



**Quality Strategy
for the
New Hampshire
Medicaid Care Management
Program**

August 3, 2015

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Preface

The New Hampshire Medicaid Care Management (MCM) Quality Strategy is technical document required by the Code of Federal Regulations, CFR438.200, and the Center for Medicare and Medicaid Services programs to ensure the delivery of quality health care by managed care organizations. It is not intended to comprehensively describe all the activities that the Department of Health and Human Services undertakes to ensure Medicaid program quality.

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

I. Introduction

A. General Information

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

The Medicaid Care Management program will be rolled out in three phases (Appendix A). Step One of the Medicaid Care Management program included all State Plan Amendment services, except dental and long term care supports and services. Step One was mandatory for all NH Medicaid beneficiaries that did not also utilize waiver services. Populations utilizing waiver services could, but were not required to, enroll on a voluntary basis. Step One was fully implemented and coverage for enrolled Medicaid beneficiaries began on December 1, 2013.

With Center for Medicare and Medicaid Services (CMS) approval, Step Two will be implemented in multiple phases. In Phase One, all previously voluntary populations will now receive their State Plan Amendment services through the MCM program. Phase One is anticipated to begin in the summer, 2015. Additional phases will incorporate, both non-waiver and waiver long term care supports and services into the MCM program.

Step Three, begun August 15, 2014 and in advance of Step Two, included Medicaid expansion populations resulting from NH’s implementation of the Affordable Care Act, Senate Bill 413 created the NH Health Protection Program (NHHPP). The NHHPP expanded state supported health insurance through (1) mandatory participation and coverage for Medicaid eligible individuals that have access to but cannot afford, cost effective employer sponsored coverage, (2) a “Bridge to Marketplace,” wherein new eligible Medicaid beneficiaries will be covered under the existing Medicaid Care Management health plans until, (3) beginning January 1, 2016, newly eligible beneficiaries would purchase insurance, with financial support from the federal government, on NH’s Health Insurance Exchange. Covered services for the newly eligible population are outlined in Appendix A.

Under state statute, dental services will remain fee-for-service. NH Medicaid beneficiaries who are also part of the VA health system and those spending down to meet Medicaid requirements remain excluded from the Medicaid Care Management program.

Prior to the initiative of Medicaid managed care, the State had a disaggregated approach to quality oversight driven primarily by the regulatory requirements of various DHHS programs. Through this Quality Strategy for the NH Medicaid Care Management program (Quality Strategy), NH has begun to coordinate services provided by various DHHS business units and the MCM health plans into a single, unified approach and building upon the legislative goals of value, quality assurance and efficiency for the Medicaid program.

The State's initial quality objectives have been drawn from generally understood opportunities for improvement. Additionally, the Department performs regular monitoring and analysis to identify the program's successes and new opportunities for improvement and amend the Quality Strategy to include additional population-based quality improvement activities. It is also the Department's intention to, over time, harmonize the NH Medicaid Quality Strategy with the National Quality Strategy, synergistically using State's resources to champion national campaigns and capitalize on grant and other federal initiatives.

The Quality Strategy also serves to assure stakeholders that the State's managed care organizations (MCOs) are in contract compliance and have committed adequate resources to perform internal monitoring, ongoing quality improvement and actively contribute to health care improvement for the State's most vulnerable citizens.

B. Managed Care Quality Program Objectives

In complement to the State's Quality Strategy, each MCO has developed, maintains and operates a Quality Assessment and Performance Improvement (QAPI) program, as required by the Code of Federal Regulations, 42 CFR 438.240, and the NH Medicaid Care Management Contract (Appendix F and G). The QAPI is subject to the approval by the State. Each MCO's QAPI describes the four MCO performance improvement projects (PIP), at least one of which must have a behavioral health focus and, with the full roll-out of Step Two, one of which must have a long term supports and services focus. All PIPs are monitored by the State's EQRO and adhere to CMS protocols for PIPs. PIPs are based on the MCOs 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 Medical and Quality Improvement Directors. 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.

The following PIPs initiatives have been selected by the MCOs and are currently being implemented:

- New Hampshire Healthy Families
 - Vision screening for adults with diabetes;
 - Well care visits for 3,4,5,and 6 year olds;
 - Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications; and
 - Weight assessment & counseling for nutrition and physical activity for children/adolescents.

- Well Sense Health Plan
 - Diabetes Care – HbA1c Testing;
 - Percent of Women (16 to 24 years) receiving Chlamydia Screening;
 - Well-Child Visits for 3-6 years; and
 - Reduce Readmissions to New Hampshire Hospital.

The Department will continue to incorporate recommendations from the public, MCOs and the External Quality Review Organization (EQRO) Technical Report in setting future goals and revisions the Quality Strategy. Other activities at this time include:

- Comprehensive, routine, population-based measurement and monitoring;
- Health plan operations and contract compliance reporting; and
- Annual surveys of member, including special populations such as children and adults with special health care needs, and provider satisfaction with health plans and member satisfaction with Medicaid providers.

MCO QAPI programs will include performance measurement for the above initiatives as well as DHHS required Quality Indicators (Appendix B) and routine reporting on health plan operations (Appendix E). All performance data will be submitted to the State. The State has conducted an initial CAHPS survey for children, and adults and a CAHPS survey for the expansion population to serve as a baseline for enrollees' experiences with the NH Medicaid program. Beginning in 2015, each MCO began conducting comprehensive CAHPS surveys (NH Medicaid Care Management Contract) to continue to assess member satisfaction with the health plans and services.

Data from the above initiatives and assessments will be publicly reported via the NH Medicaid Quality website (<http://medicaidquality.nh.gov/>), which serves as the primary public clearinghouse for NH Medicaid quality information. Selected data will also be publicly reported via the NH DHHS website which also contains a webpage specific to the Medicaid Quality program <http://www.dhhs.nh.gov/ombp/quality/index.htm>.

II. Assessment

As required by 42 CFR 438.202(d), the State assesses how well the Care Management program is meeting the objectives outlined in the Introduction through:

- A. Analysis of the quality and appropriateness of care and services delivered to enrollees;
- B. The level of contract compliance of MCOs; and
- C. Monitoring MCO activities through the use of health information technology on an on-going basis.

A. Quality and Appropriateness of Care and Services

New Hampshire assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through:

- NH Medicaid Quality Indicators monitoring on the NH Medicaid Quality website, <http://medicaidquality.nh.gov/>, including the CMS Pediatric and Adult Quality Measures (Appendix B),
- PIP projects,
- NH Medicaid Care Management Contract Compliance, Operations and Quality Reporting,
- NH DHHS, Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems Population-based, special and ad hoc analysis and reporting,
- MCO National Committee for Quality Assurance (NCQA) accreditation review, and

- External Quality Review Organization (EQRO) activities, including NH Medicaid population analysis and the EQRO Technical Report, and
- NH Medicaid clinical Medicaid Care Management standards.

NH Medicaid Quality Indicators

The NH Medicaid program aggregates population-based measures to enhance the identification of program strengths and opportunities and makes this data publicly available on the NH Medicaid Quality website (<http://medicaidquality.nh.gov/>)

The website includes a robust list of validated quality measures (Appendix B) required by the MCOs for Step One, Phase 1 of Step Two, and Step Three. Future iterations of MCM measures will include quality measures specific to the remaining Step Two phases. Measures currently include, but are not limited to, standardized and validated measures from the following recognized and credible organizations:

- Center for Medicare and Medicaid Services (CMS) including the CMS Adult and Pediatric Quality Indicators ;
- Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS); and
- National Center for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS).

It is the intent of DHHS to expand this measure set with the implementation of additional Step Two phases to include measures specific to long term supports and services. These measures will be drawn from measures currently in use, measures used for regulatory compliance, measures based on public listening sessions and recommendations from other stakeholders.

NH also reviews data at the individual health plan level. Data are assessed by comparing health plan performance against:

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

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.

The NH Medicaid Quality website continues to be updated whenever new data becomes available according to measure specific submission schedules.

Performance Improvement Projects

Each MCO has begun implementation on four MCO performance improvement projects (PIP), subject to the approval of the State, at least one of which must have a behavioral health focus and, in future phases of Step Two, one must have a long term care services and supports focus. Each MCO made an initial assessment of its membership and worked in consultation with their consumer and provider advisory boards to determine the greatest potential for health care quality

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

MCO Contract Compliance, Operations and Quality Reporting

The NH Medicaid Care Management Program includes a robust list of Required Quality Reports (Appendix E) and a comprehensive list of encounter data elements (Appendix C). 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 Medicaid Quality program first analyzes measures, plans and reports for data quality. Data that passes this review is then evaluated at the population and MCO level. The State reviews for:

- Performance that is concerning relative to contract standards;
- Performance that is concerning relative to national, regional, or NH fee-for-service or NH Medicaid historic comparison data;
- Continued trends over 3 measurement cycles; and
- Notable increases and decrease from the prior reporting period.

MCO compliance, operations and quality reporting are then reviewed monthly with each health plan by the quality team and the State's contract managers. The other attendees are brought in to discuss specific quality measures, reports or plans as needed based on concerns identified during data review.

NH DHHS Bureau Healthcare Analytics and Data Systems

As part of the Quality program, the NH DHHS Bureau of Healthcare Analytics and Data Systems has oversight of data, analysis and reporting. The Bureau currently functions to create routine and ad hoc reports to ensure the delivery of quality care, the development of sound policy and for financial oversight of the Medicaid program. The Bureau supports DHHS reporting on the NH Medicaid Care Management program, including but not be limited to:

- Oversight of the maintenance and aggregation of MCO encounter data (individual beneficiary data) into a single database, which will be accomplished inside the Medicaid Management Information System (MMIS) Reporting Repository;
- Development and oversight of the Medicaid Quality Indicators Systems (MQIS), a reporting repository for aggregate data;
- Performing population-wide, DHHS-wide, special and ad hoc analysis reporting;
- Acting as the point of contact for MCO data; and
- Assisting the EQRO in their oversight of MCO functions and in the creation of statewide, population-based reports on the Medicaid Care Management program.

The NH Medicaid Quality Indicators System is housed within the Bureau. In December 2012, DHHS received a CMS Adult Medicaid Quality grant allowing the Department to further

improve NH Medicaid quality oversight. Specifically, the State's capacity to aggregate and monitor Quality Indicators has been markedly expanded through the development of:

- The Medicaid Quality Indicators System (MQIS) launched in December of 2014 with:
 - The capacity to accept data from multiple submitters,
 - The capacity for comprehensive data analysis and routine surveillance of large amounts of data,
 - An ability to automatically flag measures requiring further quality review, and
 - User driven, customized reporting available via the NH Medicaid Quality website.
- Linking existing data bases for use including the Medicaid administrative data, NH Hospital data and Vital Records data; and
- Expanding State staffing with two new data analysis and two quality program specialists.

MQIS went live in the summer of 2015.

The Bureau is also home for NH's All Payer Claims Database (APCD), the NH Comprehensive Health Care Information System (CHIS). CHIS was created by NH State statute to make health care data "available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices."¹ The same legislation that created the CHIS also enacted statutes that mandated that health insurance carriers, including the new Medicaid MCOs, submit their encrypted health care claims data, Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data to the State. Access to this database allows for robust Medicaid reports and commercial health plan benchmarking.

MCO NCQA Accreditation Review

The NH DHHS required that the MCOs obtain and maintain NCQA accreditation. Additionally, each MCO conducts an annual HEDIS and CAHPS surveys. The maintenance of accreditation activities and the results of the annual HEDIS and CAHPS will be reviewed and posted on the NH Medicaid Quality website. The first MCO HEDIS and CAHPS reports will be presented in late summer 2015. The MCOs Annual Report and QAPI reporting will also address activities related to maintenance of NCQA accreditation, identify MCO program strengths and impact, and articulate how opportunities for improvement will be addressed in the upcoming year. The MCO Annual Report and QAPI Report will also be posted to the DHHS Medicaid Quality webpage and the NH Medicaid Quality website.

External Quality Review Organization Activities

The NH DHHS has contracted with an external quality review organization as required by 42 CFR 438 Subpart E. To comply with Federal regulations, 42 CFR 438.358(b), the federally mandatory EQRO scope of work for the NH Medicaid EQRO includes:

- Validation of Performance Improvement Projects and Quality Incentive Projects;
- Validation of MCO quality performance measures (Appendix B); and
- Preparation of an EQRO Technical Report for each Medicaid managed care plan.

¹ NH CHIS Welcome website. Accessed at: <http://www.nhchis.org/> on July 3, 2012.

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

- Validation of MCO encounter data submissions;
- Validation of MCO consumer and provider surveys;
- Calculation of NH Medicaid aggregate performance measures in addition to those reported by the MCOs; and
- Performance improvement projects in addition to those conducted by the MCOs, (i.e.: conduction of focused studies of health service delivery issues such as coordination, continuity, access and availability of needed services).

As part of its annual reporting, the State's EQRO will continue to prepare a Technical Report as a compendium of each MCO's 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 includes:

- 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 MCOs 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. This EQRO activity will commence after the first year of NH Medicaid Care Management program operations.

Each EQRO Technical Report will also include information on trends in health plan enrollment, provider network characteristics, complaints and grievances, identification of special needs populations, trends in utilization, statements of deficiencies and other on-site survey findings, and financial data, in addition to the scope of work outlined above on projects, performance measures, the quality of the encounter data, and any requested EQRO measures or focused clinical study findings. The EQRO will then compile an executive summary of each MCO, including a summary of each plans strengths and weaknesses. The executive summary and full report are available on the New Hampshire Department of Health and Human Services Medicaid Quality webpage and the NH Medicaid Quality website.

The Department uses the annual Technical Report to:

- Report Medicaid Care Management program activities;
- Apply sanctions or take other corrective action as designated in the NH Medicaid Care Management Contract,
- Evaluate existing program goals and inform new program goal development; and
- Inform any needed contract amendments or revisions.

Data on Race, Ethnicity and Primary Language

The State currently obtains race (multiple categories), Hispanic ethnicity, and primary language spoken, during its eligibility and NH Medicaid enrollment process. This information will be shared with the MCOs as a part of daily eligibility data feeds.

Data on race, ethnicity and primary language, as well as other demographic and health status information, will be captured more robustly during each MCO's enrollment process via the MCO enrollment form and the new enrollee health risk assessment. The implementation of the State's new MMIS program will allow the State to collect additional information on race, ethnicity and primary language.

NH Medicaid Care Management Clinical Standards and Guidelines

The Department has taken four complementary approaches to establishing high clinical standards and guidelines:

- Compliance with specific federal regulation for Medicaid MCO clinical standards and guidelines,
- Compliance with federal agency and national organizations recommendations and guidelines,
- DHHS review and approval of all MCO standards and guidelines, and
- Comprehensive compliance with federal and state regulatory standards and guidelines.

Consistent with 42 CFR 438.204(g), the NH Medicaid Care Management program has adopted clinical standards and guidelines for access to care, structure and operations, and quality measurement and improvement at least as stringent as in 42 CFR 438 Subpart D. Compliance with these specific standards and guidelines can be found throughout the NH Medicaid Care Management Contract and are catalogued in Appendix D.

The State has built upon the credibility and strength of several federal agencies and national organizations in adopting guidelines for care management. NH Medicaid Care Management Contract refers MCOs to the Agency for Healthcare Research and Quality guidelines for the development of Patient Centered Medical Homes. NH Medicaid Care Management Contract also requires that MCO develop programs to assess and support, wherever possible, primary care providers to act as patient centered medical homes as defined by the Center for Medicare and Medicaid Services. MCO wellness and prevention programs must comport with the American Academy of Pediatrics Bright Futures program recommendations and with all United States Prevention Services Task Force A and B rated prevention and primary services for children and adults.

The NH Medicaid Care Management 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 Quality Assessment and Performance Improvement programs. All MCO practice guidelines are subject to DHHS approval prior to the onset of a new program and annually thereafter. All practice guidelines are available on the MCOs' online provider portals, and to providers, members and potential members upon request. MCO practice guidelines will be used to inform coverage decisions, utilization management and member educational activities.

Finally, the NH Medicaid Care Management Contract requires the MCOs, their subcontractors, and their providers to be comprehensively compliant with all applicable federal and state regulation, both present and future. Specific NH Medicaid Care Management Contract Sections also cross reference and require compliance with specific corresponding federal or state regulations as appropriate for that Medicaid Care Management program element.

B. Level of Contract Compliance and How New Hampshire Medicaid Determines Compliance

As required by 42 CFR 438.204(g), the State has established standards in the Medicaid Care Management Contract regarding access to care, structure and operations, and quality measurement and improvement. Appendix D outlines each required component of the federal regulations and identifies the section of the NH Medicaid Care Management Contract where this requirement is addressed. In addition to the federal regulatory standards, the NH Medicaid Care Management standards are present throughout the contract and as discussed in the Quality and Appropriateness of Care and Services section above.

The State ensures MCO contract compliance in requiring MCO self-regulation and through direct DHHS oversight. NH Medicaid Care Management Contract obligates each MCO to have a Compliance Officer whose primary responsibility is the assurance of the program's contractual and regulatory compliance.

Direct DHHS oversight of MCO contract compliance is the primary responsibility of the NH Medicaid Deputy Director and the NH Medicaid Care Management Account Management Teams, one team for each of the MCOs. The Account Managers act as a liaison between DHHS and the MCO Compliance Officer on all issues of MCO monitoring. The NH Medicaid Care Management Account Managers work collaboratively with the cross functioning Medicaid Care Management Quality team and various cross functioning program subject matter experts.

As discussed in the Quality Strategy "Part II. Assessment, A. Quality and Appropriateness of Care and Services," MCO contract compliance and the equally importantly impact of contract compliance on beneficiaries will be monitored by the following activities:

- NH Medicaid Quality Indicators monitoring, including the CMS Pediatric and Adult Quality Measures;
- MCO PIP projects;
- MCO Contract Compliance, Operations and Quality Reporting (Appendix D);
- NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems population-wide, DHHS wide, special, other and ad hoc analysis and reports;

- MCO NCQA accreditation review, and
- External Quality Review Organization (EQRO) activities, including the EQRO Technical Report and NH Medicaid population wide, aggregated reports.

C. The Role of Health Information Technology

New Hampshire assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through the collection and analyses of data from many sources including:

- New Heights - the State's eligibility database;
- Medicaid encounter and provider data that will be processed and stored in the MMIS Reporting Repository;
- National Committee on Quality Assurance (NCQA):
 - The Healthcare Effectiveness Data and Information Set (HEDIS); and
 - The Consumer Assessment of Healthcare Providers and Systems (CAHPS);
- Behavioral Health satisfaction survey;
- Other data accessible to NH Medicaid, such as the Comprehensive Healthcare Information System database (all payer claims database, managed by NH DHHS);
- Online web access to MCO applications and data to access, analyze, or utilize data captured in the MCO systems and to perform reporting and operational activities;
- External Quality Review Organization's Technical Report; and
- NH Division of Public Health Services implementation of CDC's Behavioral Risk Factor Surveillance System (BRFSS), among others.

In December 2012, DHHS received a CMS Adult Medicaid Quality (AMQ) grant allowing the Department to further improve NH Medicaid quality oversight. The AMQ grant allowed the State to create linkages between existing but underutilized data sets, specifically Medicaid administrative claims data (including encounter data), NH Hospital data and vital records. The AMQ grant allowed NH to expand internal resources for data analysis and use, by funding four additional positions within the Medicaid quality program: two additional data analysts and two new quality program specialists. DHHS has reconfigured the NH Medicaid Quality website, improving the capacity for data examination to include programmed data analysis, routine surveillance of large amounts of data and automatically flagging measures requiring further quality review. Additionally, the NH Medicaid Quality website allows user-driven, custom reporting directly from the website. These system changes have enabled DHHS to actively manage over 400 quality measures through the tactical use of HIT and the strategic use of human support as needed.

The MCOs are required to have information systems capable of collecting, analyzing and submitting the required data and reports. The State's EQRO and pharmacy benefit administrator will ensure the accuracy and validity of the MCO data submitted.

While MCOs are not eligible for incentives under the Health Information Technology for Economic and Clinical Health (HITECH) Electronic Health Record (EHR) incentive program, they will benefit from an increase in the meaningful use of. Additional, NH received a CMMI State Innovations Model Design cooperative agreement. The Health Information Exchange work within the NH SIM Model Design will take into consideration the health technology needs of Medicaid beneficiaries within the MCM program.

III. Improvement

A. Assessment Based Activities

The State of New Hampshire is initially working to improve the quality of care delivered through the utilization of incentives and disincentives including:

- Contract Activities, including:
 - Performance Improvement Projects;
 - Payment Reform Incentive Plan, and
 - MCO sanctions;
- Convening Cross-MCO Quality Activities;
- EQRO Technical Review and Report; and
- Public, transparent reporting on the NH Medicaid Quality website.

Contract Incentives, Project, Plans and Sanctions

The State's initial quality objectives are drawn from generally understood opportunities for improvement. Initial performance targets have been selected for all measures. These targets are based on DHHS expectations of MCO performance against National Quality Compass for Medicaid MCO Data.

Each MCO's QAPI program includes four MCO initiated performance improvement projects (PIP), at least one of which must have a behavioral health focus (NH Medicaid Care Management Contract) and, in future phases of Step Two, one of which must have a long term services and supports focus. The MCOs have had the opportunity to make an initial assessment of its membership and, in consultation with its member and provider advisory boards, determined the greatest health care quality improvement opportunity for its members. Consistent with 42 CFR 438.240, and working with the EQRO, the State biannually reviews the MCO PIP projects.

The NH Medicaid Care Management contract requires each MCO to annually submit and implement payment reform strategies. Tentatively beginning July 1, 2016 DHHS will withhold 1% of the total capitation payment amount, which MCOs can then recoup when implementation milestones from the Payment Reform Incentive Plan have been achieved. The MCO payment reform proposals must comply with all state and federal regulations and the NH Medicaid Care Management Contract.

The NH Medicaid Care Management 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 5 levels, each with an associated financial remedy. Category 1, the highest level, for example, would be levied against an MCO for a failure to provide medically necessary services at a cost of \$100,000/violation; failure to meet telephone inquiries performance standards is an example of Category 5 violation with a lesser fine of \$1,000/violation.

Convening Cross-MCO Quality Activities

The State convenes quarterly Quality Assurance and Improvement meetings with the Medical Directors and Quality Improvement Directors. These quarterly meetings routinely bring the State and MCO quality teams together, take a population perspective on NH Medicaid program, and, to the greatest degree possible, harmonize of quality initiatives across the NH Medicaid program.

In addition, DHHS meets with each individual MCO on a monthly basis to discuss issues that have been identified from the data submitted by each health plan and to discuss other concerns specific to each health plan.

EQRO Technical Review and Report

The State's EQRO Technical Report includes an assessment of each MCOs 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 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, after the first year of NH Medicaid Care Management program operations. This information is used to inform any needed benefit changes, NH Medicaid Care Management 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.

B. And C. Proposed Progress Toward Meeting Quality Objectives

The State routinely performs the following mandatory quality assurance activities:

- Quality Indicators monitoring, through NH Medicaid Quality Indicators (Appendix B);
- MCO Quality Planning and Operations, through the MCO Quality Assessment and Performance Improvement plans;
- Quality Projects, including the PIP, and Payment Reform projects;
- External organization reviews, through NCQA accreditation review, including HEDIS and CAHPS results and the EQRO activities and Technical Report;
- Standardized routine reporting, through required MCO operations and other contractual reports (Appendix E, and the NH DHHS Bureau Healthcare Analytics and Data Systems Population-based and ad hoc analysis;
- MCO NCQA accreditation review; and
- External Quality Review Organization (EQRO) Reports.

The results of these assessments inform improvements or changes needed to ensure high quality health care delivery and optimize Medicaid beneficiary health outcomes.

IV. Review of Quality Strategy**A. Public Input**

The State looked to 42 CFR 438.200, the CMS State Quality Strategy Tool Kit for State Medicaid and Children's Health Insurance Agencies, the quality strategies of other states and

DHHS staff to develop the Quality Strategy framework. With each update, the State distributes and posts the draft quality strategy and modifies the Quality Strategy in response to public comments, stakeholder feedback and any Medicaid Care Management contract amendments. The State initially submitted the Quality Strategy in October 2013 and received CMS approval in May 2014.

Since the implementation of the NH Medicaid Care Management program, each MCO has implemented advisory committees composed of representatives from the provider community (primary care and specialty care), members, and family caregivers of MCO members, the advocacy community, and MCO staff. These committees provide a forum for beneficiaries and providers to be actively engaged in MCO quality improvements, raise issues and concerns, discuss possible solutions, and provide advice and recommendations on a wide range of issues. Additionally, the State’s EQRO semi-annually conducts formal focus group discussions to elicit beneficiary feedback without the presence of either DHHS or MCO representatives. The results of each report are posted to the DHHS Medicaid Quality webpage and the NH Medicaid Quality website.

The State conducts Quality Assurance and Improvement meetings with the Medical Directors and Quality Improvement Directors. These quarterly meetings routinely bring the State and MCO quality teams together, take a population perspective on NH Medicaid program, and, to the greatest degree possible, harmonize quality initiatives across the NH Medicaid program.

In addition to input from these committees, the quality strategy and supporting reports and documents are available at the following weblinks for public review and comments:

- DHHS Medicaid Quality webpage: <http://www.dhhs.nh.gov/ombp/quality/index.htm>
- NH Medicaid Quality website: <http://medicaidquality.nh.gov/>

B. Strategy Assessment Timeline

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

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

Quality Strategy Activity	Date Complete
Post Draft Quality Strategy for Step One for Public Comment	July 15, 2012
Post Final Quality Strategy	October 1, 2013
Monitor Quality Performance Results	Continuously
Post Draft of Quality Strategy for Step Three for Public Comments	July 15, 2014

Post Final Quality Strategy	September 1, 2014
Post Draft of Quality Strategy for Step Two Phase 1 for Public Comments	August 3, 2015
Post Final Quality Strategy	September 1, 2015
Post Draft Quality Strategy for later phases for Step Two for Public Comment	60 days prior to implementation
Post Final Updated Quality Strategy	30 days prior to implementation
Monitor Quality Performance Results	Continuously
Post Triennial Update Draft Quality Strategy for Public Comment	60 days prior to Agreement Year
Post Final Updated Quality Strategy	30 days prior to Agreement Year
Monitor Quality Performance Results	Continuously

V. Achievements and Opportunities

The most up to date achievements in quality improvement will be presented on the NH Medicaid Quality Indicators website, but will also be included in each MCO's annual report and the EQRO annual Technical Report; both of these reports will be accessible from the NH Medicaid Care Management website and/or the DHHS Medicaid Quality Indicators website. Additional program successes will be shared with the Department Public Information Office. Every three years, at a minimum, the Quality Strategy will be formally reviewed and amended to reflect and retain programmatic successes and to address new or unmet quality improvement opportunities.

Appendix A: NH Medicaid Care Management Program Covered Populations and Services Matrix

The planned three-step phase-in of population groups and service is depicted in the Tables below.

