Quality Strategy
for the
New Hampshire Medicaid
Care Management Program

Updated: September 4, 2013

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Preface

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

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I. Introduction

A. General Information

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

The Care Management program will be rolled out in three phases. Step One of the Care Management program will include all State Plan Amendment services, except dental and long term care services, for all NH Medicaid beneficiaries (mandatory for those populations that do not require a waiver for mandatory enrollment). With Center for Medicare and Medicaid Services (CMS) approval, Step Two will begin mandatory enrollment for all populations and will incorporate, both non-waiver and waiver long term care services into the Care Management program. Step Three allows for the enrollment of any New Hampshire Medicaid expansion populations that could result from State's implementation of the Affordable Care Act, and completes the State's strategy for a comprehensive statewide program inclusive of all NH Medicaid populations and all Medicaid services (Appendix A). Under state statute, dental services will remain fee-for-service. NH Medicaid beneficiaries who are also part of the VA health system and those spending down to meet Medicaid requirements are currently excluded from the Care Management program.

To date, the State has had a disaggregated approach to quality oversight driven primarily by the regulatory requirements of various DHHS programs. With the comprehensive nature of the new Care Management program, DHHS has the opportunity to develop a comprehensive NH Medicaid Quality Strategy, building upon the legislative goals of value and efficiency, and focused on improving the health of Medicaid beneficiaries. The State's initial quality improvement objectives will be drawn from generally understood opportunities for improvement. After the Care Management program has been established, the Department will perform regular monitoring and analysis to identify the program's successes and new opportunities for improvement and amend the Quality Strategy to include additional population-based quality improvement activities. It is also the Department's intention to, over time, harmonize the NH Medicaid Quality Strategy with the National Quality Strategy, synergistically using State's resources to champion national campaigns and capitalize on grant and other federal initiatives.

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

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B. Managed Care Quality Program Objectives

The State's initial quality improvement objectives will be drawn from generally understood NH Medicaid opportunities for improvement and will include four Quality Incentive Projects (QIP) of the State's choosing and four Performance Improvement Projects (PIP) of the MCOs choosing, subject to DHHS approval. Other activities will include: comprehensive, routine, population-based measurement and monitoring; health plan operations and contract compliance reporting; and annual surveys of member and provider satisfaction with health plans and member satisfaction with Medicaid providers. After the Care Management program has been established, the Department will draw from these and other activities to identify additional Medicaid program priorities, strengths and opportunities, and will establish additional program goals. The Department will also incorporate recommendations from the public, MCOs and the External Quality Review Organization (EQRO) Technical Report in setting new goals and revising the Quality Strategy.

In complement to the State's Quality Strategy, each MCO shall develop, maintain and operate a Quality Assessment and Performance Improvement (QAPI) program, as required by the Code of Federal Regulations, 42 CFR 438.240, and the NH Medicaid Care Management Contract. The QAPI is subject to the approval by the State. Each MCO's QAPI will describe the four MCO performance improvement projects (PIP), at least one of which must have a behavioral health focus. After the MCOs have had the opportunity to make initial assessments of their membership and, in consultation with their consumer and provider advisory boards, determined the greatest potential health care quality improvement opportunities, the State will begin quarterly Quality Improvement meetings with the three MCO Medical and Quality Improvement Directors. These meetings will routinely bring all of the MCOs together, take an agnostic perspective on the NH Medicaid program, and, to the greatest degree possible, harmonize the PIPs and other quality initiatives across the three MCOs and the NH Medicaid program.

In addition to the four annual MCO performance improvement projects, each year the DHHS will select four quality improvement initiatives for its Quality Incentive Program (QIP). For each of the initiatives selected, the MCO will be eligible to receive up to one-quarter of the one percent (0.25%) of QIP premium withhold for successfully meeting or exceeding the improvement target (withhold waived in through June 30, 2014). These quality incentive initiatives may change each contract year and will reflect both NH Medicaid priorities and achievable targets for the MCOs. For the Quality Year 1 (January 1, 2013-December 31, 2013) the following QIP initiatives have been selected:

- Prenatal and Post-partum Care (PPC) Timeliness of Prenatal Care Components, a Healthcare Effectiveness Data and Information Set (HEDIS) measure;
- Follow Up After Hospitalization for a Mental Illness Within 7 Days of Discharge, a HEDIS measure;
- Parental Satisfaction with Children Getting Appointments for Care, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure; and
- Satisfaction (Adults) with Getting Appointments for Care, CAHPS measure.

