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

Due Date	Last edited	Edited By	Status
12/27/2022	12/27/2022	Laura Ringelberg	Submitted

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

Section A: Program Information

Point of Contact

Number	Indicator	Response
A.1	**State name** Auto-populated from your account profile.	New Hampshire
A.2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Shirley Iacopino
A.2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	shirley.a.iacopino@dhhs.nh.gov
A.3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Laura Ringelberg

Number	Indicator	Response
A.3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	laura.v.ringelberg@dhhs.nh.gov
A.4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/27/2022

Reporting Period

Number	Indicator	Response
A.5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2021
A.5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2022
A.6	**Program name**	New Hampshire Medicaid Care Management Program

Number	Indicator	Response
	Auto-populated from report dashboard.	

Add plans (A.7)

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

Add BSS entities (A.8)

	Indicator	Response
	BSS entity name	State Government Entity State Health Insurance Program (SHIP) Aging and Disability Resource Network (ADRN) Subcontractor (Maximus)

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
B.I.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	241,797
B.I.2	**Statewide Medicaid managed care enrollment** Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or	235,841

Number	Indicator	Response
	more than one managed care plan.	

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
B.X.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	The Department has implemented a FWA waste report in the Fall of 2021 for quarterly reporting of recoveries. PIU also reviews the monthly lock-in reports for compliance with over prescribing. A collaborative effort with FFS and MCOs was initiated to develop a work plan for 1) auditing Opioid Treatment Program claims with required documentation, 2) training sessions, and 3) on-going monitoring efforts for the OTPs.
B.X.2	**Contract standard for overpayments**	Allow plans to retain overpayments

Number	Indicator	Response
	Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	
B.X.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	MCO Contract Section 5.3.3
B.X.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on	The MCO is required to have internal policies and procedures for documentation, retention and recovery of all overpayments, specifically for the recovery of overpayments due to fraud, waste and abuse, and for reporting and returning overpayments. The MCO is required to report to DHHS within 60 calendar days when it has identified capitation payments or other payment amounts received in excess to the amounts specified in the MCO Contract. DHHS may recover overpayments that are not recovered by or returned to the MCO within 60 calendar days of notification by DHHS to pursue.

Number	Indicator	Response
	whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	
B.X.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces	DHHS monitors plan performance in reporting overpayments through two specific reports. FWA.02 is a fraud reporting tool submitted monthly for all investigations and overpayments identified by the MCO. DHHS monitors these reports to ensure adherence to the 60-day episode. FWA.06 reports waste recoveries on a quarterly basis. The report details all other reporting of recoveries for waste and abuse in billing claims, and is monitored for potential fraud.

Number	Indicator	Response
	(whether annually or promptly). This indicator is asking the state how it monitors that reporting.	
B.X.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	DHHS does this a number of ways. A monthly Date of Death report is sent by each MCO with evidence of death. The details are matched against member eligiblity. Incarcerated individuals are monitored by the state through communication with the Department of Corrections (DOC). The DOC file is matched and discrepancies are sent to DHHS' Member Eligibility program area for resolution. To identify frequent switching of plans, member activity is monitored through the enrollment and disenrollment data captured in DHHS Member Eligibility reporting.
B.X.7a	**Changes in provider circumstances: Monitoring plans**	Yes **Changes in provider circumstances: Metrics** No

Number	Indicator	Response
	Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	
B.X.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person	No

Number	Indicator	Response
	with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
B.X.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
B.X.10	**Periodic audits** If the state conducted any audits	The contracted EQRO completed this activity. See C.1.III.2. Encounter Review results can be found in the EQRO Technical Report found here: https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%202021.pdf

Number	Indicator	Response
	during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1.I.1	**Program contract** Enter the title and date of the contract between the state and plans participating in the managed care program.	New Hampshire Department of Health and Human Services - Medicaid Care Management Services Contract
		07/01/2021

Number	Indicator	Response
C1.I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://sos.nh.gov/media/e3lfqzhr/008a-gc-agenda-060221.pdf
C1.I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1.I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-	Behavioral health Transportation

Number	Indicator	Response
	service should not be listed here.	
C1.I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	None
C1.I.5	**Program enrollment** Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	235,841
C1.I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	There were no major changes to the population enrolled. Continuous enrollment due to the extension of the PHE remained in place for this time period.

