Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
ACCESSREQ.05	Requests for Assistance Accessing MCO Designated Primary Care Providers by County	Count and percent of member telephone and/or email requests for assistance accessing MCO Designated Primary Care Providers (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer appearing on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						
ACCESSREQ.06	Requests for Assistance Accessing Physician/APRN Specialists (non-MCO Designated) by County	Count and percent of member telephone and/or email requests for assistance accessing non-MCO Designated Physician/APRN Specialists (as defined by the health plan) per 1,000 average member months by New Hampshire county. Reported request types reflect the need for the MCO to help members select a provider due to new member enrollment, replacing a provider due to the current provider retiring, leaving the practice, or no longer on the MCO provider list, etc. Exclusions for this measure include provider searches performed on the health plan's website and provider changes related to member preferences.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
ANNUALRPT.01	Medicaid Care Management Program Comprehensive Annual Report	The annual report is the Managed Care Organization's PowerPoint presentation on the accomplishments and opportunities of the prior agreement year. The report will address how the MCO has impacted Department priority issues, social determinants of health, improvements to population health, and developed innovative programs. The audience will be the NH Governor, legislature, and other stakeholders.	Narrative Report	Agreement Year	Annually	August 30th			X						X
APM.01	Alternative Payment Model Plan	Implementation plan that meets the requirements for Alternative Payment Models outlined in the MCM Model Contract and the Department's Alternative Payment Model Strategy.	Plan	Varies	Annually	May 1st									X
APM.02	Alternative Payment Model Quarterly Update	Standard template showing the quarterly results of the alternative payment models.	Table	Varies	Quarterly	4 Months after end of Measurement Period									X
APM.03	Alternative Payment Model Completed HCP-LAN Assessment Results	The HCP-LAN Assessment is available at: https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf; the MCO is responsible for completing the required information for Medicaid (and is not required to complete the portion of the assessment related to other lines of business, as applicable).	Narrative Report	Varies	Annually	October 31st									X
APPEALS.01	Resolution of Standard Appeals Within 30 Calendar Days	Count and percent of appeal resolutions of standard appeals within 30 calendar days of receipt of appeal for appeals filed with the MCO during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.02	Resolution of Extended Standard Appeals Within 44 Calendar Days	Count and percent of appeal resolutions of extended standard appeals within 44 calendar days of receipt of appeal for appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
APPEALS.03	Resolution of Expedited Appeals Within 72 Hours	Count and percent of appeal resolutions of expedited appeals within 72 hours of receipt of appeal for appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.04	Resolution of All Appeals Within 45 Calendar Days	Count and percent of appeal resolutions within 45 calendar days of receipt of appeal for appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.05	Resolution of Appeals by Disposition Type	Count and percent of appeals where member abandoned appeal, MCO action was upheld, or MCO action was reversed for all appeals received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
APPEALS.16	Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population	Standard template that provides counts of MCO resolved appeals by resolution type (i.e. upheld, withdrawn, abandoned) by category of service. The counts are broken out by State Plan and 1915B waiver populations.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X			X			
APPEALS.17	Pharmacy Appeals by Type of Resolution and Therapeutic Drug Class by State Plan, 1915B Waiver, and Total Population	Standard template providing counts of MCO appeals resolutions by resolution type and category of pharmacy class	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X			X			
APPEALS.18	Services Authorized within 72 Hours Following a Reversed Appeal	Count and percent of services authorized within 72 hours following a reversed appeal for the service that was previously denied, limited or delayed by the MCO.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
APPEALS.19	Member Appeals Received	Count and percent of Member appeals filed during the measurement period, per 1,000 member months.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						X
BHDRUG.01	Severe Mental Illness Drug Prior Authorization Report	Standard template to monitor MCO pharmacy service authorizations (SA) for drugs to treat severe mental illness that are prescribed to members receiving services from Community Mental Health Programs. The report includes aggregate data detail related to SA processing timeframes, untimely processing rates, peer-to-peer activities, SA approval and denial rates. The report also includes a log of member specific information related to SA denials.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
BHPARITY.01	Behavioral Health Parity Attestation	Standard report for MCO to attest to compliance with behavioral health parity requirements.	Table	Calendar Year	Annually	January 31st			X						X

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
BHSTRATEGY.01	Behavioral Health Strategy Plan and Report	Annual comprehensive plan describing the MCO's program, policies and procedures regarding the continuity and coordination of covered physical and Behavioral Health Services and integration between physical health and behavioral health Providers. The initial Plan shall address but not be limited to how the MCO shall 1) assure Participating Providers meet SAMHSA Standard Framework for Levels of Integrated Healthcare; 2) assure appropriateness of diagnosis, treatment, and referral of behavioral health disorders commonly seen by PCPs; 3) assure promotion of Integrated Care; 4) reduce Psychiatric Boarding; 5) reduce Behavioral Health Readmissions; 6) reduce Behavioral Health related emergency department utilization; 7) support the NH 10-Year Mental Health Plan; 8) assure appropriateness of psychopharmacological medication; 9) assure access to appropriate services; 10) implement a training plan that includes, but is not limited to, Trauma-Informed Care and Integrated Care; and 11) other information in accordance with Exhibit O: Quality and Oversight Reporting Requirements.	Plan	Agreement Year	Annually	May 15th									X
BHSURVEY.01	Behavioral Health Satisfaction Survey Annual Report	Standard template to report the results of the annual behavioral health consumer satisfaction survey for members with mental health and substance use disorder (SUD) conditions. The report includes all mandatory questions for the survey.	Table	Calendar Year	Annually	June 30th								X	

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAHPS_A.01	Adult CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the Adult Medicaid CAHPS 5.0 survey population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS® Volume 3; Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_A.02	Adult CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the Adult Medicaid CAHPS 5.0H Validated Member Level Data File.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_A.03	Adult CAHPS: Medicaid Adult Survey Results Report	This report includes summary information about the Adult Medicaid CAHPS 5.0H survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_A.04	Adult CAHPS: CAHPS Survey Results with Confidence Intervals	This file provides CAHPS 5.0H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	
CAHPS_A.05	Adult CAHPS: Survey Instrument Proofs created by Survey Vendor	Adult Medicaid CAHPS 5.0H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	Feb 28th			X	X				X	

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAHPS_A.06	Adult CAHPS: Submission of Data to AHRQ CAHPS Database for CMS Child Core Set	Submission of CAHPS Data to AHRQ CAHPS Database for CMS Child Core Set	Upload to AHRQ	Standard HEDIS Schedule	Annually	June 5 – June 30				X					
CAHPS_A_SUP	Adult CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Measure	Standard HEDIS Schedule	Annually	July 31st			X					X	X
CAHPS_CCC.01	Child w CCC CAHPS: Validated Member Level Data File (VMLDF)	Respondent-level file for the CAHPS Medicaid Child with CCC 5.0H survey population. This file will include respondents identified as either General Population, or Child with Chronic Conditions (Child with CCC) Population. Please note: MCOs must achieve at least 411 "Complete and Eligible" surveys for both the adult and child CAHPS components. In addition, each of the following should have a denominator exceeding 100 to ensure NCQA can report the data. Please reference HEDIS® Volume 3, Specifications for Survey Measures for definitions of these question types and their denominators. If either number was not achieved in prior years, the MCO should consider oversampling or, increasing previous oversampling rates.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_CCC.02	Child w CCC CAHPS: Validated Member Level Data File (VMLDF) - Layout	This document should include the layout information for the CAHPS Child with CCC 5.0H Survey Validated Member Level Data File.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_CCC.03	Child w CCC CAHPS: Medicaid Child with CCC - CCC Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAHPS_CCC.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - Child with CCC	This file provides CAHPS 5.0H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	
CAHPS_CCC.05	Child w CCC CAHPS: Survey Instrument Proofs created by Survey Vendor	CAHPS Child with CCC 5.0H survey instrument proofs created by Survey Vendor, for validation of questions included in survey, including supplemental questions as outlined in Exhibit O.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	Feb 28th			X	X				X	
CAHPS_CCC.06	Child w CCC CAHPS: Submission of Data to AHRQ CAHPS Database for CMS Child Core Set	Submission of CAHPS Data to AHRQ CAHPS Database for CMS Child Core Set	Upload to AHRQ	Standard HEDIS Schedule	Annually	June 5 – June 30				X					
CAHPS_CCC_SUP	Child CAHPS: Supplemental Questions	Up to 12 supplemental questions selected by DHHS and approved by NCQA, typically questions developed by AHRQ.	Measure	Standard HEDIS Schedule	Annually	July 31st			X	X				X	X
CAHPS_CGP.03	Child w CCC CAHPS: Medicaid Child with CCC - General Population Survey Results Report	This report includes summary information about the survey sample, as well as results for some survey questions and values for composite measures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
CAHPS_CGP.04	Child w CCC CAHPS: Survey Results with Confidence Intervals - General Population	This file provides CAHPS 5.0H survey results for each question and breakout listed in the DHHS CAHPS file submission specifications. It will include the following data points for each question and breakout: Frequency/Count, Percent, Standard Error of Percent, 95% Confidence Lower Limit for Percent, and 95% Confidence Upper Limit for Percent.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CARECOORD.05	Members Receiving Provider-based Care Coordination	Count and percent of members receiving provider-based care coordination during the measurement quarter.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
CARECOORD.06	Members Receiving Provider-based Care Coordination by Provider Group Practice	Count and percent of members receiving provider-based care coordination at the end of the measurement quarter, by Provider Group Practice.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
CARECOORD.07	Provider-based Care Coordination Plan	Overview of the MCO plan to implement and operate their Provider-based Care Coordination program for the next agreement year.	Plan	Agreement Year	Annually	May 1st									X
CARECOORD.08	Provider-based Care Coordination Quarterly Report	Narrative report describing the status of the Provider-based Care Coordination program, including successes and challenges, how it is going with provider engagement, what providers, etc. Include data to illustrate findings.	Narrative Report	Agreement Year	Annually	May 1st									X
CAREMGT.28A	Members Receiving MCO-based Care Management by Priority Population: Behavioral health inpatient admissions in the previous twelve (12) months	Standard template capturing quarterly counts of members enrolled in care management during the quarter broken out by special populations outlined in the Care Management section of the MCM Contract: Individuals who have required an inpatient admission for a behavioral health diagnosis within the previous twelve (12) months	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
CAREMGT.28B	Members Receiving MCO-based Care Management by Priority Population: Low Birth Weight and NAS Babies	Standard template capturing quarterly counts of members enrolled in care management during the quarter broken out by special populations outlined in the Care Management section of the MCM Contract: Babies diagnosed with low birth weight and/or neonatal abstinence syndrome (NAS)	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

