Managed Care Program Annual Report (MCPAR) for New Hampshire: New Hampshire Medicaid Care Management Program

Due date	Last edited	Edited by	Status
12/27/2023	12/21/2023	Laura Ringelberg	Submitted

	Indicator	Response
	Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Point of Contact

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	New Hampshire
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Shirley Iacopino
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	shirley.a.iacopino@dhhs.nh.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Laura Ringelberg
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	laura.v.ringelberg@dhhs.nh.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/21/2023

Reporting Period

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2023
A6	**Program name** Auto-populated from report dashboard.	New Hampshire Medicaid Care Management Program

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Find in the Excel Workbook
A_Program_Info

	Indicator	Response
	Plan name	AmeriHealth Caritas New Hampshire NH Healthy Families WellSense Health Plan

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Find in the Excel Workbook
A_Program_Info

	Indicator	Response
	BSS entity name	DHHS Customer Service Center (State Government Entity) ServiceLink (16 Community-Based Programs) ServiceLink State Health Insurance Program (SHIP) ServiceLink Aging and Disability Resource Network (ADRN) Maximus (Enrollment Broker) First Choice (Navigator) Health Market Connect (Navigator)

Topic I. Program Characteristics and Enrollment

Find in the Excel Workbook
B_State

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	244,610
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	237,181

Topic III. Encounter Data Report

Find in the Excel Workbook
B_State

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	EQRO

Topic X: Program Integrity

Find in the Excel Workbook
B_State

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	The MCOs submit a FWA Fraud and Abuse Report monthly for fraud and abuse overpayments and recoveries, and a FWA Waste Report quarterly of waste overpayment and recoveries. The NH DHHS Program Integrity Unit (PIU) also reviews the monthly Lock-in Report for compliance with over prescribing. In addition, a collaborative effort with FFS and Managed Care was initiated for auditing claims from Opioid Treatment Programs, including required documentation, training sessions and on-going monitoring efforts.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	Allow plans to retain overpayments
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	MCO Contract Section 5.3.3
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	The MCO is required to have internal policies and procedures for documentation, retention and recovery of all overpayments, specifically for the recovery of overpayments due to fraud, waste and abuse, and for reporting and returning overpayments. The MCO is required to report to NH DHHS within 60 calendar days when it has identified capitation payments or other payment amounts received in excess to the amounts specified in the MCO Contract. NH

		DHHS may recover overpayments that are not recovered by or returned to the MCO within 60 calendar days of notification by NH DHHS to pursue.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	NH DHHS monitors plan performance in reporting overpayments through two specific reports. FWA.02 is a fraud reporting tool submitted monthly for all investigations and overpayments identified by the MCO. NH DHHS monitors these reports to ensure adherence to the 60-day episode. FWA.06 reports waste recoveries on a quarterly basis. The report details all other reporting of recoveries for waste and abuse in billing claims and is monitored for potential fraud.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	NH DHHS does this in a number of ways. A monthly Date of Death report is sent by each MCO with evidence of death. The details are matched against member eligibility. Incarcerated individuals are monitored by the state through communication with the Department of Corrections (DOC). The DOC file is matched and discrepancies are sent to NH DHHS' Member Eligibility program area for resolution. To identify frequent switching of plans, member activity is monitored through the enrollment and disenrollment data captured in DHHS Member Eligibility reporting.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	**Changes in provider circumstances: Describe**	MCO reporting performance is done by monitoring the monthly FWA.04 report for

	metric Describe the metric or indicator that the state uses.	accuracy.
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	https://medicaidquality.nh.gov/external-quality-review-organization-eqro-technical-report

Topic I: Program Characteristics

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	New Hampshire Department of Health and Human Services - Medicaid Care Management Services Contract
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	07/01/2022
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-care-management
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by	N/A

	service area or population)? Enter "N/A" if not applicable.	
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	237,181
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	1. NH DHHS increased the medically needy income limit effective 01/01/2023. This change may have resulted in some individuals having spenddown eliminated and enrolled in MCO. 2. Continuous enrollment due to the extension of the PHE and unwinding began during this time period.

Topic III: Encounter Data Report

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	MCO Contract Sections 5.1.3 Encounter Data, subsections 5.1.3.1, 5.1.3.2, 5.1.3.34.1, 5.1.3.34.2, 5.1.3.34.3, and 5.1.3.34.4
C1III.4	**Financial penalties contract language**	MCO Contract Section 5.5.2 Exhibit N (Liquidated Damages Matrix)

	Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	There has been a member auto-assignment award incentive twice over the course of the MCO Contract. The incentive was to award 1,000 new members to the MCO that scored the best on the contract standards over a specific measurement period.
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	NH DHHS had no barriers.

Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	MCO Contract Section 4.5.3.10 The MCO shall resolve one hundred percent (100%) of standard Member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)]
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	MCO Contract Section 4.5.5.3 The MCO shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the MCO receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)]
C1IV.4	**State definition of "timely" resolution for grievances**	MCO Contract Section 4.5.2.4 The MCO shall complete the resolution of a grievance and provide notice to the affected parties as

	Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance or within fifty-nine (59) calendar days of receipt of the grievance for grievances extended for up to fourteen (14) calendar days even if the MCO does not have all the information necessary to make the decision, for one hundred percent (100%) of Members filing a grievance. [42 CFR 438.408(a); 42 CFR 438.408(b)(1)]

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	NH continues to experience insufficient NH Medicaid enrolled specialty providers, especially in northern and rural areas.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	MCOs are encouraged to have all NH Medicaid enrolled providers in their networks to ensure adequacy. When gaps are identified, the MCO submits an Exception Request to the Department for review. The Exception Request details how members can access those services/providers (for example, offering out-of-network, telehealth and/or enhanced transportation). NH DHHS works in partnership with the MCOs to identify opportunities to develop the network through recruitment of providers not enrolled in Medicaid.

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Find in the Excel Workbook
C2_Program_State

Access measure total count: 8

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 8

C2.V.2 Measure standard

2 within 40 min or 15 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

At procurement and annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 8

C2.V.2 Measure standard

1 within 45 min or 25 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

At procurement and annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

3 / 8

C2.V.2 Measure standard

1 within 60 min or 45 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review

C2.V.8 Frequency of oversight methods

At procurement and annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

4 / 8

C2.V.2 Measure standard

2 within 40 min or 15 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

5 / 8

C2.V.2 Measure standard

2 within 40 min or 15 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

6 / 8

C2.V.2 Measure standard

1 within 45 min or 25 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

7 / 8

C2.V.2 Measure standard

1within 45 min or 25 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

8 / 8

C2.V.2 Measure standard

1 within 60 min or 45 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Topic IX: Beneficiary Support System (BSS)

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://nheasy.nh.gov, https://www.servicelink.nh.gov/
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	The NH Managed Care beneficiary support systems through DHHS are accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested. Beneficiaries are able to contact DHHS via a toll-free number nationwide, including TDD Relay. Individuals can access supports through eleven District Offices throughout the state, and sixteen Community-Based Organizations for ServiceLink programs. All are ADA compliant. Auxiliary aids are provided under Section 1557. DHHS has a contract for interpretation services that is accessed in a timely manner to assist beneficiaries as needed. In addition, both beneficiary support websites are 508 compliant.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	LTSS services are not covered under the Medicaid Care Management Program.
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Through the state's enrollment website, NH EASY uses a feedback loop to capture client comments and feedback. NH EASY up time and google analytics are monitored to identify conflicts with supported devices. To evaluate the quality, effectiveness and efficiency of the ServiceLink system, DHHS has multiple strategies in place. One of the strategies is to provide an opportunity for participants of

		ServiceLink service the ability to complete a satisfaction survey. The survey is designed to measure: • Satisfaction that they received proper service • Satisfaction with the delivery of service • Informed of long-term care support options • Usefulness - If they would use ServiceLink again or refer a friend. For the state's evaluation of its BSS entities and their performance, the state includes performance metrics in its contracts with the entities.

Topic X: Program Integrity

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic I. Program Characteristics & Enrollment

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**AmeriHealth Caritas New Hampshire** 53,837 **NH Healthy Families** 87,799 **WellSense Health Plan** 95,545
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**AmeriHealth Caritas New Hampshire** 22% **NH Healthy Families** 35.9% **WellSense Health Plan** 39.1%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**AmeriHealth Caritas New Hampshire** 22.7% **NH Healthy Families** 37% **WellSense Health Plan** 40.3%

Topic II. Financial Performance

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**AmeriHealth Caritas New Hampshire** 91.9% **NH Healthy Families** 90.3% **WellSense Health Plan** 94.9%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**AmeriHealth Caritas New Hampshire** Program-specific statewide **NH Healthy Families** Program-specific statewide **WellSense Health Plan** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**AmeriHealth Caritas New Hampshire** Group VIII expansion is reported separate from non-expansion (91.2%) **NH Healthy Families** Group VIII expansion is reported separate from non-expansion (88.8%) **WellSense Health Plan** Group VIII expansion is reported separate from non-expansion (89.5%)