Topic III: Encounter Data Report

Number	Indicator	Response
C1.III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1.III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract	Timeliness of initial data submissions Timeliness of data corrections Use of correct file formats Overall data accuracy (as determined through data validation) Provider ID field complete Timeliness of data certifications

Number	Indicator	Response
	between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	
C1.III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	5.1.3 Encounter Data, subsections 5.1.3.1, 5.1.3.2, 5.1.3.34.1, 5.1.3.34.2, 5.1.3.34.3, and 5.1.3.34.4
C1.III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	5.5.2 Exhibit N (Liquidated Damages Matrix)

Number	Indicator	Response
C1.III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	There has been a member auto-assignment award incentive twice over the course of the MCO Contract. The incentive was to award 1,000 new members to the MCO that scored the best on the contract standards over a specific measurement period.
C1.III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	None

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response

Number	Indicator	Response
C1.IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1.IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	4.5.3.10 The MCO shall resolve one hundred percent (100%) of standard Member appeals within thirty (30) calendar days from the date the appeal was filed with the MCO. [42 CFR 438.408(a); 42 CFR 438.408(b)(2)]

Number	Indicator	Response
C1.IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	4.5.5.3 The MCO shall make a decision on the Member's request for expedited appeal and provide notice, as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after the MCO receives the appeal. [42 CFR 438.408(a); 42 CFR 438.408(b)(3)]
C1.IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	4.5.2.4 The MCO shall complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the Member's health condition requires, but not later than forty-five (45) calendar days from the day the MCO receives the grievance or within fifty-nine (59) calendar days of receipt of the grievance for grievances extended for up to fourteen (14) calendar days even if the MCO does not have all the information necessary to make the decision, for one hundred percent (100%) of Members filing a grievance. [42 CFR 438.408(a); 42 CFR 438.408(b)(1)]

Topic V. Availability, Accessibility and Network Adequacy

Number	Indicator	Response
C1.V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	NH continues to experience an insufficient number of NH Medicaid enrolled providers, especially in northern rural areas.
C1.V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	MCOs are encouraged to have all NH Medicaid enrolled providers in their networks to ensure adequacy. When gaps are identified, the MCOs submit Exception Requests to the Department for review. The state works in partnership with the MCOs to identify opportunities to develop the network through recruitment of providers not enrolled in Medicaid, or those that offer telehealth.

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

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

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

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

Find in the Excel Workbook
C2_Program_State

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 1 / 5

C2.V.2 Measure standard

2 within 40 min or 15 miles

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Plan provider roster review, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

At procurement, quarterly, and annually.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

2 / 5

C2.V.2 Measure standard

1 within 45 min or 25 miles

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Plan provider roster review, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

At procurement, quarterly, and annually.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

3 / 5

C2.V.2 Measure standard

1 within 60 min or 45 miles

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Plan provider roster review, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

At procurement, quarterly, and annually.

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

4 / 5

C2.V.2 Measure standard

Varies

C2.V.1 General category

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care, behavioral health, and hospital.	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Plan provider roster review, Secret shopper calls, Review of grievances related to access

C2.V.8 Frequency of oversight methods

At procurement, quarterly, and annually.

Complete

C2.V.3 Standard type: Exceptions to time and distance standards 5 / 5

C2.V.2 Measure standard

Varies

C2.V.1 General category

Maximum time or distance

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

C2.V.7 Monitoring Methods

Plan provider roster review, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Ongoing as needed

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1.IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS	https://nheasy.nh.gov, https://www.servicelink.nh.gov/

Number	Indicator	Response
	through electronic means. Separate entries with commas.	
C1.IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	The NH Managed Care beneficiary support systems through DHHS are accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested. Beneficiaries are able to contact DHHS via a toll-free number nationwide, including TDD Relay. Individuals can access supports through ten District Offices throughout the state which are ADA compliant. Auxiliary aids are provided under Section 1557. DHHS has a contract for interpretation services that is accessed in a timely manner to assist beneficiaries as needed. In addition, both beneficiary support websites are 508 compliant.
C1.IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	N/A. LTSS services are not covered under NH Managed Care.
C1.IX.4	**State evaluation of BSS entity performance**	NH EASY uses a feedback loop to capture client comments and feedback. NH EASY up time and