Members	Step 1	Step 2	NHHPP	Excluded/FFS
OAA/ANB/APTD/MEAD/TANF/Poverty Level - Non-Duals ²	X			
Foster Care - With Member Opt Out	X			
Foster Care - Mandatory Enrollment (w/CMS waiver)		X		
HC-CSD (Katie Beckett) - With Member Opt Out	X			
HC-CSD (Katie Beckett) - Mandatory Enrollment		X		
Children with special health care needs (enrolled in Special Medical Services / Partners in Health) - Mandatory Enrollment		X		
Children with Supplemental Security Income (SSI) - Mandatory Enrollment		X		
M-CHIP	X			
TPL (non-Medicare) except members with VA benefits	X			
Auto eligible and assigned newborns	X			
Breast and Cervical Cancer Program (BCCP)	X			
Pregnant Women	X			
Native Americans and Native Alaskans w/ member opt out ³	X			
Native Americans and Native Alaskans - Mandatory Enrollment (w/CMS waiver)		X		
Medicare Duals - With Member Opt Out	X			

² Per 42 USC §1396u-2(a)(2)(A) Non-dual members under age 19 receiving SSI, or with special healthcare needs, or who receive adoption assistance or are in out of home placements, have member opt out.

³ Per 42 USC §1396u-2(a)(2)(c); however, NH has no recognized tribes.

Members	Step 1	Step 2	NHHPP	Excluded/ FFS
Medicare Duals - Mandatory Enrollment (w/CMS waiver)		X		
Members with VA Benefits				X
NHHPP Enrollees			X	
Family Planning Only Benefit				X
Initial part month and retroactive/PE eligibility segments (excluding auto eligible newborns)				X
Spend-down				X
QMB/SLMB Only (no Medicaid)				X
Health Insurance Premium Payment Program (HIPP)				X

Services	Step 1	NH HPP	Step 2 Phase 1	Step 2 Phase 2	Step 2 Phase 3	Step 2 Phase 4	Excl./ FFS
Maternity & Newborn Kick Payments	X	X	X				
Inpatient Hospital	X	X	X				
Outpatient Hospital ⁴	X	X	X				
Inpatient Psychiatric Facility Services Under Age 22	X	X	X				
Physicians Services	X	X	X				
Advanced Practice Registered Nurse	X	X	X				
Rural Health Clinic & FQHC	X	X	X				
Prescribed Drugs	X	X	X				
Community Mental Health Center Services	X	X	X				
Psychology	X	X	X				
Ambulatory Surgical Center	X	X	X				
Laboratory (Pathology)	X	X	X				
X-Ray Services	X	X	X				
Family Planning Services	X	X	X				
Medical Services Clinic (mostly methadone clinic)	X	X	X				
Physical Therapy ⁵	X	X	X				
Occupational Therapy ⁶	X	X	X				

⁴ Including facility and ancillary services for dental procedures

⁵ Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

⁶ Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

Services	Step 1	NH HPP	Step 2 Phase 1	Step 2 Phase 2	Step 2 Phase 3	Step 2 Phase 4	Excl./ FFS
Speech Therapy ⁷	X	X	X				
Audiology Services	X	X	X				
Podiatrist Services	X	X	X				
Home Health Services	X	X	X				
Private Duty Nursing	X	EPSDT only	X				
Adult Medical Day Care	X	X	X				
Personal Care Services	X	EPSDT only	X				
Hospice	X	X	X				
Optometric Services Eyeglasses	X	X	X				
Furnished Medical Supplies & Durable Medical Equipment	X	X	X				
Non-Emergent Medical Transportation ⁸	X	X	X				
Ambulance Service	X	X	X				
Wheelchair Van	X	X	X				
Independent Care Management	X	EPSDT only	X				
Home Visiting Services	X	X ⁶	X				
Acquired Brain Disorder Waiver Services						X	

⁷ Combined PT, OT, ST 20 visit limit in the CMS-approved State Plan is equivalent to combined 20 hours

⁸ Also includes mileage reimbursement for medically necessary travel

Services	Step 1	NH HPP	Step 2 Phase 1	Step 2 Phase 2	Step 2 Phase 3	Step 2 Phase 4	Excl./ FFS
Developmentally Disabled Waiver Services						X	
Choices for Independence Waiver Services				X			
In Home Supports Waiver Services						X	
Skilled Nursing Facility					X		
Skilled Nursing Facility Atypical Care					X		
Inpatient Hospital Swing Beds, SNF					X		
Intermediate Care Facility Nursing Home					X		
Intermediate Care Facility Atypical Care					X		
Inpatient Hospital Swing Beds, ICF					X		
Glencliff Home					X		
Cedarcrest					X		
Developmental Services Early Supports and Services						X	
Home Based Therapy – DCYF						X	
Child Health Support Service – DCYF						X	
Intensive Home and Community Services – DCYF						X	
Placement Services – DCYF						X	
Private Non-Medical Institutional For Children – DCYF						X	
Crisis Intervention – DCYF						X	

Services	Step 1	NH HPP	Step 2 Phase 1	Step 2 Phase 2	Step 2 Phase 3	Step 2 Phase 4	Excl./ FFS
Substance use disorder services as per He-W 513 (NHHPP population only)		x					
Chiropractic services (NHHPP population only)		x					
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)							x
Medicaid to Schools Services							x
Dental Benefit Services ⁹							x

⁹ except facility and ancillary services for dental procedures

Appendix B: Medicaid Quality Indicators

Data detail as presented in the NH Medicaid Care Management Contract and as referenced. *Last Updated 6.19.15. Consult with the Department for any recent updates prior to use.*

NH Medicaid Care Management Quality and Oversight Information

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
ACCESSREQ.01	Member Requests for Assistance Accessing MCO Designated Primary Care Providers per Average Members by County - Excluding NHHPP Members	Measure	Quarterly	2 months after the end of the quarter
ACCESSREQ.02	Member Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated Primary Care) Providers per Average Members by County - Excluding NHHPP Members	Measure	Quarterly	2 months after the end of the quarter
ACCESSREQ.03	Member Requests for Assistance Accessing Other Providers (non-Physician/APRN) per Average Members by County - Excluding NHHPP Members	Measure	Quarterly	2 months after the end of the quarter
ACCESSREQ.04	CFI Waiver Services: Member Requests for Assistance Accessing CFI Providers per Average Members by County - Excluding NHHPP Members	Measure	Quarterly	2 months after the end of the quarter
AMBCARE.02	Ambulatory Care: Physician/APRN/Clinic Visits per Member per Month by County - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the calendar quarter
AMBCARE.05	Ambulatory Care: Emergency Department Visits per Member per Month by County - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the calendar quarter
AMBCARE.08	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care per Member per Month by County - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the calendar quarter
AMBCARE.10	Ambulatory Care: Physician/APRN/Clinic Visits per Member per Month by Population Subgroup - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
AMBCARE.11	Ambulatory Care: Emergency Department Visits for Medical Health Conditions per Member per Month by Population Subgroup - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
AMBCARE.12	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care per Member per Month by Population Subgroup - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
AMBCARE.13	Ambulatory Care: Emergency Department Visits for Behavioral Health Conditions per Member per Month by Population Subgroup - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
AMBCARE.14	Ambulatory Care: Emergency Department Visits for Substance Use Related (Chronic or Acute) Conditions per Member per Month by Population Subgroup - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
APPEALS.01	Resolution of Standard Appeals Within 30 Calendar Days	Measure	Quarterly	2 months after the end of the quarter
APPEALS.02	Resolution of Extended Standard Appeals Within 44 Calendar Days	Measure	Quarterly	2 months after the end of the quarter
APPEALS.03	Resolution of Expedited Appeals Within 3 Calendar Days	Measure	Quarterly	2 months after the end of the quarter
APPEALS.04	Resolution of All Appeals Within 45 Calendar Days	Measure	Quarterly	2 months after the end of the quarter
APPEALS.05	Resolution of Appeals by Disposition Type	Measure	Quarterly	2 months after the end of the quarter
APPEALS.08	Appeals Elevated to State Fair Hearing	Measure	Quarterly	2 months after the end of the quarter
APPEALS.09	Appeals by Reason Type	Measure	Quarterly	2 months after the end of the quarter
APPEALS.17	Pharmacy Appeals by Type of Resolution and Select Therapeutic Drug Classes	measure	quarterly	2 months after the end of the quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
BHCHLDMEDMGT.01	Percent of continuously enrolled children using behavioral health medications who received a psychiatric consultation for behavioral health medications	Measure	CY	June 30th
BHDISCHARGE.01	Community Hospital Discharges for Behavioral Health Conditions Where Patient Had a Visit With a Mental Health Practitioner Within 7 Calendar Days of Discharge by Subpopulation - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
BHDISCHARGE.02	Community Hospital Discharges for Behavioral Health Conditions Where Patient Had a Visit With a Mental Health Practitioner Within 30 Calendar Days of Discharge by Subpopulation - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
BHDISCHARGE.03	Readmission to Community Hospital for Behavioral Health Conditions at 30 days by Subpopulation - Excluding NHHPP Members	Measure	June 1 of the prior SFY to June 30 of the measurement year. A 13 month period.	September 1st
BHDISCHARGE.04	Readmission to Community for Behavioral Health Conditions at 180 days by Subpopulation - Excluding NHHPP Members	Measure	January 1 of the prior SFY to June 30 of the measurement year. An 18 month period	September 1st
BHISP.01	Percent of Community Mental Health Annual Individual Service Plans That Were Reviewed by the MCO of Those That Were Due for Review	Measure	Quarterly	2 months after the end of the quarter
BHISP.02	Percent of Community Mental Health Service Quarterly Reports That Were Reviewed by the MCO of Those That Were Due for Review	Measure	Quarterly	2 months after the end of the quarter
CAHPS_A_	Adult CAHPS: CAHPS 5.0H Core Survey - Adults	Measure	Standard HEDIS schedule	June 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
CAHPS_A_	Adult CAHPS: CAHPS Supplement: Chronic Conditions - In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment?	Measure	Standard HEDIS schedule	June 30th
CAHPS_A_	Adult CAHPS: CAHPS Supplement: Chronic Conditions - In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan?	Measure	Standard HEDIS schedule	June 30th
CAHPS_A_	Adult CAHPS: CAHPS Supplement: Chronic Conditions - In the last 6 months, did you need someone to come into your home to give you home health care or assistance?	Measure	Standard HEDIS schedule	June 30th
CAHPS_A_	Adult CAHPS: CAHPS Supplement: Chronic Conditions - In the last 6 months, how often was it easy to get home health care or assistance through your health plan?	Measure	Standard HEDIS schedule	June 30th
CAHPS_A_	Adult CAHPS: CAHPS Supplement: Behavioral Health - In the last 6 months, did you need any treatment or counseling for a personal or family problem?	Measure	Standard HEDIS schedule	June 30th
CAHPS_A_	Adult CAHPS: CAHPS Supplement: Behavioral Health - In the last 6 months, how often was it easy to get the treatment or counseling you needed through your health plan?	Measure	Standard HEDIS schedule	June 30th
CAHPS_A_	Adult CAHPS: CAHPS Supplement: Coordination of Care from Other Health Providers - In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers?	Measure	Standard HEDIS schedule	June 30th
CAHPS_A_	Adult CAHPS: CAHPS Supplement: Coordination of Care from Other Health Providers - In the last 6 months, who helped to coordinate your care?	Measure	Standard HEDIS schedule	June 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
CAHPS_A_	Adult CAHPS: CAHPS Supplement: Coordination of Care from Other Health Providers - How satisfied are you with the help you received to coordinate your care in the last 6 months?	Measure	Standard HEDIS schedule	June 30th
CAHPS_A_	Adult CAHPS: CAHPS Supplement: Quality Improvement Customer Service - Were any of the following a reason you did not get the information or help you needed from your health plan's customer service?	Measure	Standard HEDIS schedule	June 30th
CAHPS_C_	Child CAHPS: CAHPS 5.0H Core and Children with Chronic Conditions Survey - Children	Measure	Standard HEDIS schedule	June 30th
CAHPS_C_	Child CAHPS: CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor?	Measure	Standard HEDIS schedule	June 30th
CAHPS_C_	Child CAHPS: CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers?	Measure	Standard HEDIS schedule	June 30th
CAHPS_C_	Child CAHPS: CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers?	Measure	Standard HEDIS schedule	June 30th
CAHPS_C_	Child CAHPS: CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - In the last 6 months, who helped to coordinate your child's care?	Measure	Standard HEDIS schedule	June 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
CAHPS_C_	Child CAHPS: CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - How satisfied are you with the help you got to coordinate your child's care in the last 6 months?	Measure	Standard HEDIS schedule	June 30th
CAHPS_C_	Child CAHPS: CAHPS Supplement: Quality Improvement Customer Service - Were any of the following a reason you did not get the information or help you needed from customer service at your child's health plan?	Measure	Standard HEDIS schedule	June 30th
CARECOORD.01	Percent of Members Receiving Care Coordination Services for Behavioral Health, Behavioral/Physical Health, and Physical Health by Reason	Measure	Quarterly	Two months after the end of the data period
CARECOORD.02	Percent of Members Receiving Community Mental Health Services Who Are Receiving Care Coordination Services From the MCO	Measure	Quarterly	Two months after the end of the data period
CFI_CAREMGRS.02	CFI Waiver Services: Care Manager to Member Ratio	Measure	Quarterly	Two months after the end of the data period
CFI_CAREMGRS.03	CFI Waiver Services: Care Manager Member Every 30 Day Contact	Measure	Quarterly	Two months after the end of the data period
CFI_CAREMGRS.04	CFI Waiver Services: Care Manager Member Every 60 Day Face-to-Face Contact	Measure	Quarterly	Two months after the end of the data period
CFI_CAREMGRS.05	CFI Waiver Services: On Time Care Manager Voice Mail Call Backs	Measure	Quarterly	Two months after the end of the data period
CFI_CAREPLAN.01	CFI Waiver Services: Percent of Comprehensive Care Plans That Show Documentation Participant Risk Assessment	Measure	Quarterly	Two months after the end of the data period
CFI_CAREPLAN.02	CFI Waiver Services: Percent of Comprehensive Care Plans That Address All of Participant Assessed Needs and Perceived Risks	Measure	Annual	Two months after the end of the data period
CFI_CAREPLAN.03	CFI Waiver Services: Percent of Comprehensive Care Plans That Address Personal Goals	Measure	Quarterly	Two months after the end of the data period

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
CFI_CAREPLAN.04	CFI Waiver Services: Percent of Comprehensive Care Plans With Case Manager Documentation of All Required Care Plan Elements	Measure	Quarterly	Two months after the end of the data period
CFI_CAREPLAN.05	CFI Waiver Services: Percent of Comprehensive Care Plans Updated Annually or When Warranted by Changes	Measure	Quarterly	Two months after the end of the data period
CFI_CAREPLAN.06	CFI Waiver Services: Percent of Comprehensive Care Plans Containing Documentation of Service Monitoring	Measure	Quarterly	Two months after the end of the data period
CFI_CAREPLAN.07	CFI Waiver Services: Percent of Comprehensive Care Plans That Show Evidence of Provider Choice	Measure	Quarterly	Two months after the end of the data period
CFI_CAREPLAN.08	CFI Waiver Services: Percent of Comprehensive Care Plans With Identified Primary Care Provider and Date of Last PCP Visit	Measure	Quarterly	Two months after the end of the data period
CFI_CAREPLAN.09	CFI Waiver Services: Percent of Care Plans Developed Within 30 Days of MCO Receipt of Eligibility Determination and Related Data from DHHS	Measure	Quarterly	Two months after the end of the data period
CFI_CAREPLAN.10	CFI Waiver Services: Percent of Initial Face-to-Face Appointments Made Within 10 Business Days of Effective Date of Care Plan Receipt by Member	Measure	Quarterly	Two months after the end of the data period
CFI_COMMRATIO.01	CFI Waiver Services: Ratio of Members in Community Setting via CFI Waiver to Members in Nursing Home	Measure	Quarterly	Two months after the end of the data period
CLAIM.01	Timely Professional and Facility Medical Claim Processing	Measure	Numerator and denominator calculated daily / summary measure reported monthly	45 calendar days after end of reporting period
CLAIM.04	Timely Pharmacy Claim Processing	Measure	Monthly	45 calendar days after end of reporting period
CLAIM.05	Claims Quality Assurance: Claims Processing Accuracy	Measure	Monthly	45 calendar days after end of reporting period

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
CLAIM.06	Claims Quality Assurance: Claims Payment Accuracy	Measure	Monthly	45 calendar days after end of reporting period
CLAIM.07	Claims Quality Assurance: Claims Financial Accuracy	Measure	Monthly	45 calendar days after end of reporting period
CLAIM.08	Interest on Late Paid Claims	Measure	Monthly	45 calendar days after end of reporting period
CLAIM.09	Timely Professional and Facility Medical Claim Processing: Sixty Days of Receipt	Measure	Numerator and denominator calculated daily / summary measure reported monthly	45 calendar days after end of reporting period
CLAIM.11	Professional and Facility Medical Claim Processing Results - Paid, Suspended, Denied	Measure	Numerator and denominator calculated daily / summary measure reported monthly	45 calendar days after end of reporting period
CLAIM.12	CFI Waiver Services: Timely Claim Processing	Measure	Numerator and denominator calculated daily / summary measure reported monthly	45 calendar days after end of reporting period
CLAIM.13	CFI Waiver Services: Claim Processing Results - Paid, Suspended, Denied	Measure	Numerator and denominator calculated daily / summary measure reported monthly	45 calendar days after end of reporting period
CLAIM.14	CFI Waiver Services: Claims Processing Accuracy	Measure	Monthly	45 calendar days after end of reporting period
CLAIM.15	CFI Waiver Services: Claims Payment Accuracy	Measure	Monthly	45 calendar days after end of reporting period
CLAIM.16	CFI Waiver Services: Claims Financial Accuracy	Measure	Monthly	45 calendar days after end of reporting period