MCO QAPI programs will include performance measurement for the above initiatives as well as DHHS required Quality Indicators (Appendix B) and routine reporting on health plan operations (Appendix E). All performance data will be submitted to the State. The State will conduct an

initial CAHPS survey to serve as a baseline of standardized information on enrollees' experiences with the NH Medicaid program. Each MCO will then annually conduct a comprehensive CAHPS survey (NH Medicaid Care Management Contract Section 15.7.3 and 20.5.2) to continue to assess member satisfaction with the health plans and services. The results of these assessments will be shared with the Department and posted on the State's NH Medicaid Quality Indicators website.

II. Assessment

As required by 42 CFR 438.202(d), the State will assesses how well the Care Management program is meeting the objectives outlined in the Introduction through analysis of the quality and appropriateness of care and services delivered to enrollees, the level of contract compliance of MCOs and by monitoring MCO activities through the use of health information technology on an on-going basis.

A. Quality and Appropriateness of Care and Services

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

- NH Medicaid Quality Indicators monitoring (on the NH Medicaid Quality Indicators website, http://nhmedicaidquality.org and Appendix B), including the CMS Pediatric and Adult Quality Measures,
- PIP and QIP projects,
- NH Medicaid Care Management Contract Compliance, Operations and Quality Reporting,
- NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems Population-based, special and ad hoc analysis and reporting,
- MCO National Committee for Quality Assurance (NCQA) accreditation review, and
- External Quality Review Organization (EQRO) activities, including NH Medicaid population analysis and the EQRO Technical Report.

NH Medicaid Quality Indicators

The NH Medicaid Quality Indicators is a relatively new initiative for the NH Medicaid program, aimed at aggregating population-based measures to enhance the identification of program strengths and opportunities and make this data publicly available on the NH Medicaid Health Indicator website. The measures are a selection of standardized and validated measures from recognized and credible organizations including the Center for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), the Healthcare Effectiveness Data and Information Set (HEDIS), Center for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS), among others. The current measure set includes all of the CMS Adult and Pediatric Quality Indicators that NH Medicaid collects data to report. It is the intent of DHHS to have this measure set grow to include additional measures on physical health, behavioral health, lifestyle measures, and Medicaid services and supports. With Step Two, the addition of the waiver populations and services, further measures related to home and community-based services will be added. The NH Medicaid Quality Indicators website will also include the HEDIS and CAHPS measures for each of the NH Medicaid Care Management programs. To ensure the integrity, reliability, and validity of the MCO encounter data, the State

will contract with an EQRO to audit and validate encounter data and to provide technical assistance to MCOs in collecting and submitting the requested information.

The NH Medicaid Quality Indicators website will receive a significant overhaul funded by the CMS Adult Medicaid Quality grant. These changes are discussed below in "NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems."

The NH Medicaid Quality Indicators website, and its subsequent iterations, will be updated whenever new data becomes available according to measure specific submission schedules.

Performance Improvement Projects and Quality Incentive Program Initiatives
Each MCO shall develop and implement four MCO performance improvement projects (PIP), subject to the approval of the State, at least one of which must have a behavioral health focus. After each MCO has had the opportunity to make an initial assessment of its membership, and in consultation with their consumer and provider advisory boards, determined the greatest potential for health care quality improvement opportunities, the State will begin quarterly Quality Assurance and Improvement meetings with the three MCO Medical and Quality Improvement Directors. These meetings will routinely bring all of the MCOs together, take an agnostic perspective on NH Medicaid program, and, to the greatest degree possible, harmonize the PIPs and other quality initiatives across the three MCOs and the NH Medicaid program.