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Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.28C	Members Receiving MCO-based Care Management by Priority Population: Incarcerated Individuals with Behavioral Health Needs	Standard template capturing quarterly counts of members enrolled in care management during the quarter broken out by special populations outlined in the Care Management section of the MCM Contract: Individuals with behavioral health needs who are incarcerated in the State's prisons and eligible for participation in the Department's Community Reentry demonstration waiver (pending CMS approval)	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
CAREMGT.28D	Members Receiving MCO-based Care Management by Priority Population: DCYF Involved Children and Youth	Standard template capturing quarterly counts of members enrolled in care management during the quarter broken out by special populations outlined in the Care Management section of the MCM Contract: Infants, children and youth who are involved in the State's protective services and juvenile justice system, Division for Children Youth and Families (DCYF), including those in foster care, and/or those who have elected voluntary supportive services.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
CAREMGT.28E	Members Receiving MCO-based Care Management by Special Population: TBD	Standard template capturing quarterly counts of members enrolled in care management during the quarter broken out by special populations outlined in the Care Management section of the MCM Contract.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
CAREMGT.43	Members Receiving MCO-based Care Management	Count and percent of members enrolled in MCO-based care management on the last day of the month, by special population group.	Measure	Month	Monthly	1 Month after end of Measurement Period						X			X
CAREMGT.47	Care Management Plan for MCO-based Special Population Care Management	MCO plan to implement and operate their special population care management program for the next agreement year, to include how the MCO will take social determinants of health into account.	Plan	Agreement Year	Annually	May 1st									X

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CAREMGT.48	MCO-based Care Management for Special Populations Quarterly Report	Narrative report describing the status of the MCO care management program for special populations, including successes and challenges, and how the MCO took social determinants of health into account. Include data to illustrate findings.	Narrative Report	Agreement Year	Annually	May 1st									X
CLAIM.08	Interest on Late Paid Claims	Total interest paid on professional and facility claims not paid within 30 calendar days of receipt using interest rate published in the Federal Register in January of each year for the Medicare program. Note: Claims include both Medical and Behavioral Health claims.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.11	Professional and Facility Medical Claim Processing Results	Count and percentage of professional and facility medical claims received in the measurement period, with processing status on the last day of the measurement period that are Paid, Suspended, or Denied.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.17	Average Pharmacy Claim Processing Time	The average pharmacy claim processing time per point of service transaction, in seconds. The contract standard in Amendment 7, section 14.1.9 is: The MCO shall provide an automated decision during the POS transaction in accordance with NCPDP mandated response times within an average of less than or equal to three (3) seconds. Note: Claims include both Medical and Behavioral Health claims.	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.21	Timely Processing of Electronic Provider Claims: Fifteen Days of Receipt	Count and percent of clean electronic provider claims processed within 15 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CLAIM.22	Timely Processing of Non-Electronic Provider Claims: Thirty Days of Receipt	Count and percent of clean non-electronic provider claims processed within 30 calendar days of receipt, for those claims received during the measurement period, excluding pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.23	Timely Processing of All Clean Provider Claims: Thirty Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 30 calendar days of receipt, or receipt of additional information for those claims received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT).	Measure	Month	Monthly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.24	Timely Processing of All Clean Provider Claims: Ninety Days of Receipt	Count and percent of clean provider claims (electronic and non-electronic) processed within 90 calendar days of receipt of the claim, for those received during the measurement period. Exclude pharmacy point of service (POS) claims and non-emergent medical transportation (NEMT) claims.	Measure	Month	Monthly	110 Calendar Days after end of Measurement Period			X						X
CLAIM.25	Claims Quality Assurance - Claims Payment Accuracy	Sampled percent of all provider claims that are paid or denied correctly during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure	Quarter	Quarterly	50 Calendar Days after end of Measurement Period			X						X

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CLAIM.26	Claims Quality Assurance: Claims Financial Accuracy	Sampled percent of dollars accurately paid for provider claims during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims. Note: It is measured by evaluating dollars overpaid and underpaid in relation to total paid amounts taking into account the dollar stratification of claims.	Measure	Quarter	Quarterly	50 Calendar Days after end of Measurement Period			X						X
CLAIM.27	Claims Quality Assurance: Claims Processing Accuracy	Sampled percent of all provider claims that are accurately processed in their entirety from both a financial and non-financial perspective during the measurement period by claim type: A. Professional Claims Excluding Behavioral Health; B. Facility Claims Excluding Behavioral Health; C. Pharmacy Point Of Service (POS) Claims; D. Non-Emergent Medical Transportation (NEMT) Claims; E. Behavioral Health Professional Claims; F. Behavioral Health Facility Claims.	Measure	Quarter	Quarterly	50 Calendar Days after end of Measurement Period			X						X
CMS_A_AMM.01	Antidepressant Medication Management: Effective Acute Phase Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS AMM measure.	Measure	May 1 of year prior to measurement year to Oct 31 of measurement year.	Annually	September 30th				X			X		

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_A_AMM.02	Antidepressant Medication Management: Effective Continuation Phase Treatment	CMS Adult Core Set - Age breakout of data collected for HEDIS AMM measure.	Measure	May 1 of year prior to measurement year to Oct 31 of measurement year.	Annually	September 30th				X			X		
CMS_A_AMR	Asthma Medication Ratio	CMS Adult Core Set - Age breakout of data collected for HEDIS AMR measure.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_BCS	Breast Cancer Screening	CMS Adult Core Set - Age breakout of data collected for HEDIS BCS measure.	Measure	2 Calendar Years	Annually	September 30th				X					
CMS_A_CBP	Controlling High Blood Pressure	CMS Adult Core Set - Age breakout of data collected for HEDIS CBP measure.	Measure	Calendar Year	Annually	September 30th				X			X		
CMS_A_CCP.01	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 3 Days	CMS Adult and Child Core Sets - The percentage of women ages 15 through 44 who had a live birth and were provided a most or moderately effective method of contraception within 3 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CCP.02	Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 90 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a most or moderately effective method of contraception within 90 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CCP.03	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 3 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_A_CCP.04	Contraceptive Care – Postpartum Women: Long-Acting Reversible Method of Contraception (LARC) – 90 days	CMS Adult and Child Core Sets - The percentage of women ages 15 to 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 90 days of delivery by age group.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_CDF	Screening for Clinical Depression and Follow-up Plan	CMS Adult and Child Core Sets (member age determines in which set the member is reported)	Measure	Calendar Year	Annually	September 30th				X			X		
CMS_A_COL.01	Colorectal Cancer Screening	CMS Adult Core Set - Age breakout of data collected for HEDIS COL measure.	Measure	Calendar Year with a 10 Year Look-back	Annually	September 30th				X					
CMS_A_CUOB	Concurrent Use of Opioids and Benzodiazepines	CMS Adult Core Set - Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines.	Measure	Calendar Year	Annually	September 30th				X	X				
CMS_A_FUA.01	Follow-Up after Emergency Department Visit for Substance Use: Within 7 Days of ED Visit	CMS Adult Core Set - Age breakout of data collected for HEDIS FUA measure. Include supplemental data as described in the DHHS reporting specification.	Measure	Calendar Year	Annually	September 30th				X			X		
CMS_A_FUA.02	Follow-Up after Emergency Department Visit for Substance Use: Within 30 Days of ED Visit	CMS Adult Core Set - Age breakout of data collected for HEDIS FUA measure. Include supplemental data as described in the DHHS reporting specification.	Measure	Calendar Year	Annually	September 30th				X			X		
CMS_A_HBD.01	Hemoglobin A1c Control for Patients With Diabetes - HbA1c control (<8.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c control (<8.0%).	Measure	Calendar Year	Annually	September 30th				X			X		