Number	Indicator	Response
	What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	google analytics are monitored to identify conflicts with supported devices. To evaluate the quality, effectiveness and efficiency of the ServiceLink system, DHHS has multiple strategies in place. One of the strategies is to provide an opportunity for participants of ServiceLink service the ability to complete a satisfaction survey. The survey is designed to measure: • Satisfaction that they received proper service • Satisfaction with the delivery of service • Informed of long-term care support options • Usefulness - If they would use ServiceLink again or refer a friend

Topic X: Program Integrity

Number	Indicator	Response
C1.X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1.I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**AmeriHealth Caritas New Hampshire** 53,098 **NH Healthy Families** 87,317 **WellSense Health Plan** 95,426
D1.I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**AmeriHealth Caritas New Hampshire** 22% **NH Healthy Families** 36.1% **WellSense Health Plan** 39.5%
D1.I.3	**Plan share of any Medicaid managed care**	**AmeriHealth Caritas New Hampshire** 22.5%

Number	Indicator	Response
	What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**NH Healthy Families** 37% **WellSense Health Plan** 40.5%

Topic II. Financial Performance

Number	Indicator	Response
D1.II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in	**AmeriHealth Caritas New Hampshire** 93.6% **NH Healthy Families** 88% **WellSense Health Plan** 93.1%

Number	Indicator	Response
	item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	
D1.II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**AmeriHealth Caritas New Hampshire** Program-specific statewide **NH Healthy Families** Program-specific statewide **WellSense Health Plan** Program-specific statewide
D1.II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**AmeriHealth Caritas New Hampshire** Group VIII expansion is reported separate from non expansion (91.6%) **NH Healthy Families** Group VIII expansion is reported separate from non expansion (87.3%) **WellSense Health Plan** Group VIII expansion is reported separate from non expansion (89.1%)

Number	Indicator	Response
D1.II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**AmeriHealth Caritas New Hampshire** Yes 07/01/2020 06/30/2021 **NH Healthy Families** Yes 07/01/2020 06/30/2021 **WellSense Health Plan** Yes 07/01/2020 06/30/2021

Topic III. Encounter Data

Number	Indicator	Response
D1.III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of	**AmeriHealth Caritas New Hampshire** 100% of the MCO Encounter Data shall be submitted weekly, within fourteen (14) calendar days of claim payment for all claim types. **NH Healthy Families** 100% of the MCO Encounter Data shall be submitted weekly, within fourteen (14) calendar days of claim payment for all claim types.

Number	Indicator	Response
	encounter within this program, please explain.	**WellSense Health Plan** 100% of the MCO Encounter Data shall be submitted weekly, within fourteen (14) calendar days of claim payment for all claim types.
D1.III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**AmeriHealth Caritas New Hampshire** 100% **NH Healthy Families** 42% **WellSense Health Plan** 58%
D1.III.3	**Share of encounter data submissions that were HIPAA compliant**	**AmeriHealth Caritas New Hampshire** 100%

Number	Indicator	Response
	What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**NH Healthy Families** 100% **WellSense Health Plan** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was	**AmeriHealth Caritas New Hampshire** 74 **NH Healthy Families** 106 **WellSense Health Plan** 69

Number	Indicator	Response
	wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	
D1.IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**AmeriHealth Caritas New Hampshire** 99 **NH Healthy Families** 178 **WellSense Health Plan** 127
D1.IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A

Number	Indicator	Response
	actively receiving LTSS at the time that the appeal was filed).	
D1.IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”.	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A

Number	Indicator	Response
	The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1.IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided	**AmeriHealth Caritas New Hampshire** 325 **NH Healthy Families** 522

Number	Indicator	Response
	by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**WellSense Health Plan** 384
D1.IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**AmeriHealth Caritas New Hampshire** 97 **NH Healthy Families** 162 **WellSense Health Plan** 146
D1.IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service.	**AmeriHealth Caritas New Hampshire** 307 **NH Healthy Families** 409 **WellSense Health Plan** 339

Number	Indicator	Response
	(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	
D1.IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**AmeriHealth Caritas New Hampshire** 3 **NH Healthy Families** 48 **WellSense Health Plan** 0
D1.IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 22 **WellSense Health Plan** 4