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
CMS_A_CDF	Screening for Clinical Depression and Follow-up Plan by Age Group (CMS Adult Core Set) (First submission due 9/2016)	Measure	CY	September 30th
CMS_A_CTR.01	Care Transition - Transition Record Transmitted to Health Care Professional (CMS Adult Core Set)	Measure	CY	September 30th
CMS_A_MSC	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation (CMS Adult Core Set) Ages 18 to 64, 65+	Measure	CY	September 30th
CMS_A_PQI01	Diabetes Short-Term Complications Admission Rate per 100,000 Member Months (CMS Adult Core Set) - Excluding NHHPP Members	Measure	CY	September 30th
CMS_A_PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months (CMS Adult Core Set) - Excluding NHHPP Members	Measure	CY	September 30th
CMS_A_PQI08	Congestive Heart Failure (CHF) Admission Rate per 100,000 Member Months (CMS Adult Core Set) - Excluding NHHPP Members	Measure	CY	September 30th
CMS_A_PQI15	Asthma in Younger Adults Admission Rate per 100,000 Member Months - Adults (CMS Adult Core Set) - Excluding NHHPP Members	Measure	CY	September 30th
CMS_C_BHRA	Behavioral Health Risk Assessment for Pregnant Women (CMS Child Core Set) (First Submission Due 9/2016)	Measure	CY	September 30th
CMS_C_DEV	Developmental Screening in the First Three Years of Life (CMS Child Core Set) (Administrative only data for 9/30/2015 report)	Measure	CY	September 30th
CMS_C_SRA	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (CMS Child Core Set) (first submission due 9/2016)	Measure	CY	September 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
DEMGPROF.01	Community Demographic, Cultural, and Epidemiologic Profile: Preferred Spoken Language	Measure	July 1 (for initial submission use any date prior to due date) Annually	September 30th
DEMGPROF.02	Community Demographic, Cultural, and Epidemiologic Profile: Preferred Written Language	Measure	July 1 (for initial submission use any date prior to due date)	September 30th
DEMGPROF.03	Community Demographic, Cultural, and Epidemiologic Profile: Ethnicity	Measure	July 1 (for initial submission use any date prior to due date)	September 30th
DEMGPROF.04	Community Demographic, Cultural, and Epidemiologic Profile: Race	Measure	July 1 (for initial submission use any date prior to due date)	September 30th
GHDISCHARGE.06	Glenclyff Home Discharges Where Member Received Discharge Instruction Sheet and Progress Notes	Measure	Quarterly	4 months after the end of the quarter
GHDISCHARGE.07	Glenclyff Home Discharges Where Attempt Was Made to Contact Member Within 3 Calendar Days of Discharge	Measure	Quarterly	4 months after the end of the quarter
GHDISCHARGE.08	Glenclyff Home Discharges Where Member Was Successfully Contacted Within 3 Calendar Days of Discharge	Measure	Quarterly	4 months after the end of the quarter
GHDISCHARGE.09	Glenclyff Home Discharges Where Patient Had a Follow up Appointment Scheduled for Within 7 Calendar Days of Discharge	Measure	Quarterly	4 months after the end of the quarter
GHDISCHARGE.10	Glenclyff Home Discharges Where Patient Had a Visit With a Mental Health Practitioner Within 7 Calendar Days of Discharge	Measure	Quarterly	4 months after the end of the quarter
GHDISCHARGE.11	Glenclyff Home Discharges Where Plan Failed to Contact Member Within 3 Calendar Days of Discharge by Reason for Failure	Measure	Quarterly	4 months after the end of the quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
GHREADMIT.05	Readmission to Glenclyff Home at 30 days	Measure	June 1 of the prior SFY to June 30 of the measurement year. A 13 month period.	September 1st
GHREADMIT.06	Readmission to Glenclyff Home at 180 days	Measure	January 1 of the prior SFY to June 30 of the measurement year. An 18 month period	September 1st
GRIEVANCE.01	Grievance Dispositions Made Within 45 Calendar Days	Measure	Quarterly	2 months after the end of the quarter
HEDIS_AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_AAP	Annual Access to (use of) Preventive/Ambulatory Health Services- Adults by Age Group - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_ABA	Adult BMI Assessment - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_ADD.01	Follow Up Care for Children Prescribed ADHD Medication - Initiation	Measure	A year starting March-April 1 of the year prior to the measurement year and ending February 28 of the measurement year.	June 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HEDIS_ADD.02	Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	Measure	A year starting March-April 1 of the year prior to the measurement year and ending February 28 of the measurement year.	June 30th
HEDIS_AMB-1a	Outpatient and Emergency Dept. Visits/1000 Member Months - Total Population - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_AMB-1b	Outpatient and Emergency Dept. Visits/1000 Member Months - Medicaid/Medicare Dual-Eligibles - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_AMB-1c	Outpatient and Emergency Dept. Visits/1000 Member Months - Disabled - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_AMB-1d	Outpatient and Emergency Dept. Visits/1000 Member Months - Other Low Income - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_AMM.01	Antidepressant Medication Management - Effective Continuation Phase Treatment - Adults - Excluding NHHPP Members	Measure	May 1 of the year prior to the measurement year to Oct 31 of the measurement year.	June 30th
HEDIS_AMM.02	Antidepressant Medication Management - Effective Acute Phase Treatment - Adults - Excluding NHHPP Members	Measure	May 1 of the year prior to the measurement year to Oct 31 of the measurement year.	June 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HEDIS_APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Measure	CY	June 30th
HEDIS_ASM	Use of Appropriate Medications for People with Asthma - Age 5 to 64 - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_AWC	Adolescent Well Care Visits - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_BCR.01	Board Certification - Percent of Family Medicine Physicians	Measure	CY	June 30th
HEDIS_BCR.02	Board Certification - Percent of Internal Medicine Physicians	Measure	CY	June 30th
HEDIS_BCR.03	Board Certification - Percent of Pediatricians	Measure	CY	June 30th
HEDIS_BCR.04	Board Certification - Percent of OB/GYNs	Measure	CY	June 30th
HEDIS_BCR.05	Board Certification - Percent of Geriatricians	Measure	CY	June 30th
HEDIS_BCR.06	Board Certification - Percent of Other Physician Specialists	Measure	CY	June 30th
HEDIS_BCS	Breast Cancer Screening - Age 50-74 Excluding NHHPP Members	Measure	2 CY	June 30th
HEDIS_CAP	Children and Adolescents' Access To PCP - Age 12 Months - 19 Years - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_CBP	Controlling High Blood Pressure - Age 18 to 85 - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_CCS	Cervical Cancer Screening - Age 24-64 - Excluding NHHPP Members	Measure	See HEDIS Specification	June 30th
HEDIS_CDC.01	Comprehensive Diabetes Care - HbA1c Testing - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_CDC.02	Comprehensive Diabetes Care - HbA1c Poor Control (>9%) - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_CDC.03	Comprehensive Diabetes Care - HbA1c Control (<8%) - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_CDC.04	Comprehensive Diabetes Care - HbA1c Control (<7%) for a selected population - Excluding NHHPP Members	Measure	CY	June 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HEDIS_CDC.05	Comprehensive Diabetes Care - Eye Exam - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_CDC.08	Comprehensive Diabetes Care - Medical Attention for Nephropathy - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_CDC.10	Comprehensive Diabetes Care - BP Control (<140/90) - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_CHL	Chlamydia Screening in Women - Age 16 to 24 - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_CIS.01	Childhood Immunization Status - Combo 2	Measure	CY	June 30th
HEDIS_CIS.02	Childhood Immunization Status - Combo 3	Measure	CY	June 30th
HEDIS_CIS.03	Childhood Immunization Status - Combo 4	Measure	CY	June 30th
HEDIS_CIS.04	Childhood Immunization Status - Combo 5	Measure	CY	June 30th
HEDIS_CIS.05	Childhood Immunization Status - Combo 6	Measure	CY	June 30th
HEDIS_CIS.06	Childhood Immunization Status - Combo 7	Measure	CY	June 30th
HEDIS_CIS.07	Childhood Immunization Status - Combo 8	Measure	CY	June 30th
HEDIS_CIS.08	Childhood Immunization Status - Combo 9	Measure	CY	June 30th
HEDIS_CIS.09	Childhood Immunization Status - Combo 10	Measure	CY	June 30th
HEDIS_CIS.10	Childhood Immunization Status - DTaP	Measure	CY	June 30th
HEDIS_CIS.11	Childhood Immunization Status - IPV	Measure	CY	June 30th
HEDIS_CIS.12	Childhood Immunization Status - MMR	Measure	CY	June 30th
HEDIS_CIS.13	Childhood Immunization Status - HiB	Measure	CY	June 30th
HEDIS_CIS.14	Childhood Immunization Status - Hepatitis B	Measure	CY	June 30th
HEDIS_CIS.15	Childhood Immunization Status - VZV	Measure	CY	June 30th
HEDIS_CIS.16	Childhood Immunization Status - Pneumococcal Conjugate	Measure	CY	June 30th
HEDIS_CIS.17	Childhood Immunization Status - Hepatitis A	Measure	CY	June 30th
HEDIS_CIS.18	Childhood Immunization Status - Rotavirus	Measure	CY	June 30th
HEDIS_CIS.19	Childhood Immunization Status - Influenza	Measure	CY	June 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HEDIS_CWP	Appropriate Testing for Children With Pharyngitis	Measure	July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.	June 30th
HEDIS_FPC	Frequency of Ongoing Prenatal Care by Percent of Expected Number of Visits (<21%, 21-40%, 41-60%, 61-80%, >=81%) - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_FUH.01	Follow Up After Hospitalization For Mental Illness - 7 days - Excluding NHHPP Members	Measure	January 1 through December 1 of the measurement year	June 30th
HEDIS_FUH.02	Follow Up After Hospitalization For Mental Illness - 30 days - Excluding NHHPP Members	Measure	January 1 through December 1 of the measurement year	June 30th
HEDIS_HPV	Human Papillomavirus (HPV) Vaccine for Female Adolescents	Measure	CY	June 30th
HEDIS_IET.01	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Initiation - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_IET.02	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment: Engagement - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_IMA.01	Immunizations for Adolescents - Combination 1	Measure	CY	June 30th
HEDIS_IMA.02	Immunizations for Adolescents - Meningococcal	Measure	CY	June 30th
HEDIS_IMA.03	Immunizations for Adolescent - Tdap/Td	Measure	CY	June 30th
HEDIS_LBP	Use of Imaging Studies for Low Back Pain - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_MMA.01	Medication Management for People with Asthma - At Least 75% of Treatment Period - Excluding NHHPP Members	Measure	CY	June 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HEDIS_MMA.02	Medication Management for People with Asthma - At Least 50% of Treatment Period - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_MPM.01	Annual Monitoring for Patients on Persistent Medications - Adults - ACE or ARB - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_MPM.02	Annual Monitoring for Patients on Persistent Medications - Adults - Digoxin - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_MPM.03	Annual Monitoring for Patients on Persistent Medications - Adults - Diuretics - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_MPM.04	Annual Monitoring for Patients on Persistent Medications - Adults - Total Rate - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_NCQA	MCO Submission of Audited HEDIS Results as Submitted to NCQA in NCQA Format	Measure	CY	June 30th
HEDIS_PCE	Pharmacotherapy Management of COPD Exacerbation - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_PPC.01	Prenatal and Postpartum Care - Timeliness of Prenatal Care - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_PPC.02	Prenatal and Postpartum Care - Postpartum Care - Total - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_SAA	Adherence to Antipsychotics for Individuals with Schizophrenia - Adults Age 19-64 - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD - Excluding NHHPP Members	Measure	CY	June 30th
HEDIS_SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications - Excluding NHHPP	Measure	CY	June 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HEDIS_URI	Appropriate Treatment for Children With Upper Respiratory Infection	Measure	July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.	June 30th
HEDIS_W15	Well-Child Visits in the first 15 Months of Life (0 visits, 1 visit, 2 visits, 3 visits, 4 visits, 5 visits, 6 or more visits)	Measure	CY	June 30th
HEDIS_W34	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - Total Population	Measure	CY	June 30th
HEDIS_WCC.01	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile documentation	Measure	CY	June 30th
HEDIS_WCC.02	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	Measure	CY	June 30th
HEDIS_WCC.03	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	Measure	CY	June 30th
HNA.01	New Member Health Needs Assessment Two Attempts Percentage	Measure	Quarterly	Four months after the end of the quarter
HNA.02	New Member Health Needs Assessment Completion Percentage	Measure	Quarterly	Four months after the end of the quarter
HNA.03	Annual Health Needs Assessment Three Attempts Percentage	Measure	Reported Quarterly on Rolling Year	Last day of the month following quarter
HNA.04	Annual Health Needs Assessment Completion Percentage	Measure	Reported Quarterly on Rolling Year	Last day of the month following quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HNA.05	Annual Health Needs Assessment Completion for Higher Risk Populations	Measure	Reported Quarterly on Rolling Year	Last day of the month following quarter
HPP_ACCESSREQ.01	Member Requests for Assistance Accessing MCO Designated Primary Care Providers per Average Members by Region - NHHPP Members	Measure	Quarterly	2 months after the end of the quarter
HPP_ACCESSREQ.02	Member Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated Primary Care) Providers per Average Members by Region - NHHPP Members	Measure	Quarterly	2 months after the end of the quarter
HPP_ACCESSREQ.03	Member Requests for Assistance Accessing Other Providers (non-Physician/APRN) per Average Members by Region - NHHPP Members	Measure	Quarterly	2 months after the end of the quarter
HPP_AMBCARE.01	Ambulatory Care: Physician/APRN/Clinic Visits per Member per Month by Age Group - NHHPP Members	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_AMBCARE.02	Ambulatory Care: Physician/APRN/Clinic Visits per Member per Month by County - NHHPP Members	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_AMBCARE.04	Ambulatory Care: Emergency Department Visits per Member per Month by Age Group - NHHPP Members	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_AMBCARE.05	Ambulatory Care: Emergency Department Visits per Member per Month by County - NHHPP Members	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_AMBCARE.07	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care per Member per Month by Age Group - NHHPP Members	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_AMBCARE.08	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care per Member per Month by County - NHHPP Members	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_AMBCARE.11	Annual Access to (use of) Preventive/Ambulatory Health Services, Adults by County - NHHPP Members	Measure	CY	June 30th
HPP_CMS_A_FUH.01	Follow-Up After Hospitalization for Mental Illness: Within 7 days of Discharge (CMS Adult Core Set) - NHHPP Members	Measure	CY	September 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HPP_CMS_A_FUH.02	Follow-Up After Hospitalization for Mental Illness: Within 30 Days of Discharge (CMS Adult Core Set) - NHHPP Members	Measure	CY	September 30th
HPP_CMS_A_HA1C	Comprehensive Diabetes Care: Hemoglobin A1c Testing (CMS Adult Core Set) - NHHPP Members	Measure	CY	September 30th
HPP_CMS_A_LDL	Comprehensive Diabetes Care: LDL-C Screening (CMS Adult Core Set) - NHHPP Members	Measure	CY	September 30th
HPP_CMS_A_PQI01	Diabetes Short-Term Complications Admission Rate per 100,000 Member Months - Adults (CMS Adult Core Set) - NHHPP Members	Measure	CY	September 30th
HPP_CMS_A_PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate per 100,000 Member Months - Adults (CMS Adult Core Set) - NHHPP Members	Measure	CY	September 30th
HPP_CMS_A_PQI08	Congestive Heart Failure Admission Rate per 100,000 Member Months - Adults (CMS Adult Core Set) - NHHPP Members	Measure	CY	September 30th
HPP_CMS_A_PQI15	Asthma in Younger Adults Admission Rate per 100,000 Member Months - Adults (CMS Adult Core Set) - NHHPP Members	Measure	CY	September 30th
HPP_HEDIS_AAP	Annual Access to (use of) Preventive/Ambulatory Health Services- Adults by Age Group - NHHPP Members	Measure	CY	June 30th
HPP_HEDIS_AMB-1d	Outpatient and Emergency Dept. Visits/1000 Member Months - NHHPP Members	Measure	CY	June 30th
HPP_HEDIS_CDC.01	Comprehensive Diabetes Care - HbA1c Testing - NHHPP Members	Measure	CY	June 30th
HPP_HEDIS_CDC.05	Comprehensive Diabetes Care - Eye Exam - NHHPP Members	Measure	CY	June 30th
HPP_HEDIS_CDC.06	Comprehensive Diabetes Care - LDL-C Screening - NHHPP Members	Measure	CY	June 30th
HPP_HEDIS_CDC.08	Comprehensive Diabetes Care - Medical Attention for Nephropathy - NHHPP Members	Measure	CY	June 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HPP_HEDIS_FUH.01	Follow Up After Hospitalization For Mental Illness - 7 days - NHHPP Members	Measure	January 1 through December 1 of the measurement year	June 30th
HPP_HEDIS_FUH.02	Follow Up After Hospitalization For Mental Illness - 30 days - NHHPP Members	Measure	January 1 through December 1 of the measurement year	June 30th
HPP_HEDIS_IET.01	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - NHHPP Members	Measure	CY	June 30th
HPP_HEDIS_IET.02	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - NHHPP Members	Measure	CY	June 30th
HPP_INPASC.01	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members per Member per Month - Quarterly Rate - NHHPP Members	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_INPASC.02	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members- Annual Rate by Age Group - NHHPP Members	Measure	CY	June 30th
HPP_NEMT.03	NEMT Requests Delivered by Mode of Transportation - NHHPP Members	Measure	Quarterly	2 month after end of reporting period
HPP_NEMT.06	NEMT Request Authorization Approval Rate by Mode of Transportation - NHHPP Members	Measure	Quarterly	2 months after end of reporting period
HPP_NEMT.07	NEMT Contracted Transportation & Wheelchair Van Provider Schedule Trip Results by Outcome - NHHPP Members	Measure	Quarterly	2 months after end of reporting period
HPP_NEMT.08	NEMT Services Delivered by Type of Medical Service - NHHPP Members	Measure	Quarterly	1 month after end of reporting period
HPP_NEMT.10	NEMT Scheduled Trip Member Cancellations by Reason for Member Cancellation for Contracted Providers - NHHPP Members	Measure	Quarterly	2 months after end of reporting period
HPP_NHHDISCHARGE.01	New Hampshire Hospital Discharges Where Members Received Discharge Instruction Sheet and Progress Notes - NHHPP Members	Measure	Quarterly	4 months after the end of the quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HPP_NHHDISCHARGE.02	New Hampshire Hospital Discharges Where Member Was Successfully Contacted Within 3 Calendar Days of Discharge - NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
HPP_NHHDISCHARGE.03	New Hampshire Hospital Discharges Where Patient Had a Visit With a Mental Health Practitioner Within 7 Calendar Days of Discharge - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
HPP_NHHDISCHARGE.04	New Hampshire Hospital Discharges Where Patient Had a Follow up Appointment Scheduled for Within 7 Calendar Days of Discharge - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
HPP_NHHDISCHARGE.05	New Hampshire Hospital Discharges Where Attempt Was Made to Contact Member Within 3 Calendar Days of Discharge - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
HPP_NHHREADMIT.02	Readmission to NH Hospital at 30 days - NHHPP Members	Measure	June 1 of the prior SFY to June 30 of the measurement year. A 13 month period.	September 1st
HPP_NHHREADMIT.03	Readmission to NH Hospital at 180 days - NHHPP Members	Measure	January 1 of the prior SFY to June 30 of the measurement year. An 18 month period	September 1st
HPP_POLYPHARM.04	Polypharmacy: adults ≥ 10 drugs - NHHPP Population	measure	quarterly	2 months after the end of the quarter
HPP_SUD.01	Substance Use Disorder Services: Percent of NHHPP Population Using Any SUD Specific Service by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HPP_SUD.02	Substance Use Disorder Services: Percent of NHHPP Population Using Outpatient Non-Facility Individual, Family, or Group SUD Counseling Service by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.03	Substance Use Disorder Services: Rate of Use of Outpatient Non-Facility Individual, Family, or Group SUD Counseling Service in NHHPP Population Using Specific Service per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.08	Substance Use Disorder Services: Percent of NHHPP Population Using Opioid Treatment Center Service by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.09	Substance Use Disorder Services: Rate of Use of Opioid Treatment Center Service in NHHPP Population Using Specific Service per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.11	Substance Use Disorder Services: Percent of NHHPP Population Using Buprenorphine by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.12	Substance Use Disorder Services: Rate of Use of Buprenorphine in NHHPP Population Using Specific Service per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.14	Substance Use Disorder Services: Percent of NHHPP Population Using Partial Hospitalization for SUD by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.15	Substance Use Disorder Services: Rate of Use of Partial Hospitalization for SUD in NHHPP Population Using Specific Service per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.17	Substance Use Disorder Services: Percent of NHHPP Population Using Intensive Outpatient Treatment for SUD by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HPP_SUD.18	Substance Use Disorder Services: Rate of Use of Intensive Outpatient Treatment for SUD in NHHPP Population Using Specific Service per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.20	Substance Use Disorder Services: Percent of NHHPP Population Using General Acute Care Inpatient Hospital Withdrawal Service by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.21	Substance Use Disorder Services: Rate of Use of General Acute Care Inpatient Hospital Withdrawal Service in NHHPP Population Using Specific Service per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.23	Substance Use Disorder Services: Percent of NHHPP Population Using SUD Rehabilitation Facility Service by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.24	Substance Use Disorder Services: Rate of Use of SUD Rehabilitation Facility Service in NHHPP Population Using Specific Service per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.26	Substance Use Disorder Services: Percent of NHHPP Population Using Outpatient Crisis Intervention Service (in provider office or community) for SUD by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.27	Substance Use Disorder Services: Rate of Use of Outpatient Crisis Intervention Service (in provider office or community) for SUD in NHHPP Population Using Specific Service per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.33	Substance Use Disorder ED Use: Rate of ED Use for Substance Abuse Disorder Diagnoses in NHHPP Population per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HPP_SUD.34	Substance Use Disorder ED Use: Rate of ED Use for Substance Abuse Disorder Diagnoses in NHHPP Population for Members Using Any SUD Service in Quarter per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.35	Substance Use Disorder ED Use: Rate of ED Use for Any Diagnosis (SUD or Other) in NHHPP Population for Members Using Any SUD Service in Quarter per Member per Month by Age Group	Measure	Quarterly	4 months after the end of the calendar quarter
HPP_SUD.36	Follow Up After SUD Rehabilitation Facility Stay - 7 days	Measure	January 1 through December 1 of the measurement year	June 30th
HPP_SUD.37	Follow Up After SUD Rehabilitation Facility Stay - 30 days	Measure	January 1 through December 1 of the measurement year	June 30th
INPASC.03	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions by Population Subgroup - Excluding NHHPP	Measure	Quarterly	4 months after the end of the quarter
INPUTIL.02	Inpatient Hospital Utilization for All Conditions Excluding Maternity/Newborns by Population Subgroup - Excluding NHHPP	Measure	Quarterly	4 months after the end of the quarter
LTSS_UTIL.XX	Measures to Support Step 2 Monitoring With Regard to Utilization Of Community and Facility Based LTSS (Specifics TBD; measures will be claims based)	Measure	N/A	TBD
MAINTMED.02	Maintenance Medication Gaps by Population Subgroup - Excluding NHHPP Members	Measure	Quarterly	2 months after the end of the quarter
MEMCOMM.01	Member Communications: Speed to Answer Within 30 Seconds	Measure	Monthly	20 calendar days after end of reporting period
MEMCOMM.03	Member Communications: Calls Abandoned	Measure	Monthly	20 calendar days after end of reporting period
MEMCOMM.05	Member Communications: Voice Mails Returned by Next Business Day	Measure	Monthly	20 calendar days after end of reporting period
MEMCOMM.06	Member Communications: Reasons for Telephone Inquiries	Measure	Monthly	20 calendar days after end of reporting period

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
MEMCOMM.07	Member Communications: Warm Transfers to NH DHHS	Measure	Monthly	20 calendar days after end of reporting period
MEMCOMM.08	Member Communications: Completed Successful New Member Welcome Calls - Excluding NHHPP Members	Measure	Monthly	20 calendar days after end of reporting period
MEMCOMM.11	Member Communications: New Members Who Had a Completed Successful New Member Welcome Call or Received At Least Three Welcome Call Attempts	Measure	Monthly	20 calendar days after end of reporting period
NEMT.03	NEMT Requests Delivered by Mode of Transportation - Excluding NHHPP Members	Measure	Quarterly	2 month after end of reporting period
NEMT.06	NEMT Request Authorization Approval Rate by Mode of Transportation - Excluding NHHPP Members	Measure	Quarterly	2 months after end of reporting period
NEMT.07	NEMT Contracted Transportation & Wheelchair Van Provider Schedule Trip Results by Outcome - Excluding NHHPP Members	Measure	Quarterly	2 months after end of reporting period
NEMT.08	NEMT Services Delivered by Type of Medical Service - Excluding NHHPP Members	Measure	Quarterly	2 months after end of reporting period
NEMT.09	NEMT Service Use by Population Subgroup - Excluding NHHPP Members	Measure	Quarterly	2 months after end of reporting period
NEMT.10	NEMT Scheduled Trip Member Cancellations by Reason for Member Cancellation for Contracted Providers - Excluding NHHPP Members	Measure	Quarterly	2 months after end of reporting period
NHHDISCHARGE.01	New Hampshire Hospital Discharges With Discharge Plan - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
NHHDISCHARGE.02	New Hampshire Hospital Discharges Where Member Was Successfully Contacted Within 3 Calendar Days of Discharge - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
NHHDISCHARGE.03	New Hampshire Hospital Discharges Where Patient Had a Visit With a Mental Health Practitioner Within 7 Calendar Days of Discharge - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
NHHDISCHARGE.04	New Hampshire Hospital Discharges Where Patient Had a Follow up Appointment Scheduled for Within 7 Calendar Days of Discharge - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
NHHDISCHARGE.10	New Hampshire Hospital Discharges Where Patient Had a Visit With a Mental Health Practitioner Within 7 Calendar Days of Discharge by Subpopulation - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
NHHDISCHARGE.11	New Hampshire Hospital Discharges Where Plan Failed to Contact Member Within 3 Calendar Days of Discharge by Reason for Failure - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
NHHDISCHARGE.12	New Hampshire Hospital Discharges Where Patient Had a Visit With a Mental Health Practitioner Within 30 Calendar Days of Discharge by Subpopulation - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
NHHREADMIT.05	Readmission to New Hampshire Hospital at 30 days by Subpopulation - Excluding NHHPP Members	Measure	June 1 of the prior SFY to June 30 of the measurement year. A 13 month period.	September 1st
NHHREADMIT.06	Readmission to New Hampshire Hospital at 180 days by Subpopulation - Excluding NHHPP Members	Measure	January 1 of the prior SFY to June 30 of the measurement year. An 18 month period	September 1st
PHARMQI.05	Quality assessment: referral to case management for all patients receiving buprenorphine or methadone SUD treatment	measure	quarterly	2 months after the end of the quarter
PHARMQI.06	Quality Assessment: Referral to Case Management for All Infants with a Diagnosis of Neonatal Abstinence Syndrome	measure	quarterly	2 months after the end of the quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
PHARMQI.07	Safety monitoring and medication review for high-risk patients discharged from hospital (medication review within 7 days by MCO pharmacist)	measure	quarterly	2 months after the end of the quarter
PHARMQI.08	Safety monitoring: high-risk medications in the non-dual eligible elderly (Beers criteria)	measure	quarterly	2 months after the end of the quarter
PHARMQI.09	Safety monitoring of opioids: daily dose assessment based on threshold daily morphine equivalent dose with cancer exclusion	measure	quarterly	2 months after the end of the quarter
PHARMQI.11	Completion of an annual comprehensive medication review for polypharmacy patients - Excluding NHHPP Population	measure	annually	2 months after the end of the program year
PHARMUTLMGT.02	Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	Measure	Quarterly	2 months after the end of the quarter
PHARMUTLMGT.03	Pharmacy Utilization Management: Generic Drug Substitution	Measure	Quarterly	2 months after the end of the quarter
PHARMUTLMGT.04	Pharmacy Utilization Management: Generic Drug Utilization	Measure	Quarterly	2 months after the end of the quarter
POLYPHARM.04	Polypharmacy: Children >=5 drugs - Excluding NHHPP Population	measure	quarterly	2 months after the end of the quarter
POLYPHARM.05	Polypharmacy: Adults ≥ 10 drugs - Excluding NHHPP Population	measure	quarterly	2 months after the end of the quarter
PROVCOMM.01	Provider Communications: Speed to Answer Within 30 Seconds	Measure	Monthly	20 calendar days after end of reporting period
PROVCOMM.03	Provider Communications: Calls Abandoned	Measure	Monthly	20 calendar days after end of reporting period
PROVCOMM.05	Provider Communications: Voice Mails Returned by Next Business Day	Measure	Monthly	20 calendar days after end of reporting period
PROVCOMM.06	Provider Communications: Reasons for Telephone Inquiries	Measure	Monthly	20 calendar days after end of reporting period
SERVICEAUTH.01	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	Measure	Quarterly	2 months after the end of the quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
SERVICEAUTH.02	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Continued/Extended Urgent Services	Measure	Quarterly	2 months after the end of the quarter
SERVICEAUTH.03	Medical Service, Equipment and Supply Service Authorization Timely (14 Day) Determination Rate: New Routine Requests (excludes NEMT and Complex Diagnostic Radiology)	Measure	Quarterly	2 months after the end of the quarter
SERVICEAUTH.04	Pharmacy Service Authorization Timely Determination Rate	Measure	Quarterly	2 months after the end of the quarter
SERVICEAUTH.08	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests That Were Extended	Measure	Quarterly	2 months after the end of the quarter
SERVICEAUTH.10	CFI Waiver Services: CFI Service Authorization Timely (14 Day) Determination Rate for New Routine Requests That Were Not Extended	Measure	Quarterly	2 months after the end of the quarter
SERVICEAUTH.11	CFI Waiver Services: CFI Timely Determination Rate for New Routine Requests That Were Extended	Measure	Quarterly	2 months after the end of the quarter
SERVICEAUTH.12	Complex Diagnostic Radiology Authorization Timely (2 Day) Determination Rate: Routine Requests	Measure	Quarterly	2 months after the end of the quarter
SERVICEAUTH.13	Medical Service, Equipment and Supply Post Delivery Service Authorization Timely (30 Day) Determination Rate	Measure	Quarterly	2 months after the end of the quarter
SUD.01	Substance Use Disorder Services: Percent of Population Using Any SUD Specific Service by Age Group - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
SUD.02	Substance Use Disorder Services: Percent of Population Using Opioid Treatment Center Service by Age Group - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
SUD.03	Substance Use Disorder Services: Percent of Population Using Buprenorphine by Age Group - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
SUD.04	Substance Use Disorder Services: Percent of Population Using General Acute Care Inpatient Hospital Withdrawal Service by Age Group - Excluding NHHPP Members	Measure	Quarterly	4 months after the end of the quarter
TIMELYNOTICE.02	Timeliness of Notice Delivery: Standard Service Authorization Denial	Measure	Quarterly	2 months after the end of the quarter
TIMELYNOTICE.03	Timeliness of Notice Delivery: Standard Service Authorization Denial With Extension	Measure	Quarterly	2 months after the end of the quarter
TIMELYNOTICE.04	Timeliness of Notice Delivery: Expedited Process	Measure	Quarterly	2 months after the end of the quarter
TRANSFORM.XX	Measures to Support 1115 Transformation Waiver Monitoring (Specifics TBD; measures will be claims, survey, & operations based)	Measure	N/A	TBD

Appendix C: NH Medicaid Care Management Program Encounter, Member and Provider Data Detail

Data detail as presented in the NH Medicaid Care Management Contract and as referenced. *Last Updated 7.2.12. Consult with the Department for any recent updates prior to use.*

MCO Encounter, Member, and Provider Data Sets Data Elements	Medical Encounter	Pharmacy Encounter	Member
Allowed amount	X	X	
Billed/Charge Amount	X	X	
Billing Provider City Name	X	X	
Billing Provider Country Name	X	X	
Billing Provider Location City Name	X	X	
Billing Provider Location State or Province	X	X	
Billing Provider Location Street Address	X	X	
Billing Provider Location ZIP Code	X	X	
Billing Provider Medicaid ID	X	X	
Billing Provider Name	X	X	
Billing Provider NPI	X	X	
Billing Provider Payer ID	X	X	
Billing Provider Specialty	X	X	
Billing Provider State or Province	X	X	
Billing Provider Street Address	X	X	
Billing Provider Type (e.g., hospital, optometrist)	X	X	
Billing Provider ZIP Code	X	X	
Category/Type of Service (e.g., 'Physician') universal across claim types to be defined in conjunction with DHHS, standard across MCOs)	X	X	
Charge Amount	X	X	
Claim Adjudication Date	X	X	
Claim ID	X	X	

MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements	Medical Encounter	Pharmacy Encounter	Member
Claim Line Number	x	x	
Claim Paid Date	x	x	
Claim Transaction Status (e.g., paid, denied)	x	x	
Claim Transaction Type (e.g., adjusted claim, void)	x	x	
Claim Type (e.g., drug, medical)	x	x	
Claim Version	x	x	
Co-pay Amount	x	x	
Date Claim Received	x	x	
Date of Service – From	x	x	
Date of Service – Through	x	x	
Date Service Approved	x	x	
Diagnosis Codes Principal and Other - MCO to Provide All Submitted by Providers	x		
Discharge Date	x		
Dual Medicare Status at Service Date of Claim	x	x	
E-Code	x		
EOB Codes	x		
Facility Type - Professional	x		
Institutional - Admission Date	x		
Institutional - Admission Hour	x		
Institutional - Admission Source	x		
Institutional - Admission Type	x		
Institutional - Admitting Diagnosis	x		
Institutional - Covered Days	x		
Institutional - Days	x		

MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements	Medical Encounter	Pharmacy Encounter	Member
Institutional - Discharge Hour	x		
Institutional - Discharge Status	x		
Institutional - Inpatient - Present on Admission Codes for All Diagnosis Codes as Specified by DHHS	x		
Institutional - Inpatient DRG (if DRG payment system is used)	x		
Institutional - Inpatient DRG allowed amount (if DRG payment system is used)	x		
Institutional - Inpatient DRG outlier amount (if DRG payment system is used)	x		
Institutional - Inpatient DRG outlier days (if DRG payment system is used)	x		
Institutional - Inpatient DRG Version (if DRG payment system is used)	x		
Institutional - Inpatient DRG Version (if used)	x		
Institutional - Occurrence Code Values/Dates - MCO to Provide All Submitted by Providers	x		
Institutional - Occurrence Codes - MCO to Provide All Submitted by Providers	x		
Institutional - Revenue Code	x		
Institutional - Type of Bill	x		
Institutional Inpatient Procedure Codes (ICD) - MCO to Provide All Submitted by Providers	x		
Institutional Paid Amount - Detail (where applicable)	x	x	
MCO Assigned Provider ID	x	x	
MCO Group ID Number	x	x	x
MCO ID	x	x	x
MCO Internal Member ID	x	x	x
Medicaid Eligibility Category at Service Date on Claim	x	x	
Medicaid Special Eligibility Category at Service Date on Claim (e.g., nursing home, waiver program)	x	x	

MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements	Medical Encounter	Pharmacy Encounter	Member
Medical Claim Drug Codes (e.g., J codes)	x		
Member Address	x	x	x
Member Age at Time of Claim Using Last Date of Service	x	x	
Member Bureau of Behavioral Health Eligibility Status			x
Member City	x	x	x
Member County			x
Member Date of Birth	x	x	x
Member Date of Death			x
Member Dual Medicare Status			x
Member Gender	x	x	x
Member Lock-In Dates			x
Member Lock-In Indicator			x
Member Lock-In Pharmacy/Provider			x
Member Medicaid Eligibility Category			x
Member Medicaid Special Eligibility Category (e.g., nursing home, waiver program)			x
Member Name	x	x	x
Member Rate Cell			x
Member Risk Score/Status			x
Member Risk Status Percentile Rank			x
Member SSN			x
Member State	x	x	x
Member Year and Month			x
Member Zip Code	x	x	x
NH Medicaid Member ID	x	x	x
Outpatient Hospital Payment Group (if used)	x		

MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements	Medical Encounter	Pharmacy Encounter	Member
Outpatient Hospital Payment Grouper Used (if used)	x		
Outpatient Hospital Payment Grouper Version (if used)	x		
Paid Amount	x	x	
Pharmacy Basis of Provider Reimbursement on the Paid Claim		x	
Pharmacy Compound Drug Indicator		x	
Pharmacy Days Supply		x	
Pharmacy Dispensed as Written Indicator		x	
Pharmacy Dispensing Fee		x	
Pharmacy Drug Name		x	
Pharmacy Drug NDC		x	
Pharmacy Fill Number		x	
Pharmacy Generic Drug Indicator		x	
Pharmacy Ingredient Cost		x	
Pharmacy Location City Name		x	
Pharmacy Location State or Province		x	
Pharmacy Location ZIP Code		x	
Pharmacy Metric Units		x	
Pharmacy Name		x	
Pharmacy NH Medicaid Pharmacy Provider ID		x	
Pharmacy Postage Amount		x	
Pharmacy Prescribing Provider DEA Number		x	
Pharmacy Prescribing Provider MCO ID		x	
Pharmacy Prescribing Provider NPI		x	
Pharmacy Prescription Number		x	
Pharmacy Tax ID		x	

MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements	Medical Encounter	Pharmacy Encounter	Member
Place of Service	x	x	
Prepaid Amount/Fee Schedule Equivalent (if provider being paid on capitated basis)	x	x	
Primary Care Provider Assigned From Date			x
Primary Care Provider Assigned To Date			x
Primary Care Provider Clinic/Business Name			x
Primary Care Provider Location City Name			x
Primary Care Provider Location State or Province			x
Primary Care Provider Location Street address			x
Primary Care Provider Location ZIP Code			x
Primary Care Provider Medicaid ID			x
Primary Care Provider Name			x
Primary Care Provider NPI			x
Primary Care Provider Payer ID			x
Primary Care Provider Specialty			x
Primary Care Provider Tax ID			x
Primary Care Provider Type (e.g., Physician, APRN)			x
Prior Authorization Number	x	x	
Procedure Codes (HCPCS/CPT) - MCO to Provide All Submitted by Providers as Specified by DHHS	x		
Procedure Modifier Codes and Description – MCO to Provide All Submitted by Providers as Specified by DHHS	x		
Quantity/Units Billed	x		
Quantity/Units Paid	x		
Referring Provider Name	x		
Referring Provider NPI	x		
Referring Provider Payer ID	x		

MCO Encounter, Member, and Provider Data Sets Data Elements Data Elements	Medical Encounter	Pharmacy Encounter	Member
Rendering/Service Provider Country Name	x	x	
Rendering/Service Provider Name	x	x	
Rendering/Service Provider NPI	x	x	
Rendering/Service Provider Payer ID	x	x	
Rendering/Service Provider Rendering/Service Location City Name	x	x	
Rendering/Service Provider Rendering/Service Location State or Province	x	x	
Rendering/Service Provider Rendering/Service Location ZIP Code	x	x	
Rendering/Service Provider Specialty	x	x	
Rendering/Service Provider Street Address	x	x	
Rendering/Service Provider Tax ID	x	x	
Rendering/Service Provider Type (e.g., physician, APRN)	x	x	
TPL Medicare Allowed Amount	x	x	
TPL Medicare Coinsurance Amount	x	x	
TPL Medicare Deductible Amount	x	x	
TPL Medicare Paid Amount	x	x	
TPL Medicare Paid Date	x	x	
TPL Other Payers Allowed Amount - MCO to Supply All Other Payer Information	x	x	
TPL Other Payers Coinsurance Amount - MCO to Supply All Other Payer Information	x	x	
TPL Other Payers Deductible Amount - MCO to Supply All Other Payer Information	x	x	
TPL Other Payers Name - MCO to Supply All Other Payer Information	x	x	
TPL Other Payers Paid Amount - MCO to Supply All Other Payer Information	x	x	
TPL Other Payers Paid Date - MCO to Supply All Other Payer Information	x	x	
<p>Note: Medical and Pharmacy are transaction specific encounter data sets; Member is a month specific file, and Provider file must represent present and historical provider network.</p>			

MCO Coordination of Benefits Data Set Data Elements (From NH Medicaid Care Management Contract)
Medicaid Member Name
NH Medicaid Member ID
Insurance Carrier, PBM, or Benefit Administrator ID
Insurance Carrier, PBM, or Benefit Administrator Name
Date of Service
Claim ID (transaction code number)
Date billed to the insurance carrier, PBM, or benefit administrator
Amount billed
Amount recovered
Denial reason code
Denial reason description
Performing provider
Note: COB is a transaction specific data set submitted monthly in a delimited flat text file.