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_A_HBD.02	Hemoglobin A1c Control for Patients With Diabetes - HbA1c poor control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for HEDIS HBD measure, reflecting the rate for HbA1c poor control (>9.0%).	Measure	Calendar Year	Annually	September 30th				X			X		
CMS_A_HPCMI	Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set - Age breakout of data collected for a former HEDIS measure.	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_IET.01	Initiation of Substance Use Disorder Treatment - Alcohol and Other Drug Abuse or Dependence (IET, CMS Adult Core Set)	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_IET.02	Engagement of Substance Use Disorder Treatment - Alcohol and Other Drug Abuse or Dependence (IET, CMS Adult Core Set)	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_IET.03	Initiation of Substance Use Disorder Treatment - Alcohol Abuse or Dependence (IET, CMS Adult Core Set)	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure	Calendar Year	Annually	September 30th				X	X		X		

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CMS_A_IET.04	Engagement of Substance Use Disorder Treatment - Alcohol Abuse or Dependence (IET, CMS Adult Core Set)	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_IET.05	Initiation of Substance Use Disorder Treatment - Opioid Abuse or Dependence (IET, CMS Adult Core Set)	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_IET.06	Engagement of Substance Use Disorder Treatment - Opioid Abuse or Dependence (IET, CMS Adult Core Set)	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_IET.07	Initiation of Substance Use Disorder Treatment - Other Drug Abuse or Dependence (IET, CMS Adult Core Set)	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_IET.08	Engagement of Substance Use Disorder Treatment - Other Drug Abuse or Dependence (IET, CMS Adult Core Set)	CMS Adult Core Set - Age breakout of data collected for HEDIS IET measure. Include supplemental data as described in the DHHS reporting specification.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_INP_PQI01	Diabetes Short-Term Complication Admissions	CMS Adult Core Set - Diabetes Short-Term Complications Admission Rate	Measure	Calendar Year	Annually	September 30th				X					

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Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
CMS_A_INP_PQI05	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions	CMS Adult Core Set - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_INP_PQI08	Heart Failure Admissions	CMS Adult Core Set - Heart Failure Admission Rate	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_INP_PQI15	Asthma in Younger Adults Admissions	CMS Adult Core Set - Asthma in Younger Adults Admission Rate	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_MSC.01	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	CMS Adult Core Set - data collected as part of CAHPS Adult Medicaid Survey	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_MSC.02	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications	CMS Adult Core Set - data collected as part of CAHPS Adult Medicaid Survey	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_MSC.03	CAHPS: Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	CMS Adult Core Set - data collected as part of CAHPS Adult Medicaid Survey	Measure	Calendar Year	Annually	September 30th				X					
CMS_A_OHD	Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage	CMS Adult Core Set - The percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more.	Measure	Calendar Year	Annually	September 30th				X	X				

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CMS_A_OUD.01	Use of Pharmacotherapy for Opioid Use Disorder - Total	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered or dispensed medication for the disorder.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.02	Use of Pharmacotherapy for Opioid Use Disorder - Buprenorphine	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Buprenorphine.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.03	Use of Pharmacotherapy for Opioid Use Disorder - Oral Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Oral Naltrexone.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.04	Use of Pharmacotherapy for Opioid Use Disorder - Long-Acting, Injectable Naltrexone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Long-Acting, Injectable Naltrexone.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_A_OUD.05	Use of Pharmacotherapy for Opioid Use Disorder - Methadone	CMS Adult Core Set - One of five rates reported, Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder who filled a prescription for or were administered Methadone.	Measure	Calendar Year	Annually	September 30th				X	X		X		
CMS_CCW.01	Contraceptive Care – All Women Ages 15 – 44: Most or Moderately Effective Contraception	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure	Calendar Year	Annually	September 30th				X					
CMS_CCW.02	Contraceptive Care – All Women Ages 15 – 44: Long-Acting Reversible Method of Contraception (LARC)	CMS Adult and Child Core Sets - including CMS age breakouts (member age determines in which set the member is reported).	Measure	Calendar Year	Annually	September 30th				X					

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CMS_CH_DEV	Developmental Screening in the First Three Years of Life	CMS Child Core Set - Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Measure	Calendar Year	Annually	September 30th				X					
CMS_CORE_SET.01	CMS Core Set Member Level Data	This file contains member/event level data for select CMS Core Set measures. Data will reflect the results for these measures in the corresponding CMS Core Set measures for the same measurement period. The list of DHHS-selected CMS Core Set measures will appear in an appendix listed in the deliverable specification and is subject to change each measurement year.	CMS Core Set Files	Calendar Year	Annually	September 30th				X					X
CULTURALCOMP.01	Cultural Competency Strategic Plan	MCO strategic plan to provide culturally and linguistically appropriate services, including, but not limited to how the MCO is meeting the need as evidenced by communication access utilization reports, quality improvement data disaggregated by race, ethnicity and language, and the community assessments and profiles.	Plan	Agreement Year	Annually	May 1st									X
DHHS_LEAD.01	Lead Screening in Children (State Requirements)	Lead Screening Measure based on State of NH requirements. Criteria will come from DHHS Division of Public Health Services.	Measure	Rolling 12 Months	Quarterly	2 Months after end of Measurement Period	X								X
DUR.01	Drug Utilization Review (DUR) Annual Report	This annual report includes Center for Medicaid and Medicaid Services (CMS) required information on the operation of the MCO's Medicaid DUR Program. Each MCO will submit this report directly to CMS utilizing a link provided by the Medicaid Pharmacy Services team.	Upload to CMS	Federal Fiscal Year	Annually	May 15th			X						X

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EMERGENCY RESPONSE.01	Emergency Response Plan	Description of MCO planning in the event of an emergency to ensure ongoing, critical MCO operations and the assurances to meet critical member health care needs, including, but not limited to, specific pandemic and natural disaster preparedness. After the initial submission of the plan the MCO shall submit a certification of "no change" to the Emergency Response Plan or submit a revised Emergency Response Plan together with a redline reflecting the changes made since the last submission.	Plan	Agreement Year	Annually	May 1st									X
EPSDT.01	Delivery of Applied Behavioral Analysis Services Under Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Benefit	Standard template that captures the total paid units of each of the ABA services by member for the purpose of fiscal impact analysis.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
EPSDT.20	Early and Periodic Screening, Diagnostics, & Treatment (EPSDT) Plan	MCO EPSDT plan includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure provider network compliance that all members under age 21 receive all the elements of the preventive health screenings recommended by the AAP's most currently published Bright Futures guidelines for well-child care in accordance with the EPSDT periodicity schedule. Additionally, the MCO EPSDT plan must include written policies and procedures for the provision of a full range of EPSDT diagnostic and treatment services.	Plan	Agreement Year	Annually	May 1st									X
EQRO.01	MCO Follow-up on EQRO Recommendations	This semi-annual report will provide a description of actions taken to address select MCO-specific findings/recommendations identified by NH EQRO quality reports.	Narrative Report	6 Months	Semi-Annually	1 Month after end of Measurement Period									X

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FINANCIALSTMT.01	MCO Annual Financial Statements	The MCO shall provide DHHS a complete copy of its audited financial statements and amended statements.	Narrative Report	MCO Financial Period	Annually	August 10th									X
FWA.02	Provider Fraud Log	Standard template log of all fraud related to providers, in process and completed during the month by the MCO or its subcontractors. This log includes but is not limited to case information, current status, and final outcome for each case including overpayment and recovery information.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X
FWA.04	Date of Death Report	Standard template that captures a list of members who expired during the measurement period.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X
FWA.05	Explanation Of Medical Benefit Report	Standard template that includes a summary explanation of medical benefits sent and received including the MCO's follow-up, action/outcome for all EMB responses that required further action.	Table	Quarter	Quarterly	1 Month after end of Measurement Period			X						X
FWA.06	Waste and Abuse Recovery Report	Standard template reporting waste and abuse identified and recovered by the MCO.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
FWA.20	Comprehensive Annual Prevention of Fraud Waste and Abuse Summary Report	The MCO shall provide a summary report on MCO Fraud, Waste and Abuse investigations. This should include a description of the MCO's special investigation's unit. The MCO shall describe cumulative overpayments identified and recovered, investigations initiated, completed, and referred, and an analysis of the effectiveness of activities performed. The MCO's Chief Financial Officer will certify that the information in the report is accurate to the best of his or her information, knowledge, and belief.	Narrative Report	Agreement Year	Annually	September 30th			X						X