D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**AmeriHealth Caritas New Hampshire** Yes **NH Healthy Families** Yes **WellSense Health Plan** Yes
N/A	Enter the start date.	**AmeriHealth Caritas New Hampshire** 07/01/2021 **NH Healthy Families** 07/01/2021 **WellSense Health Plan** 07/01/2021
N/A	Enter the end date.	**AmeriHealth Caritas New Hampshire** 06/30/2022 **NH Healthy Families** 06/30/2022 **WellSense Health Plan** 06/30/2022

Topic III. Encounter Data

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**AmeriHealth Caritas New Hampshire** 100% of the MCO Encounter Data shall be submitted weekly, within fourteen (14) calendar days of claim payment for all claim types. **NH Healthy Families** 100% of the MCO Encounter Data shall be submitted weekly, within fourteen (14) calendar days of claim payment for all claim types. **WellSense Health Plan** 100% of the MCO Encounter Data shall be submitted weekly, within fourteen (14) calendar days of claim payment for all claim types.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**AmeriHealth Caritas New Hampshire** 100% **NH Healthy Families** 98% **WellSense Health Plan** 74%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements	**AmeriHealth Caritas New Hampshire** 100% **NH Healthy Families**

	for HIPAA compliance?	100%
	If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**WellSense Health Plan** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**AmeriHealth Caritas New Hampshire** 466 **NH Healthy Families** 799 **WellSense Health Plan** 568
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan**

	actively receiving LTSS at the time that the appeal was filed).	N/A
D1IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided	**AmeriHealth Caritas New Hampshire** 341 **NH Healthy Families**

	by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	518 **WellSense Health Plan** 407
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**AmeriHealth Caritas New Hampshire** 125 **NH Healthy Families** 281 **WellSense Health Plan** 161
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**AmeriHealth Caritas New Hampshire** 423 **NH Healthy Families** 621 **WellSense Health Plan** 471
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 168 **WellSense Health Plan** 2
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's	**AmeriHealth Caritas New Hampshire** 45 **NH Healthy Families**

	denial, in whole or in part, of payment for a service that was already rendered.	25 **WellSense Health Plan** 105
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**AmeriHealth Caritas New Hampshire** 1 **NH Healthy Families** 0 **WellSense Health Plan** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0

were related to the plan's denial of an enrollee's request to dispute a financial liability.	**WellSense Health Plan** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**AmeriHealth Caritas New Hampshire** 61 **NH Healthy Families** 112 **WellSense Health Plan** 22
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**AmeriHealth Caritas New Hampshire** 16 **NH Healthy Families** 14 **WellSense Health Plan** 2
D1IV.7c	**Resolved appeals related to inpatient behavioral health services**	**AmeriHealth Caritas New Hampshire** 37

	Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**NH Healthy Families** 64 **WellSense Health Plan** 0
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**AmeriHealth Caritas New Hampshire** 9 **NH Healthy Families** 8 **WellSense Health Plan** 0
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**AmeriHealth Caritas New Hampshire** 262 **NH Healthy Families** 418 **WellSense Health Plan** 435
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families**

	were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	N/A **WellSense Health Plan** N/A
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**AmeriHealth Caritas New Hampshire** 45 **NH Healthy Families** 31 **WellSense Health Plan** 105
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	**AmeriHealth Caritas New Hampshire** 4 **NH Healthy Families** 7 **WellSense Health Plan** 3

Topic IV. Appeals, State Fair Hearings & Grievances

State Fair Hearings

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**AmeriHealth Caritas New Hampshire** 4 **NH Healthy Families** 6 **WellSense Health Plan** 10
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision**	**AmeriHealth Caritas New Hampshire** 4

	Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**NH Healthy Families** 6 **WellSense Health Plan** 10
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**AmeriHealth Caritas New Hampshire** 161 **NH Healthy Families** 339 **WellSense Health Plan** 166
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**AmeriHealth Caritas New Hampshire** 8 **NH Healthy Families** 13 **WellSense Health Plan** 11
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A

D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A

	grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**AmeriHealth Caritas New Hampshire** 153 **NH Healthy Families** 326 **WellSense Health Plan** 155

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 10 **WellSense Health Plan** 5
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 7 **NH Healthy Families** 58 **WellSense Health Plan** 22
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families**

	mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	4 **WellSense Health Plan** 5
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 3 **NH Healthy Families** 12 **WellSense Health Plan** 24
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 11 **NH Healthy Families** 8 **WellSense Health Plan** 12
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 1 **NH Healthy Families** 2 **WellSense Health Plan** 0
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A

