2021, the MCOs PIPs had progressed through 3 of the 4 stages; however, because of COVID-19 the MCO interventions had minimal provider engagement. The Department decided to extend the existing PIPs for an additional year. As a result the evaluation of the PIPs for sustained improvement has not yet occurred. See current details on the evaluation of the PIPs at: *2020 New Hampshire External Quality Review Technical Report February 2021*: https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%202020_0.pdf
Baseline	N/A
Current Results	N/A
Progress on Objective	N/A
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	The Department has extended the PIPs for an additional year.
Revisions based on evaluation (if any)	None.
Objective 6.2 – Ensure that the annual EQRO technical report includes MCO recommendations for performance improvement.	
Confirm activity was conducted	Confirmed. See report *2020 New Hampshire External Quality Review Technical Report February 2021*: https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%202020_0.pdf

	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.
Baseline	N/A
Current Results	The 2021 EQRO technical report included specific recommendations for MCO performance improvement concerning quality, timeliness of care, and access to care.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	The objective was an initial process objective to assure that recommendations were being provided. As this objective has been achieved, the Department will further evolve the objective to include the specific external quality review recommendations in the next version of the quality strategy. In addition, the Department will provide information on what activities are being undertaken to address those recommendations.
Objective 6.3 – Conduct quarterly Quality Assurance and Program Improvement meetings between the quality leadership of DHHS and the MCOs.	
Confirm activity was conducted	Confirmed. The Department conducted quarterly meetings with the MCO.

Baseline	N/A
Current Results	The Department conducted quarterly meetings with the 3 MCOs.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	Regular leadership meetings between the Department and the MCO have been adopted as a regular course of operations. These meetings fill critical operational functions which achieves this collaborative objective in the quality strategy. As a result, the objective has been implemented and is no longer required to be monitored by the quality strategy.
Objective 6.4 – Ongoing appropriate use of MCO sanctions that are compliant with 42 CFR 438 Subpart I.	
Confirm activity was conducted	Confirmed. 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.
Baseline	N/A
Current Results	Between April 1, 2021 and June 30, 2021 the Department has imposed $4,000 in liquidated damages to health plans that are out of compliance with specific provisions of the MCO contract. There are no known violations of 42 CFR 438 Subpart I for the current liquidated damages.
Progress on Objective	Met
Describe plan/provider-level	None at this time.

corrective action (if any)	
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time
Objective 6.5 – Ensure transparency by publicly reporting of over 200 MCM quality measures on http://medicaidquality.nh.gov/	
Confirm activity was conducted	Confirmed for all validated data submitted by the MCOs. See https://medicaidquality.nh.gov/ A core value of the MCM Quality Program is transparency in reporting data around the performance and outcomes of the MCM program. As a result the public has access to over 200 MCM quality measures available on https://medicaidquality.nh.gov/
Baseline	N/A
Current Results	The Department continues to publicly report over 200 MCM quality measures.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.

Goal 7 – Targeted population quality activities

Objective 7.1 – Conduct ongoing monitoring of the 1915b population to evaluate access to care, quality of care, and program impact.	
Confirm activity was conducted	Confirmed. See report NH 1915(b) Waiver Quality and Access Monitoring June, 2021 https://medicaidquality.nh.gov/sites/default/files/SFY%202021%20MQP%201915B%20Monitoring%20Update%20Final.pdf For the beneficiaries in the 1915(b) population, the MCM Quality Program has developed a comprehensive monitoring plan with activities to assure access, quality and evaluate the program impact for the population. On a quarterly basis, data is evaluated for applicable monitoring activities, which include service utilization trends as well as grievances and appeals. In addition, annual data is compiled, such as a member focus group that is conducted by the EQRO to identify potential issues for the population that may not surface with other monitoring activities. The monitoring plan includes an analysis for each activity to: • Confirm that the activity was conducted; • Summarize the results and findings; • Identify problems found; • Describe the plan/provider level corrective action plan to be administered; and • Describe the system level program changes resulting from the monitoring findings.
Baseline	N/A
Current Results	**Access to Care:** CY 2020 showed various data periods below the established control lines from current utilization trends. DHHS believes the decrease is due to COVID-19 and will continue to monitor utilization. **Quality of Care:** CY 2019 data showed a decrease in the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotic in the foster care population. DHHS has added this measure to the MCM Withhold and Incentive Program.

Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	The Department has reached saturation of the identification of issues through qualitative studies that only include 1915(b) populations. As a result DHHS will no longer conduct qualitative studies that solely focus on 1915(b) population. To assure new issues don't arise, DHHS will include a limited number of 1915(b) populations in other qualitative studies
Revisions based on evaluation (if any)	None at this time.
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.	
Confirm activity was conducted	Confirmed. DHHS uses the 834 eligibility file that is exchanged on a daily basis between the Department and the MCOs to communicate key member details.
Baseline	N/A
Current Results	The daily 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.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if	None at this time.

any)	
Objective 7.3 – Ensure there is an ongoing process for the identification, evaluation, and reduction of health disparities.	
Confirm activity was conducted	Confirmed. The State currently obtains race (multiple categories), Hispanic ethnicity, and primary language spoken, during its eligibility and NH Medicaid enrollment process. This information, in addition to disability eligibility status, is shared with the MCOs as a part of daily eligibility data feeds through the 834 file. Currently, the MCOs are required to implement Cultural Competency Plans that assure that providers, individuals, and systems within the health plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each. To complement the activities associated with the Cultural Competency Plans, DHHS is working to formally include reducing health disparities as a unique activity to be administered by the MCO's QAPI programs.
Baseline	N/A
Current Results	The Department's initial plan was to understand how MCOs were monitoring and addressing health disparities as reported in the MCO Cultural Competency plans. Since 2019 the Department has determined that a more actionable strategy is required to identify, evaluate, and reduce health disparities.
Progress on Objective	Partially met.
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	DHHS is requiring MCOs to report race and ethnicity data for all HEDIS measures that have a race and ethnicity sub-measures. Results will be available in June 2023 for calendar year 2022. For Calendar Year 2020, New Hampshire will use Member Level data from several HEDIS

	and CMS Core Set measures to begin evaluating disparities across demographic factors and identifying plans for addressing these disparities. Measures include but are not limited to: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment and Follow-up After Hospitalization for Mental Illness.
Revisions based on evaluation (if any)	NH will use these data for initial planning to identify, evaluate, and reduce health disparities which are anticipated to be in the next QS.
Objective 7.4 – Conduct ongoing monitoring of access to care and quality care for members receiving services to treat mental health conditions.	
Confirm activity was conducted	Confirmed. Activity was subset of access to care data found at: https://medicaidquality.nh.gov/sites/default/files/MCM%20Network%20Adequacy%20and%20Access%20to%20Care%202021-07%20Final.pdf and quality of care data found at: https://medicaidquality.nh.gov/measures-a-z-list The NH MCM quality program conducts targeted monitoring for members with mental health conditions. Monitoring of access to care and quality of care for this population follows the format of other goals and objectives within the NH MCM Quality Strategy. Activities include: • Network Adequacy for Mental Health providers; • Utilization monitoring; • Treatment based quality of care measures; • Mental health performance improvement projects; and • Mental health member experience of care survey. The NH MCM program requires the MCOs to work with DHHS and the NH Suicide Prevention Council to promote the "Zero Suicide Program," as well as well as other suicide prevention programs.
Baseline Data	N/A
Current Results	**Access to Care:** Through the annual network monitoring conducted in Objective 2.1 there were several instances where at least one plan did not meet 90% of either the time or distance standards for