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GRIEVANCE.02	Grievance Log Including State Plan / 1915B Waiver Flag	Standard template log of all grievances with detail on grievances and any corrective action or response to the grievance for grievances made within the measure data period.	Table	Quarter	Quarterly	15 Calendar Days after end of Measurement Period			X		X	X			
GRIEVANCE.03	Member Grievances Received	Count and Percent of member grievances received during the measure data period, per 1,000 member months.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period			X						
GRIEVANCE.05	Timely Processing of All Grievances	Count and percent of grievances processed within contract timeframes for grievances made during the measurement period.	Measure	Quarter	Quarterly	3 Months after end of Measurement Period			X					X	
HEDIS.01	HEDIS Roadmap	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
HEDIS.02	HEDIS Data Filled Workbook	Workbook containing the NCQA audited results for all HEDIS measures, with one measure appearing on each tab.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
HEDIS.03	HEDIS Comma Separated Values Workbook	This file includes NCQA audited results for all HEDIS measures, and should include the Eligible Population and/or Denominator, Numerator, Rate, and Weight (for hybrid measures) for each measure.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	June 30th			X	X				X	
HEDIS.04	NCQA HEDIS Compliance Audit™ Final Audit Report	This documentation is outlined in HEDIS Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.	HEDIS/ CAHPS Files	Standard HEDIS Schedule	Annually	July 31st			X	X				X	

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HEDIS.06	HEDIS Member Level Data	This file contains member/event level data for select HEDIS measures. Data will reflect the NCQA audited results for these measures in the corresponding HEDIS Data-Filled Workbook for the same measurement period. The current list of DHHS-selected HEDIS measures appears in *Appendix AF - HEDIS Measures Included in HEDIS.06* and is subject to change each measurement year.	HEDIS/ CAHPS Files	Calendar Year	Annually	June 30th					X				X
HEDIS_AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	HEDIS Measure, also utilized for CMS Core Sets	Measure	One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th				X				X	
HEDIS_ADD	Follow-Up Care for Children Prescribed ADHD Medication	HEDIS Measure, also utilized for CMS Core Sets	Measure	One year starting March 1 of year prior to measurement year to February 28 of measurement year.	Annually	June 30th				X			X	X	X
HEDIS_AIS-E	Adult Immunization Status	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_AMB	Ambulatory Care	HEDIS Measure for Outpatient and Emergency Dept. Visits/1000 Member Months, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X					X

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HEDIS_AMM	Antidepressant Medication Management	HEDIS Measure, also utilized for CMS Core Sets	Measure	May 1 of year prior to measurement year to Oct 31 of measurement year.	Annually	June 30th				X				X	X
HEDIS_AMR	Asthma Medication Ratio	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X				X	
HEDIS_APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	X
HEDIS_APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X	X		X			X	X	X
HEDIS_AXR	Antibiotic Utilization for Respiratory Conditions (AXR)	HEDIS Measure	Measure	Calendar Year	Annually	June 30th	X	X							X
HEDIS_BCS	Breast Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure	2 Calendar Years	Annually	June 30th	X	X		X				X	X
HEDIS_BCS-E	Breast Cancer Screening	HEDIS Measure	Measure	2 Calendar Years	Annually	June 30th								X	X
HEDIS_BPD	Blood Pressure Control for Patients With Diabetes	HEDIS Measure formerly part of HEDIS_CDC, also utilized for CMS Core Sets.	Measure	Calendar Year	Annually	June 30th	X							X	X

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HEDIS_CBP	Controlling High Blood Pressure	HEDIS Measure. Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure	Calendar Year	Annually	June 30th	X			X			X	X	X
HEDIS_CCS	Cervical Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure	3 Calendar Years	Annually	June 30th				X				X	X
HEDIS_CHL	Chlamydia Screening in Women	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X			X				X	X
HEDIS_CIS	Childhood Immunization Status	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X				X	X
HEDIS_COL	Colorectal Cancer Screening	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year with a 10 Year Look-back	Annually	June 30th				X					
HEDIS_COU	Risk of Chronic Opioid Use	HEDIS Measure	Measure	Calendar Year	Annually	June 30th					X				X
HEDIS_CRE	Cardiac Rehabilitation	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X
HEDIS_CWP	Appropriate Testing for Pharyngitis	HEDIS Measure	Measure	One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th								X	
HEDIS_EED	Eye Exam for Patients With Diabetes (EED)	HEDIS Measure formerly part of HEDIS_CDC, also utilized for CMS Core Sets.	Measure	Calendar Year	Annually	June 30th								X	X

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HEDIS_FMC	Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure	Calendar Year	Annually	June 30th									X
HEDIS_FUA	Follow-Up After Emergency Department Visit for Substance Use	HEDIS Measure, also utilized for CMS Core Sets Include supplemental data as described in the reporting specification.	Measure	Calendar Year	Annually	June 30th		X		X	X		X	X	X
HEDIS_FUH	Follow-Up After Hospitalization For Mental Illness	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure	January 1 to December 1 of measurement year	Annually	June 30th				X			X	X	X
HEDIS_FUI	Follow-Up After High-Intensity Care for Substance Use Disorder	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure	January 1 to December 1 of measurement year	Annually	June 30th								X	X
HEDIS_FUM	Follow-Up After Emergency Department Visit for Mental Illness	HEDIS Measure, also utilized for CMS Core Sets Include supplemental data as described in the reporting specification.	Measure	Calendar Year	Annually	June 30th		X		X			X	X	X
HEDIS_FVA	Flu Vaccinations for Adults Ages 18–64	HEDIS Measure Collected through the CAHPS Health Plan Survey, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_HBD	Hemoglobin A1c Control for Patients With Diabetes	HEDIS Measure formerly part of HEDIS_CDC. Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure	Calendar Year	Annually	June 30th				X				X	X
HEDIS_HDO	Use of Opioids at High Dosage	HEDIS Measure	Measure	Calendar Year	Annually	June 30th					X				X

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HEDIS_IET	Initiation and Engagement of Substance Use Disorder Treatment (IET)	HEDIS Measure Include supplemental data as described in the reporting specification.	Measure	Calendar Year	Annually	June 30th	X			X	X			X	X
HEDIS_IMA	Immunizations for Adolescents	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	X			X				X	X
HEDIS_KED	Kidney Health Evaluation for Patients with Diabetes	HEDIS Measure, also utilized for CMS Core Sets.	Measure	Calendar Year	Annually	June 30th								X	X
HEDIS_LBP	Use of Imaging Studies for Low Back Pain	HEDIS Measure	Measure	Calendar Year	Annually	June 30th	X							X	
HEDIS_LSC	Lead Screening in Children	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X					X
HEDIS_MSC	Medical Assistance With Smoking and Tobacco Use Cessation	HEDIS Measure Collected through the CAHPS Health Plan Survey	Measure	Calendar Year	Annually	June 30th				X				X	
HEDIS_PCE	Pharmacotherapy Management of COPD Exacerbation	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_PCR	Plan All-Cause Readmissions	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	X
HEDIS_PDS-E	Postpartum Depression Screening and Follow-Up	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X
HEDIS_PND-E	Prenatal Depression Screening and Follow-Up	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X

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Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_POD	Pharmacotherapy for Opioid Use Disorder	HEDIS Measure	Measure	One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th								X	X
HEDIS_PPC	Prenatal and Postpartum Care	HEDIS Measure, also utilized for CMS Core Sets Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure	Calendar Year	Annually	June 30th	x			X				X	X
HEDIS_PRS-E	Prenatal Immunization Status	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_RDM	Race/Ethnicity Diversity of Membership	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	x			X			X	X	X
HEDIS_SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X
HEDIS_SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	HEDIS Measure	Measure	Calendar Year	Annually	June 30th									X

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
HEDIS_SPC	Statin Therapy for Patients with Cardiovascular Disease	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_SPD	Statin Therapy for Patients with Diabetes	HEDIS Measure	Measure	Calendar Year	Annually	June 30th								X	
HEDIS_SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th	x	X		X				X	X
HEDIS_UOP	Use of Opioids from Multiple Providers	HEDIS Measure	Measure	Calendar Year	Annually	June 30th					X				X
HEDIS_URI	Appropriate Treatment for Upper Respiratory Infection	HEDIS Measure	Measure	One year starting July 1 of year prior to measurement year to June 30 of measurement year.	Annually	June 30th								X	
HEDIS_W30	Well-Child Visits in the First 30 Months of Life	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th			X	X					X
HEDIS_WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	HEDIS Measure, also utilized for CMS Core Sets	Measure	Calendar Year	Annually	June 30th				X			X	X	X

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HEDIS_WCV	Child and Adolescent Well-Care Visits	HEDIS Measure, also utilized for CMS Core Sets Race and ethnicity breakouts as specified in HEDIS Volume 2 - First Reporting Year will be 2023 for Measurement Year 2022.	Measure	Calendar Year	Annually	June 30th			X	X					X
HRA.10	Provider-based Health Risk Assessment Screening Implementation Plan	Overview of the MCO plan to facilitate, implement and operate a system of provider-based health risk assessment screenings.	Plan	Agreement Year	Annually	May 1st									X
HRA.11	Provider-based Health Risk Assessment Screening Quarterly Report	Narrative report on facilitation, implementation and operation of provider-based health risk assessment screenings. Include data to illustrate findings.	Narrative Report	Agreement Year	Annually	May 1st									X
HRA.12	Successful Completion of Provider-based Health Risk Assessment Screenings	Count and percent of members for whom the MCO paid claims for completion of provider-based health risk assessment screenings during the measurement year, as of the last day of the measurement year.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
HRA.13	Successful Completion of Provider-based Health Risk Assessment Screenings by Provider Group Practice	Count and percent of members for whom the MCO paid claims for completion of provider-based health risk assessment screenings during the measurement year, by provider group practice, as of the last day of the measurement year.	Table	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
HRA.14	Transmission of MCO-Collected Health Risk Assessment Data	Count and percent of members for whom the MCO transmitted health risk assessment data captured by the MCO to member primary care providers during the measurement year, as of the last day of the measurement year.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X