	(HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**WellSense Health Plan** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 8 **NH Healthy Families** 1 **WellSense Health Plan** 0
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 68 **NH Healthy Families** 213 **WellSense Health Plan** 93
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**AmeriHealth Caritas New Hampshire** 59 **NH Healthy Families** 20 **WellSense Health Plan** 7

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**AmeriHealth Caritas New Hampshire** 15 **NH Healthy Families** 229 **WellSense Health Plan** 116
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**AmeriHealth Caritas New Hampshire** 87 **NH Healthy Families** 36 **WellSense Health Plan** 2
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**AmeriHealth Caritas New Hampshire** 7 **NH Healthy Families** 17 **WellSense Health Plan** 25
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**AmeriHealth Caritas New Hampshire** 13 **NH Healthy Families** 3 **WellSense Health Plan** 13

D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**AmeriHealth Caritas New Hampshire** 34 **NH Healthy Families** 42 **WellSense Health Plan** 9
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 1 **WellSense Health Plan** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal**	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families**

	(including requests to expedite or extend appeals) Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	0 **WellSense Health Plan** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 1
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**AmeriHealth Caritas New Hampshire** 3 **NH Healthy Families** 11 **WellSense Health Plan** 0

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Find in the Excel Workbook
D2_Plan_Measures

Quality & performance measure total count: 12

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits (WCV-CH) 1 / 12

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1516

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

55.2%

NH Healthy Families

61.1%

WellSense Health Plan

55.3%

Complete

D2.VII.1 Measure Name: Breast Cancer Screening (BCS-AD)

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

2372

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

54.1%

NH Healthy Families

57.1%

WellSense Health Plan

49.7%

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Timeliness of Prenatal Care

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

1517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

79.3%

NH Healthy Families

79.3%

WellSense Health Plan

85.3%

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care: Timeliness of Post Partum Care

4 / 12

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

1517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

79.8%

NH Healthy Families

78.1%

WellSense Health Plan

83.5%

Complete

D2.VII.1 Measure Name: Controlling High Blood Pressure (CBP-AD)

5 / 12

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

0018

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

57.4%

NH Healthy Families

61.3%

WellSense Health Plan

66.9%

Complete

D2.VII.1 Measure Name: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)

6 / 12

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2801

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

62.5%

NH Healthy Families

72.7%

WellSense Health Plan

61.6%

Complete

D2.VII.1 Measure Name: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Depencence

7 / 12

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3488

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

56.7%

NH Healthy Families

56.6%

WellSense Health Plan

60.5%

Complete

D2.VII.1 Measure Name: Getting Needed Care Right Away - Usually or Always - Adult

8 / 12

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

0006

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

82.3%

NH Healthy Families

81.8%

WellSense Health Plan

84.4%

Complete

D2.VII.1 Measure Name: Getting Needed Care Right Away - Usually or Always - Child

9 / 12

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

0006

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

91.8%

NH Healthy Families

89.6%

WellSense Health Plan

91.1%

Complete

D2.VII.1 Measure Name: Getting Routine or Check-up Appointments as Soon as They Were Needed - Usually or Always - Adult

10 / 12

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

0006

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

75.4%

NH Healthy Families

84.7%

WellSense Health Plan

74.8%

Complete

D2.VII.1 Measure Name: Getting Routine or Check-up Appointments as Soon as They Were Needed - Usually or Always - Child

D2.VII.2 Measure Domain

Health plan enrollee experience of care

D2.VII.3 National Quality Forum (NQF) number

0006

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

86.0%

NH Healthy Families

89.6%

WellSense Health Plan

84.3%

Complete

D2.VII.1 Measure Name: Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8.0%)

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0575

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Standard Measure

Measure results

AmeriHealth Caritas New Hampshire

40.4%

NH Healthy Families

49.4%

WellSense Health Plan

56.2%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Find in the Excel Workbook
D3_Plan_Sanctions

Sanction total count: 3

Complete

D3.VIII.1 Intervention type: Liquidated damages 1 / 3

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
AmeriHealth Caritas New Hampshire

D3.VIII.4 Reason for intervention

Data reported was late, incorrect, or non-compliant.

Sanction details

D3.VIII.5 Instances of non-compliance
22

D3.VIII.6 Sanction amount
$31,000

D3.VIII.7 Date assessed
06/30/2023

D3.VIII.8 Remediation date non-compliance was corrected
Yes, remediated 06/30/2023

D3.VIII.9 Corrective action plan
No

Complete

D3.VIII.1 Intervention type: Liquidated damages 2 / 3

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
NH Healthy Families

D3.VIII.4 Reason for intervention

Data reported was late, incorrect, or non-compliant.