MCO to NH DHHS Provider File Data Elements (Version 0.2)
MCO ID (unique ID for the MCO that spans all MCO submitted data)
MCO Assigned Provider ID
MCO Group ID Number (if used)
Provider Certification Data (licensure, provider residency/fellowship, date and specialty of Board Certification status)
Provider In-Network Indicator
Provider Multiple Service Location Indicator
Provider Location Type (e.g., border, in-state, out-of state)
Provider ID NH Medicaid Assigned
Provider ID MCO Assigned
Provider NPI
Provider Taxonomy
Provider SSN/TIN

MCO to NH DHHS Provider File Data Elements (Version 0.2)
Provider DEA/CDS
Provider Organization or Individual?
Provider Organization Name (if non-person provider)
Provider Individual Last Name (blank if non-person provider)
Provider Individual First Name (blank if non-person provider)
Provider Individual Middle Name (blank if non-person provider)
Provider Individual Suffix (blank if non-person provider)
Provider Individual Degree (e.g., MD, CRNA) (blank if non-person provider)
Provider Specialty 1 (Primary)
Provider Specialty 2
Provider Specialty 3
Provider Specialty 4
Provider Associated Organization Name(s)
Provider Service Location(s) Street Address 1
Provider Service Location(s) Street Address 2
Provider Service Location(s) City Name
Provider Service Location(s) State or Province
Provider Service Location(s) ZIP Code
Provider Service Location(s) Country Name
Provider Service Location(s) County Name
Provider Service Location(s) Telephone Number
Provider Service Location(s) Latitude
Provider Service Location(s) Longitude
Provider Type (e.g., physician, APRN, group)
Provider Listed as Primary Care Provider in MCO Directory Flag
Number of Openings in Primary Care Provider Panel

MCO to NH DHHS Provider File Data Elements (Version 0.2)
Provider Appears in MCO Directory Flag
Non-primary care Practice: Open vs. Closed
Date Enrolled by MCO
Date Terminated by MCO
MCO Termination Reason
Provider Status (e.g., active, inactive, terminated, dead, etc.)
Provider Rendering of Service, Billing, or Both?
Provider Association to Organization(s)
Organizational or individual provider type
Medical/Health Home: yes vs. no
<i>Credentialing related</i>
Site visit date
Physical Accessibility and appearance/ADA compliant
Medical records: paper vs. electronic
Meeting meaningful use criteria: met vs. not met
Review by the appropriate accreditation organization
Medicare Provider Flag
Credentialed Medicaid Provider In Other State; indicate state
Active license; NH, other state
Malpractice Insurance: yes vs. no
Education and Work history validation: yes vs. no
National Practitioner Data Bank
License or Workplace Limits, Discipline, Loss of Privilege: Flag
License or Workplace Limits, Discipline, Loss of Privilege: Detail
Felony Conviction: yes vs. no
OIG Exclusion: yes vs. no

MCO to NH DHHS Provider File Data Elements (Version 0.2)
Tax Delinquency: yes vs. no
Criminal Background Check: criminal vs. non
Fingerprinting Required: yes vs. no
<i>Additional Technical Requirements (Solutions Pending)</i>
File(s) must represent present and historical provider network (i.e., changes in any data)
File(s) must allow individuals to be associated with multiple groups
File(s) must allow individuals to be associated with multiple service locations

Appendix D: NH Medicaid Care Management Contract Compliance with CMS Clinical Standards and Guidelines

The following table meets the requirement of 42 CFR 438.204(a) by itemizing the required components and identifies the reference for the contract provisions that incorporate the standards of 42 CFR 438 Subpart D in the NH Medicaid Care Management contract.

NOTE: Contract references are based on MCO contract amendment as of 6.19.2015. Updated cross walks are available on request.

42 CFR Subpart D: Reference and Summarized Content	Contract Provision (NH Medicaid Care Management Contract Section Reference)
<p>438.204 - Elements of state quality strategy</p> <ul style="list-style-type: none"> • The State and the MCOs must assess the quality and appropriateness of care and services to all enrollees and individuals with special health care needs • The State and the MCOs must identify race, ethnicity and primary language spoken. • The State must regular monitor MCO compliance with quality standards, including: <ul style="list-style-type: none"> • National measures, • Annual, external independent review, • The State’s information systems, and • Standards at least as stringent as those in the Federal regulations, for access to care, structure and operation, and quality measurement and improvement. 	<ul style="list-style-type: none"> • 22.1.14 • 18.2.3, 18.2.4 • 24, 23.1.1, 28 • 22.5, 23.1.1, 28 • 22.3 • 31.9.1.4, 31.9.2 • 19.1.10, 20.2.1, 24
Access Standards	
<p>438.206 - Availability of services</p> <ul style="list-style-type: none"> • The MCO must maintain and monitor a delivery network supported by written agreements and is sufficient to provide adequate access to services covered under the contract to the population to be enrolled. • The MCO must provide female enrollees direct access to women’s health specialists. • The MCO must provide for a second opinion. • The MCO must provide out of network services when not available in network. • The MCO must provide assurance that the costs to enrollees out-of-network are no greater than in-network. • The MCO must demonstrate that providers are credentialed. • The MCO must demonstrate that both the MCO and its providers furnish services with timely access and cultural competence. 	<ul style="list-style-type: none"> • 21.1.1 • 20.5.1 • 20.8 • 20.7 • 20.7.3 • 21.3 • 20.4.5, 17.9.3.9
<p>438.207 - Assurances of adequate capacity and services</p> <ul style="list-style-type: none"> • The MCO must provide documentation that demonstrates it has capacity to serve the expected enrollment, submit the documentation in a format specified by the State at time of contracting and any time there is a significant change. 	<ul style="list-style-type: none"> • 7.7.3.3, 7.8.1.1.4, 20, 20.1.2, 20.1.4.3

42 CFR Subpart D: Reference and Summarized Content	Contract Provision (NH Medicaid Care Management Contract Section Reference)
<p>438.208 - Coordination and continuity of care</p> <ul style="list-style-type: none"> The MCOs must implement procedures to deliver primary care and coordinate health care services to enrollees. The State must implement procedures to identify persons with special health care needs. <p>For individuals with special health care needs:</p> <ul style="list-style-type: none"> The MCOs must implement mechanisms for assessing enrollees identified as having special needs to identify ongoing special conditions and developing a treatment plan. The MCOs must have a mechanism to allow persons identified with special health care needs to access specialty care directly (standing referral). 	<ul style="list-style-type: none"> 10.1, 10.2, 10.3 10.9.2 10.9.4 10.9.4
<p>438.210 - Coverage and authorization of services</p> <ul style="list-style-type: none"> The MCOs must define the amount, duration and scope of services provided. The MCOs must specify “medically necessary services.” The MCOs must have a service authorization process. 	<ul style="list-style-type: none"> 8.2, 23.2.1 23.1.1, 23.1.2
Structure and Operation Standards	
<p>438.214 – Provider selection</p> <ul style="list-style-type: none"> The MCOs must implement written policies and procedures for selection and retention of providers. The State must establish a uniform credentialing and recredentialing policy. MCO must follow a documented process for credentialing and recredentialing. The MCOs cannot discriminate against providers that serve high-risk populations. The MCOs must exclude providers who have been excluded from participation in Federal health care programs. 	<ul style="list-style-type: none"> 21.2.4 21.3 21.1.2 21.1.3
<p>438.218 - Information Requirements</p> <ul style="list-style-type: none"> The State and MCOs must meet the requirements of 42CFR438.10 	<ul style="list-style-type: none"> 16.2.3
<p>438.224 - Confidentiality</p> <ul style="list-style-type: none"> The MCOs must comply with all state and federal confidentiality rules. 	<ul style="list-style-type: none"> 30.1.4; 30.1.6, 34.4.1.6
<p>438.226 - Enrollment and disenrollment</p> <ul style="list-style-type: none"> The MCOs must comply with the enrollment and disenrollment standards in 42CFR438.56. 	<ul style="list-style-type: none"> 16
<p>438.228 - Grievance systems</p> <ul style="list-style-type: none"> The MCOs must comply with grievance system requirements in 42CFR438 Subpart F. The State will conduct random reviews of enrollee notification 	<ul style="list-style-type: none"> 19.1, 19.2, 19.4, 19.7, 19.1.12 22.3; 22.3-Included into EQRO Scope

42 CFR Subpart D: Reference and Summarized Content	Contract Provision (NH Medicaid Care Management Contract Section Reference)
through its EQRO.	of Work in development
<p>438.230 - Subcontractual relationships and delegation</p> <ul style="list-style-type: none"> • The MCOs are accountable for any functions or responsibilities that it delegates. • The MCOs must have a written agreement that regularly monitors and specifies the activities and report responsibilities that are delegated and specifies the revocation of the agreement if the subcontractor’s performance is inadequate. 	<ul style="list-style-type: none"> • 5.1 • 5.3
Measurement and Improvement Standards	
<p>438.236 - Practice guidelines</p> <ul style="list-style-type: none"> • The MCOs must adopt practice guidelines that are based on valid and reliable evidence or a consensus of health care professionals in the field; consider the needs of the population, are adopted in consultation with health care professionals, and are reviewed and updated periodically • The MCOs must disseminate guidelines. • The MCOs must apply guidelines to coverage decisions. 	<ul style="list-style-type: none"> • 22.2.3
<p>438.240 - Quality assessment and performance improvement (QAPI) program</p> <ul style="list-style-type: none"> • Each MCO must have an ongoing QAPI program. • The MCOs conduct general performance measurement, including the detection of both under-utilization and over-utilization and an assessment of the quality and appropriateness of care furnished to enrollees with special health care needs. • The MCOs must measure and report to the State its performance using standard performance measures required by the state. Submit data specified by the State to measure performance. • The MCOs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. Projects should be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects should include: Measurement of performance using objective quality indicators, implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the intervention, planning and initiation of activities for increasing or sustaining improvement. Each plan must report to the State the results of each project. • The State must review at least annually, the impact and effectiveness of the each program. 	<ul style="list-style-type: none"> • 22.1.3, 22.1.4, 22.1.6, 22.1.8 • 22.1.5, 22.1.14, 22.5.1 • 22.5.1 • 22.1.11 • 22.4, 22.1.7, 22.1.4, 22.3, 22.5 • Also included in EQRO Scope of Work

42 CFR Subpart D: Reference and Summarized Content	Contract Provision (NH Medicaid Care Management Contract Section Reference)
<p>438.242 - Health information systems</p> <ul style="list-style-type: none"> • The MCOs must have a system in place that collects, analyzes, integrates, and reports data and supports the plan’s compliance with the quality requirements. • The MCOs collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system. • The MCOs must ensure that data from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic and consistency, collecting service information in standardized formats, make all data available to the State and CMS. • Make the data available to the State and CMS. 	<ul style="list-style-type: none"> • 24, 25.1.2 • 24, 25.2 • 25.1.4, 25.1.1 • 25.1.1

Appendix E: NH Medicaid Care Management Program Routine Quality Reports

General reporting requirements:

Unless otherwise specified within the NH Medicaid contract, the following standard reporting requirements apply. The MCOs must hold subcontractors accountable to the Quality Strategy requirements for any data and reporting. *Last Updated 7.17.15. Consult with the Department for any recent updates prior to use.*

Distribution and Presentation:

- All reports have specific timeframes outlined in the applicable specification manuals.
- All reports must be provided in an electronic file that allows text and visual displays of information to be exported, edited and used by DHHS (e.g. graphs in PowerPoint, executive summaries exported into other documents, etc.)

Analysis:

- All reports should include outcome measures to the greatest extent possible in addition to structure and process measures,
- All reports should include quantitative assessments to the greatest extent possible in addition to any qualitative assessments,
- All reports should incorporate appropriate comparators which must be approved by DHHS prior to use, and
- All reports should include sufficiently detailed, data driven assessments using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.

Baselines:

- Baselines for cost savings where necessary shall be the twelve (12) month period prior to the Agreement Year, or the twelve (12) month period prior to the new program initiative, but at no time may be greater than two (2) years prior to the program period being evaluated.
- Innovations in place for greater than twenty-four (24) months will have to baseline reset so that a new baseline is established for the second and for each subsequent twenty-four (24) month period of the initiative.

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
ACCIDENT.01	Accident and Trauma Claim Log	Table	Monthly	15 calendar days after end of month
ADVISORYBOARD.01	Provider Advisory Board (PAB) Annual Report	Narrative Report	Agreement Year	September 30th
ADVISORYBOARD.02	Consumer Advisory Board (CAB) Annual Report	Narrative Report	Agreement year	September 30th
ADVISORYBOARD.03	Provider Advisory Board (PAB) Quarterly Agenda and Minutes Report	Narrative Report	Quarterly	30 days after the end of the reporting period
ADVISORYBOARD.04	Consumer Advisory Board (CAB) Quarterly Agenda and Minutes Report	Narrative Report	Quarterly	30 days after the end of the reporting period
APPEALS.16	Appeals by Type of Resolution and Category of Service	Table	Monthly	30 days after the end of the month
BHCOMMRATIO.01	Community Based to Office Based Services Ratio - Excluding NHHPP Members	Table	Semi-annual based on paid dates	1 month after the end of the semi-annual period
BHCONSENT.02	Consent for Release of Information for Primary Care - Behavioral Health Care Coordination Annual Report - Excluding NHHPP Members	Narrative Report	Agreement year	July 31st
BHCRISIS.01	Behavioral Health Crisis Line and Emergency Services Report on Innovative and Cost Effective Models	Narrative Report	N/A	October 31st
BHHOMELESS.01	New Hampshire Hospital Homelessness Reduction Plan	Plan	Agreement year	September 30th
BHHOMELESS.02	New Hampshire Hospital Homelessness Quarterly Report - Excluding NHHPP Members	Narrative Report	Quarterly	Within 30 days of the end of each quarter
BHSURVEY.01	Behavioral Health Satisfaction Survey Annual Report - Excluding NHHPP Members	Narrative Report	Annually	June 30th
BOARDCERT.01	MCO Network Board Certification Report	Table	N/A	Upon request by DHHS
CAREMGT.01	Care Management Plan Including Plan to Assess and Report on the Quality and Appropriateness of Care Furnished to Members With Special Health Care Needs	Plan	N/A	May 1st
CAREMGT.02	Systems of Care for Children With Serious Emotional Disturbance Report - Excluding NHHPP Members	Narrative Report	TBD	TBD
CAREMGT.20	Care Management Program Comprehensive Annual Report	Narrative and Analytic Report		30-Aug

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
CFI_CAREMGRS.01	CFI Waiver Services: Care Manager Ratio Plan	Plan	N/A	May 1st
CFI_CASEMGR.02	CFI Waiver Services: Care Manager Ratio Plan	Plan	N/A	May 1st
CFI_CMS372.01	Long Term Care Summary Totals of Participants, Enrollment and Average Length of Stay for Inclusion in CMS 372 Submission (MCOs will not be required to submit if encounter data is available and proves sufficient for DHHS to generate information)	Table	Annual	16 months after the end of the data period
CFI_CMS372.02	Long Term Care Participants and Payments by Service for Inclusion in CMS 372 Submission (MCOs will not be required to submit if encounter data is available and proves sufficient for DHHS to generate information)	Table	Annual	16 months after the end of the data period
CFI_INTEGRATION.01	CFI Waiver Services: Community Integration Plan	Plan	N/A	May 1st
CLAIM.10	Claims Payment Quality Assurance Corrective Action Plans	Plan	N/A	As needed
COMMUNICATION.01	Communications Plan	Plan	N/A	May 1st
CULTURALCOMP.01	Cultural Competency Strategic Plan	Plan	N/A	September 30th
CULTURALCOMP.02	Cultural Competency Annual Report	Narrative Report	Agreement year	September 30th
EMERGENCYRESPONSE.01	Emergency Response Plan	Plan	N/A	May 1st
EPSDT.20	EPSDT Plan	Plan	N/A	May 1st
FINANCIALSTATEMENT	Audited Financial Statement	Narrative Report	Annually	Within 120 days after the end of the MCOs fiscal year
FWA.02	Fraud Waste and Abuse Log: FWA Related to Providers	Table	Monthly	30 days after the end of the month
FWA.03	Fraud Waste and Abuse Log: Court Ordered Treatment Report	Table	Monthly	30 days after the end of the month
FWA.04	Fraud Waste and Abuse Log: Date of Death Report	Table	Monthly	30 days after the end of the month
FWA.05	Fraud Waste and Abuse Log: Explanation Of Medical Benefit Report	Table	Monthly	30 days after the end of the month

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
FWA.06	Fraud Waste and Abuse Log: Underutilization of Services Report	Table	Monthly	4 months after the end of the month
FWA.20	Comprehensive Annual Fraud Waste and Abuse Summary Annual Report	Narrative Report	Agreement Year	September 30th
FWA.21	Comprehensive Quarterly Program Integrity Summary Report of Program Activity	Narrative Report	Quarterly	2 months after the end of the quarter
GHREADMIT.01	Glenciff Home Reductions in Readmission Plan	Plan	N/A	June 30th
GRIEVANCE.02	Grievance Log Including CFI Member / Provider Flag	Table	Monthly	15 calendar days after the end of the month
HPP_BHCOMMRATIO.01	Community Based to Office Based Services Ratio - NHHPP Members	Table	Semi-annual based on paid dates	1 month after the end of the semi-annual period
HPP_BHCONSENT.02	Consent for Release of Information for Primary Care - Behavioral Health Care Coordination Annual Report - NHHPP Members	Narrative Report	Agreement year	July 31st
HPP_BHHOMELESS.02	New Hampshire Hospital Homelessness Quarterly Report - NHHPP Members	Narrative Report	Quarterly	Within 30 days of the end of each quarter
HPP_BHSURVEY.01	Behavioral Health Satisfaction Survey Annual Report - NHHPP Members	Narrative Report	Annually	June 30th
HPP_INPUTIL.01	Quarterly Inpatient Hospital Utilization Summary - NHHPP Members	Table	Quarterly	Within 4 months after the end of the quarter
HPP_PHARMMGT.22	Pharmacy Management Utilization Controls Summary Semi-Annual Report - NHHPP Members	Narrative and Analytic Report	Semi-Annual	2 months after the end of the semi-annual period
HPP_PHARMQI.02	Pharmacy Quality Improvement Initiatives Annual Summary Report - NHHPP Members	Narrative Report	Annual	September 30th
HPP_PHARMQI.03	Pharmacy Quality Improvement Initiatives Semi-Annual Summary Update Report - NHHPP Members	Narrative Report	Semi-Annual	March 31st
HPP_SERVICEAUTH.05	Service Authorization Determination Summary - NHHPP Members	Table	Quarterly	2 months after the end of the quarter
HPP_SERVICEAUTH.06	Service Authorization Denial Detail Log - NHHPP Members	Table	Quarterly	2 months after the end of the quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
HPP_SUD.40	Substance Use Disorder Population Profile: Counts and Proportion of NHHPP SUD Diagnosed Members by Specific Substance Use Diagnoses, Mental Health Dual Diagnosis, Co-Occurring Chronic Disease , Age Groups, Gender, County of Residence, City of Residence, and Use of SUD Services	Table	Agreement Year	4 months after the end of the agreement year
HPP_UMSUMMARY.02	Utilization Management Impact Annual Report - NHHPP Members	Narrative Report	Agreement Year	September 30th
INTEGRITY.01	Program Integrity Plan	Plan	N/A	Upon revision
LOCKIN.01	Pharmacy Lock-in Member Enrollment Log	Table	Monthly	30 calendar days after end of month
LOCKIN.02	Pharmacy Lock-in Member Disenrollment Log	Table	Monthly	30 calendar days after end of month
LOCKIN.03	Pharmacy Lock-in Activity Summary	Table	Monthly	30 calendar days after end of month
MCISPLANS.01	Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	Plan	N/A	June 1st
NETWORK.01	Comprehensive Provider Network and Equal and Timely Access Semi-Annual Filing	Narrative Report	Semi-annual	45 days after the end of the semi-annual period
NETWORK.02	Corrective Action Plan for Non-Compliance With Timely Access Standards	Plan	N/A	As needed
NETWORK.10	Corrective Action Plan to Restore Provider Network Adequacy	Plan	N/A	As needed
NHHREADMIT.01	New Hampshire Hospital Reductions in Readmission Plan	Plan	N/A	June 30th
PAYREFORM.01	Payment Reform Plan	Plan	N/A	May 1st
PAYREFORM.02	Payment Reform Annual Report	Narrative Report	Agreement year	April 1st
PAYREFORM.03	Payment Reform Quarterly Update Report	Narrative Report	Quarterly	30 days after the end of the reporting period
PHARMMGT.22	Pharmacy Management Utilization Controls Summary Semi-Annual Report - Excluding NHHPP Members	Narrative and Analytic Report	Semi-Annual	2 months after the end of the semi-annual period
PHARMQI.01	Pharmacy Quality Improvement Initiative Plans	Plan	Annual Plan	September 30th

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
PHARMQI.02	Pharmacy Quality Improvement Initiatives Annual Summary Report - Excluding NHHPP Members	Narrative Report	Annual	September 30th
PHARMQI.03	Pharmacy Quality Improvement Initiatives Semi-Annual Summary Update Report - Excluding NHHPP Members	Narrative Report	Semi-Annual	March 31st
PHARMQI.10	Safety monitoring of psychotropics: polypharmacy; ADHD, antipsychotics (typical and atypical), antidepressants, mood stabilizers	template	quarterly	2 months after the end of the quarter
PIP.01	Performance Improvement Project Semi-Annual Report	Narrative Report	Semi-Annual	July 31st and January 31st
PMP.01	Program Management Plan	Plan	N/A	May 1st
PRIVACYBREACH.01	Privacy Breach Notification	Narrative Report	As Needed	Preliminary notice within one (1) day of breach and final detailed notice after MCO assessment
PROVQUAL.01	MCO Provider Quality Report Card	Table	N/A	Upon request
PROVSATISFACTION.01	Provider Satisfaction Survey	Narrative Report	Semi-Annual First Year, Then Annual	September 30th
PROVTERM.01	Provider Termination Log	Table	As needed or weekly	Within 15 calendar days of the notice of termination or effective date, whichever is sooner
PROVTRAINING.01	Provider Training Annual Report	Narrative Report	Agreement Year	September 30th
QAPI.01	Quality Assessment and Performance Improvement (QAPI) Annual Summary Report - Excluding NHHPP Members	Narrative Report	Annually	September 30th
QAPI.02	Quality Assessment and Performance Improvement (QAPI) Semi-Annual Update Report - Excluding NHHPP Members	Narrative Report	Semi-Annual	March 31st
SERVICEAUTH.05	Service Authorization Determination Summary by Service Category - Excluding NHHPP Members	Table	Quarterly	2 months after the end of the quarter
SERVICEAUTH.06	Service Authorization Denial Detail Log - Excluding NHHPP Members	Table	Quarterly	2 months after the end of the quarter

Reporting Reference ID	Name	Type	Measure Data Period	Standard Due Date
SERVICEAUTH.09	Number of Prior Authorizations Overall and Stratified By Select Therapeutic Drug Classes	Table	quarterly	2 months after the end of the quarter
STAFFINGPLAN.01	MCO Staffing Contingency Plan	Plan	N/A	As Needed
TERMINATIONPLAN.01	MCO Termination Plan	Plan	N/A	As needed
TPLCOB.01	Coordination of Benefits: Costs Avoided	Table	Quarterly	2 months after the end of the quarter
TPLCOB.02	Coordination of Benefits: Medical Costs Recovered Claim Log	Table	Quarterly	2 months after the end of the quarter
TPLCOB.03	Coordination of Benefits: Pharmacy Costs Recovered Claim Log	Table	Quarterly	2 months after the end of the quarter
UMSUMMARY.02	Utilization Management Impact Annual Report	Narrative Report	Agreement Year	September 30th



**New Hampshire Healthy Families
QAPI. 02 Evaluation Report for 2014
Due 3.31.15**

Granite State Health Plan d/b/a New Hampshire Healthy Families Quality Improvement Program Evaluation January 1, 2014 to December 31, 2014

Introduction

The New Hampshire Healthy Families' (NHHF) 2014 Quality Improvement (QI) Program Evaluation provides an overview and analysis of the quality improvement activities completed in 2014. The NHHF QI Department evaluates the quality of care and services available to our members as well as implements and monitors activities related to NHHF's mission to improve the health of all enrolled members. This evaluation documents and reflects NHHF's 2014 activities and the cross-departmental efforts to provide and continuously improve the quality of care and services available to the NHHF membership.