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IMDDISCHARGE.01	State of NH IMD Hospital Discharges - New CMHC Patient Had Intake Appointment with CMHC within 7 Calendar Days Post Member Discharge	Count and percent of State of NH IMD Hospital discharges where the member had an intake appointment with a NH Community Mental Health Center (NH CMHC) within 7 calendar days post discharge AND was not a patient of the applicable CMHC at admission to the State of NH IMD Hospital.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
IMDDISCHARGE.02	State of NH IMD Hospital Discharges – Successful Contacts For Community-based Follow-up Within 72-Hours Post Member Discharge	Count and percent of members discharged from a State of NH IMD Hospital during the measurement period, where the State of NH IMD Hospital 1) provided the Discharge Plan to the member's community-based provider and 2) contacted the provider, both within 72-hours post discharge. This lays the groundwork for the provider to reach out to the member and encourage appropriate follow-up care from the provider.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
INLIEUOF.01	In Lieu of Services Report	A narrative report describing the cost effectiveness of each approved In Lieu of Service by evaluating utilization and expenditures. *Note: Report will not be required if there are no In Lieu of Services.*	Narrative Report	Agreement Year	Annually	November 1st			X						X
INTEGRITY.01	Program Integrity Plan	Plan for program integrity which shall include, at a minimum, the establishment of internal controls, policies, and procedures to prevent, detect, and deter fraud, waste, and abuse, as required in accordance with 42 CFR 455, 42 CFR 456, and 42 CFR 438.	Plan	Agreement Year	Annually	May 1st, Upon Revision			X						
LOCKIN.01	Pharmacy Lock-in Member Enrollment Log	Standard template listing specific members being locked in to a pharmacy for the measurement period.	Table	Month	Monthly	1 Month after end of Measurement Period									X
LOCKIN.03	Pharmacy Lock-in Activity Summary	Standard template with aggregate data related to pharmacy lock-in enrollment and changes during the measurement period.	Table	Month	Monthly	1 Month after end of Measurement Period									X

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MCISPLANS.01	Managed Care Information System Contingency Plans (Disaster Recovery, Business Continuity, and Security Plan)	MCO shall annually submit its managed care information system (MCIS) plans to ensure continuous operation of the MCIS. This should include the MCOs risk management plan, systems quality assurance plan, confirmation of 5010 compliance and companion guides, and confirmation of compliance with IRS publication 1075.	Plan	Agreement Year	Annually	June 1st									X
MEMCOMM.01	Member Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound member calls answered by a live voice within 30 seconds, by health plan vendor.	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X
MEMCOMM.03	Member Communications: Calls Abandoned	Count and percent of inbound member calls abandoned while waiting in call queue, by health plan vendor.	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X
MEMCOMM.06	Member Communications: Reasons for Telephone Inquiries	Count and percent of inbound member telephone inquiries connected to a live person by reason for Inquiry. Reasons include A: Benefit Question Non-Rx, B: Rx-Question, C: Billing Issue, D: Finding/Changing a PCP, E: Finding a Specialist, F: Complaints About Health Plan, G: Enrollment Status, H: Material Request, I: Information/Demographic Update, J: Giveaways, K: Other, L: NEMT Inquiry	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X
MEMCOMM.24	Member Communications: Calls Returned by the Next Business Day	Count and percent of member voicemail or answering service messages responded to by the next business day.	Measure	Month	Monthly	1 Month after end of Measurement Period			X						X

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MEMINCENTIVE.01	Member Incentive Table	Standard template reporting detail around member incentives including category, number of payments, and dollar value of payments for member incentive payments during the measurement period. Annually the MCO will include a statistically sound analysis of the member incentive program and identify goals and objectives for the following year.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X
MEMINCENTIVE.02	Member Incentive Plan	Annual member incentive plan including goals and objectives associated with the MCOs member incentive strategy.	Plan	Agreement Year	Annually	May 1st									X
MHDISCHARGE.01	Follow-up Visit after Discharge for Mental Health-Related Conditions - Within 7 Days of Discharge	Count and percent of member discharges with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a mental health practitioner within 7 calendar days of discharge, by facility type, age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period						X			X
MHDISCHARGE.02	Follow-up Visit after Discharge for Mental Health-Related Conditions - Within 30 Days of Discharge	Count and percent of member discharges with a primary diagnosis for a mental health-related condition where the member had at least one follow-up visit with a mental health practitioner within 30 calendar days of discharge, by facility type, age group, CMHC eligibility, and Medicare/Medicaid dual enrollment.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period						X			X

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MHDISCHARGE.03	ED Visits for Mental Health Preceded by a State of NH IMD Hospital Stay in Past 30 Days	Count and percent of mental health related emergency department (ED) visits where: 1) The member was discharged from a State of NH IMD Hospital or Designated Receiving Facility (DRF) up to 30 days prior to the ED visit, and 2) The primary diagnosis for the ED visit was mental health related, and 3) The ED visit did not result in an inpatient admission or direct transfer to a State of NH IMD Hospital or DRF. Report the values for continuously enrolled Medicaid members, by age group, CMHC eligibility (SMI, SED and Non-CMHC subpopulations), and Medicare/Medicaid dual enrollment.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
MHEDBRD.01	Emergency Department Psychiatric Boarding Table	Standard template broken out by children and adults with the number of members who awaited placement in the emergency department or medical ward for 24 hours or more. Summary totals by disposition of those members who were waiting for placement; the average length of stay while awaiting placement; and the count and percent of those awaiting placement who were previously awaiting placement within the prior 30, 60 and 90 days.	Table	Month	Monthly	1 Month after end of Measurement Period									X
MHREADMIT.03	Mental Health Readmissions: Service Utilization Prior to Readmission	For Members for the measurement month who represented a readmission within 180 days, the MCO will report on the mental health and related service utilization that directly preceded each such readmission in accordance with Exhibit O.	Table	Quarter	Quarterly	4 Months after end of Measurement Period						X			X
MHREADMIT.04	Readmissions for Mental Health Conditions within 30 Days of Discharge	Count and percent of member discharges with a primary diagnosis for a mental health-related condition, readmitted for a mental health-related condition within 30 days of a previous discharge, by facility type, age group, CMHC eligibility (SMI, SED and Non-CMHC subpopulations), and Medicare/Medicaid dual enrollment.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period						X			X

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MHREADMIT.05	Readmissions for Mental Health Conditions within 90 Days of Discharge	Count and percent of member discharges with a primary diagnosis for a mental health-related condition, readmitted for a mental health-related condition within 90 days of a previous discharge, by facility type, age group, CMHC eligibility (SMI, SED and Non-CMHC subpopulations), and Medicare/Medicaid dual enrollment.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period						X			X
MHREADMIT.06	Readmissions for Mental Health Conditions within 180 Days of Discharge	Count and percent of member discharges with a primary diagnosis for a mental health-related condition, readmitted for a mental health-related condition within 180 days of a previous discharge, by facility type, age group, CMHC eligibility (SMI, SED and Non-CMHC subpopulations), and Medicare/Medicaid dual enrollment.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period						X			X
MHSUICIDE.01	Zero Suicide Plan	Plan for incorporating the "Zero Suicide" model promoted by the National Action Alliance for Suicide Prevention (US Surgeon General) with providers and beneficiaries.	Plan	Agreement Year	Annually	May 1st									X
MLR.01	Medical Loss Ratio Report	Standard template developed by DHHS actuaries that includes all information required by 42 CFR 438.8(k), and as needed other information.	Table	Quarter	Quarterly	9 Months after end of Measurement Period			X						
MONTHLYOPS.01	Monthly Operations Report	This report will include details about various operational components required by the MCO contract, as determined by DHHS.	Table	Month	Monthly	1 Month after end of Measurement Period									X
MSQ.01	Medical Services Inquiry Letter	Standard template log of Inquiry Letters sent related to possible accident and trauma. DHHS will require a list of identified members who had a letter sent during the measurement period with a primary or secondary diagnosis code requiring an MSQ letter. For related ICD Codes please make a reference to Trauma Code Tab in this template.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X