Additionally, DHHS will annually select four quality improvement initiatives for its NH Medicaid Quality Incentive Program (QIP). For each of the initiatives selected, the MCO will be eligible to receive up to one-quarter of the one percent (0.25%) of QIP premium withhold for successfully meeting or exceeding a improvement target. Beginning October 1, 2014, or nine months after the MCM program start date, whichever is later, if the MCO performance drops below the performance threshold set for a measure, the MCO will receive a further reduction of one-quarter of the one percent (0.25%) of the total capitation payment received by the MCO for the year in which the measure was selected. the These quality incentive initiatives may change each Agreement year and will reflect both NH Medicaid priorities and achievable targets for the MCOs. For the Agreement year 1 (July 1, 2013-June 30, 2014) the following QIP initiatives have been selected:

- Prenatal and Post-partum Care (PPC) Timeliness of Prenatal Care Components, a Healthcare Effectiveness Data and Information Set (HEDIS) measure;
- Follow Up After Hospitalization for a Mental Illness Within 7 Days of Discharge, a HEDIS measure;
- Parental Satisfaction with Children Getting Appointments for Care, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure; and
- Satisfaction (Adults) with Getting Appointments for Care, CAHPS measure.

MCO Contract Compliance, Operations and Quality Reporting
The NH Medicaid Care Management Program includes a robust list of Required Quality Reporting Measures (Appendix E) and a comprehensive list of encounter data elements (Appendix C). These data will be presented both as individual measures and aggregated into measure sets to demonstrate the impact of specific programs and overall MCO program impact. MCO encounter data will be validated by the State's EQRO.

NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems
NH DHHS Office of Medicaid Business and Policy, Bureau of Healthcare Analytics and Data Systems has oversight of data, analysis and reporting. The Bureau currently functions to create ad hoc reports as requested or needed to ensure the delivery of quality care, the development of sound policy and for financial oversight of the Medicaid program. The Bureau will continue to support DHHS reporting on the NH Care Management program. The Bureau will be responsible for oversight of the maintenance and aggregation of MCO data into a single database, which will be accomplished inside the Medicaid Management Information System (MMIS) Reporting Repository. The Bureau will also provide population-wide, DHHS-wide, special and ad hoc analysis and reporting from the repository. The Bureau will be the primary DHHS contact for online web access to applications and data to access, analyze, or utilize data captured in the MCO systems and to perform reporting and operational activities. (Section 22.5.4.3) The Bureau will assist the EQRO in their oversight of MCO functions and in the creation of statewide, population-based reports on the Care Management program.

The NH Medicaid Quality Indicators website is housed within the Bureau. In December 2012, DHHS received a CMS Adult Medicaid Quality grant allowing the Department to further improve NH Medicaid quality oversight. Specifically, the State's capacity to aggregate and monitor Quality Indicators will be markedly expanded through the development of:

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

This system is scheduled to "go live" in the summer of 2014.

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

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

MCO NCQA Accreditation Review

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

External Quality Review Organization Activities

The NH DHHS has contracted with an external quality review organization (pending G&C approval August 14, 2013) as required by 42 CFR 438 Subpart E. To comply with Federal regulations, 42 CFR 438.358(b), the federally mandatory EQRO scope of work for the NH Medicaid EQRO includes:

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

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

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

NH DHHS will provide data files to the EQRO for each of the MCOs. As part of its annual reporting, the State's EQRO will prepare a Technical Report as a compendium of each MCO's plan-specific activities, services and operations adherent to the CMS protocols found in 42 CFR 438.364 for external review quality reports. Specifically the EQRO Technical Report will include:

- An overview of MCO activities, including,
  - A description of the manner in which MCO data was aggregated and analyzed;
  - The conclusions drawn from the data on the quality, timeliness, and access to care provided by the MCO;
  - For each MCO activity reviewed, the EQRO will address:
    - The objective of the MCO activity and the objective of the EQRO oversight function,
    - The technical methods of data collection and analysis,
    - A description of the data obtained, and
    - The conclusions drawn from the data;

- An assessment of each MCOs strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO;
- Comparative information across the State's three MCO programs;
- Population-based aggregate measurement and analysis; and
- An assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year. This EQRO activity will commence after the first year of NH Medicaid Care Management program operations.

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

The Department will use the annual Technical Report to apply sanctions or take other corrective action as designated in the NH Medicaid Care Management Contract, to evaluate existing program goals and inform new program goal development. The Department will also use the Technical Report to inform any needed contract amendments or revisions.

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

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

NH Medicaid Care Management Clinical Standards and Guidelines
The Department has taken four complementary approaches to establishing high clinical standards and guidelines:

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

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

The State has built upon the credibility and strength of several federal agencies and national organizations in adopting guidelines for care management. NH Medicaid Care Management Contract Section 10.2.3 of the contract refers MCOs to the Agency for Healthcare Research and Quality guidelines for the development of Patient Centered Medical Homes. NH Medicaid Care Management Contract Section 10.2.4 requires that MCO participate in the development and support of Health Homes as defined by the Center for Medicare and Medicaid Services. MCO wellness and prevention programs must comport with the American Academy of Pediatrics Bright Futures program recommendations and with all United States Prevention Services Task Force A and B rated prevention and primary services for children and adults.