Number	Indicator	Response
D1.IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0
D1.IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0
D1.IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care**	**AmeriHealth Caritas New Hampshire** 14 **NH Healthy Families**

Number	Indicator	Response
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	0 **WellSense Health Plan** 0
D1.IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.7a	**Resolved appeals related to general inpatient services**	**AmeriHealth Caritas New Hampshire** 40

Number	Indicator	Response
	Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**NH Healthy Families** 22 **WellSense Health Plan** 10
D1.IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**AmeriHealth Caritas New Hampshire** 38 **NH Healthy Families** 18 **WellSense Health Plan** 5

Number	Indicator	Response
D1.IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**AmeriHealth Caritas New Hampshire** 25 **NH Healthy Families** 15 **WellSense Health Plan** 0
D1.IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**AmeriHealth Caritas New Hampshire** 5 **NH Healthy Families** 3 **WellSense Health Plan** 0
D1.IV.7e	**Resolved appeals related to covered outpatient prescription drugs**	**AmeriHealth Caritas New Hampshire** N/A

Number	Indicator	Response
	Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**NH Healthy Families** N/A **WellSense Health Plan** N/A
D1.IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A
D1.IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A

Number	Indicator	Response
	personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	
D1.IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A
D1.IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A
D1.IV.7j	**Resolved appeals related to other service types**	**AmeriHealth Caritas New Hampshire** N/A

Number	Indicator	Response
	Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	**NH Healthy Families** N/A **WellSense Health Plan** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**AmeriHealth Caritas New Hampshire** 6 **NH Healthy Families** 9 **WellSense Health Plan** 11
D1.IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee**	**AmeriHealth Caritas New Hampshire** 0

Number	Indicator	Response
	Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**NH Healthy Families** 0 **WellSense Health Plan** 0
D1.IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0
D1.IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	**AmeriHealth Caritas New Hampshire** 1 **NH Healthy Families** 0 **WellSense Health Plan** 0

Number	Indicator	Response
D1.IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A
D1.IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A".	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A

Number	Indicator	Response
	External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**AmeriHealth Caritas New Hampshire** 140 **NH Healthy Families** 184 **WellSense Health Plan** 85
D1.IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**AmeriHealth Caritas New Hampshire** 10 **NH Healthy Families** 37 **WellSense Health Plan**

Number	Indicator	Response
		17
D1.IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A
D1.IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in	**AmeriHealth Caritas New Hampshire** N/A **NH Healthy Families** N/A **WellSense Health Plan** N/A

Number	Indicator	Response
	the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for	

Number	Indicator	Response
	whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1.IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**AmeriHealth Caritas New Hampshire** 157 **NH Healthy Families** 214 **WellSense Health Plan** 174

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan	**AmeriHealth Caritas New Hampshire** 1 **NH Healthy Families**

Number	Indicator	Response
	during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	3 **WellSense Health Plan** 3
D1.IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 6 **NH Healthy Families** 26 **WellSense Health Plan** 10

Number	Indicator	Response
D1.IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 4
D1.IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 9 **WellSense Health Plan** 8

Number	Indicator	Response
D1.IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 5 **NH Healthy Families** 6 **WellSense Health Plan** 1
D1.IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 1 **WellSense Health Plan** 0
D1.IV.15g	**Resolved grievances related to long-term services and supports (LTSS)**	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families**

Number	Indicator	Response
	Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	1 **WellSense Health Plan** 0
D1.IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**AmeriHealth Caritas New Hampshire** 5 **NH Healthy Families** 1 **WellSense Health Plan** 0
D1.IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the	**AmeriHealth Caritas New Hampshire** 62 **NH Healthy Families** 120 **WellSense Health Plan**

Number	Indicator	Response
	managed care plan does not cover this type of service, enter "N/A".	50
D1.IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**AmeriHealth Caritas New Hampshire** 56 **NH Healthy Families** 14 **WellSense Health Plan** 6

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that	**AmeriHealth Caritas New Hampshire** 12 **NH Healthy Families** 126

Number	Indicator	Response
	were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**WellSense Health Plan** 59
D1.IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**AmeriHealth Caritas New Hampshire** 83 **NH Healthy Families** 9 **WellSense Health Plan** 4