The NHHF QI Program is comprehensive and addresses both the quality and safety of clinical care and the quality of healthcare services provided to NHHF members including medical, behavioral health, and vision care. NHHF incorporates all demographic groups, benefit packages, care settings, and services into QI activities, including outpatient care, inpatient care, preventive care, family planning, behavioral health care, emergency care, primary care, specialty care, acute care, short-term care and ancillary care services. Adequate resources have been assigned to support these QI efforts including clinical staff, technical and analytical staff, and administrative expertise. Throughout the year, the program is monitored and evaluated to continually assess the quality of care and service NHHF members receive.

In 2014, NHHF was in its infancy as a health plan, beginning operations in December 2013. However, the QI Program was established and conducted its normal programs and committee meetings throughout the year.

Purpose

NHHF's mission is to provide better health outcomes at lower costs for its Medicaid enrollees. The purpose of the QI Program is to provide the infrastructure and activities necessary to support NHHF's mission to improve the quality and safety of the clinical care and services provided and delivered in a safe, appropriate setting. Whenever possible, NHHF's QI Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of members.

The QI Program focuses on meeting the needs of members, providers/practitioners, the community, regulatory/accreditation agencies, and other key stakeholders. NHHF supports and complies with the Quality Strategy for the New Hampshire Medicaid Care Management Program. The QI Program also directs activities designed to improve the health of all enrolled members, and meet their cultural and linguistic needs.

Membership Demographics

NHHF began operations in New Hampshire in December 2013, with a population primarily comprised of Temporary Assistance for Needy Families (TANF) members, with children ages 0-20 being the largest age group, and a slightly higher percentage of female members. The overall

membership grew significantly throughout 2014, as demonstrated below. NHHF ended 2014 with a significant increase in the overall members due to the Medicaid expansion product (i.e. NHHF) for adult members meeting the income requirements. NHHF uses available demographic and diagnostic information to design and implement QI Program initiatives.

Product	% of Population	Age Group	% of Population	Gender	% of Population
Foster Care	<1%	0-10	35%	M	46%
LTC Dual	1%	11-20	29%	F	54%
LTC Non-Dual	1%	21-30	10%	Total	100%
SSI Dual	3%	31-40	8%		
SSI Non-Dual	8%	41-50	7%		
TANF	71%	51-60	7%		
NHHP	14%	61-70	3%		
Total	100%	>71	1%		
		Total	100%		

Membership by month in 2014 (total of 62,712 in December 2014):

Product	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
TANF	28,786	30,217	31,007	31,991	32,566	33,121	36,693	44,856	44,064	44,467	44,462	44,573
Foster Care	205	214	210	232	237	238	275	344	348	366	378	379
SSI Dual	1444	1472	1452	1451	1602	1630	1781	2104	2071	2072	2086	2086
SSI Non-D	3450	3508	3424	3424	3390	3425	4162	5075	5072	5037	5033	4984
LTC Dual	666	666	656	651	657	645	710	835	834	867	861	859
LTC Non-D	352	355	366	386	426	439	564	773	776	818	824	851
NHHPP*	NA	3448	5666	7482	8980							

* NHHPP is a Medicaid expansion product for adults meeting the income requirements.

NHHF also has members enrolled in the health plan who receive waiver services, i.e. home and community based wrap around services. Members included in the population comprise a small portion of the overall NHHF membership, i.e. approximately 3%.

The top 5 diagnostic categories of the NHHF membership are as follows (information is from claims/encounter data pulled from NHHF’s Enterprise Data Warehouse [EDW]):

2014 Adult Membership (19 years of age and older) Top 5 Diagnoses NH Medicaid	2014 Adult Membership (19 years of age and older) Top 5 Diagnoses NHHPP
SUPERVISION OTHER NORMAL PREGNANCY	ROUTINE GEN MED EX@HLTH CARE FACL
DIABETES MELLITUS W/O MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TY	OTHER PHYSICAL THERAPY
ROUTINE GEN MED EX@HLTH CARE	NEED FOR PROPHYLACTIC VACC AND

FACL	INOCULATION AGAINST, INFLUENZA
OTHER PHYSICAL THERAPY	DIABETES MELLITUS W/O MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TY
END STAGE RENAL DISEASE	LUMBAGO

2014 Child Membership (0 to 18 years of age) Top 5 Diagnoses NH Medicaid	2014 Child Membership (0 to 18 years of age) Top 5 Diagnoses NHHPP
ROUTINE INFANT/CHILD HEALTH CHECK	NA
NEED FOR PROPHYLACTIC VACC AND INOCULATION AGAINST, INFLUENZA	NA
ACUTE URIS OF UNSPECIFIED SITE	NA
ACUTE PHARYNGITIS	NA
UNSPECIFIED OTITIS MEDIA	NA

Scope of the Quality Improvement Program

NHMF systematically monitors and evaluates the QI Program throughout the year by analyzing and reporting key indicators of clinical and non-clinical outcomes. Areas monitored include: cultural competency; access/availability of network practitioners; Member Rights and Responsibilities; Member Services Call Center accessibility statistics; performance measures, such as HEDIS, and other quality improvement activities and associated interventions; utilization, clinical practice guideline adherence, member and provider experience, patient safety, credentialing, and delegated vendor oversight. Applicable metrics are reported to the QIC at designated intervals and meet NCQA standards.

Quality Improvement Program Effectiveness/2014 QI Program Highlights:

- Continued development and implementation of a comprehensive quality program and HEDIS strategy.
- Conducted numerous member and provider HEDIS interventions.
- Conducted Quality Improvement Committee meetings with robust internal staff and external physician involvement.
- Analysis of the CAHPS survey, completed by the New Hampshire Department of Health & Human Services (DHHS) (off cycle).
- Continued ongoing evaluation and tracking of member appeals and grievances.
- Provider Satisfaction Survey completed and analyzed.
- Member Advisory Board Committee meetings convened.
- Initiated provider incentives for Notification of Pregnancy, for early pre-natal intervention.
- Conducted oversight of delegated entities in collaboration with NHMF Compliance and Centene Corporate Compliance departments.
- Continued comprehensive review and tracking of potential quality of care events.

- Performed ongoing evaluation of provider access and availability.
- Participated in two External Quality Review Organization (EQRO) audits and received favorable results.

QI Program Structure and Resources

Quality is integrated throughout NHHF, and represents the strong commitment to the quality and safety of clinical care and services for members. To this end, various committees, subcommittees and ad-hoc committees have been established to monitor and support the QI Program. Ultimate authority is held by the Board of Directors, which delegates oversight of the QI Program to the Quality Improvement Committee (QIC). The NHHF QIC met four (4) times in 2014.

The QIC is supported by several subcommittees that report to the QIC on a regular basis per the Annual QI Work Plan. The subcommittees supporting quality improvement include:

- Credentialing Committee - met 12 times in 2014
- Grievance and Appeals Committee – met over 12 times 2014 (i.e. as needed per volume of grievance and appeals cases)
- Peer Review Committee (Ad Hoc Committee) - met once in 2014
- Pharmacy & Therapeutics Committee - met 4 times in 2014
- Performance Improvement Team - met 7 times in 2014
- Utilization Management Committee - met 4 times in 2014
- HEDIS Steering Committee - met 10 times in 2014
- Member Advisory Board - met 2 times in 2014
- Provider Advisory Board - met 1 time in 2014

NHHF was successful in fully implementing all essential committees in 2014, the first full year of operations for the health plan, and believes the current committee structure is adequate to support the QI Program in 2015. While there was adequate external practitioner participation on all applicable committees, NHHF will make efforts in 2015 to recruit additional physicians/practitioners to participate in the QIC and other relevant subcommittees. There will be no substantial changes to the committee structure in 2015.

NHHF acknowledges that the planning and execution of the QI Program plan requires appropriate resources. The type and number of resources allocated are based on the planned number and types of QI activities and what is needed to ensure successful completion of these activities. The QI Department resources for 2014 included:

- Chief Executive Officer, serving as the Senior Executive for Quality Initiatives (SEQI)
- Medical Director
- Vice President Medical Management (VPMM) (RN)
- Senior Director of Medical Management
- Director of Pharmacy
- Regional Manager, Accreditation and HEDIS
- Data Analyst
- Manager, Quality Improvement (RN)
- QI Coordinator I (RN)

- Early Prevention Screening Diagnostic and Treatment (EPSDT) Coordinator (RN)
- Grievance & Appeals Coordinator

Organizational Changes in 2014

In late 2014, NHHF recruited a Vice President of Quality to join the Quality Improvement Department. This decision was based on the importance of quality in the organization and NHHF's commitment to patient safety, quality of care, and achieving NCQA accreditation. NHHF feels the QI Department staff resources are adequate to support the QI Program in 2015, but plans to add an Administrative Assistant to the department to support documentation standards.

Other Resources

The central Management Information Systems (MIS), which is maintained by NHHF's parent company Centene Corporation, supports NHHF's QI Program. The MIS resources provide the data management capabilities that support the monitoring, measurement and analysis of data required to manage NHHF's QI activities. These resources were determined to be adequate, with no substantial changes identified for 2015. As a subsidiary of the Centene Corporation, NHHF's QI Program has many corporate resources at its disposal. NHHF obtains data and analytical support through the Information and Management Systems Department, Centene Corporate Quality Improvement and Measurement Analytics departments, and other support resources as deemed necessary. Other resources specific to quality improvement include consulting services by Centene Corporate NCQA accreditation staff, Corporate Quality Improvement staff, and access to corporate-sponsored training and webinars. Resources available through Centene Corporate were all found to be adequate in 2014, with no needs identified for 2015.

Cultural Competency

NHHF provided 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 each with dignity. To that end, NHHF has developed a Cultural Competency Plan. The Plan is based on state definitions of cultural competency, the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards), and the Georgetown University National Center for Cultural Competence model framework. NHHF's program defines its values and principles, and demonstrates behaviors, attitudes, policies, and structures that enable employees and providers to work effectively across cultures. The QI Program actively supports the goals, objectives and evaluation of the Cultural Competency Plan. NHHF collects data and/or takes action to address the needs of a culturally diverse population each year as described in the Annual QI Work Plan and in the Cultural Competency Program Description.

One area where NHHF addresses cultural competency is through analysis of data regarding member cultural, ethnic, racial, and linguistic needs and preferences. Data is evaluated at least annually to determine whether the current practitioner network is meeting member needs. The following tables display language and ethnicity demographics for the NHHF membership, per self-reported data received from state-provided enrollment files:

English	59899
French	85
Greek	7
Spanish	1786
Other	1548
Total	63325

AMERICAN INDIAN OR ALASKAN NATIVE	147
ASIAN OR PACIFIC ISLANDER	1048
BLACK (NON-HISPANIC)	1762
HISPANIC	4055
NATIVE HAWAIIAN	32
OTHER RACE OR ETHNICITY	3483
WHITE (NON-HISPANIC)	52791
UNKNOWN	7
TOTAL	63325

Other sources of data include the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results on respondent race and ethnicity, the US census, and language line utilization.

CAHPS Results and U.S. Census Data

Race / Ethnicity Category	2014 Adult CAHPS	2014 Child CAHPS	2013 Census Data*
White	85.6%	84.4%	94.2%
Black / African American	3.9%	3.8%	1.5%
Hispanic / Latino**	3.7%	9.6%	3.2%
Asian	3.7%	4.6%	2.4%
Hawaiian / Pacific Islander	0.6%	0.2%	<0.1%
American Indian / Alaskan	7.0%	1.9%	0.3%
Other	4.7%	6.5%	1.6%

* U.S. Census Bureau www.census.gov

** Percentages may not total 100% as “Hispanic/Latino” is evaluated separately in CAHPS as an Ethnicity rather than Race

***Includes 2013 Census category of “Two or More Races” (%) and CAHPS categories of “Multi-Racial” and “Other”

Per the 2009-2013 American Community Survey estimates, the U.S Census Bureau web site reported 92% of the population of New Hampshire report speaking only English at home, and 8% speak a language other than English at home. Of those, 2.1% of New Hampshire residents report speaking Spanish at home, 4.1% speak other Indo-European languages, 1.3% speak Asian and Pacific Island languages and 0.5% report speaking other languages.

NHHF offers language assistance services to members who require translation services. The table below represents the top five languages for which members have requested translation services.

Top 5 Language Service Line Requests from 1/1/2014 – 12/31/2014:

Language	Number of calls	Percentage of Total
Spanish	785	81.9%
Nepali	28	2.9%
Arabic	22	2.3%
Bosnian	19	1.9%

Brazil - Portuguese	15	1.6%
All Other Languages	90	9.4%
Total	959	100%

Analysis of the available data indicates NHHF members’ most prominent secondary language is Spanish, by a significant percentage. Data from the CAHPS surveys and state census also indicate that Hispanic members make up the largest percentage of NHHF members, after those reporting their race/ethnicity as White. These results suggest NHHF members have a cultural and linguistic need for Hispanic/Latino practitioners and practitioners who speak Spanish. NHHF members identifying as Black and as American Indian /Alaskan make up a significant percentage of the membership as well. NHHF also assessed grievances from members relating to cultural or linguistic concerns; there were no grievances initiated that relate to cultural or linguistic needs received in calendar year 2014.

NHHF compares the information available regarding members’ language and race/ethnicity against data available for network practitioners. The health plan has data on practitioners who speak languages other than English from credentialing applications. Below are the results of the review of the top five languages spoken by providers in NHHF’s network. The NHHF network also includes practitioners who speak over 100 additional languages.

Practitioner Language Capabilities* - January 1, 2014 - December 31, 2014

Language	Count PCPs	Count Specialists	Count PCP & Specialist	Total
Spanish	672	909	43	1624
French	182	432	25	639
Portuguese	164	192	10	366
Hindi	90	154	8	252
Russian	70	134	6	210

Self-reported data based upon credentialing applications

NHHF believes the practitioner network is able to meet the linguistic and cultural needs of the membership, based on the availability of translation services, the availability of practitioners in the network that speak other languages, and based on the lack of grievances regarding cultural/linguistic issues. Cultural and linguistic availability of services is an important characteristic of the services NHHF provides to its membership. NHHF will continue to monitor all available data sources to assess the needs of the population against the network’s ability to support and manage those needs adequately.

In addition to the availability of language line interpreter services, NHHF also employs Spanish speaking staff to assist members contacting the Member Services Call Center; NHHF currently has two (2) Spanish speaking customer service representatives on staff to assist members. NHHF also has one (1) customer service representative who speaks Haitian-Creole.

The available data demonstrates that the current Spanish speaking capabilities among practitioners, together with the language assistance services available to members and the availability of Spanish speaking call center staff, adequately meets the cultural and linguistic

needs of NHHF’s Hispanic/Latino and Spanish speaking members. There were no other significant cultural or linguistic needs identified for NHHF members; telephonic and onsite interpreter services as well as translation of written materials, is available to any member as needed.

Additionally, our Member Handbook has also been translated into the following languages as was requested by members and are available for download:

- Spanish
- Italian
- Nepali
- Large Print
- Swahili

We also have the following translated versions of the Health Protection Program Handbook available for download:

- Bosnian

Practitioner Availability

NHHF monitors practitioner availability annually against established standards, both geographic and numeric, and initiates actions as needed to improve practitioner availability. NHHF contracts with Cenpatico, a sister organization and a National Committee for Quality Assurance (NCQA) accredited Managed Behavioral Health Organization (MBHO), to provide behavioral health care and services to members, which includes monitoring and analysis of behavioral health practitioner availability.

Practitioner availability monitoring is completed for primary care providers (PCPs) and high volume specialty care practitioners. NHHF identifies high volume practitioner specialists through analysis of the number of visits, based on claim/encounter data. NHHF identified high volume specialties based on volume of healthcare visits in calendar year 2014 as: Obstetrics/Gynecology, Cardiology, General Surgery, Neurology, Orthopedic Surgery, and Otolaryngology. The table below displays that standards and results for each practitioner type.

Results by Practitioner Type

Practitioner Type	Standard	Results	Goal Met?
PCPs: All Types	95% of members have at least 2 PCPs within 15 miles or 40 minutes.	99.75%	Yes
	At least 1 PCP per 200 members	1:35	Yes
PCPs: Family Practitioners / General Practitioners	95% of members have at least 2 PCPs within 15 miles or 40 minutes.	96.00%	Yes
	At least 1 PCP per 200 members	1:64	Yes

Results by Practitioner Type

Practitioner Type	Standard	Results	Goal Met?
PCPs: Internal Medicine	95% of adult members have at least 2 PCPs within 15 miles or 40 minutes	88.91%	No
	At least 1 PCP per 200 adult members	1:141	Yes
PCPs: Pediatrics	95% of child members (≤ 18 years of age) have at least 2 pediatricians within 15 miles or 40 minutes	92.32%	No
	At least 1 pediatrician per 200 members ≤ 18	1:152	Yes
Obstetrics and Gynecology	95% of female members have at least 1 OB/GYN within 45 miles or 60 minutes	99.95%	Yes
	At least 1 OB/GYN per 500 members	1:32	Yes
Cardiology	95% of members have at least 1 cardiologist within 45 miles or 60 minutes	97.56%	Yes
	At least 1 cardiologist per 2000 members	1:287	Yes
General Surgery	95% of urban members have at least 1 general surgeon within 45 miles or 60 minutes	100%	Yes
	At least 1 general surgeon per 2000 members	1:265	Yes
Neurology	95% of members have at least 1 neurologist within 45 miles or 60 minutes	100%	Yes
	At least 1 neurologist per 2000 members	1:316	Yes
Orthopedics	95% of members have at least 1 orthopedist within 45 miles or 60 minutes	100%	Yes
	At least 1 orthopedist per 2000 members	1:290	Yes
Otolaryngology	95% of members have at least 1 otolaryngologist within 45 miles or 60 minutes	99.44%	Yes
	At least 1 otolaryngology practitioner per 2000 members	1:856	Yes

Availability for PCP types by family/general practitioners met NHHF's geographic and numeric standards; internists did not meet the standards for miles and minutes criteria, but met for the ratio of providers to members. PCP access for internists overall is hindered by accessibility in two of the most rural counties (Carroll and Coos) in the state. In the case of pediatric providers, the average access standards for PCP services were decreased due to access in Coos County, which has a limited number of pediatric practitioners, mostly practicing out of the Federally Qualified Health Centers. Similar to internists, the ratio of providers to members is within the criteria for pediatricians. It should be noted, however, that PCP access does meet the 95% threshold statewide when all PCP type practitioners are examined in aggregate. The geographic and numeric standards were met for all specialty types.

NHHF also monitors member inquiries and grievances regarding practitioner availability. No grievances were received during the calendar year 2014 that were related to practitioner availability. Despite not meeting the geographic standards for internists and pediatricians, NHHF determined there is not a significant issue with the availability of primary care services, based on the lack of grievances related to the availability of PCPs, and due to the availability of family/general practitioners, including in the rural areas of the state. Practitioner availability is monitored by a collaborative workgroup of NHHF staff and the workgroup determined the geographic standards were not met for pediatricians and internists due to an overall lack of these types of primary care providers in rural areas of the state. However, NHHF will continue efforts in 2015 to increase primary care availability, with particular emphasis on rural areas.

Accessibility of Primary Care Services

NHHF conducted a survey of 50% of its primary care providers in December of 2014 to determine appropriate access to primary care services for NHHF members. This data is currently under analysis by a multidisciplinary team. For any deficiencies identified, NHHF will perform barrier analysis, identify opportunities for improvement, and initiate corrective action.

Members Rights and Responsibilities

Member Rights and Responsibilities are provided to the member upon enrollment with NHHF through the Member Handbook and on the member website. Every spring issue of our member newsletter, mailed to each member household, details and reviews Members Rights and Responsibilities. One of these rights is the right to privacy, which is closely guarded by NHHF. All member-sensitive information is only accessible to authorized staff and is locked in secured cabinets, maintained in secure electronic files, or is placed in locked trash receptacles when documents are to be shredded. The NHHF Compliance Officer performs Health Insurance Portability and Accountability Act (HIPAA) audits to assess access to protected health information.

NHHF has established policies and procedures which address privacy and confidentiality of member information. Specific policies detail NHHF's safeguards, collection, use and disclosure of protected health information (PHI) and how PHI is shared with the members based upon HIPAA. In accordance with NHHF's policy, the following tasks are undertaken to ensure the protection of member information:

- Annual compliance training for all personnel
- New hire Compliance and HIPAA training
- Monitoring of member complaints regarding management of health information
- All member information maintained in secure systems and hard copies kept in locked locations

Compliance Program

NHHF's Compliance and Ethics Program is intended to assist the health plan in developing effective internal controls that ensure adherence to federal and state legislation, and program requirements of federal, state law, and program regulations which are applicable to private health maintenance organizations and their contractors. It is also designed to prevent fraud, waste and abuse throughout the organization while furthering NHHF's fundamental mission; to provide access to high quality care to its members. The adoption and implementation of the Compliance Program demonstrates NHHF's strong commitment to compliance with all applicable laws, regulations, accreditation standards and contractual obligations of the New Hampshire Medicaid Managed Care Contract.

The Compliance Program is designed to create a culture of compliance within NHHF that promotes the prevention, detection and resolution of instances of conduct inconsistent with federal and state law, state health care program requirements, and internal (Centene Corporation and NHHF) business and ethics policies. It is intended to promote ethical behavior among NHHF staff in their daily interactions with members, providers, regulators, co-workers, and vendors. Finally, it establishes the foundation for compliant and ethical business practices as part of routine operations. As noted above, one of the tasks ensuring protection of member information is HIPAA desktop audits. Following completion of the desktop audits, the Compliance Departments notifies all NHHF of the results and information regarding what caused any failing scores. All managers are also notified to discuss the results individual with their employees who did not pass an audit, and to provide additional education. The results of the Compliance Officer's PHI desk audits, which began in Q2 2014, are displayed below:

Quarterly Desktop Audits	Q4-2014	Q3-2014	Q2-2014
Total Desktop/Work Areas Audited	97	89	60
Total Failed	8	4	3
Total Passed	89	85	57
% of Passed/Compliant	92%	96%	95%

Member Services Call Center

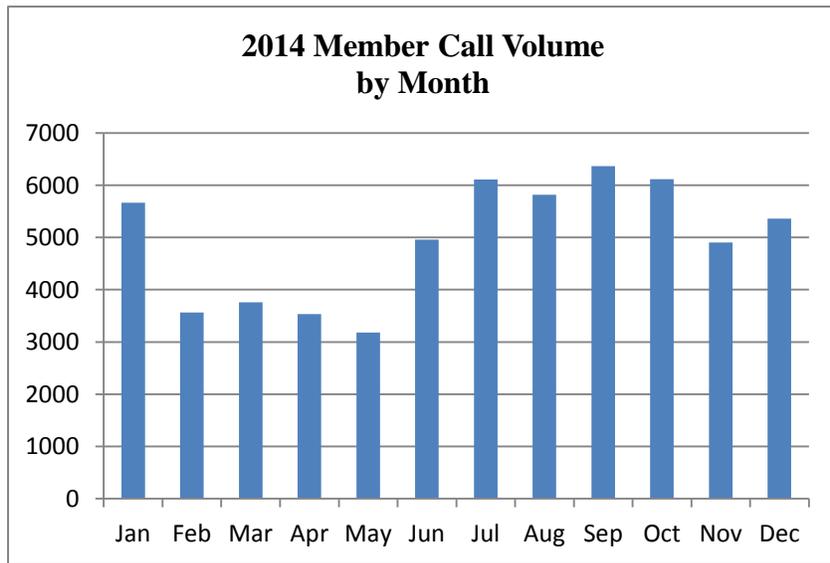
NHHF consistently met established internal benchmarks for Call Center telephone metrics during calendar year 2014. Due to start of health plan operations in December 2013 and growth in 2014, the inbound and outbound call volume increased significantly throughout 2014. The Call Center staff was increased to accommodate membership needs.

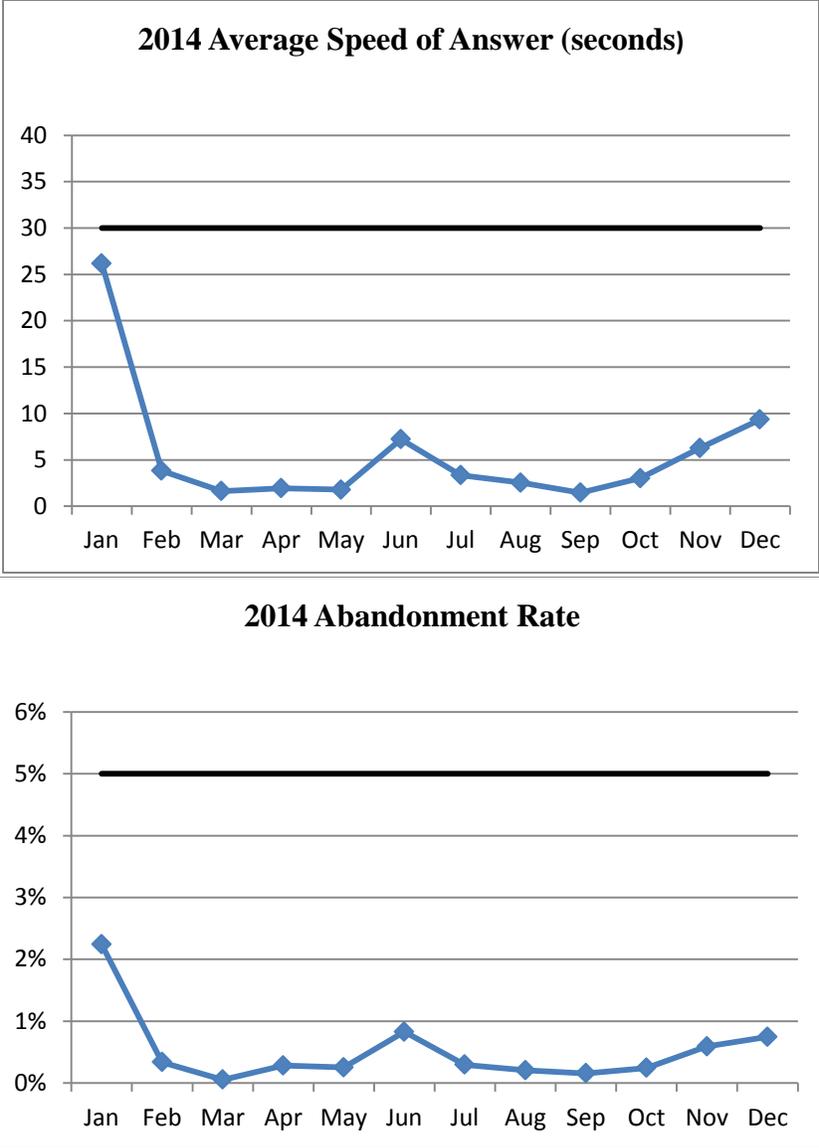
Call Center statistics are monitored on a monthly basis by Centene Corporate through the automatic call distribution (ACD) software, and by NHHF's Performance Improvement Team (PIT). NHHF conducts ongoing training of Member Services staff to ensure contract standards are met and/or exceeded. Throughout 2014, NHHF met each Call Center goal. NHHF's goal for Average Speed to Answer (ASA) is 90% of call answered in <30 seconds, the goal for Call Abandonment Rate is <5%, and the goal for overall Service Level is $\geq 90\%$.