	mental health providers. In all instances the MCO had a plan for members in the county to access services. • Developmental Behavioral Health Pediatrician (Belknap, Carroll, Cheshire, Coos, Grafton, Stafford); and • General Inpatient Psychiatric Facilities (Coos) Monitoring primary consists of Emergency Department (ED) Visits and Clinic/Office visits for the population receiving services from Community Mental Health Centers (CMHC). From 10/1/2019 through 12/31/2020 utilization measures are within historical control limits suggesting no significant changes in member's accessing care. All utilization measures showed a decrease in the 2nd quarter of calendar year 2020 followed by a return to historical utilization levels in the 3rd quarter. The decrease is likely attributable to the COVID-19 pandemic. 2020 marked the third year that the MCOs utilized the same member survey. Aggregate rates indicate there are no significant differences in member's accessing care as indicated in the following questions: • Services were available at times that were good for me (Strongly Agree & Agree); • I was able to see a psychiatrist when I wanted (Strongly Agree & Agree); • I felt my child has someone to talk with when he/she was troubled (Strongly Agree & Agree) **Quality of Care:** The following Quality of Care measures showed members receiving services from Community Mental Health Centers with equal to or better outcomes than those who did not receive services from these agencies: • Follow-Up Care for Children Prescribed ADHD Medication (ADD) • Antidepressant Medication Management (AMM) • Metabolic Monitoring for Children and Adolescents on Antipsychotics Total (APM) • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

	(APP) • Breast Cancer Screenings (BCS) • Pharmacotherapy Management of COPD Exacerbation (PCE) • Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SMD) • Adherence to Antipsychotics for Individuals with Schizophrenia (SAA)
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
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	
Confirm activity was conducted	Confirmed. NH DHHS received approval from CMS for a Uniform Dollar or Percentage Increases for Community Mental Health Programs for Assertive Community Treatment, Mobile Crisis Services, Same Day Access upon New Hampshire Hospital Discharge and Step Down Community Residence Beds for individuals dually diagnosed with Serious Mental Illness and Developmental Disabilities. The approval by CMS is linked to the NH Medicaid Care Management Quality Strategy and will be evaluated by determining the increase from the baseline period of the following measures: • CMS Core Set: Follow-up after hospitalization for mental illness: Within 7 Days of discharge; • CMS Core Set: Follow-up after hospitalization for mental illness: Within 30 Days

	of discharge; and • Members receiving Community Mental Health Services who were discharged from New Hampshire Hospital (NHH) and readmitted within 30 calendar days. • Members receiving Community Mental Health Services who were discharged from New Hampshire Hospital (NHH) and readmitted within 90 calendar days.
Baseline Data	CY 2019 – 4 out of 4 measures did not meet the goal. See report: https://medicaidquality.nh.gov/sites/default/files/2021%20NH%20CMHC%20Evaluation%202021.4.pdf
Current Results	CY 2020 – 4 out of 4 measures did not meet the goal. See report above.
Progress on Objective	Not Met
Describe plan/provider-level corrective action (if any)	These data represent an opportunity for NH to course correct by focusing on improving the program implementation. Efforts include the production of regular program utilization and readmission rate reports to be regularly discussed with the CMHCs for the identification of promising practices and opportunities for improvement. In the early stages of this practice, the Department identified gaps in notifying CMHCs when a member was discharged from a DRF and is currently determining if a new event notification system could be used to address this barrier.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	The Department will separate the Directed Payment goals into a separate objective in the future quality strategy.
Objective 7.5 – Conduct ongoing monitoring of access to care and quality care for members receiving services to substance use disorders.	
Confirm activity was conducted	Confirmed. Activity was subset of access to care data found at: https://medicaidquality.nh.gov/sites/default/files/MCM%20Network%20Adequacy%20and%20Access%20to%20Care%202021-07%20Final.pdf, utilization can be found at:

	https://medicaidquality.nh.gov/sites/default/files/NH_SUD_MonitoringReport_DY3_Q3_%20FINAL%206%2018%2021.pdf, and quality of care monitoring can be found at: https://medicaidquality.nh.gov/sites/default/files/SFY%202021%20NH%20MCM%20Quality%20Improvement%20Priority%20Update%20F3.pdf. The NH MCM quality program conducts targeted monitoring for members receiving services to treat substance use disorders. Monitoring of access to care and quality of care for this population follows the format of other goals and objectives within the NH MCM Quality Strategy. Activities include: • Network adequacy for substance use disorder treatment providers; • Substance use disorder performance improvement projects; and • Treatment based quality of care measures.
Baseline Data	N/A
Current Results	**Access to Care** During annual network monitoring conducted in Objective 2.1 there were several instances where at least one plan did not meet 90% of either the time or distance standards for mental health providers. In all instances the MCO had a plan for members in the county to access services. • Methadone Clinic (Coos, Carroll, Grafton) Department utilizes monitoring from the CMS 1115 SUD waiver to monitor trends in utilization that could indicate an access to care issue. The most recent CMS monitoring report indicated: • Increases in the utilization of Outpatient Services, Intensive Outpatient/Partial Hospitalization Services, Residential Inpatient Services, Withdrawal Management, and MAT services. New Hampshire did not have concerns as this is the desired directionality; and • Increases in the rate of emergency department visits and inpatient hospital stays for SUD treatment in the quarter ending 9/30/2020. While these are not the desired

	directionality the Department anticipates the increase is related to the Public Health Emergency. **Quality of Care:** The SUD quality of care measure, Engagement of Alcohol and Other Drug Dependence Treatment (IET) reached the desired objective found in 1.2 of the quality strategy for Calendar Year 2019. The Department awaits national benchmarks for 2020 to determine quality of care for this measure.
Progress on Objective	Met
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	None at this time.
Revisions based on evaluation (if any)	None at this time.
Objective 7.6 – Improved care coordination.	
Confirm activity was conducted	Confirmed. The NH MCM quality program includes monitoring of two key MCO contract standards related to care coordination. First, the Department is evaluating whether or not the MCOs achieve a standard of 15% of their population, defined as high risk / high need, and are enrolled in the MCOs care management program. Second, the Department is evaluating whether or not the MCOs achieve a standard of 50% of their population enrolled in care management being managed by a Local Care Management Entity. Failure to meet either of these contract standards may result in a corrective action plan or liquidated damages.

Baseline Data	N/A
Current Results	**Enrollment in Care Management:** All MCO have been unable to reach the original target standard of 15% of their membership being enrolled in Care Management. The Department has lowered the standard to 3%. As of 6/30/2021, all MCOs are below the standard. **Enrollment in Local Care Management:** The Department has delayed the local care management program.
Progress on Objective	Made progress
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program changes made as a result of monitoring findings (if any)	The Department has delayed the local care management program. MCOs who do not reach the 3% standard will be assessed liquidated damages.
Revisions based on evaluation (if any)	The NH MCM Quality Strategy will be updated to reflect changes in policy at the time the strategy is next updated.
Objective 7.7 – Reduction in member gaps in eligibility.	
Confirm activity was conducted	The activity was delayed.
Baseline Data	N/A
Current Results	The Department's requirement for MCOs to assist members with recertification has been delayed due to the public health emergency. The Department is no longer requiring the MCOs to assist with Community Engagement and Work Requirements.
Progress on Objective	**N/A**
Describe plan/provider-level corrective action (if any)	None at this time.
Describe system-level program	None at this time.

changes made as a result of monitoring findings (if any)	
Revisions based on evaluation (if any)	Quality strategy will be updated to reflect current policy.

Appendix A: Outcome Goals and Objectives

Metric Name	Metric Specification	Baseline Performance (year)	Performance Target	Current Rate (Year) (Goal Met/Not Met)	Medicaid/ CHIP
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.					
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	HEDIS/Adult Core Set	61.9% (CY2018)	Current 75th Percentile National Medicaid	79.2% (CY2019) (Not Met)	Both
Chlamydia Screening in Women (CHL-CH) (CHL-AD)	HEDIS/Adult & Child Core Set	46.5% (CY2018)	Current 75th Percentile National Medicaid	48.1% (CY2019) (Not Met)	Both
Immunizations for Adolescents Combination 1 (IMA-CH)	HEDIS/Child Core Set	78% (CY2018)	Current 75th Percentile National Medicaid	78.2% (CY2019) (Not Met)	Both
Immunizations for Adolescents Combination 2 (IMA-CH)	HEDIS/Child Core Set	33.1% (CY2018)	Current 75th Percentile National Medicaid	33.1% (CY2019) (Not Met)	Both
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.					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)	HEDIS/Adult Core Set	80.9% (CY2018)	Current 75th Percentile National Medicaid	76.6% (CY2019) (Met)	Medicaid
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	HEDIS/Adult Core Set	80.5% (CY2018)	Current 75th Percentile National Medicaid	82.7% (CY2019 (Not Met)	Medicaid