Section 20.2 of the NH Medicaid Care Management Contract requires the MCOs to adopt evidence-based practice guidelines built upon high quality data and strong evidence. In addition to their standard practice guidelines, MCOs are required to develop additional guidelines to meet the health needs and other opportunities for improvement identified in their Quality Assessment and Performance Improvement programs. All MCO practice guidelines will be subject to DHHS approval prior to the onset of the Care Management program and annually thereafter (NH Medicaid Care Management Contract Section 21.1.3). All practice guidelines will be available on the MCO websites (NH Medicaid Care Management Contract Section 20.2.3), and to providers, members and potential members upon request. MCO practice guidelines will be used to inform their coverage decisions, utilization management and member educational activities.

Finally, Section 26 of the NH Medicaid Care Management Contract requires the MCOs, their subcontractors, and their providers to be comprehensively compliant with all applicable federal and state regulation, both present and future. Specific NH Medicaid Care Management Contract Sections also cross reference and require compliance with specific corresponding federal or state regulation as appropriate for that Care Management program element.

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

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

The State will ensure MCO contract compliance in requiring MCO self-regulation and through direct DHHS oversight. NH Medicaid Care Management Contract Section 6.1.1.13 obligates

each MCO to have a Compliance Officer whose primary responsibility is the assurance of the program's contractual and regulatory compliance.

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

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

- NH Medicaid Quality Indicators monitoring, including the CMS Pediatric and Adult Quality Measures,
- MCO PIP and QIP projects,
- MCO Contract Compliance, Operations and Quality Reporting (Appendix D,
- NH DHHS Office of Medicaid Business and Policy, Bureau Healthcare Analytics and Data Systems population-wide, DHHS wide, special, other and ad hoc analysis and reports,
- MCO NCQA accreditation review, and
- External Quality Review Organization (EQRO) activities, including the EQRO Technical Report and NH Medicaid population wide, aggregated reports

C. The Role of Health Information Technology

New Hampshire assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through the collection and analyses of data from many sources including: New Heights - the State's eligibility database, the Medicaid encounter and provider data that will be processed and stored in the MMIS Reporting Repository; the National Committee on Quality Assurance (NCQA), the Healthcare Effectiveness Data and Information Set (HEDIS), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS); and other data accessible to NH Medicaid, such as the Comprehensive Healthcare Information System database (all payer claims database, managed by NH DHHS). DHHS will also have online web access to MCO applications and data to access, analyze, or utilize data captured in the MCO systems and to perform reporting and operational activities. Other sources of data will include findings from the External Quality Review Organization's Technical Report and the NH Division of Public Health Services implementation of CDC's Behavioral Risk Factor Surveillance System (BRFSS), among others.

In December 2012, DHHS received a CMS Adult Medicaid Quality (AMQ) grant allowing the Department to further improve NH Medicaid quality oversight. The AMQ grant will allow the State to create linkages between existing but underutilized data sets, specifically Medicaid administrative claims data (including encounter data), NH Hospital data and vital records. The AMQ grant requires NH to expand internal resources for data analysis and use, and will fund four additional positions within the Office of Medicaid Business and Policy: two additional data analysts and two new quality program specialists. DHHS will reconfigure the Quality Indicators

website, improving the capacity for data examination to include programmed data analysis, routine surveillance of large amounts of data and automatically flagging measures requiring further quality review. Additionally, the Quality Indicators website will allow user-driven, custom reporting directly from the website. These system changes enable DHHS to actively manage over 400 quality measures through the tactical use of HIT and the strategic use of human support as needed. The system enhancements are scheduled to "go live" in the summer of 2014.

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

Both Medicaid fee for service and MCO encounter data history for their enrolled members will be provided to each MCO on a regular basis. Enrolled provider data and active service authorization data will also be shared.

While MCOs are not eligible for incentives under the Health Information Technology for Economic and Clinical Health (HITECH) Electronic Health Record (EHR) incentive program, they will benefit from an increase in the meaningful use of EHRs that the HITECH program promotes. In 2013, the New Hampshire Health Information Organization began deployment of a statewide Health Information Exchange (HIE) that would greatly increase capacity of provider-to-provider transmission of health information.