As noted, NHHF Member Services’ call standards were met in each quarter in 2014. Call volume fluctuated between a low of 3178 calls in May 2014, and a high of 6367 calls in September 2014. The Average Speed of Answer has also fluctuated, between 26 seconds in January 2014 to 1 second in September 2014. The Abandonment Rate ranged from .1% in March, to a high of 2.2% in January. The Service Level of 90% of calls answered in 30 seconds was met in all four quarters in calendar year 2014. The NHHF Call Center results are displayed below:

Metric	Q1	Q2	Q3	Q4	2014 Average	Goal Met? Yes or No
% answered within 30 seconds	93.6%	95.9%	97.8%	94.1%	95.5%	Yes
Abandonment Rate	1.1%	0.5%	0.2%	0.5%	0.6%	Yes

2014 Call Statistics	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Call Volume	5661	3564	3757	3533	3178	4957	6109	5814	6367	6116	4902	5361
ASA (seconds)	26	4	2	2	2	7	3	3	1	3	6	9
Service Level	87.8%	97.4%	98.8%	98.0%	98.5%	92.7%	96.6%	97.8%	99.0%	96.9%	93.3%	91.8%
Abandonment Rate	2.2%	0.3%	0.1%	0.3%	0.3%	0.8%	0.3%	0.2%	0.2%	0.2%	0.6%	0.7%





NHHF will continue to monitor Member Services call activity to ensure the contractual requirements/NHHF’s goals are being met. If deficiencies are identified, corrective action plans will be implemented.

Care Delivery/Performance Measures and Outcomes

In collaboration with the DHHS Quality Strategy, NHHF is actively engaged in improving the following eight (8) quality indicators, through planning and implementation of intervention strategies aimed towards sustained improvement over time.

Quality Improvement Programs (QIPs)

- Adult satisfaction with access to care (Adult CAHPS survey question)

- Parental satisfaction with access to care for children (Child CAHPS survey question)
- Timely pre-natal visits during first trimester of pregnancy (HEDIS PPC- Pre-natal)
- Behavioral health follow up after hospitalization with mental health diagnosis (HEDIS FUH- 7 Day)

Performance Improvement Programs (PIPs)

- Diabetes-vision screening for adults with diabetes (HEDIS CDC- Eye)
- Diabetes screening for patients with bipolar or schizophrenia on antipsychotic medications (HEDIS SSD)
- Well Child visits, ages 3-6 (HEDIS W34)
- BMI assessment and nutritional and activity counseling for children (HEDIS WCC)

Member Experience

In 2014, NHHF had an off-cycle CAHPS Satisfaction survey administered by New Hampshire's Department of Health & Human Services survey to identify areas in need of improvement in order to meet the membership's needs. Results are reviewed at the regularly-scheduled multidisciplinary Performance Improvement Team meetings. Discussions include the CAHPS member satisfaction results, complaints and recent disenrollment survey data to identify areas in need of improvement and ongoing and proposed interventions regarding improving member experiences and access to care.

Quality Improvement Activities

In 2014, NHHF conducted the following quality improvement activities:

- Four (4) Quality Improvement Committees meetings, with external physician participation;
- Four (4) Utilization Management Committee meetings, with external physician participation;
- Four (4) Pharmacy and Therapeutics (P&T) Committee meetings with external physician participation;
- Performance Improvement Team (PIT) meetings throughout the year;
- HEDIS Steering Committee meetings throughout the year;
- Joint Operating and Operations (JOC) meetings with NHHF vendors/ sister organizations throughout the year.
- Conducted Grievance and Appeals Committee meetings throughout the year;
- Continued a comprehensive review and tracking of reported of member grievances, appeals, and quality of care investigations;
- One (1) Peer Review Committee (PRC) meeting, with external physician participation;

- Member grievances and quality of care incident ongoing monitoring presented to the Credentialing Committee twice in 2014;
- Performed ongoing evaluation of provider access and availability and completed annual appointment wait time and network adequacy reporting with follow-up in areas needed;
- Member Advisory Board Committee meetings convened;
- Member disenrollment calls completed.

In 2014, being the first full year of health plan operations, NHHF began several initiatives aimed to improve the health of the members and the healthcare NHHF contracted providers offer to their patients.

Quality Improvement Interventions

Member Newsletters

NHHF produced and distributed four (4) Member Newsletters in English and Spanish to all enrolled members. The newsletters included health-related articles and tips educating members about recommended preventive services and screenings, as well as how to make healthy choices. Newsletter topics included: women's preventive screenings and the recommended frequency, tobacco cessation, flu and cold symptoms, importance of getting the flu vaccination, heart health, staying on top of your diabetes/recommended screening tests, healthy eating suggestions, NHHF's Case and Disease Management programs, and much more.

Diabetes Report Card

NHHF distributed a four-page personalized health "report card" to 538 NHHF members that are in the Comprehensive Diabetes Care (CDC) HEDIS population. The report card included educational information on the four recommended screening tests members should have completed annually. Based on the current claims data available at the time of distribution, the postcard informed the members which of the four tests had been completed. The report card explained each of the tests, their importance, and what the results should be to be considered in the healthy range. Further, the member was encouraged to share the report card with their doctor to determine what, if any, next steps should be taken. The member was also informed that the report card was available in Spanish upon request.

Annual Diabetes Eye Exam

NHHF partnered with OptiCare, NHHF's vision care vendor and a sister organization, on a diabetic eye intervention. OptiCare representatives conducted a member intervention that consisted of outbound calls to 977 members who were showing as non-compliant in receiving their annual diabetic eye exam. Assistance in scheduling an appointment was offered, and if an appointment was made, the provider received a fax confirmation with the member information and date and time of the appointment. At this time, claims analysis is unavailable and therefore NHHF cannot determine how many members obtained their exam after the intervention.

Health Coaching

NHHF also partners with Nurtur, NHHF's disease management vendor and a sister organization on a diabetes program. Nurtur employees Health Coaches who are Certified Diabetes Educators that teach participants and/or their parent or caregiver how to control blood glucose levels,

comply with recommended screenings, promote healthy eating habits, and encourage regular physical activity. The diabetes program provides health coaching and support delivered through telephonic coaching and educational materials. Nurtur coaches also address lifestyle barriers, self-management skills, and promote adherence to prescribed treatment guidelines in order to minimize the development and/or progression of diabetic complications. Members are identified for enrollment based on medical and pharmacy claims data. Members may also be referred to the program by a health plan physician, case manager or self-referral. NHHF believes this effort also helps educate members and better the health of NHHF members with diabetes. Nurtur also conducts health coaching for members with asthma, heart disease, weight management and tobacco cessation needs.

Reminder cards for yearly well child MD visits

NHHF sent 2,742 mailings in December 2014 to parents of children (members) to remind them of the importance of bringing children in for their annual physical examination.

Mammogram reminders

Reminders were sent to 2,904 female members in December 2014 who were identified as in need of mammograms.

Smoking Cessation Mailers

In November 2014, NHHF mailed 4,961 educational flyers to members identified as using nicotine, to encourage smoking cessation behaviors and offer smoking cessation assistance.

2014 Provider Specific Interventions

Newsletters

Provider newsletters were developed and posted to the NHHF website in 2014. The provider newsletters contain information on the quality improvement program, recommended preventive services and screenings for their patients, healthy tips to share with their patients, and information about diseases and conditions relevant to the NHHF membership.

Chlamydia Screening

NHHF conducted a targeted PCP provider letter mailing in the fall of 2014. Each PCP with non-compliant members on their member panel received a letter offering information on the importance of the screening as well as a list of the members due for their screening. NHHF requested that each provider outreach to the members to schedule the screening, or send medical record confirmation that the member had received their recommended screening during the measurement year. 500 providers received this outreach, impacting 982 members.

HEDIS Educational Letters

716 letters were sent to providers informing them of the Performance Improvement Project on the WCC measure-Weight Assessment and Counseling for Nutrition and Activity for children- and the documentation required to meet this measure.

1,052 letters were sent to providers informing them of a new HEDIS measure and the Performance Improvement Project on SSD-screening for diabetes for patients on antipsychotic medications who have schizophrenia or bipolar illness.

Quality Measures Successes and Opportunities

Based on the NHHF January 2015 HEDIS data run, the following measures are trending in positive directions toward NCQA Quality Compass benchmarks:

- (AAP) Adult Access to Preventative/Ambulatory Health Services, ages 20-44
- (AAP) Adult Access to Preventative/Ambulatory Health Services, ages 45-64
- (AAP) Adult Access to Preventative/Ambulatory Health Services, ages 65+
- (FUH 30) Follow up after BH hospitalization-30 days
- (FUH 7) Follow up after BH hospitalization-7days
- (URI) Appropriate treatment for Children with Upper Respiratory Infection

NHHF HEDIS 2015 (MY 2014) Measure	HEDIS 2015 (MY 2014) 12/5/14 Run	HEDIS 2015 (MY 2014) 1/13/15 Run	Medicaid HMO 50% Percentile 2013	Medicaid HMO 75% Percentile 2013	Medicaid HMO 90% Percentile 2013
Adults' Access to Preventive/Ambulatory Health Services (AAP) ages 20-44	86.67%	88.26%	83.27%	86.21%	88.52%
Adult's Access to Preventive/Ambulatory Health Services (AAP) ages 45-64	93.14%	94.30%	88.74%	90.98%	92.16%
Adult's Access to Preventive/Ambulatory Health Services (AAP) ages 65+	86.16%	87.48%	88.28%	90.70%	92.61%
Follow-Up aft Hops MH (FUH)	81.86%	85.26%	64.63%	74.09%	80.34%
Follow-Up aft Hops MH (FUH)	59.07%	60.96%	42.30%	54.45%	63.21%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)	92.23%	92.17%	86.11%	91.21%	94.39%

NHHF identified opportunities for improvement for the following measures:

- (CDC Eye) Eye exams for people with diabetes
- (W34) Well Child Exams for children ages 3-6

NHHF HEDIS 2015 (MY 2014) Measure	HEDIS 2015 (MY 2014) 12/5/14 Run	HEDIS 2015 (MY 2014) 1/13/15 Run	Medicaid HMO 50% Percentile 2013	Medicaid HMO 75% Percentile 2013	Medicaid HMO 90% Percentile 2013
Comp Diabetes Care (CDC)Eye Exam	37.03%	45.67%	54.10%	63.14%	68.04%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	63.98%	75.22%	71.76%	77.26%	82.69%

NHHF conducted barrier analysis for the following HEDIS measures in order to identify potential opportunities for improvement and interventions. Interventions began in 2014 and will continue throughout 2015:

Barriers: CDC-Retinal Eye Exam	Plan
Inability to contact members via mail and phone due to incorrect/ outdated member demographic information.	For returned mail, NHHF call center representatives contact the member to verify and update mailing address.
The member outreach project started with Opticare later than desired.	NHHF verifies member demographics on incoming calls to ensure the Plan has the most up to date contact information on file.
First year of a measure that captures two years of data.	Improved timelines for 2015.
NHHF members are new to managed care and are unfamiliar with the new provider network.	Improving HEDIS score relies heavily on medical record review.
	Improve communication regarding available network providers and inform members that NHHF can assist in finding providers.

Barriers: Well Child Visits (W34)	Plan
Providers do not always document or accurately bill with correct codes.	NHHF will continue to educate providers on accuracy of documentation to capture applicable visits for this population.
HEDIS scores rely heavily on medical	Perform targeted chart reviews to capture

<p>record review.</p> <p>Parents/guardians of children may not always be aware of the importance of annual well visits</p> <p>NHHF members are new to managed care and are unfamiliar with the new provider network.</p>	<p>positive results.</p> <p>NHHF will mail reminders, and educate parents/guardians of children during telephonic interactions and via the Member Newsletter to stress the importance of well visits.</p> <p>Improve communication regarding available network providers and inform members that NHHF can assist in finding providers.</p>
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Preventive Health and Clinical Practice Guidelines

NHHF analyzes membership data to determine at risk members and develop programs that will facilitate better health outcomes. To address the needs of this at-risk population, NHHF has developed and adopted specific preventive health and clinical practice guidelines. These guidelines facilitate preventive health services and enhance NHHF’s case management programs. Guidelines are reviewed and revised annually as needed. NHHF’s adopted preventive health and clinical practice guidelines are evidence based, and adopted from recognized sources. The guidelines are incorporated in NHHF’s disease management programs, and work in synergy with the disease management vendor, Nurtur.

Preventive Health and Clinical Practice Guidelines are available to the NHHF provider network through the Provider website and by request. They also are referenced in the Provider Newsletter and Provider Manual, and hard copies are available upon request. Examples of the guidelines include, but are not limited to topics such as: Pediatric Preventive Care, Immunizations, Heart Failure, Diabetes, Asthma, Chronic Lung Disease and Hypertension.

Member Experience Survey

In 2014, HSAG conducted an off-cycle CAHPS survey (both Adult and Child) per a contract with New Hampshire’s Department of Health & Human Services for all MCOs in New Hampshire. Results are currently being stratified by health plan, including NHHF. NHHF’s Performance Improvement Team will meet regularly in 2015 to discuss the CAHPS member satisfaction survey results, complaints, and recent disenrollment survey data to identify areas in need of improvement. When the CAHPS results are analyzed, NHHF will implement an action plan to improve member satisfaction based on the survey findings. A multidisciplinary team has been formed to educate staff on the importance of member experience and the importance of sustained improvement.

Member Grievances

The member grievances received by NHHF between January 1, 2014 and December 31, 2014 were evaluated and the totals by category were as follows:

- Coverage & Benefits - 13
- Systems & Materials - 17
- Attitude & Service - 42
- Access - 2
- Billing & Financial - 0
- Quality of Practitioner Office Sites - 0
- Quality Of Care - 0

NHHF’s QI Department tracks and monitors all member grievances, including tracking of type of grievance, and timeliness of resolution.

Patient Safety

Patient safety is a key focus of NHHF’s QI program. Monitoring and promoting patient safety is integrated throughout many activities across NHHF, but primarily through identification of potential and/or actual quality of care events. A potential quality of care (QOC) issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care, or that signals a potential sentinel event, up to and including death of a member. Below are the results of quality of care investigations for 2014:

2014 Quality of Care Investigations	
Total QOC cases received:	27
Dissatisfied with care	4
Inadequate discharge planning	4
Adverse medical event	1
Adverse surgical event	2
Lack of Physician Oversight for Narcotics	5
Unplanned readmission	5
Falls	2
Pending cases	4
Average days to close:	
Average days to close:	43
Total cases closed within 30 days:	5
Percent closed within 30 days:	21.7%
Total cases closed within 45 days:	10
Percent closed within 45 days:	43.5%
Closure Severity Level:	
Level 0:	13
Level I:	6
Level II:	3
Level III:	1
Level IV:	0

Four cases remained open at the end of 2014 due to pending receipt of medical records. In 2014, NHHF identified the need to add two additional categories for QOC cases. These categories were “Lack of physician oversight when prescribing narcotics for non-cancer pain” and “Falls”.

There was one facility with a total of six QOC incidents in 2014. Three of the six cases were rated a severity level of 0. Two cases were rated a severity level 1 and one case was rated a severity level of 2. There was a trend noted with unplanned readmissions with this facility as three of the six cases were in this category. A letter was sent by the NHHF Medical Director to the facility Medical Director, encouraging the facility to perform a root cause analysis on the particular cases, and to review their systems and processes regarding transitions of care and medication reconciliation.

There was one case rated a severity level of 3. This case was referred to the Peer Review Committee and resulted in a corrective action letter being sent to the involved providers.

No other trends regarding quality of care incidents were noted in 2014, and there were no barriers identified. The grid below describes NHHF’s definitions for quality of care incidents severity levels:

Level 0	Investigation indicates acceptable Quality of Care has been rendered.
Level I	Investigation indicates that a particular case was without significant potential for serious adverse effects, but could become a problem if a pattern developed.
Level II	Investigation indicates that a particular case demonstrated a moderate potential for serious adverse effects.
Level III	Investigation indicates that a particular case has demonstrated a significant potential for serious adverse effects.
Level IV	Investigation indicates that a particular case has demonstrated a serious, significant adverse outcome.

Credentialing

The Credentialing Committee is a standing subcommittee of the QIC and oversees and has operating authority of the Credentialing Program. The Credentialing Committee facilitates timely review of practitioners and providers and met 12 times in 2014. The following table displays the NHHF Credentialing information for 2014:

Total number of practitioners in network (includes delegated providers) as of 12/31/2014	5571
Initial Credentialing	
Number practitioners initially credentialed in 2014	1005 (329 PCP; 676 Specialists)
Number of practitioners credentialed within 30 days of completed application - PCPs	299
% credentialed timely	91%
Number of practitioners credentialed within 45 days of completed application - specialists	639

% credentialed timely	95%
Recredentialing	
Number practitioners recredentialled in 2014	NA
Number practitioners recredentialled within 36 months	NA
% recredentialled timely	NA
Terminated/Rejected/Suspended/Denied	
Number with cause	0
Number denied	4

Delegated Vendors and Sister Companies Oversight

NHHF does not delegate QI function to any external (non-Centene Corporation) entity or organization.

NHHF Vendor Oversight - Joint Operations Committees (JOCs) & Annual Onsite Audits

NHHF conducts oversight meetings, referred to as JOCs, for vendors with delegated service agreements, including Centene specialty companies. The JOC meetings are attended by both health plan and vendor staff. The meetings review the vendor's compliance with the delegation service agreement. It also serves as an opportunity to review the issues and identify opportunities for improvement. Each vendor was reviewed at least twice during the course of during the course of the 2014.

Annual oversight audits are completed by Centene Corporate. Centene Corporate deploys a team of auditors to the vendor's headquarters to review files and interview vendor staff. Each vendor received a corporate onsite audit to measure their performance against their contract with NHHF.

Overall Effectiveness of the QI Program

In summary, NHHF's annual evaluation determined that the resources allotted to the QI Program are appropriate regarding staffing, information technology, and corporate resources. The committee structure provides for adequate direction and commitment to quality starting with the QIC, as well as through the subcommittees reporting to the QIC. NHHF senior management is involved in the QI Program through the QIC and applicable subcommittees, indicating senior management's commitment to quality. Network practitioners are actively involved and encouraged to participate in the QIC and its subcommittees. NHHF has identified a need to increase external physician/practitioner involvement in the QI Program, and will continue to recruit additional practitioners in 2015. As NHHF matures as a health plan, and gains more experience in the New Hampshire managed Medicaid market, the QI Program is expected to continue to gain strength and effectively improve the care delivery.



**Well Sense Health Plan
Quality Assessment and Performance
Improvement (QAPI) Semi-Annual Update Report
(QAPI.02)**

March 31, 2015

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Section 1: Executive Summary

The 2014 Quality Assessment and Performance Improvement (QAPI) Work Plan update is based on the Well Sense Health Plan (Well Sense, the Plan) Quality Improvement (QI) Program's 2014 Annual Work Plan. This document provides information on ongoing quality activities including project names, goals, data, identified barriers and actions taken during 2014. All goals detailed within were goals for 2014 unless specifically noted in the project grid. This update shows that the Plan has actively worked towards improving the quality of care and services to members and has continuously promoted safe clinical practices. Activities identified as "ongoing" have been carried over to 2015 as they continue to be implemented and address project goals.

The March 31st update outlines changes within the work plan including measures that were added or retired, changes in project leads, updates to interventions, and measurement period changes. All changes are documented throughout the work plan. The Plan monitored and adjusted projects throughout the year when appropriate.

Most of the measures in the work plan are Healthcare Effectiveness Data and Information Set (HEDIS[®]) and Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) based. As a result, some projects may have preliminary baseline data for calendar year 2014. Once HEDIS and CAHPS data are available, Well Sense will update the Work Plan with final rates. Results will be used to adjust and develop new goals for calendar year 2016. A final analysis for each project will be provided in the final submission in September 2015.

Overall Accomplishments

In 2014, Well Sense successfully implemented many activities and established processes to help identify and educate members regarding appropriate preventive care and self-management of chronic conditions. The Plan actively engaged with many provider groups throughout the state to promote quality improvement activities and educate providers on best practices. The Plan also engaged with statewide collaboratives to help align quality improvement activities. Additionally, Well Sense successfully implemented a multidisciplinary Wellness and Disease Management workgroup to develop and implement member and provider focused interventions. The Plan continues to monitor the Well Sense membership for prevalence of conditions and trending data.

Overall Barriers

Well Sense does not have access to continuous enrollment data prior to December 1, 2013. This impeded the Plan's ability to generate HEDIS rates specific to some of the projects in the work plan throughout 2014. Additionally, the Plan identified one project currently at risk, Provider Satisfaction, due to issues with reporting.

QAPI Oversight

The QAPI Work Plan is presented to the Quality Improvement Committee (QIC), Quality and Clinical Management Committee (Q&CMC) and the Board of Trustees for review and approval. Progress during the year is monitored by both the QIC and the Q&CMC.

QAPI Projects

This document details activities carried out in 2014. Activities identified as ongoing have been carried over to 2015. The sections identified in the project grids are updated as follows:

- **Post-approval Change Log:** This section details any changes made to the Program Description, Measurement & Goal, or Project Team sections since the last approval date. Significant post-approval changes to other sections may also be noted in the Change Log for ease of formatting.
- **Description and implementation date:** These sections contain specific details of actions and actual dates they were completed.
- **Additional Actions Implemented:** This section is completed for any additional interventions implemented that were not outlined in the previously approved Work Plan.
- **Barriers Encountered:** This section is updated throughout the year as barriers are identified.
- **Measurement Milestones:** This section is updated with interim data throughout the year to track progress towards the goals.
- **Final Analysis:** This section will be completed for the QAPI Work Plan Evaluation once all data are available.

This document will be updated and also serve as the annual QAPI Work Plan Evaluation, once data are available and the final analysis is completed.

Section 2: QAPI Projects Semi-Annual Updates

Diabetes Program

Diabetes Program		Post-Approval Change Log
Program Description		
<p>According to the Center for Disease Control’s 2011 National Diabetes Fact Sheet, diabetes affects 25.6 million Americans (age 20 and over {diagnosed and undiagnosed}). Diabetes causes increased risk of heart attack and stroke, blindness, kidney disease and neuropathy.</p> <p>Research demonstrates that effective management reduces these complications. The program is aimed at improving the quality of life and self-management skills of members through educational materials, care management and actionable provider reports.</p>		
Measurement & Goal		
Performance Improvement Project (HbA1c testing)		<p>▲ HEDIS retired the following measures from the HEDIS 2015 measure set: LDL-C screening, LDL-C control, and BP<140/80.</p> <p>▲ Added BP<140/90 to measures.</p> <p>▲ Per HSAG, PIP measurement period changed to calendar year.</p> <p>▲ Due to the change in the measurement period for the PIP, HEDIS hybrid measures will supplement administrative data.</p> <p>▲ The Plan replaced diabetes LDL-C screening with HbA1c testing as one of the EQRO Performance Improvement Projects (PIP). This new PIP topic was submitted to HSAG on April 1, 2014.</p>
HEDIS 2015 specifications and rates		
Measure	Goal	
HbA1c testing	Establish baseline	
LDL-C screening	<i>Retired measure</i>	
LDL-C < 100	<i>Retired measure</i>	
Eye exams	Establish baseline	
Nephropathy screening	Establish baseline	
BP <140/80	Retired measure	
BP<140/90	Establish baseline	
Project Team		
Lead: Susan Vermette, RN		Was: Christine Dubuc, RN
Medical Director: Karen Boudreau, MD		

2014 Actions			
Action	Expected date	Description	Implementation date
Orient providers to the diabetes disease and care management program and quality initiatives promoting diabetes self-management and compliance with recommended diabetes screenings.	December 2014	Providers are oriented to diabetes disease and care management programs, quality initiatives, and member self-management tools during provider orientation. Information about the diabetes care management program is included in the Provider Manual and in the orientation slides on the Plan’s provider website.	October 2013 and ongoing

2014 Actions			
Action	Expected date	Description	Implementation date
Provide a link on the Plan’s website to the most recent American Diabetes Association clinical practice guideline. Hard copies of the guideline are available on request.	December 2014	A link to the current American Diabetes Association clinical practice guideline is available on the Plan’s website.	December 2013 and ongoing
Send actionable reports regarding members in need of diabetic screenings to providers semi-annually.	December 2014	The first Diabetes Treatment Advisory Reports (DTAR) were mailed in December 2014 to 20 primary care providers (PCP), 2 endocrinologists, and 2 other prescribers, for a total of 25 members identified. These reports identified members who are on 3 or more unique noninsulin antidiabetic agents, and/or members with the following lab results: HbA1c \geq 8 and/or LDL-C \geq 100 mg/dL.	December 2014 and ongoing semi-annually
Provide diabetes care management (CM) and disease management (DM) Programs.	April 2014	Care Management is offered to members with diabetes identified through the Plan’s registry (beginning in April 2014), Health Risk Assessment, and provider or member referrals. In 2014, 132 members were actively managed in care management for diabetes.	April 2014 and ongoing
Utilize Plan registries to identify members for possible CM, DM and mailings.	April 2014	In April 2014 the Plan implemented a care management registry to identify members with diabetes. The registry is utilized to identify members for the care management program.	April 2014 and ongoing
Mail Diabetes Self-Management information to all diabetics.	December 2014	Information on diabetes self-management is mailed to members identified as having diabetes through the registry and from other sources (i.e. HRA). Mailings sent in 2014 include: <ul style="list-style-type: none"> • Diabetes Heart Health mailer sent February 2014 to 797 members. • Diabetes Self-management mailer sent March 2014 to 770 members. • Diabetes Eye Health mailer sent April 2014 to 961 members. • Diabetes HbA1c mailer sent May 2014 to 1,189 members. 	February 2014 and ongoing
Use the Plan’s website to promote diabetes chart reminders for providers with paper medical records.	N/A	The Plan did not implement this intervention after further analysis of electronic health record (EHR) utilization in NH. The Plan identified that over 50% of the provider groups already use EHRs and no longer use paper records. Additionally	N/A

2014 Actions			
Action	Expected date	Description	Implementation date
		the Plan confirmed limited use of these reminders in the Massachusetts product during 2014.	
Promote Plan website as resource for additional educational material on diabetes.	March 2014	Member and provider mailings refer members to the Well Sense Health Plan website for further information. Diabetes self-management is promoted on the Health Topics page of the Plan’s website. The diabetes webpage was launched in March 2014. The diabetes webpage has had approximately 548 unique page views since going live.	March 2014 and ongoing
Mail educational diabetes material to members enrolled in CM.	January 2014	Members enrolled in diabetes care management are mailed educational packets and Krames Health Sheets which are also available to all members on the Well Sense Health Plan website.	January 2014 and ongoing
Include article on diabetes care in both Member and Provider Newsletters.	December 2014	The Plan promoted the American Diabetes Association clinical practice guideline in the April 2014 Well Sense Health Plan Provider Newsletter. The Plan did not distribute a member newsletter in 2014.	April 2014 and ongoing
Well Sense Health Plan will participate in all MCO meetings related to diabetes.	December 2014	The Plan participates in quarterly DHHS quality meetings. Since November 2014, the Plan has been working collaboratively with DHHS diabetes programs to align initiatives.	January 2014 and ongoing

Additional Actions Implemented		
Action	Description	Implementation date
Provider Quality Incentive Program (QIP)	Provider groups are given the opportunity to participate in the Plan’s QIP. In calendar year 2014, 11 out of 39 provider groups selected the HEDIS HbA1c testing measure.	February 2014 and ongoing

Barriers Encountered
Data to identify members with diabetes based on HEDIS criteria throughout 2014 could not be generated due to lack of eligibility data to calculate continuous enrollment prior to December 1, 2013.
Some diabetes educational materials (i.e. diabetes calendar) for both members and providers were delayed to 2015.
Actionable provider reports were delayed due to the lack of historical data for members to confirm gaps in diabetes care.
The following HEDIS measures were retired for HEDIS 2015: LDL-C screening, LDL-C control, and BP less than 140/80

Measurement Milestones							
Measure	Baseline 1/1/2014 -12/31/2014	Goal	Current	Progress toward goal			Goal met?
HbA1c testing*	75.14% (535/712)	Establish baseline	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Yes
LDL-C screening	<i>Retired Measure</i>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A
LDL-C < 100	<i>Retired Measure</i>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Eye exams*	36.80% (262/712)		N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Yes
Nephropathy screening*	65.03% (463/712)		N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Yes
BP<140/80	<i>Retired Measure</i>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A
BP <140/90*	0.84% (6/712)		N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Yes

*Preliminary administrative rates. Final rates will be submitted in the September 2015 submission.