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MSQ.01	Medical Services Inquiry Letter	Standard template log of Inquiry Letters sent related to possible accident and trauma. DHHS will require a list of identified members who had a letter sent during the measurement period with a primary or secondary diagnosis code requiring an MSQ letter. For related ICD Codes please make a reference to Trauma Code Tab in this template.	Table	Month	Monthly	1 Month after end of Measurement Period			X						X
NEMT.15	NEMT Legs Delivered by Covered Medical Service	Count and percent of Non-Emergent Medical Transportation (NEMT) delivery legs completed during the measurement period, by primary covered medical service for the leg. The measure includes eight submeasures: A: Hospital, B: Medical Provider, C: Behavioral Health Provider, D: Dentist, E: Pharmacy, F: Methadone Treatment, G. Other, and H. Dialysis. This measure excludes return legs (e.g. legs back to the original pick-up location, typically the member's home).	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.18	Results of Scheduled NEMT Legs by Outcome	Percent of Non-Emergent Medical Transportation contracted transportation provider and wheelchair van requests scheduled for all legs requested during the measurement period by outcome of the leg. This measure includes methadone treatment legs. Exclude all Family and Friends Mileage Reimbursement Program legs from this measure. Outcomes include: A: Member Canceled or Rescheduled, B: Transportation Provider Canceled or Rescheduled, C: Member No Show, D: Transportation Provider No Show, E: Other Reason Leg Wasn't Made, F: Delivered, G: Unknown if Leg Occurred, H. Unable to Secure Transportation, and I. Incorrect Mode of Transportation Dispatched.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

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NEMT.22	Family and Friends Program NEMT Legs	Count and percent of Non-Emergent Medical Transportation one-way legs delivered through the Family and Friends Mileage program.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.24	Timeliness of Scheduled and Delivered NEMT Legs	Count and percent of Non-Emergent Medical Transportation (NEMT) legs scheduled with and delivered by a contracted transportation provider during the measurement period, with an outcome of delivered on time. This measure excludes legs for methadone treatment, Family and Friends Mileage Reimbursement Program legs, legs provided by Easter Seals or other providers that offer their own NEMT services and directly transport members, and legs scheduled by a medical provider with a vendor other than the health plan's NEMT broker.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.25	Scheduled NEMT Legs from Nursing Facilities Delivered On Time	Count and percent of Non-Emergent Medical Transportation (NEMT) contracted transportation provider and wheelchair van requests from nursing facilities scheduled and delivered during the measurement period, with an outcome of delivered on time.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.26	Timely Processing of Electronic NEMT Claims: Thirty Days of Receipt	Count and percent of clean electronic Non-Emergent Medical Transportation (NEMT) claims processed within 30 calendar days of receipt, for those claims received during the measurement period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
NEMT.27	NEMT Network Adequacy Report	This will be quarterly by mode of transportation and county. Will work through specifications with MCOs and transportation brokers. This is separate from NETWORK.01.	Table	Quarter	Quarterly	TBD									X
NEMT.28	NEMT Complaint Log	Standard template providing a quarterly report of all Non-Emergent Medical Transportation (NEMT) complaints received from a member, medical provider, or transportation provider during the measurement quarter.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X

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NETWORK.01	Comprehensive Provider Network and Equal and Timely Access Annual Filing	Standard template for the MCO to report on the adequacy of its provider network and equal access, including time and distance standards.	Table	Calendar Year	Annually	45 Calendar Days after end of Measurement Period		X	X		X	X			
NETWORK.10	Corrective Action Plan to Restore Provider Network Adequacy	MCO provider exceptions to network adequacy standards. Exceptions should include necessary detail to justify the exception and a detailed plan to address the exception.	Table	Calendar Year	Annually, Ad hoc as warranted	45 Calendar Days after end of Measurement Period			X		X	X			
NETWORK.11	Access to Care Provider Survey	Results of the MCO annual timely access to care provider survey reported in a standard template.	Table	Agreement Year	Annually	45 Calendar Days after end of Measurement Period			X		X	X			
PCP_VISITS.01	Member Visits with Assigned PCP/PCP Team in the Last 12 months	Percent of members who had one or more visits with their assigned PCP/PCP Team in the last 12 months, by age group. Do not include visits where the member sees a practitioner other than the assigned PCP.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
PCP_VISITS.02	Well Care Visits with Assigned PCP/PCP Team in the Last 12 Months	Percent of members who had one or more well care visits with their PCP/PCP Team in the last 12 months, by age group. Do not include visits where the member sees a practitioner other than the assigned PCP.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X

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PDN.04	Private Duty Nursing: Authorized Hours for Children Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for child members (age 0-20 years of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
PDN.05	Private Duty Nursing: Authorized Hours for Adults Delivered and Billed by Quarter	Percent of authorized private duty nursing hours delivered and billed in the measurement period for adult members (age 21 and older of age) by the following hour breakouts: A. Day/Evening Hours, B. Night/Weekend Hours, C. Intensive Care (Ventilator Dependent) Hours, and D. Unbilled Hours. Each hour breakout is reported on a quarterly basis. Authorized hours can be used for either Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) level of care.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
PDN.07	Private Duty Nursing: Individual Detail for Members Receiving Private Duty Nursing Services	Year to Date detail related to members receiving private duty nursing services.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
PDN.08	Private Duty Nursing: Network Adequacy Report	Standard template measuring the adequacy of the MCOs network for delivering private duty nursing services	Narrative Report	Quarter	Quarterly	2 Months after end of Measurement Period									X
PHARM_PDC.01	Proportion of Days Covered - Diabetes All Class Rate (PDC-DR)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Diabetes All Class.	Measure	Calendar Year	Annually	April 30th									X

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PHARM_PDC.02	Proportion of Days Covered - Renin Angiotensin System Antagonists (PDC-RASA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for Renin Angiotensin System Antagonists.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.03	Proportion of Days Covered - Statins (PDC-STA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for statins.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.04	Proportion of Days Covered - Beta-Blockers (PDC-BB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for beta-blockers.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.05	Proportion of Days Covered - Calcium Channel Blockers (PDC-CCB)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for calcium channel blockers.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.10	Proportion of Days Covered (PDC) - Adherence to Direct-Acting Oral Anticoagulants (PDC-DOAC)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to direct-acting oral anticoagulants.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.11	Proportion of Days Covered - Adherence to Long-Acting Inhaled Bronchodilator Agents in COPD Patients (PDC-COPD)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to long-acting inhaled bronchodilator agents in COPD patients.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.12	Proportion of Days Covered - Antiretroviral Medications (PDC-ARV)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for antiretroviral medications.	Measure	Calendar Year	Annually	April 30th									X

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PHARM_PDC.13	Proportion of Days Covered - Adherence to Non-Infused Disease Modifying Agents Used to Treat Multiple Sclerosis (PDC-MS)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused disease modifying agents used to treat Multiple Sclerosis.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.14	Adherence to Non-Infused Biologic Medications Used to Treat Rheumatoid Arthritis (PDC-RA)	Count and percent of Medicaid members 18 years and older who met Proportion of Days Covered threshold during the measurement period for adherence to non-infused biologic medications used to treat rheumatoid arthritis.	Measure	Calendar Year	Annually	April 30th									X
PHARM_PDC.15	Proportion of Days Covered Composite (PDC-CMP)	The composite percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement year for: diabetes medications, RAS antagonists, and statins. This is a composite health plan performance measure that combines rates from the following component measures: • Component 1: Proportion of Days Covered: Diabetes All Class (PDC-DR) • Component 2: Proportion of Days Covered: Renin Angiotensin System Antagonist (PDC-RASA) • Component 3: Proportion of Days Covered: Statins (PDC-STA)	Measure	Calendar Year	Annually	April 30th									X
PHARMQI.09	Safety Monitoring - Opioid Prescriptions Meeting NH DHHS Morphine Equivalent Dosage Prior Authorization Compliance	Count and percent of opioid prescription fills that were prior authorized to meet the NH DHHS Morphine Equivalent Doses (MED) Prior Authorization policy in effect for the measurement period, including members with cancer or other terminal illnesses.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

EXHIBIT O – Quality and Oversight Reporting Requirements (Draft)

Description				Measurement Period and Delivery Dates			Purpose of Monitoring								
Reporting Reference ID	Name	Description / Notes	Type	Measurement Period	MCO Submission Frequency	Standard Delivery Date for Measure or Report	DHHS Quality Improvement Priorities	DHHS Quality Improvement Levers	Federal Mandate	CMS Core Sets	1115 SUD/SMI IMD Waiver	1915b Waiver	CCBHC	NCQA Accreditation	DHHS Monitoring
PHARMQI.10A	Child Psychotropic Medication Monitoring Report - Aggregate Data	Standard template of aggregated data related to children 0-18 with multiple prescriptions for psychotropic, ADHD, antipsychotic, antidepressant and mood stabilizer medications. Totals are broken out by age categories and whether the child was involved with the Division for Children, Youth, and Families.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
PHARMQI.10B	Child Psychotropic Medication Monitoring Report - DCYF PHI Data	Standard template of member specific information related to children 0-18 who have DCYF involvement and have multiple prescriptions for psychotropic, ADHD, antipsychotic, antidepressant and mood stabilizer medications.	Table	Quarter	Quarterly	1 Month after end of Measurement Period									X
PHARMQI.19	Provider-based Annual Comprehensive Medication Review and Counseling Completions	Count and percent of eligible polypharmacy members who completed an annual provider-based comprehensive medication review and counseling (CMR) session in the twelve (12) months following the "Polypharmacy Initiation Date" by age group. Age Groups include: Age 0-17 Years, Age 18-64 Years, and Age 65 and Older. Exclude Duals.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
PHARMQI.20	Provider-based Annual Comprehensive Medication Review and Counseling: Impact of Review	Count and percent of eligible polypharmacy members with an annual provider-based comprehensive medication review (CMR) due date during the measurement period who had a medication change as a result of the completed CMR, by age group. For this measure, the member must complete the CMR in the 12 months preceding the CMR due date, and the medication change must occur within 120 days following the CMR. Age Groups include: Age 0-17 Years, Age 18-64 Years, and Age 65 and Older. Exclude Duals.	Measure	Rolling 12 Months	Quarterly	4 Months after end of Measurement Period									X
PHARMQI.21	Pharmacy Data Sharing Plan	Plan for data sharing efforts on data sharing efforts between the MCO and PCPs and behavioral health providers for member pharmacy data.	Plan	Annual	Annually	May 1st									X