Sanction details

D3.VIII.5 Instances of non-compliance

17

D3.VIII.6 Sanction amount

$139,000

D3.VIII.7 Date assessed

06/30/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/30/2023

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

3 / 3

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

WellSense Health Plan

D3.VIII.4 Reason for intervention

Data reported was late, incorrect, or non-compliant.

Sanction details

D3.VIII.5 Instances of non-compliance

71

D3.VIII.6 Sanction amount

$258,000

D3.VIII.7 Date assessed

06/30/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 06/30/2023

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**AmeriHealth Caritas New Hampshire** 2 **NH Healthy Families** 2 **WellSense Health Plan** 5
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**AmeriHealth Caritas New Hampshire** 24 **NH Healthy Families** 31 **WellSense Health Plan** 17
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**AmeriHealth Caritas New Hampshire** 24:53.8 **NH Healthy Families** 31:87.8 **WellSense Health Plan** 17:95.5
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**AmeriHealth Caritas New Hampshire** 15 **NH Healthy Families**

		17 **WellSense Health Plan** 8
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**AmeriHealth Caritas New Hampshire** 15:53.8 **NH Healthy Families** 17:87.8 **WellSense Health Plan** 8:95.5
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**AmeriHealth Caritas New Hampshire** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **NH Healthy Families** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **WellSense Health Plan** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**AmeriHealth Caritas New Hampshire** 24 **NH Healthy Families** 31 **WellSense Health Plan** 17
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the	**AmeriHealth Caritas New Hampshire** 24:53.8 **NH Healthy Families**

	state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.1) as the denominator.	31:87.8 **WellSense Health Plan** 17:95.5
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).	**AmeriHealth Caritas New Hampshire** SIU identified $179,207.66 Fraud and Abuse dollars during the period 7/1/22 through 6/30/23, of which $174,025.87 was recovered by SIU. Of the $174,025.87, $98,602.45 was recovered by check and the remaining funds were recovered via claims off set. Waste recovered (non-SIU related) for the reporting period was $3,754,267.90, of which $29,592.74 was recovered by check with the remaining balance recovered via claims offset. The ratio for overpayments is 0.107% **NH Healthy Families** For the reporting period of 7/1/22 to 6/30/23, the SIU identified $388,856.60 as initial overpayments. After appeals, that amount was reduced to $177,296.55. During the 7/1/22 to 6/30/23 reporting period, $226,310.72 was recovered. Of the recovered dollars, $124,737.26 was recovered via claims projects (offsetting from future claims), $55,759.20 was recovered via payment plan checks, and $45,814.26 was paid by lump sum checks. The total waste recovery amount for the 7/1/22-6/30/23 reporting period was $2,220,859. The ratio for overpayments is 1.229% **WellSense Health Plan** WellSense identified overpayments related to suspected provider fraud investigations totaling $143,668.16. WellSense recovered $70,674.51 in overpayments related to ten fraud investigations during the fiscal year, $70,274.69 of which was related to overpayments identified in the current fiscal year. These recoveries were obtained through offsetting recoveries against future payments. The ratio for overpayments is 0.033%
D1X.10	**Changes in beneficiary circumstances**	**AmeriHealth Caritas New Hampshire**

Select the frequency the plan reports changes in beneficiary circumstances to the state.	Daily **NH Healthy Families** Daily **WellSense Health Plan** Daily

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Find in the Excel Workbook
E_BSS_Entities

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**DHHS Customer Service Center (State Government Entity)** State Government Entity **ServiceLink (16 Community-Based Programs)** State Government Entity **ServiceLink State Health Insurance Program (SHIP)** State Health Insurance Assistance Program (SHIP) **ServiceLink Aging and Disability Resource Network (ADRN)** Aging and Disability Resource Network (ADRN) **Maximus (Enrollment Broker)** Enrollment Broker **First Choice (Navigator)** Other Community-Based Organization **Health Market Connect (Navigator)** Other Community-Based Organization
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that	**DHHS Customer Service Center (State Government Entity)** Enrollment Broker/Choice Counseling

apply. Refer to 42 CFR 438.71(b).

Beneficiary Outreach

ServiceLink (16 Community-Based Programs)

Enrollment Broker/Choice Counseling

Beneficiary Outreach

ServiceLink State Health Insurance Program (SHIP)

Enrollment Broker/Choice Counseling

Beneficiary Outreach

ServiceLink Aging and Disability Resource Network (ADRN)

Enrollment Broker/Choice Counseling

Beneficiary Outreach

Maximus (Enrollment Broker)

Enrollment Broker/Choice Counseling

Beneficiary Outreach

First Choice (Navigator)

Enrollment Broker/Choice Counseling

Health Market Connect (Navigator)

Enrollment Broker/Choice Counseling