Number	Indicator	Response
D1.IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**AmeriHealth Caritas New Hampshire** 140 **NH Healthy Families** 184 **WellSense Health Plan** 85
D1.IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**AmeriHealth Caritas New Hampshire** 3 **NH Healthy Families** 12 **WellSense Health Plan** 9

Number	Indicator	Response
D1.IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**AmeriHealth Caritas New Hampshire** 5 **NH Healthy Families** 1 **WellSense Health Plan** 3
D1.IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**AmeriHealth Caritas New Hampshire** 34 **NH Healthy Families** 21 **WellSense Health Plan** 4

Number	Indicator	Response
D1.IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0
D1.IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0

Number	Indicator	Response
	involving potential or actual patient harm.	
D1.IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0
D1.IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution	**AmeriHealth Caritas New Hampshire** 0 **NH Healthy Families** 0 **WellSense Health Plan** 0

Number	Indicator	Response
	of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	
D1.IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**AmeriHealth Caritas New Hampshire** 3 **NH Healthy Families** 15 **WellSense Health Plan** 1

Topic VII: Quality & Performance Measures

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

Find in the Excel Workbook
D2_Plan_Measures

Complete

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

1 / 11

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1516

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

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

55.8%

NH Healthy Families

58.4%

WellSense Health Plan

58.6%

Complete

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

2 / 11

D2.VII.2 Measure Domain

Primary care access and preventative care

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

2372

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

52.7%

NH Healthy Families

53.5%

WellSense Health Plan

47.9%

Complete

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

3 / 11

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517

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

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

82.7%

NH Healthy Families

80.8%

WellSense Health Plan

83.0%

Complete

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

4 / 11

D2.VII.2 Measure Domain

Maternal and perinatal health

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

1517

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

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

80.8%

NH Healthy Families

76.9%

WellSense Health Plan

79.8%

Complete

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

5 / 11

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0018

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

52.1%

NH Healthy Families

59.4%

WellSense Health Plan

56.4%

Complete

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

6 / 11

D2.VII.2 Measure Domain

Behavioral health care

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

2801

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

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

supressed due to small sample size

NH Healthy Families

74.2$

WellSense Health Plan

60.3%

Complete

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

7 / 11

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

45.4%

NH Healthy Families

37.3%

WellSense Health Plan

44.7%

Complete

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

8 / 11

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

85.4%

NH Healthy Families

76.0%

WellSense Health Plan

87.8%

Complete

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

9 / 11

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

91.3%

NH Healthy Families

93.3%

WellSense Health Plan

92.0%

Complete

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

10 / 11

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

87.1%

NH Healthy Families

79.5%

WellSense Health Plan

81.7%

Complete

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

11 / 11

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Cross-program rate: Medicaid, CHIP

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

Standard measure

Measure results

AmeriHealth Caritas New Hampshire

86.6%

NH Healthy Families

87.3%

WellSense Health Plan

89.7%

Topic VIII. Sanctions

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

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

Find in the Excel Workbook
D3_Plan_Sanctions

Complete

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

D3.VIII.2 Intervention topic	D3.VIII.3 Plan name
Reporting	AmeriHealth Caritas New Hampshire

D3.VIII.4 Reason for intervention

Data reported was late, incorrect, or incomplete.

Sanction details

D3.VIII.5 Instances of non-compliance

37

D3.VIII.6 Sanction amount

$ 48,000

D3.VIII.7 Date assessed

06/30/2022

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

06/30/2022

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

2 / 3

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

NH Healthy Families

D3.VIII.4 Reason for intervention

Data reported was late, incorrect, or incomplete.

Sanction details

D3.VIII.5 Instances of non-compliance

20

D3.VIII.6 Sanction amount

$ 95,000

D3.VIII.7 Date assessed

06/30/2022

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

06/30/2022

D3.VIII.9 Corrective action plan

No

Complete

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

D3.VIII.2 Intervention topic
Reporting

D3.VIII.3 Plan name
WellSense Health Plan

D3.VIII.4 Reason for intervention

Data reported was late, incorrect, or incomplete.