Final Analysis

Status: (Please Check)

- On Track
- At Risk

Asthma Program

Asthma Program		Post-Approval Change Log
Program Description		
This project aims to improve the health of members with asthma by promoting interventions that improve member self-management and raise provider awareness of asthma guidelines and medication compliance.		
Measurement & Goal		
Measure	Goal	Δ Per further analysis of available New Hampshire Medicaid data, the Plan is no longer using the Asthma Program as one of the EQRO Performance Improvement Projects.
Percentage of members with asthma identified by the Plan that are sent member education material	Establish baseline	
Percentage of providers oriented to actionable reports	Establish baseline	
Project Team		
Lead: Susan Vermette, RN		Was: Christine Dubuc, RN
Medical Director: Karen Boudreau, MD		

2014 Actions			
Action	Expected date	Description	Implementation date
Orient providers to the asthma care and disease management programs and quality initiatives promoting asthma control and self-management.	December 2014	Providers are oriented to asthma disease and care management programs, quality initiatives, and member self-management tools during provider orientation. Information on care management programs are included in the Provider Handbook and orientation slides available on the Plan’s provider website.	October 2013 and ongoing
Maintain link on Plan’s website to National Asthma Education and Prevention Program (NAEPP)/National Heart Lung Blood Institute (NHLBI) Asthma clinical practice guideline.	December 2014	A link to the asthma clinical practice guideline is available on the Plan’s website.	December 2013 and ongoing
Mail actionable reports annually to PCPs and specialists identifying members with persistent asthma and the dates of their most recent ED visits and hospitalizations related to asthma in the past 12 months.	December 2014	Actionable asthma reports could not be distributed to providers until January 2015 to allow enough time to appropriately identify members with asthma using HEDIS criteria suppressing one of the two years of continuous enrollment required. With one month of claims lag the Plan was able to distribute the Asthma Treatment Advisory Reports (ATAR) in January 2015. This report identifies members with asthma who did not have a pharmacy claim for an asthma controller medication within the previous 60 days however did have one or more pharmacy claims for a rescue inhaler medication within the same time period.	January 2015 and ongoing

2014 Actions			
Action	Expected date	Description	Implementation date
		This report was mailed to 84 PCPs and specialists, representing 92 members.	
Mail seasonal asthma postcards with targeted messages.	April 2014	In 2014 the Plan used the care management registry and member self-reported data from the Health Risk Assessment to identify members with asthma. In 2014, seasonal asthma postcards were mailed to members with asthma in: <ul style="list-style-type: none"> • April (3,888 members) • July (4,359 members) • November (5,307 members) 	April 2014 and ongoing
Promote Plan website as resource for additional educational material on asthma.	December 2014	The Plan’s website address is included on the asthma post cards. Asthma self-management is promoted on the Health Topics page of the Plan’s website.	December 2013 and ongoing
Well Sense Health Plan will participate in all MCO meetings related to asthma.	December 2014	Well Sense Health Plan actively participates in the NH Asthma Collaborative and the NH Healthy Homes Steering Committees.	January 2014 and ongoing
Promote the use of the Asthma Control Test (ACT) to providers and members with asthma.	December 2014	The Asthma Control Test (ACT) has been promoted to Providers in the National Heart, Lung, and Blood Institute asthma clinical practice guideline which is available on the Plan’s website. The ACT was also promoted to providers in the ATAR report.	December 2013

Additional Actions Implemented		
Action	Description	Implementation date
Sponsored asthma camp at Zebra Crossings in Dover, NH	The Plan supported Camp Spinnaker and their mission to educate and support children with asthma. Camp Spinnaker offers a supportive community that provides children with the tools needed to manage their condition, maintain a healthy lifestyle, and prepare for a successful future. The camp provides scholarships to low income families to ensure access for all children. Well Sense provided bags with inhaler pouches, stickers to identify the types of inhalers, pens, and educational activity books.	August 2014

Barriers Encountered
Data to identify members with asthma based on HEDIS criteria cannot be generated due to lack of eligibility data to calculate continuous enrollment prior to December 1, 2013.
Mailing of ATAR reports to providers was delayed to January 2015 due to the lack of continuous enrollment data to appropriately identify members with asthma using HEDIS specifications.
Mailing of member letters corresponding to ATAR reports was delayed to February 2015 due to revisions of the letter to reduce Flesch-Kincaid reading level, which required internal review, approval by DHHS, and translation into Spanish.

Barriers Encountered
Rate for percentage of providers oriented to actionable reports was 0% in Measurement Milestones as there were no actionable reports distributed until January 2015 due to the lack of continuous enrollment data to appropriately identify members with asthma using HEDIS specifications.

Measurement Milestones					
Measure	Baseline (1/1/14 – 12/31/14)	Goal	Current	Progress toward goal	Goal met?
Percentage of members with asthma identified by the Plan that are sent member education material	100%	Establish baseline	N/A		Yes
Percentage of providers oriented to actionable reports	0%	Establish baseline	N/A		No

Final Analysis

Status: (Please Check)

- On Track
- At Risk

Well-Child Visits 3-6 Year Olds

Well-Child Visits 3-6 Year Olds		Post-Approval Change Log
Program Description		
Historical Data from NH DHHS shows that the CY 2010 NH Medicaid rate of Well-Child visits for 3-6 year olds was 74.2 % which is in the 50th percentile (72.26%) when compared with the 2013 NCQA Quality Compass. The CY 2010 NH Rate based on the NH Medicaid Quality Indicators website was 81.7%.		
Measurement & Goal		
Performance Improvement Project		<p>Please Note: This Performance Improvement Project (PIP) Topic was submitted to Health Services Advisory Group (HSAG), the New Hampshire External Quality Review Organization (EQRO) on April 1, 2014. Data will be analyzed to determine interventions and next steps.</p> <p>Δ Removed the Year two measure goal (achieve statistically significant improvement over baseline) to be more consistent with the measurement periods for the 2014 QI Work Plan projects.</p>
HEDIS 2015 specifications and rates		
Measure	Goal	
Percentage of Well Sense members 3-6 years with a well-child visit.	Establish a baseline rate	
Project Team		
Lead: Susan Vermette, RN		Was: Christine Dubuc, RN
Medical Director: Karen Boudreau, MD		

2014 Actions			
Action	Expected date	Description	Implementation date
Analyze the baseline data to identify appropriate interventions to increase the well-child visit rate for 3-6 year olds.	2014 and ongoing	Initial well-child visit data for 3-6 year olds were analyzed using HEDIS specifications to identify opportunities for improvement and develop and implement member and provider interventions. Further drill down of the data was performed to identify any disparities based on age, region, race, language, and provider group.	2014 and ongoing

Final Analysis

Status: (Please Check)

- On Track
- At Risk

Chlamydia Screening

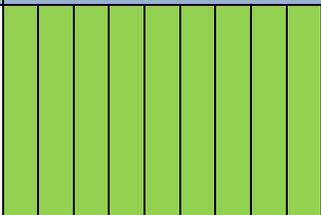
Chlamydia Screening		Post-Approval Change Log
Program Description		
Historical Data from NH DHHS shows that the calendar year (CY) 2010 NH Medicaid rate for Chlamydia Screening was 39.3% which is less than the 10th percentile (46.22%) when compared with the 2013 NCQA Quality Compass. The CY 2010 NH Rate based on the NH Medicaid Quality Indicators website was 36.1%.		
Measurement & Goal		
Performance Improvement Project		<p>Δ Updated the measure to align with HEDIS description.</p> <p>Δ Removed the Year two measure goal (achieve statistically significant improvement over baseline) to be more consistent with the measurement periods for the 2014 QI Work Plan projects.</p>
HEDIS 2015 specifications and rates		
Measure	Goal	
% Well Sense female members 16-24 years old who were identified as sexually active and had at least one test for chlamydia within the measurement period.	Establish a baseline rate	
Project Team		
Lead: Susan Vermette, RN		Was: Christine Dubuc, RN
Medical Director: Karen Boudreau, MD		

2014 Actions			
Action	Expected date	Description	Implementation date
Analyze baseline data and identify interventions to improve the rate.	2014 and ongoing	<p>Initial chlamydia screening data for female members 16-24 years old were analyzed using HEDIS specifications to identify opportunities for improvement and develop and implement member and provider interventions to increase the chlamydia screening rates.</p> <p>Further drill down of the data was performed to identify any disparities based on age, region, race, language, and provider group.</p>	2014 and ongoing

Additional Actions Implemented		
Action	Description	Implementation date
Provider Quality Incentive Program (QIP)	Provider groups are given the opportunity to participate in the Plan’s QIP. In calendar year 2014, 3 of 39 provider groups participating in the QIP selected the HEDIS Chlamydia Screening measure as their primary measure and 9 provider groups selected this as an alternate measure.	February 2014 and ongoing

Additional Actions Implemented		
Action	Description	Implementation date
Developed and convened Wellness & Disease Management (WDM) Workgroup	An interdepartmental WDM workgroup was developed to review data and develop interventions to improve the health and wellness of members. For 2014, chlamydia screening for women aged 16-24 was a focus of the WDM workgroup.	September 2014 and ongoing

Barriers Encountered
Due to the New Hampshire Medicaid Care Management program starting on 12/1/13, continuous enrollment criteria were not met until 12/1/14 for members that were enrolled with the Plan since 12/1/13. This impacted the Plan’s ability to confirm chlamydia screening compliance within the twelve month measurement period based on HEDIS specifications
Some provider groups are hesitant to offer chlamydia screening to patients, especially adolescents, due to the stigma and possible risk of compromising protected health information with parents or guardians through claims or explanation of benefits documents.
The Plan does not have access to all claims data for chlamydia screenings completed and billed to DHHS grants.
PCPs do not receive notification about Chlamydia screenings performed for their patients by other providers and billed to DHHS grants rather than to the Plan.

Measurement Milestones					
Measure	Baseline (1/1/14 – 12/31/14)	Goal	Current (1/1/14 – 12/31/14)	Progress toward goal	Goal met?
% Well Sense female members 16-24 years old who were identified as sexually active and had at least one test for chlamydia within the measurement period.	42.27%* (648/1,533)	Establish baseline	N/A		Yes

*Preliminary administrative rates. Final rates will be submitted in the September 2015 submission.

Final Analysis

Status: (Please Check)

- On Track
- At Risk

Reduce Readmissions to New Hampshire Hospital

Reduce Readmissions to New Hampshire Hospital		Post-Approval Change Log
Program Description		
<p>Evidence suggests that the rate of avoidable behavioral health related re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing coaching, education, and support for patient self-management.</p> <p>Readmissions to New Hampshire Hospital (NHH) can be impacted through cultivation of the network of Community Mental Health Centers (CMHCs) and other community behavioral health providers.</p>		
Measurement & Goal		
Performance Improvement Project		<p>Δ Per HSAG, PIP measurement period changed to calendar year.</p>
Measure	Goal	
30 day readmission rate to NHH	Establish plan baseline, and reduce rate below DHHS baseline:	
60 day readmission rate to NHH	Establish plan baseline, and reduce rate below DHHS baseline:	
90 day readmission rate to NHH	Establish plan baseline, and reduce rate below DHHS baseline:	
Project Team		
Lead: Kim Trvalik, RN		
Medical Director: Reyka Rao, MD		

2014 Actions			
Action	Expected date	Description	Implementation date
Outreach to members that have been discharged to offer assistance with planning aftercare service needs	April 2014	The NHH Liaison meets with every member discharged from NHH to go over their discharge plans. During this reporting period, there were 264 discharges and the NHH Liaison met with 232 unique members.	April 2014 and ongoing
Educate members about their benefits and encourage members to make appointments with their Behavioral Health (BH) providers	April 2014	The NHH Liaison meets with each member prior to discharge to ensure that he/she understands his/her discharge plan and has the information needed for follow up appointments. The NHH Liaison also offers assistance with planning aftercare needs.	April 2014 and ongoing
Complete Assessment of Network Capacity and Access and Availability to BH services	April 2014	Beacon’s Network Department assesses and improves access and availability of BH services to members.	April 2014 and ongoing
Assess common reasons for NHH readmissions through provider focus groups and other forums	April 2014	Beacon will continue to meet with key staff and physicians at NHH twice monthly where such issues are discussed.	April 2014 and ongoing
Work with Community Mental Health Centers (CMHCs) and other	April 2014	The NHH Liaison has participated in a work group at NHH to develop documentation	April 2014 and ongoing

2014 Actions			
Action	Expected date	Description	Implementation date
community providers to offer continuing appointments after initial engagement in care, and establish best practice strategies to promote community tenure		of group notes in readiness for the electronic health record at the hospital.	
Promote best practices by community providers to partner with NHH regarding discharge planning	April 2014	The NHH Liaison at NHH continues to build relationships and improve the discharge process for Well Sense members. The discharge plan at NHH is being filled out more frequently and sent to the NHH Liaison and the outpatient facility, where follow-up with the member will take place.	April 2014 and ongoing
Consider implementation of Assertive Community Treatment models	April 2014	Six of the ten CMHCs have Assertive Community Treatment models in place. Beacon is assessing the extent of continuity among these programs to identify best practices for further implementations of this model of care.	April 2014 and ongoing
Promulgate best practices for member engagement in community services	April 2014	Beacon has conducted trainings and provided resources to the leadership at NHH to support best practices for documentation and effective treatment planning, and is prepared to offer continued trainings upon approval from the hospital.	April 2014 and ongoing

Additional Actions Implemented		
Action	Description	Implementation date
Conduct Inpatient Chart Audits	Conduct annual inpatient chart audits to collect data on the processes, such as communication between inpatient and outpatient providers. Beacon will analyze the data and send feedback to the facilities. In 2014, chart audits were conducted at six inpatient facilities for a total of 137 charts. The average score was 70.32%. Two NHH units were audited with scores of 61.26% and 55.94%.	July 2014 and ongoing
Conduct Outpatient Chart Audits	Conduct annual outpatient chart audits at outpatient facilities to collect data and help identify barriers to care/ services. Beacon will analyze the data and send feedback to the facilities. In 2014, chart audits were conducted at six outpatient facilities for a total of 65 charts. The average score was 73.95%.	July 2014 and ongoing
Established a Technical Assistance Clinician (TAC) Program.	The TAC Program is a process of network management that affords oversight capabilities by partnering and	November 2014 and ongoing

Additional Actions Implemented		
Action	Description	Implementation date
	<p>engaging with contracted providers to ensure proper clinical and operational management. The TAC Program works with the Community Mental Health Centers (CMHCs) to ensure that program operations and service delivery consistently focus on key factors that result in quality and efficacious treatment for members. The program involves:</p> <ol style="list-style-type: none"> 1. Regular TAC meetings. 2. Facilitating CMHC Provider Quality Improvement Plans as needed. 3. Member referral process and service linkage. 4. Individualized treatment planning and frequency of service provider interaction. 5. Inpatient discharge facilitation. 6. Clinical escalation and case rounding. 7. Training and enhancement of service delivery. 8. Oversight and reporting through identified metrics. 9. Collaborating in order to implement the mandates set forth in the Settlement Agreement. 	

Barriers Encountered
Treatment team meetings at NHH may not include all key players, including community treatment providers and Primary Care Physicians (PCPs).
NHH does not invite the NHH Liaison to the treatment team meetings.
Lack of coordination with aftercare providers at discharge meetings may impact community tenure.
NHH continues to discharge child members without a scheduled 7 day appointment and does not inform NHH Liaison of their discharges.
Lack of collaboration at NHH with the key stakeholders and Quality and Utilization Management (UM) Manager.
NHH is implementing an Electronic Health Record (EHR); therefore, managerial staff has prioritized rolling out the software over clinical changes at the facility.
A full discharge summary by the doctor is provided after a member’s discharge versus on the day of discharge.
Clinical groups focusing on coping skills (Dialectical Behavior Therapy, Cognitive Behavioral Therapy, and Illness Management and Recovery) are not provided on a daily basis to members.
Groups are held off the unit which prevents some members from attending.
Family or significant others are not engaged in treatment by the clinical team at the hospital.

Measurement Milestones					
Measure	Baseline (CY2014)	Goal	Current	Progress toward goal	Goal met?
30 day readmission rate to NHH	12.09% (37/306)	Establish plan baseline, and reduce rate below DHHS baseline	N/A		Yes

Measurement Milestones								
60 day readmission rate to NHH	19.93% (61/306)	Establish plan baseline, and reduce rate below DHHS baseline	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Yes
90 day readmission rate to NHH	20.92% (64/306)	Establish plan baseline, and reduce rate below DHHS baseline	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Yes

Final Analysis

Status: (Please Check)

- On Track
- At Risk

Prenatal and Postpartum Care (PPC)

Prenatal and Postpartum Care		Post-Approval Change Log
Program Description		
This project is designed to improve the health of pregnant women by promoting interventions that improve member education and raise provider awareness of timely prenatal and postpartum care		
Measurement & Goal		
Quality Incentive Project (Timeliness of Prenatal Care)		▲ Updated goal for HEDIS 2015 Timeliness of Prenatal Care measure for calendar year 2014 to align with QIP.
Modified HEDIS 2015 specifications and rate and standard HEDIS 2015 specification and rate.		
Measure	Goal	
Timeliness of prenatal care	Meet or exceed the most recent NCQA Quality Compass HEDIS Medicaid HMO 75th percentile.	
Timeliness of prenatal care w/in measurement period (program start – 6/30/14)	Meet or exceed the most recent NCQA Quality Compass HEDIS Medicaid HMO 75th percentile.	
Postpartum Care	Establish baseline	
Project Team		
Lead: Jeanne Murphy, RN		
Medical Director: Karen Boudreau, MD		

2014 Actions			
Action	Expected date	Description	Implementation date
Identify pregnant women using the Plan’s registry, Health Risk Assessment (HRA), self-reporting and other sources of referrals for enrollment in Care Management (CM)	December 2014	The Plan utilizes the Plan’s registry, Health Risk Assessment, provider and member self-referral, and referrals from internal programs to identify pregnant members. In 2014, the Plan identified and outreached to 1,334 pregnant members.	December 2013 and ongoing
Continue appropriate outreach, engagement of identified pregnant women in the Plan’s Sunny Start Program (CM of pregnant women including prenatal and post-partum care) and manage member’s risk and needs	December 2014	Members are identified and outreached to enroll in the Sunny Start Program, the Plan’s prenatal and postpartum care management program. Members enrolled in the Sunny Start Program are contacted throughout the pregnancy and postpartum to ensure appropriate coordination of care and community resources. Upon enrollment a notification letter is sent to the member’s maternity provider.	Ongoing
Mail educational pregnancy material to members enrolled in CM	December 2014	The Plan distributes both prenatal and postpartum educational packets to members enrolled in the Sunny Start Program. The prenatal packet includes the following materials: “What To Do When You’re Having a Baby” book, Text4baby flyer, WIC – “Grow	Ongoing

2014 Actions			
Action	Expected date	Description	Implementation date
		<p>Healthy”, March of Dimes Smoking/Pregnancy document, Safe Home checklist, “Why the Last Weeks of Pregnancy Count”, Postpartum Post Card.</p> <p>The postpartum packet includes the following materials: “What to Do When Your Child Gets Sick” book, Safe Home checklist, Tobacco Cessation brochure to include NH Tobacco Help Line, 1-800QuitNow and www.trytostopNH.org, Well Sense Health Plan baby bib, Well Sense Health Plan Magnet with important numbers to include Well Sense Member Services, Behavioral Health, Help Lines to include the Poison Center, NH Community Resource Directory, 24 hour Behavioral Health Line, 24 hour Nurse Advice Line, WIC “Be a Healthy Mom” brochure, WIC “Grow Healthy”, NH WIC – Milestones, the National Center on Shaken Baby Syndrome: “Crying Just Doing What Comes Natural” and “Shh Baby’s Sleeping” door hanger, National Child Abuse Hotline, and information from New York State department of Health – www.breastfeedingpartners.org: “I am a Newborn”, “How I can Sit with Some Help”, “How I can Sit on My Own”, CDC “How We Can Protect Our Children from Secondhand Smoke”, Satisfaction Survey with business return envelope.</p> <p>In 2014, 383 prenatal and 232 postpartum packets were mailed to Well Sense members.</p>	
Promote text4baby	December 2014	Text4baby information is included in care management packets and a link is provided on the Plan’s website. In the Sunny Start assessment, members are asked if they are enrolled in or using Text4Baby. If not enrolled in or using the program, they are encouraged to do so.	December 2013 and ongoing
Promote member access to educational health sheets available on Plan’s website	December 2014	Krames health sheets are available in the Health Topics section of the Plan’s website. Care management encourages members to access the health sheets online and prints and sends the health sheets when necessary.	December 2013 and ongoing
Mail Postpartum postcards to pregnant women engaged in CM approximately one month prior to delivery	December 2014	Postpartum postcards reminding members of the importance of a postpartum visit are included in the prenatal and postpartum packets.	December 2013 Ongoing
Promote Plan website as resource for additional	December 2014	The Plan website is promoted as a resource for additional educational material regarding	December 2013 and ongoing

2014 Actions			
Action	Expected date	Description	Implementation date
educational material regarding pregnancy, well child visits and immunizations.		pregnancy, well child visits and immunizations during care management calls.	
Identify obstetrical network providers for Sunny Start program education.	December 2014	The Sunny Start Program is included in the provider orientation slides on the Plan’s website for all providers.	December 2013 and ongoing
Provide a link on the Plan’s website to the most recent Institute for Clinical Systems Improvement (ICSI) Prenatal Care Guideline. The guideline is used for identification of high risk pregnancies, screening and follow-up. Hard copies of the guideline are available on request.	December 2014	A link to the most current ICSI Prenatal Care Guideline is available on the Plan’s website and updated as needed.	December 2013 and ongoing

Additional Actions Implemented		
Action	Description	Implementation date
Postpartum Diaper Incentive	To encourage members to go to a postpartum visit 21-56 days after delivery, the Plan implemented a postpartum visit diaper incentive. Members are provided a form to complete and have their provider sign confirming that the postpartum visit occurred within 21-56 days after delivery, members then receive a free box of diapers. This incentive is promoted through care management, prenatal and postpartum packets, and the website.	December 2014 and ongoing

Barriers Encountered
The initial volume of pregnant women identified in the enrollment files was greater than anticipated, making successful contact with all pregnant members difficult.
Members are not always identified early in pregnancy to help ensure appropriate appointments are kept.
Providers schedule follow-up visits for members who had cesarean sections for two weeks following delivery and then the postpartum visit is beyond the 56 day HEDIS timeframe.
Members may not keep postpartum visits within the appropriate HEDIS time frame.
Members do not attend the postpartum visit even though when speaking with care management staff they state they plan to keep the appointment and deny the existence of barriers.