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PHARMQI.22	Pharmacy Data Sharing Report	Narrative report describing outcome of data sharing efforts with providers, including successes and challenges, of the data sharing efforts.	Narrative Report	Readiness and Annual	Annually	May 1st									X
PHARMUTLMGT.02	Pharmacy Utilization Management: Generic Drug Utilization Adjusted for Preferred PDL brands	Count and percent of prescriptions filled for generic drugs adjusted for preferred PDL brands. (To adjust for PDL, remove brand drugs which are preferred over generics from the multi-source claims; and remove their generic counterparts from generic claims).	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PHARMUTLMGT.03	Pharmacy Utilization Management: Generic Drug Substitution	Count and percent of prescriptions filled where generics were available, including multi-source claims.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PHARMUTLMGT.04	Pharmacy Utilization Management: Generic Drug Utilization	Count and percent of prescriptions filled with generic drugs out of all prescriptions filled.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PMP.01	Program Management Plan	The Program Management Plan (PMP) is a document used to provide an overview of the managed care organization's (MCO) delivery of the program as it operates in New Hampshire. Details and specifications are listed below as the PMP includes key topics and associated descriptions. After the initial year the MCO should submit a certification of no change or provide a red-lined copy of the updated plan.	Plan	Agreement Year	Annually	May 1st									X

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POLYPHARM.04	Polypharmacy Monitoring: Children with 4 or More Prescriptions for 60 Consecutive Days	Count and percent of child Medicaid members with four (4) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter, by age group: A. Age 0-5 years, B. Age 6-17 years. A PDC of 80 percent or Higher indicates compliance with treatment.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
POLYPHARM.06	Polypharmacy Monitoring: Adults With 5 or More Prescriptions in 60 Consecutive Days	Count and percent of adult Medicaid members with five (5) or more maintenance drug prescriptions filled in any consecutive 60 day period during the measurement quarter who met the proportion of days covered (PDC) of 80 percent or greater for each of the four (4) or more prescriptions dispensed during the measurement quarter by age group: A. Age 18-44, B. Age 45-64 years. A PDC of 80 percent or Higher indicates compliance with treatment.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
PROVAPPEAL.01	Resolution of Provider Appeals Within 30 Calendar Days	Count and percent of provider appeals resolved within 30 calendar days of the Final Provider Appeal Filing Date, for Final Provider Appeals received during the measure data period.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period			X						
PROVAPPEAL.02	Provider Appeals Log	Standard template log of appeals with detail on all provider appeals including the MCO response to the appeal for provider appeals filed within the measurement period.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X						
PROVAPPEAL.02	Provider Appeals Log	Standard template log of appeals with detail on all provider appeals including the MCO response to the appeal for provider appeals filed within the measure data period.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X						

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PROVCOMM.01	Provider Communications: Speed to Answer Within 30 Seconds	Count and percent of inbound provider calls answered by a live voice within 30 seconds by health plan vendor.	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMM.03	Provider Communications: Calls Abandoned	Count and percent of inbound provider calls abandoned either while waiting in call queue by health plan vendor.	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMM.07	Provider Communications: Reasons for Telephone Inquiries	Count and percent of inbound provider telephone inquiries connected to a live person by reason for Inquiry. Reasons include A: Verifying Member Eligibility, B: Billing / Payment, C: Service Authorization, D: Change of Address, Name, Contact info., etc. E: Enrollment / Credentialing, F: Complaints About Health Plan, G: Other.	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMM.08	Provider Communications: Calls Returned by Next Business Day	Count and percent of provider voicemail or answering service messages returned by the next business day.	Measure	Month	Monthly	1 Month after end of Measurement Period									X
PROVCOMPLAINT.01	Provider Complaint and Appeals Log	Standard template providing a quarterly report of all provider complaints and appeals in process during the quarter.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X						
PROVCOMPLAINT.01	Provider Complaint and Appeals Log	Standard template providing a quarterly report of all provider complaints and appeals in process during the quarter. Exclude NEMT-related complaints from this log.	Table	Quarter	Quarterly	2 Months after end of Measurement Period			X						

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PROVOUTNET.01	Out of Network Providers	Standard template providing a listing of out of network providers for which the MCO had paid claims during the measurement month.	Table	Month	Monthly	1 Month after end of Measurement Period									X
PROVPREVENT.01	Hospital-Acquired and Provider-Preventable Condition Table	Standard template that identifies denials or reduced payment amounts for hospital-acquired conditions and provider preventable conditions. Table will include MCO claim identifier, provider, date of service, amount of denied payment or payment reduction and reason for payment denial or reduction.	Table	Annual	Annually	April 30th			X						
PROVPRIV.01	Behavioral Health Written Consent Report	Narrative reporting of the results of the MCO review of a sample of case files where written consent was required by the member to share information between the behavioral health provider and the primary care provider. In these sample cases, the MCO will determine if a release of information was included in the file. The MCO shall report instances in which consent was not given, and, if possible, the reason why.	Narrative Report	Agreement Year	Annually	4 Months after end of Measurement Period			X						X
PROVTERM.01	Provider Termination Log - including Program Integrity Elements	Standard template log of providers who have given notice, been issued notice, or have left the MCOs network during the measurement period, including the reason for termination. Number of members impacted, impact to network adequacy, and transition plan if necessary.	Table	Month	Monthly	TBD			X						X
PROVTERM.01	Provider Termination Log - including Program Integrity Elements	Standard template log of providers who have given notice, been issued notice, or have left the MCOs network during the measurement period, including the reason for termination. Number of members impacted, impact to network adequacy, and transition plan if necessary.	Table	Month	Monthly	TBD			X						X

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QAPI.01	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Plan	Annual description of the MCO's organization-wide QAPI program structure. The plan will include the MCO's annual goals and objectives for all quality activities. The plan will include a description of the mechanisms to detect under and over utilization, assess the quality and appropriateness of care for Member with special health care needs and disparities in the quality of and access to health care (e.g. age, race, ethnicity, sex, primary language, and disability); and process for monitoring, evaluating and improving the quality of care for members receiving behavioral health services.	Plan	Calendar Year	Annually	November 30th			X						
QAPI.02	Quality Assessment and Performance Improvement (QAPI) Annual Evaluation Report	The report will describe completed and ongoing quality management activities, performance trends for QAPI measures identified in the QAPI plan; and an evaluation of the overall effectiveness of the MCO's quality management program including an analysis of barriers and recommendations for improvement.	Narrative Report	Calendar Year	Annually	September 30th			X						
SDH.XX	Social Determinants of Health	Placeholder for additional measures to show MCO impact on social determinants of health (SDH)	Measure	TBD	TBD	TBD									X
SERVICEAUTH.01	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: Urgent Requests	Count and percent of medical service, equipment, and supply service authorization determinations for urgent requests made within 72 hours after receipt of request for requests made during the measure data period.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

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SERVICEAUTH.03	Medical Service, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests	Count and percent of medical service, equipment, and supply service, authorization determinations for new routine requests made within 14 calendar days after receipt of request for requests made during the measure data period. Exclude authorization requests that extend beyond the 14 day period due to the following: The member requests an extension, or The MCO justifies a need for additional information and the extension is in the member's interest. Exclude requests for non-emergency transportation from this measure.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.04	Pharmacy Service Authorization Timely Determination Rate	Count and percent of pharmacy service authorization determinations made during the measurement period where the MCO notified the provider via telephone or other telecommunication device within 24 hours of receipt of the service authorization request.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.05	Service Authorization Determination Summary by Service Category by State Plan, 1915B Waiver, and Total Population	Standard template summary of service authorization determinations by type and benefit decision for request received during the measure data period.	Table	Quarter	Quarterly	2 Months after end of Measurement Period					X				
SERVICEAUTH.13	Medical Service, Equipment and Supply Post-Delivery Service Authorization Timely Determination Rate	Count and percent of post-delivery authorization determinations made within 30 calendar days of receipt of routine requests, for medical services, equipment, and supply services. Exclude requests for non-emergency transportation from this measure.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X