Metric Name	Metric Specification	Baseline Performance (year)	Performance Target	Current Rate (Year) (Goal Met/Not Met)	Medicaid/ CHIP
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment Engagement of AOD Treatment -(IET-AD)	HEDIS/Adult Core Set	17.9% (CY2018)	Current 75th Percentile National Medicaid	22% (CY2019) (Met)	Both
Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance (ADD-CH)	HEDIS/Child Core Set	57.3% (CY2018)	Current 75th Percentile National Medicaid	52.3% (CY2019) (Not Met)	Both
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	HEDIS/Child Core Set	70.4% (CY2018)	Current 75th Percentile National Medicaid	75.4% (CY2019) (Met)	Both
Use of Imaging Studies for Low Back Pain (LBP)	HEDIS	68.8% (CY2019)	Current 75th Percentile National Medicaid	75.5% (CY2019) (Met)	Medicaid
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					
Getting Needed Care Right Away (Usually + Always) - Child	HEDIS/AHRQ	93.7%	Current National Medicaid Average	95.9% (CY2019)(Met)	Both
Getting Needed Care Right Away (Usually + Always) - Adult	HEDIS/AHRQ	88.6%	Current National Medicaid Average	87.8% (CY2019)(Met)	Medicaid
Getting Appointment to See Specialist as Soon as Needed (Usually + Always) - Child	HEDIS/AHRQ	93.2%	Current National Medicaid Average	94.5% (CY2019)(Met)	Both
Getting Appointment to See Specialist as Soon as Needed (Usually + Always) - Adult	HEDIS/AHRQ	80.7%	Current National Medicaid Average	79.2% (CY2019)(Met)	Medicaid
Getting Routine or Check-up Appointments as Soon as They Were Needed (Usually + Always) - Child	HEDIS/AHRQ	93.2%	Current National Medicaid Average	94.5% (CY2019)(Met)	Both
Getting Routine or Check-up Appointments as Soon as They Were Needed (Usually + Always) - Adult	HEDIS/AHRQ	83.8%	Current National Medicaid Average	79.9% (CY2019)(Met)	Medicaid
Objective 7.4 – Conduct ongoing monitoring of access to care and quality care for members receiving services to treat mental health conditions. – CMS Directed Payment Quality Targets					

Metric Name	Metric Specification	Baseline Performance (year)	Performance Target	Current Rate (Year) (Goal Met/Not Met)	Medicaid/ CHIP
Members receiving Community Mental Health Services who were discharged from New Hampshire Hospital or Designated Receiving Facility and readmitted within 30 calendar days	NH DHHS	6.4% (CY 2019)	4.4%	7.9% (CY 2020) (Not Met)	Both
Members receiving Community Mental Health Services who were discharged from New Hampshire Hospital or Designated Receiving Facility and readmitted within 90 calendar days	NH DHHS	15.5% (CY 2019)	13.5%	15.4% (CY 2020) (Not Met)	Both
Follow-up after hospitalization for mental illness: 7 Days of discharge (FUH-AD)	HEDIS/Adult Core Set	63% (CY 2017)	65%	56.1% (CY 2020) (Not Met)	Both
Follow-up after hospitalization for mental illness: 30 Days of discharge (FUH-AD)	HEDIS/Adult Core Set	80.2% (CY 2017)	82.2%	74% (CY 2020) (Not Met)	Both