Measurement Milestones					
Measure	Baseline (HEDIS 2015)	Goal	Current (1/1/2014 – 12/31-2014)	Progress toward goal	Goal met?
Timeliness of prenatal care	55.86%* 705/1262	89.62%**	N/A		In progress

Measurement Milestones						
QIP: Timeliness of Prenatal Care (12/1/13 – 6/30/14)	92.63% (355/383)	89.62%**	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Goal met
Postpartum care	47.62%* (601/1262)	Establish baseline	N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

*Preliminary administrative rates. Final rates will be submitted in the September 2015 submission.
 **2014 NCQA Quality Compass HEDIS Medicaid HMO 75th percentile

Final Analysis

Status: (Please Check)

- On Track
- At Risk

7 Day Follow-up after Mental Health Hospitalization

7 Day Follow-up after Mental Health Hospitalization		Post-Approval Change Log
Program Description		
<p>This project is designed to improve the ongoing care for members with a discharge from an inpatient hospital or treatment facility (mental health primary diagnosis) by increasing appropriate follow up within 7 days.</p> <p>The objective of this project is:</p> <ul style="list-style-type: none"> To identify Well Sense Health Plan (Well Sense) members discharged from an inpatient hospital or treatment facility with mental health as a primary diagnosis and facilitate appropriate follow up care within 7 days Collaborate with the Well Sense liaison to New Hampshire Hospital (NHH) to ensure linkages with community mental health programs for 7 day aftercare appointments. 		
Measurement & Goal		
Quality Incentive Project		<p>Δ Added HEDIS 2015 measure to establish baseline for calendar year 2014.</p>
Modified HEDIS 2015 specifications and rate and standard specifications and rate.		
Measure	Goal	
7 Day Follow Up after Mental Health Hospitalization during the measurement period. (12/1/13 – 6/30/14)	Meet or exceed the 75th percentile for 7 Day Follow-Up after Mental Health Hospitalization of the most recent Quality Compass National Medicaid HMO data within the measurement period	
7 Day Follow Up after Mental Health Hospitalization during the measurement period. (CY2014)	Meet or exceed the 75th percentile for 7 Day Follow-Up after Mental Health Hospitalization of the most recent Quality Compass National Medicaid HMO data within the measurement period	
Project Team		
Lead: Kim Trvalik, RN		
Medical Director: Reyka Rao, MD		

2014 Actions			
Action	Expected date	Description	Implementation date
Facilitate follow up visit within 7 days after a discharge from an inpatient facility for a mental health diagnosis	April 2014	Follow up visits within 7 days after a discharge from an inpatient facility for a mental health diagnosis is facilitated.	January 2014 Ongoing
Schedule day of discharge appointment with inpatient facilities that have co-located outpatient clinics	April 2014	Day of discharge appointments are scheduled with inpatient facilities that have a co-located outpatient clinic. With the implementation of the TAC program, facilities with co-located outpatient clinics are scheduling their own follow-up.	January 2014 Ongoing
Educate members on the importance	April 2014	Members are educated on the importance of	January 2014

2014 Actions			
Action	Expected date	Description	Implementation date
of a follow up visit within 7 days of discharge		a follow up visit within 7 days of discharge at the time of discharge by the NHH Liaison and by the Aftercare Department during the Aftercare follow up phone call.	Ongoing
Remind members of appointments	April 2014	The Aftercare Department reaches out to members to remind them of their upcoming follow up appointments within 3 days of discharge from an inpatient facility.	January 2014 Ongoing
Confirm with provider that scheduled follow up appointment was kept	April 2014	Member's compliance with keeping the follow up visit is confirmed with the provider.	January 2014 Ongoing
Assist members with rescheduling or finding new appointments if needed	April 2014	Member is assisted with rescheduling appointment if needed.	January 2014 Ongoing
Establish bi-monthly meetings between the aftercare program manager, aftercare coordinator and the Managed Behavioral Health Organization (MBHO) clinical manager at the plan to ensure members are receiving aftercare within 7 days of discharge	April 2014	Bi-monthly meetings occur to discuss progress and to ensure all members are being contacted.	January 2014 Ongoing
Provide semi-annual aftercare training for all behavioral health clinicians.	December 2014	All clinicians are mandated to complete semi-annual aftercare training twice a year on a rolling basis based on dates of hire. This training provided and tracked through Beacon's web-based training database.	January 2014 Ongoing
Identify and promote best practices	December 2014	Identify and promote best practices by sharing within the behavioral health provider network through newsletter articles and best practice bulletins as requested, website updates when necessary, the annual provider postcard (July 2014), and a survey blast (June 2014).	January 2014 Ongoing

Additional Actions Implemented		
Action	Description	Implementation date
Provide Intensive Case Management (ICM) to members who meet the criteria	A case will be opened if a member meets the ICM criteria.	January 2014 Ongoing
Provide assistance to members when scheduling follow up appointments	If a member is having trouble getting an appointment within 7 days at the CMHC, the TAC or NHH Liaison will contact the CMHC to find an earlier appointment or another Outpatient (OP) provider if there is not anyone available at the CMHC.	January 2014 Ongoing

Additional Actions Implemented		
Action	Description	Implementation date
Enhance the discharge process at NHH for improved care and coordination of services	The NHH Liaison will continue to work with facilities to procure discharge notices and continue to encourage the doctors at NHH to fill out the discharge paperwork in a timely manner.	January 2014 Ongoing
Educate members on the importance of aftercare appointments and discuss the benefits available to them through Well Sense/Beacon.	The NHH Liaison meets with all discharging members to educate them on the importance of aftercare appointments and reviews their benefits.	January 2014 Ongoing
Conduct The Member Satisfaction Survey	The formal Beacon Member Satisfaction Survey was updated in 2013 to include additional information about community resources, necessary services, and experiences of care and in 2014 to include further questions about staff cultural sensitivity, authorization timeliness, and benefits explanations (for example). Beacon is working with The Myers Group to begin completing the annual survey earlier in the year as a mode for implementing necessary interventions sooner and with enhanced effect. The formal Member Satisfaction Survey for Well Sense members will go out in 2015 for CY 2014, at which time Beacon will be able to analyze the information for further interventions. As an interim measure, Beacon is in the process of conducting a DHHS approved CMHC Member Satisfaction Survey that began in January 2015. Final results will be available in February 2015.	February 2015
Conduct Inpatient Chart Audits	Conduct annual inpatient chart audits to collect data on the processes, such as communication between inpatient and outpatient providers. Beacon will analyze the data and send feedback to the facilities. In 2014 chart audits were conducted at six inpatient facilities for a total of 137 charts. The average score was 70.32%. Two NHH units were also audited with scores of 61.26% and 55.94%.	July 2014 Ongoing
Conduct Outpatient Chart Audits	Conduct annual outpatient chart audits at outpatient facilities to collect data and help identify barriers to care/ services. Beacon will analyze the data and send feedback to the facilities. In 2014, chart audits were conducted at six outpatient facilities for a total of 65 charts. The average score was 73.95%.	July 2014 Ongoing
Send out Survey Monkey Survey - Continuity of Care survey	Beacon sent out a survey to BH providers for them to self-report how they communicate with other providers; along with the survey was an educational material regarding continuity of care.	June 2014
Update the Outpatient Review Form (ORF)	Both paper and electronic ORFs have been updated to gather information on whether communication is taking place between providers.	September 2014
Promote coordination of care	The NHH Liaison meets with all discharging members to talk	November 2014

Additional Actions Implemented		
Action	Description	Implementation date
	with them about the importance of aftercare appointments.	
TAC Program	<p>The TAC Program is a process of network management that affords oversight capabilities by partnering and engaging with contracted providers to ensure proper clinical and operational management. The TAC Program works with the CMHCs to ensure that program operations and service delivery consistently focus on key factors that result in quality and efficacious treatment for members. The program involves the following:</p> <ol style="list-style-type: none"> 1. Regular TAC meetings. 2. Facilitating CMHC Provider Quality Improvement Plans as needed. 3. Member referral process and service linkage. 4. Individualized treatment planning and frequency of service provider interaction. 5. Inpatient discharge facilitation. 6. Clinical escalation and case rounding. 7. Training and enhancement of service delivery. 8. Oversight and reporting through identified metrics. 9. Collaborating in order to implement the mandates set forth in the Settlement Agreement. 	November 2014 Ongoing
Promote Best Practices	Best practices are promoted during NHH clinical and operations meetings.	January 2014 Ongoing

Barriers Encountered
The waiting list for treatment at CMHCs is often greater than 7 days.
CMHCs have specific appointment “slots” for 7 day follow-up appointments. These “slots” may not be flexible with school or work schedules.
Members, parents, and guardians may be unaware of the importance of follow up appointments to assist in maintaining health status within the community.
For children and adolescents, certain CMHCs will only allow a parent or guardian to make appointments, making it difficult to schedule appointments pre-discharge.
Lack of coordination between inpatient facilities and outpatient providers when setting up aftercare services.
Low volume of member contact and responsiveness, primarily due to inaccurate member contact information.
Members cancelling, rescheduling, or missing aftercare appointments.
Providers do not consistently develop transition plans with members.
Providers do not consistently provide transition information to Beacon.
Lack of family support for receiving services or family minimization of the problem.
Lack of Masters level clinicians to complete aftercare appointments.
Lack of continuity of care between the 7 day follow up and a new member being taken on for ongoing therapy at the CMHCs often leaving the member without care for up to six weeks.
Discharge paperwork is not consistently filled out and not in a timely manner.
NHH may discharge child members without a scheduled 7 day appointment and does not inform NHH Liaison of their discharges.
A full discharge summary by the doctor is provided after a member’s discharge versus on the day of discharge.

Barriers Encountered
Clinical groups focusing on coping skills (Dialectical Behavior Therapy, Cognitive Behavioral Therapy, and Illness Management and Recovery) are not provided on a daily basis to members.
Family or significant others are not engaged in treatment by the clinical team at the hospital.

Measurement Milestones					
Measure	Baseline	Goal	Current	Progress toward goal	Goal met?
7 Day Follow Up after Mental Health Hospitalization during the measurement period (12/1/13-6/30/14)	59.97% (118/197)	54.45%**	N/A		Goal met
7 Day Follow Up after Mental Health Hospitalization during the measurement period (CY 2014)	62.34%* (293/470)	54.45%**	N/A		Goal met

*Preliminary administrative rates. Final rates will be submitted in the September 2015 submission.

**2014 NCQA Quality Compass HEDIS Medicaid HMO 75th percentile

Final Analysis

Status: (Please Check)

- On Track
- At Risk

Disparities Initiatives

Disparities Initiative		Post-Approval Change Log
Program Description		
<p>Racial and ethnic disparities in health care have been well documented. Data analysis has demonstrated that racial and ethnic disparities contribute to lower HEDIS effectiveness of care scores.</p> <p>This project seeks to improve overall care of members by identifying the racial and ethnic composition of Well Sense membership so that potential health care disparities can be identified and addressed.</p> <p>The Plan will be able to identify and track similarities and differences in performance and quality of care in various geographic, cultural and ethnic communities.</p>		
Measurement & Goal		
Measure	Goal	
Set a baseline rate of race, ethnicity and language data collected from eligible members.	Establish baseline	
Set a baseline rate of preferred spoken language	Establish baseline	
Set a baseline rate of preferred written language	Establish baseline	
Project Team		
Lead: Ana Berridge		

2014 Actions			
Action	Expected date	Description	Implementation date
Provide Cultural Competency training to all new employees through the new hire orientation/training.	January 2014	Well Sense Health Plan has provided cultural competency training to all employees through the new hire orientation/training.	January 2014
Collect R/E/L data in a sensitive manner.	January 2014	The Plan is currently collecting R/E/L data in a sensitive manner through member services, care management, and the health risk assessment.	January 2014
Collect both preferred spoken and preferred written language data.	January 2014	The Plan is currently collecting both preferred spoken and preferred written language from members.	January 2014
Use available R/E/L data and HEDIS rates to identify possible disparities and barriers to care when adequate data are available.	December 2014	The Plan does not have adequate data to identify possible disparities yet.	N/A
Use R/E/L data to implement culturally and linguistically appropriate interventions when adequate data are available.	December 2014	The Plan does not have adequate data to implement specific culturally and linguistically appropriate interventions at this time. However, the Plan does distribute materials in English and Spanish to members based on their preference.	January 2014

Additional Actions Implemented		
Action	Description	Implementation date
None		

Barriers Encountered
Data to identify disparities based on R/E/L data using HEDIS rates cannot be generated due to lack of eligibility data to calculate continuous enrollment prior to December 1, 2013.
The Plan does not have adequate data to identify possible disparities and/or to develop specific culturally and linguistically appropriate interventions based on data yet.

Measurement Milestones					
Measure	Baseline (CY2014)	Goal	Current	Progress toward goal	Goal met?
Set a baseline rate of race, ethnicity and language data collected from eligible members.	35.72%	Establish baseline	N/A		Goal met
Set a baseline rate of preferred spoken language	36.39%	Establish baseline	N/A		Goal met
Set a baseline rate of preferred written language	36.39%	Establish baseline	N/A		Goal met

Final Analysis

Status: (Please Check)

- On Track
- At Risk

Member Satisfaction with Getting Appointments for Care (CAHPS)

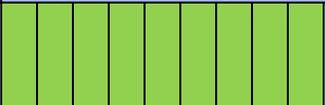
Member Satisfaction with Getting Appointments for Care (CAHPS)		Post-Approval Change Log
Program Description		
The project is designed to ensure member satisfaction with access to non-urgent care and to educate providers of the standards for appointment timeframes.		
Measurement & Goal		
Quality Incentive Project		▲ Initial QIP baseline period approved by HSAG was 7/1/2013 to 6/30/2014. ▲ Added CAHPS data and a baseline period of CY2014.
CAHPS 2014 specifications and rates		
Measure	Goal	
CAHPS survey results: Not counting the times you needed care right away, how often did you get an appointment for healthcare at a doctor’s office or clinic as soon as you thought your child needed it? (% usually or always) NH DHHS will conduct and provide CAHPS survey results for measurement period 12/1/13 – 6/30/14.	Meet or exceed the 90 th percentile for Member Satisfaction With Getting Appointments for Care of the most recent Quality Compass HMO data within the measurement period.	
CAHPS survey results: Not counting the times you needed care right away, how often did you get an appointment for healthcare at a doctor’s office or clinic as soon as you thought your child needed it? (% usually or always). Well Sense will conduct and provide CAHPS survey results for measurement period 1/1/14 – 12/31/14.	Meet or exceed the 90 th percentile for Member Satisfaction With Getting Appointments for Care of the most recent Quality Compass HMO data within the measurement period.	
Project Team		
Lead: Gail Evans		

2014 Actions			
Action	Expected date	Description	Implementation date
Educate providers on appointment standards in the Provider Manual, Provider Newsletter and on the Provider website	January 2014	Providers are educated on appointment time standards during orientation. Orientation materials are available on the Plan’s website. Appointment time standards are included in the Provider Manual available on the Plan’s website. Article on “Getting Needed Care in the Appropriate Time” was included in the November 2013 Provider newsletter.	January 2014 and ongoing
Promote and encourage open dialog between members and providers	January 2014	Open dialog between providers and members is promoted. Provider relations (PR) consultants remind provider office	January 2014 and ongoing

2014 Actions			
Action	Expected date	Description	Implementation date
		staff of appointment standards during site visits and encourage them to discuss appointment availability during members' office visits.	
Send email blast to providers about appointment standards	July 18, 2014	An email related to appointment time standards was sent to 490 provider offices.	July 18, 2014
Conduct after hours survey	August 29, 2014	<p>Network primary care providers are required to be available to respond to urgent healthcare needs of Plan members 24 hours a day, seven days a week, with a telephone answered by a live voice, or have arrangements for such coverage by another Plan-participating PCP. A Plan medical director must approve coverage arrangements that are not in compliance with this requirement.</p> <p>An annual telephonic random sample of provider office hours outside of normal business hours was conducted. 73 provider offices were surveyed and 72 offices were found to be in compliance, for a pass rate of 98.64%. The only provider office which did not pass will be required to either create a means for providing after hours care, or terminate their agreement with the Plan.</p>	July 30, 2014

Additional Actions Implemented		
Action	Description	Implementation date
Presentation to Physician Advisory Council (PAC)	A presentation on appointment standards and results of the after hours survey was delivered to the PAC, and open discussion regarding the standards was conducted.	September 2014

Barriers Encountered
Well Sense Health Plan launched on 12/1/13, and the DHHS conducted the CAHPS survey for the Plan in Fall 2014. Due to significant operational changes in the NH Medicaid Care Management Program, previous years' CAHPS results cannot be compared to 2014 results.
The Plan does not know the methodology being used by DHHS for the baseline CAHPS survey (i.e. oversampling).

Measurement Milestones					
Measure	Baseline	Goal	Current	Progress toward goal	Goal met?
CAHPS survey results: (Q6) In the last 6 months, how often did you get an	81.1% (50 th percentile)	84.65%	N/A		No

Measurement Milestones										
appointment for a check-up or routine care at a doctor’s office or clinic as soon as you needed? (% usually or always) (12/1/13 – 6/30/14)										
CAHPS survey results: (Q6) In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor’s office or clinic as soon as you needed? (% usually or always) (1/1/14 – 12/31/14)	N/A	84.65%	N/A							

Final Analysis

Status: (Please Check)

- On Track
- At Risk

Parental Satisfaction with Children Getting Appointments for Care (CAHPS)

Parental Satisfaction with Children Getting Appointments for Care (CAHPS)		Post-Approval Change Log
Program Description		
The project is designed to ensure member satisfaction with access to non-urgent care within the appropriate timeframe and to educate providers of the standards for appointment timeframes.		
Measurement & Goal		
Quality Incentive Project		Δ Initial QIP baseline period approved by HGAG was 12/1/2013 to 6/30/2014. Δ Added CAHPS data and a baseline period of CY2014.
CAHPS 2014 specifications and rates		
Measure	Goal	
CAHPS survey results: Not counting the times your child needed care right away, how often did you get an appointment for healthcare at a doctor’s office or clinic as soon as you thought your child needed it? (% usually or always) NH DHHS will conduct and provide CAHPS survey results for measurement period 12/1/13 to 6/30/14.	Meet or exceed the 90 th percentile for Parental Satisfaction with Children Getting Appointments for Care of the most recent Quality Compass HMO data within the measurement period	
CAHPS survey results: Not counting the times your child needed care right away, how often did you get an appointment for healthcare at a doctor’s office or clinic as soon as you thought your child needed it? (% usually or always) Well Sense will conduct and provide CAHPS survey results for measurement period 1/1/14 – 12/31/14.	Meet or exceed the 90 th percentile for Parental Satisfaction with Children Getting Appointments for Care of the most recent Quality Compass HMO data within the measurement period	
Project Team		
Lead: Gail Evans		

2014 Actions			
Action	Expected date	Description	Implementation date
Educate providers on appointment standards in the Provider Manual, Provider Newsletter and on the Provider website.	2014 and on-going	Providers are educated on appointment time standards during orientation. Orientation materials are available on the Plan’s website. Appointment time standards are included in the Provider Manual available on the Plan’s website. An article on “Getting Needed Care in the Appropriate Time” was included in the November 2013 Provider newsletter.	January 2014
Promote and encourage open dialog between members and providers	2014 and on-going	Open dialog between providers and members is promoted. Provider relations	January 2014

2014 Actions			
Action	Expected date	Description	Implementation date
		consultants remind provider office staff of appointment standards during site visits and encourage them to discuss appointment availability during members' office visits.	
Send email blast to providers about appointment standards.	July 18, 2014	An email related to appointment time standards was sent to 490 provider offices.	July 18, 2014
Conduct after hours survey	August 29, 2014	<p>Network primary care providers are required to be available to respond to urgent healthcare needs of Plan members 24 hours a day, seven days a week, with a telephone answered by a live voice, or have arrangements for such coverage by another Plan-participating PCP. A Plan medical director must approve coverage arrangements that are not in compliance with this requirement.</p> <p>An annual telephonic random sample of provider office hours outside of normal business hours was conducted. 73 provider offices were surveyed and 72 offices were found to be in compliance, for a pass rate of 98.64%. The only provider office which did not pass will be required to either create a means for providing after hours care, or terminate their agreement with the Plan.</p>	July 30, 2014

Additional Actions Implemented		
Action	Description	Implementation date
Presentation to Physician Advisory Council	A presentation on appointment standards and results of the after hours survey was delivered to the PAC, and open discussion regarding the standards was conducted.	September 2014

Barriers Encountered
Well Sense Health Plan launched on 12/1/13, and the DHHS conducted the CAHPS survey for the Plan in Fall 2014. Due to significant operational changes in the NH Medicaid Care Management Program, previous years' CAHPS results cannot be compared to 2014 results.
The Plan does not know the methodology being used by DHHS for the baseline CAHPS survey (i.e. oversampling).

Measurement Milestones					
Measure	Baseline (12/1/13 – 6/30/14)	Goal	Current	Progress toward goal	Goal met?
CAHPS survey results: (Q6) In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor’s office or clinic, how often did you get an appointment as soon as your child needed? (% usually or always) (12/1/13 – 6/30/14)	92.1% (75 th percentile)	93.04%	N/A		No
CAHPS survey results: (Q6) In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor’s office or clinic, how often did you get an appointment as soon as your child needed? (% usually or always) (1/1/14 – 12/31/14)	N/A	93.04%	N/A		In Progress

Final Analysis

Status: (Please Check)

- On Track
- At Risk

Special Needs Program

Special Needs Program		Post-Approval Change Log
Program Description		
<p>The Plan will identify, outreach and provide CM for members with special needs as defined by the NH contract</p> <p>The objective of this program is providing education, promote self-management of chronic diseases, facilitate coordination of care through the continuum, and address psychosocial needs. Ensure utilization of care at the right time, right place and right level of care.</p>		
Measurement & Goal		
Measure	Goal	
Evaluation of all work plan measures for the members that are in the Special Needs Program.	Establish baseline	
Project Team		
Lead: Jeanne Murphy, RN		
Medical Director: Karen Boudreau, MD		

2014 Actions			
Action	Expected date	Description	Implementation date
Review and update the criteria used by the Plan to identify members eligible for the Special Needs Program.	December 2014	Criteria to identify members eligible for the Special Needs Program have been implemented utilizing specific State contract language. Special needs conditions are identified through the registry or Health Risk Assessment. If a member has any special need attributes such as language, speech, mobility, cognitive, hearing or vision impairments, care managers work to accommodate these via avenues that include a translator, TTY system, and ensuring handicapped access. In 2014, 1,055 distinct members have been identified through the registry as eligible for the Special Needs Program.	December 2014
Identify sources of data that will be used to identify members for the Special Needs Program such as: the Health Risk Assessment, welcome calls, claims, referrals, and eligibility Files.	December 2014	Members with special needs are identified using the following sources: Health Risk Assessments, welcome calls, claims, referrals, eligibility files and the Plan's registry.	April 2014 and ongoing

2014 Actions			
Action	Expected date	Description	Implementation date
Establish a process to monitor the quality and effectiveness of care for members with Special Needs who are eligible for the CM program throughout the measurement year.	December 2014	As part of the Special Needs Program and member’s agreement into the care management program, providers receive notification that their patients have been enrolled in our care management program and assigned a care manager. Care management helps coordinate available services including social services, medical services, assistive equipment and individual care plans for our members to facilitate communication among care givers, families and practitioners. This is followed by monitoring, reassessing and evaluating the care plan and collaborative efforts with all providers. For each concern or barrier identified, the Social Care Management Plan has observable and measurable goals for each concern or barrier identified and expected outcomes. Progress toward goals is periodically measured by the social care manager in collaboration with the member, family members/caregivers, and care team members. Based on the outcomes and progress, changes are made to the plan as needed.	April 2014 and ongoing

Additional Actions Implemented		
Action	Description	Implementation date
None		

Barriers Encountered
Rates using HEDIS specification for the special needs population cannot be generated due to lack of eligibility data to calculate continuous enrollment prior to December 1, 2013.
HEDIS results will not be available until the final submission to analyze HEDIS rates for this specific cohort.
Some hybrid HEDIS measures will need to be excluded from the analysis due to a small sample size.

Measurement Milestones					
Measure	Baseline (1/1/13 – 12/31/13)	Goal	Current	Progress toward goal	Goal met?
Evaluation of all work plan measures for the members that are in the Special Needs Program.	N/A	Establish baseline	N/A		In progress

Final Analysis

Status: (Please Check)

- On Track
- At Risk

Prescription Drug Monitoring Program

Prescription Drug Monitoring Program	Post-Approval Change Log
Program Description	
The purpose of this project is to improve the management of clinical conditions that require therapy with controlled substance medications and non-controlled substance medications that have high potential for abuse. The program monitors appropriate use of these medications and intervenes as necessary to promote member education and assist providers with improved coordination of care. The program utilizes interventions such as direct provider communication, pharmacy and/or provider restrictions to encourage more appropriate use of these medications, and referrals to fraud and abuse for further evaluation.	
Measurement & Goal	
Goal	
<ul style="list-style-type: none"> • Evaluate program impact and effectiveness • Evaluate the appropriateness of member identification criteria • Identify opportunities for improvement 	
Project Team	
Lead: Phuong Pham, Pharm D.	
Medical Director: Karen Boudreau, MD	

2014 Actions			
Action	Expected date	Description	Implementation date
Identify members for program using criteria algorithms incorporating pharmacy and medical claims	April 2014 and ongoing	Members identified for a pharmacy-lock intervention under the New Hampshire Fee-For-Service program were enrolled in the Prescription Drug Monitoring Program (PDMP). Since April 2014, 109 members have been identified through the registry or referred into the program by providers, care management, or pharmacy benefit manager (PBM). Of those identified, 31 members received a pharmacy lock-in intervention.	April 2014 and ongoing
Perform automated interventions or refer member cases to Plan pharmacists for review	April 2014 and ongoing	Case review and interventions were implemented for members meeting criteria. To determine appropriate intervention actions, Plan pharmacists and pharmacy coordinators evaluate several data elements including ED visits, geography, patterns of medication use, gaps in coordination of care among providers, and amount and frequency of medication filling.	April 2014 and ongoing
Implement member specific interventions as appropriate.	April 2014 and ongoing	Potential interventions include: sharing member’s pharmacy profile with the PCP, psychiatrist, or other provider, contacting the member, contacting pharmacy, or other actions deemed appropriate.	April 2014 and ongoing
Utilize CareEnhance® Clinical	April 2014	The program is currently being documented	April 2014 and

Provider Satisfaction

Provider Satisfaction		Post-Approval Change Log
Program Description		
<p>Our current experience is that 92% of claims received are processed as “clean claims” and do not require any adjustment. Claims that are not auto adjudicated require a manual process to resolve.</p> <p>Some factors that impact the process are beyond the Plan’s control.</p> <p>Re-processing a claim impacts proper and final payment to providers.</p>		
Measurement & Goal		
Measure	Goal	
# of claims received on an annual basis	Establish baseline	
% of claims corrected on an annual basis	Establish baseline	
% of claims appealed on an annual basis	Establish baseline	
Project Team		
Lead: Michael Curry		Was: Dawn McDonald
Executive Sponsor: Eric Hunter		

2014 Actions			
Action	Expected date	Description	Implementation date
Work with Provider Relations staff to educate providers on timely claims submission and prior authorization guidelines	December 2013	Providers are oriented to timely claims submission and prior authorization during provider orientation. The orientation slides are available on the Plan’s website. Resources on claims submission are available on the Provider page of the Plan’s website and in the Provider handbook.	December 2013 and ongoing
Reinforce clinical edit policy with providers and/or billing managers	December 2013	The NH Claims Supervisor and Manager have worked with the PR Manager and members of PR staff to reinforce clinical edit policies and general billing policies.	December 2013 and ongoing
Work with the Provider Services team to identify opportunities to implement processes that impact claims adjustment and payment	December 2013	Data from provider inquiry calls are being collected. These data will be used to identify trends and redefine processes.	December 2013 and ongoing
Create standard operating procedures for provider services representatives to adjust certain claim types at the point of contact	Ongoing	For certain identified claim types, providers can give information at the point of contact and the claim can be adjusted without an adjustment form.	December 2013 and ongoing

Additional Actions Implemented		
Action	Description	Implementation date
None		

Appendix H: Abbreviations and Acronyms

AHRQ	Agency for Healthcare Research and Quality
BRFSS	Behavioral Risk Factor Surveillance System
CAHPS	Consumer Assessment of Health Providers and Systems
CDC	Center for Disease Control and Prevention
CFR	Code of Federal Regulations
CHIS	Comprehensive Health Care Information System
CMS	Center for Medicare and Medicaid Services
DHHS	Department of Health and Human Services
EQRO	External Quality Review Organization
HEDIS	Healthcare Effectiveness Data and Information Set
HER	Electronic Health Record
HIE	Health Information Exchange
HITECH	Health Information Technology for Economic and Clinical Health
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MQIS	Medicaid Quality Information System
NCQA	National Committee for Quality Assurance
NH	New Hampshire
PIP	Performance Improvement Program
QAPI	Quality Assurance Performance Improvement
SAMHSA	Substance Abuse and Mental Health Services Administration