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SERVICEAUTH.14	Service Authorization Denials for Waiver & Non-HCBC Waiver Populations	Rate of service authorizations denied during the measurement period, broken out by the following waiver groups: Non-Waiver, Developmentally Disabled (DD) Waiver, Acquired Brain Disorder (ABD) Waiver, In-Home Supports (IHS) Waiver, and Choices for Independence (CFI) Waiver.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SERVICEAUTH.15	Service Authorizations: Physical, Occupational & Speech Therapy Service Authorization Denials by Waiver & Non-HCBC Waiver Populations	Rate of physical, occupational and speech therapy service authorizations denied during the measurement period, broken out by the following groups: Non-Waiver, Developmentally Disabled (DD) Waiver, Acquired Brain Disorder (ABD) Waiver, In-Home Supports (IHS) Waiver, and Choices for Independence (CFI) Waiver.	Measure	Quarter	Quarterly	2 Months after end of Measurement Period									X
SMI_CMS.26	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Members with SMI by Subpopulation	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period. (CMS 1115 SMI DEMONSTRATION Metric #26)	Measure	Calendar Year	Annually	6 Months after end of Measurement Period					X				
SMI_CMS.30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries who are age 18 years and older, and completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication. (CMS 1115 SMI DEMONSTRATION Metric #30)	Measure	Calendar Year	Annually	6 Months after end of Measurement Period					X				
STATEFAIR HEARING.01	MCM Member State Fair Hearing Request Log	Template to provide DHHS with a quarterly report of all member MCM State Fair Hearing requests in process and resolved during the quarter. Include the record in future quarterly reports until the State Fair Hearing request is reported resolved.	Table	Quarter	Quarterly	2 Months after end of Measurement Period									X

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SUBROGATION.01	Subrogation Report	Standard template identifying information regarding cases in which DHHS has a Subrogation lien. DHHS will inform the MCO of claims related to MCO subrogation cases that need to be included in the report.	Table	Month	Monthly	15 Calendar Days after end of Measurement Period			X						X
SUBROGATION.02	No Lien Report	List of members in which the MCO has a request for subrogation claims for which the MCO sent a letter stating there were no lien.	Table	Month	Monthly	1 Month after end of Measurement Period									
SUD.27	Member Access to Clinically Appropriate Services as Identified by ASAM Level of Care Determination Table	Standard template reporting members receiving ASAM SUD services as identified by initial or subsequent ASAM level of care criteria determination within 30 days of the screening. The table will include a file review of a sample of members who received an ASAM SUD service during the measurement period. Age breakouts are 0-17, 18+; exclude duals.	Table	Calendar Year	Annually	6 Months after end of Measurement Period					X				X
SUD.39	High Opioid Prescribing Provider Monitoring Report	Narrative reporting of the MCO's identification of providers with High opioid prescribing rates and efforts to follow up with providers. The report should include the MCO's operational definition of a provider with a High opioid prescribing rate, the process for identifying and following up with providers. The report should include aggregate data about the number of providers that are identified and the follow up. Age breakouts are 0-17, 18+; exclude duals.	Narrative Report	Agreement Year	Annually	2 Months after end of Measurement Period									X
SUD.42	MCO Contacts and Contact Attempts Following ED Discharges for SUD	Count and percent of member Emergency Department discharges with an SUD principal diagnosis during the measurement period, where the MCO either successfully contacted the member within 3 business days of discharge, or attempted to contact the member at least 3 times within 3 business days of discharge, by age, 0 to 17 years and 18 years or older.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X

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SUD.52	Timely Access to SUD Assessment	Percent of all Medicaid members with one or more SUD Treatment Services during the measurement period and a 60-day Negative Diagnosis History prior to the first treatment session who had a SUD Assessment within 3 days of the Initial SUD Treatment Service or a SUD Assessment over the course of 3 SUD treatment service sessions delivered within 30 days of the Initial Treatment Service. This assessment can be with the same provider or a different provider.	Measure	Calendar Year	Annually	6 Months after end of Measurement Period					X				X
SUD_CMS.25	Readmissions among Members with SUD by Subpopulation	The count and percent of acute inpatient stays among Medicaid members with substance use disorder (SUD), during the measurement period, followed by an acute readmission within 30 days, by SUD IMD subpopulation.	Measure	Agreement Year	Annually	4 Months after end of Measurement Period					X				X
SUD_CMS.32_CY	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Members with SUD by Subpopulation	Count and percent of Medicaid members with substance use disorder (SUD) who had an ambulatory or preventive care visit during the measurement period by SUD IMD Waiver subpopulation. (CMS 1115 SUBSTANCE USE DISORDER DEMONSTRATION Metric #32	Measure	Calendar Year	Annually	6 Months after end of Measurement Period					X				X
SUDAUDIT.01	SUD Record Audits	All completed audit tools for each of the successive periods under review (PUR).	Table	6 Months	Semi-Annually	January 15th and July 15th									X
SUDAUDIT.03	SUD Record Audits – Opioid Treatment Providers	Case level data from the MCOs audit of clinical records and claims for Members receiving substance use disorder treatment services provided by Substance Use Disorder Programs and Medication Assisted Treatment Services provided by Opioid Treatment Programs (OTP).	Table	6 Months	Semi-Annually	January 15th and July 15th									X

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SUDAUDIT.05	Quality and Performance Improvement Monitoring Report for SUD	An annual narrative report that describes the MCO quality and performance improvement activities based on the data findings from SUDAUDIT.01 to ensure the SUD full continuum of care is appropriately provided and supports Member access to timely and quality services. The report will include an analysis of the effectiveness of provider engagement activities over the past 12 months toward meeting the desired improved outcomes.	Narrative Report	6 Months	Semi-Annually	January 15th and July 15th									X
SUDAUDIT.06	Quality and Performance Improvement Monitoring Report for Opioid Treatment Providers	An annual narrative report that describes the MCO quality and performance improvement activities based on the data findings from SUDAUDIT.03 to ensure the Opioid Treatment Provider (OTP) full continuum of care is appropriately provided and supports Member access to timely and quality services. The report will include an analysis of the effectiveness of provider engagement activities over the past 12 months toward meeting the desired improved outcomes.	Narrative Report	6 Months	Semi-Annually	January 15th and July 15th									X
TIMELYCRED.01	Timely Provider Credentialing - PCPs	The percent of clean and complete provider (PCP) applications for which the MCO or subcontractor credentials the PCP and the provider is sent notice of enrollment within 30 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure.	Measure	Quarter	Quarterly	3 Months after end of Measurement Period									X

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TIMELYCRED.02	Timely Provider Credentialing - Specialty Providers	The percent of clean and complete specialty provider applications for which the MCO or credentials the specialty provider and the provider is sent notice of enrollment within 45 days of receipt of the application. Providers designated by an MCO to do their own credentialing are excluded from this measure. Subcontractors and sister agencies designated to do credentialing are included in the measure. Specialty providers include Durable Medical Equipment (DME) and Optometry providers.	Measure	Quarter	Quarterly	3 Months after end of Measurement Period									X
TOBACCO.01	Annual Report of MCO Tobacco Cessation Program Offerings, Operations, and Utilization	The report captures information about MCO Tobacco Cessation offerings, operations and utilization on an annual basis. For each annual submission, submit an updated clean report and a redline version of the updated report.	Narrative Report	Agreement Year	Annually	4 Months after end of Measurement Period									X
TOBACCO.04	Tobacco Cessation Activity Report	Report reflecting the volume of members utilizing different tobacco cessation supports such as counseling, medication, and messaging.	Table	Quarter	Quarterly	4 Months after end of Measurement Period									X
TOBACCO.05	Tobacco Use: Screening and Cessation Intervention	Count and percent of members aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user, by CMHC and non-CMHC eligible members.	Measure	Quarter	Quarterly	4 Months after end of Measurement Period									X
TPLCOB.01	Coordination of Benefits: Costs Avoided Summary Report	Standard template reporting total charge and potential paid amount for claims denied due to other benefit coverage by insurance type for the measure data period.	Table	Quarter	Quarterly	45 Calendar Days after end of Measurement Period									X

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TPLCOB.02	Coordination of Benefits: Medical Costs Recovered Claim Log	Standard template log of COB medical benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans, and workers compensation.	Table	Quarter	Quarterly	45 Calendar Days after end of Measurement Period									X
TPLCOB.03	Coordination of Benefits: Pharmacy Costs Recovered Claim Log	Standard template log of COB pharmacy benefit collection efforts involving, but not limited to, insurance carriers, public payers, PBMs, benefit administrators, ERISA plans.	Table	Quarter	Quarterly	45 Calendar Days after end of Measurement Period									X
UMSUMMARY.03	Medical Management Committee	MCO shall provide copies of the minutes from each of the MCO Medical Utilization Management committee (or the MCO's otherwise named committee responsible for medical utilization management) meetings.	Narrative Report	Agreement Year	Annually	2 Months after end of Measurement Period			X						X
WELLCARE.01	Adult Preventive Well Care Visits	Count and percent of members 22 years of age and over who had at least one comprehensive well care visit with a PCP or an OB/GYN practitioner during the measurement year, by age group.	Measure	Calendar Year	Annually	4 Months after end of Measurement Period									X