Sanction details

D3.VIII.5 Instances of non-compliance
57

D3.VIII.6 Sanction amount
$ 67,000

D3.VIII.7 Date assessed
06/30/2022

D3.VIII.8 Remediation date non-compliance was corrected
06/30/2022

D3.VIII.9 Corrective action plan
No

Topic X. Program Integrity

Number	Indicator	Response

Number	Indicator	Response
D1.X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**AmeriHealth Caritas New Hampshire** 3 **NH Healthy Families** 3 **WellSense Health Plan** 6
D1.X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**AmeriHealth Caritas New Hampshire** 37 **NH Healthy Families** 19 **WellSense Health Plan** 20
D1.X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in	**AmeriHealth Caritas New Hampshire** 7:1,000 **NH Healthy Families** 2:1,000

Number	Indicator	Response
	the plan on the first day of the last month of the reporting year?	**WellSense Health Plan** 2:1,000
D1.X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**AmeriHealth Caritas New Hampshire** 37 **NH Healthy Families** 15 **WellSense Health Plan** 20
D1.X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**AmeriHealth Caritas New Hampshire** 7:1,000 **NH Healthy Families** 2:1,000 **WellSense Health Plan** 2:1,000
D1.X.6	**Referral path for program integrity referrals to the state**	**AmeriHealth Caritas New Hampshire** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Number	Indicator	Response
	What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Count of program integrity referrals to the state** 4 **NH Healthy Families** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 4 **WellSense Health Plan** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 2
D1.X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the	**AmeriHealth Caritas New Hampshire** 0.08 **NH Healthy Families** 0.05 **WellSense Health Plan** 0.02

Number	Indicator	Response
	reporting year (reported in indicator D1.I.2) as the denominator.	
D1.X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	**AmeriHealth Caritas New Hampshire** During the period 7/1/21 through 6/30/22, identified recoveries were $346,777.16, of which $335,849.06 was recovered by SIU. DHHS does not have MLR reports ending 06/30/22 so an actual ratio cannot be calculated. However, for 7/1/21 to 12/31/21, AmeriHealth reports $121,506,113 in revenue, the $335,849 equates to 0.14% for a full year of overpayments on doubled up revenue. **NH Healthy Families** For the reporting period of 7/1/21 to 6/30/22, the SIU identified $86,806.34 as initial overpayments. After appeals, that amount was reduced to $46,786.57. During the 7/1/21 to 6/30/22 reporting period, $68,144.30 was recovered. DHHS does not have MLR reports ending 06/30/22 so an actual ratio cannot be calculated. However, for 7/1/21 to 12/31/21, using the same method as described in AmeriHealth, NH Healthy Families would be 0.016%. **WellSense Health Plan** During the reporting period 7/1/2021 through 6/30/2022, WellSense identified overpayments

Number	Indicator	Response
		related to suspected provider fraud investigations totaling $74,849.14. Well Sense has recovered $40,800.05 in overpayments related to ten fraud investigations during the current fiscal year, $4,513.10 of which was related to overpayments identified in the current fiscal year. The sub-contractor for Behavioral Health, Beacon SIU, recovered $16,500.00 on behalf of WellSense members in the current fiscal year related to one case where the provider was on a 24 month payment plan. DHHS does not have MLR reports ending 06/30/22 so an actual ratio cannot be calculated. However, for 7/1/21 to 12/31/21, using the same method as described in AmeriHealth, WellSense would be 0.008%
D1.X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**AmeriHealth Caritas New Hampshire** Daily **NH Healthy Families** Daily **WellSense Health Plan** Daily

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Number	Indicator	Response
E.IX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**State Government Entity** State Government Entity **State Health Insurance Program (SHIP)** State Health Insurance Assistance Program (SHIP) **Aging and Disability Resource Network (ADRN)** Aging and Disability Resource Network (ADRN) **Subcontractor (Maximus)** Subcontractor
E.IX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**State Government Entity** Enrollment Broker/Choice Counseling Beneficiary Outreach **State Health Insurance Program (SHIP)** Enrollment Broker/Choice Counseling Beneficiary Outreach

Number	Indicator	Response
		Aging and Disability Resource Network (ADRN) Enrollment Broker/Choice Counseling Beneficiary Outreach **Subcontractor (Maximus)** Enrollment Broker/Choice Counseling