



**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_HP	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 \geq 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	
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.			

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

Appendix F: NH Medicaid Care Management MCO Quality Assurance and Performance Improvement Plan Reports: New Hampshire Healthy Families

The following is the most recent semi-annual update on the results of the New Hampshire Healthy Families Quality Assurance and Performance Improvement Plan.



NHMF QAPI
Semi-Annual Report

Appendix G: NH Medicaid Care Management MCO Quality Assurance and Performance Improvement Plan Reports: Well Sense Health Plan

The following is the most recent semi-annual update on the results of the Well Sense Quality Assurance and Performance Improvement Plan.



WS QAPI
Semi-Annual Report

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