III. Improvement

A. Assessment Based Activities

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

- Contract Activities, including:
  - Quality Incentive Program with Financial Incentives,
  - Performance Improvement Projects,
  - Payment Reform Incentive Plan, and
  - MCO sanctions;
- Convening Cross-MCO Quality Activities; and
- EQRO Technical Review and Report.

Contract Incentives, Project, Plans and Sanctions

For each of the NH Medicaid Care Management Contract years, DHHS will select four Quality Incentive Program (QIP) initiatives. Each MCO will have 1% of the total capitation payment amount withheld to support the QIP. This withhold will be repaid, either in part or in full, when the MCO performance measure makes significant progress toward and/or meets the improvement goal. Additional financial penalties, after October 1, 2014 or 9 months after the start date, whichever is later, will be levied for reductions from measure baselines. The first program year QIP initiatives are:

- Timeliness Prenatal and Post-partum Care (PPC): Using the HEDIS measure for Timeliness of Prenatal and Post-partum Care, the MCO will measure the percentage of

deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization and the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. The MCO will receive 0.25% of the withhold for exceeding 75% of the National Quality Compass National Medicaid CMO rate for the measurement year, and a penalty of up to 0.25% for a measure below 25% of the National Quality Compass National Medicaid CMO rate for the measurement year.

- Follow Up After Hospitalization for a Mental Illness Within 7 Days of Discharge: Using the HEDIS measure for Follow Up After Hospitalization for a Mental Illness Within 7 Days of Discharge, the MCO will measure the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization within 7 days of inpatient discharge with a mental health practitioner. This rate will include discharges from New Hampshire Hospital. The MCO will receive 0.25% of the withhold for exceeding 75% of the National Quality Compass National Medicaid CMO rate for the measurement year, and a penalty of up to 0.25% for a measure below 25% of the National Quality Compass National Medicaid CMO rate for the measurement year.
- Parental Satisfaction with Children Getting Appointments for Care: Using the CHAPS measure Getting Needed Care, the MCO will measure responses of "usually" or "always" when parents of child managed care members have been asked "Not counting the times your child needed care right away, how often did you get an appointment at your doctor's office or clinic as soon as you thought your child needed?" The MCO will receive 0.25% of the withhold for exceeding 90% of the National Quality Compass National Medicaid CMO rate for the measurement year, and a penalty of up to 0.25% for a measure below 50% of the National Quality Compass National Medicaid CMO rate for the measurement year.
- Satisfaction (Adults) with Getting Appointments for Care, CAHPS measure Using the CHAPS measure Getting Needed Care, the MCO will measure responses of "usually" or "always" when managed care members have been asked "Not counting the times you needed care right away, how often did you get an appointment at your doctor's office or clinic as soon as you thought you needed?" The MCO will receive 0.25% of the withhold for exceeding 90% of the National Quality Compass National Medicaid CMO rate for the measurement year, and a penalty of up to 0.25% for a measure below 50% of the National Quality Compass National Medicaid CMO rate for the measurement year.

Each MCO's QAPI program must also include four MCO initiated performance improvement projects (PIP), at least one of which must have a behavioral health focus (NH Medicaid Care Management Contract Section 20.1.11). After the MCO has had the opportunity to make an initial assessment its membership and, in consultation with its member and provider advisory boards, determined the greatest health care quality improvement opportunity for its members, consistent with 42 CFR 438.240, working with the ERQO, the State will biannually review the MCO PIP project proposals.

Section 9 of the NH Medicaid Care Management contract requires each MCO to annually submit and implement payment reform strategies. Beginning July 1, 2014, DHHS will withhold 1% of

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the total capitation payment amount, which MCOs can then recoup when implementation milestones from the Payment Reform Incentive Plan have been achieved. The MCO payment reform proposals must comply with all state and federal regulations and the NH Medicaid Care Management Contract (Section 9).

Section 32 of the NH Medicaid Care Management Contract addresses remedies at the State's disposal to address MCO performance concerns. Section 32.2 lists the liquidated damages that may be enacted and stratifies MCO violations into 5 levels, each with an associated financial remedy. Category 1, the highest level, for example, would be levied against an MCO for a failure to provide medically necessary services at a cost of $100,000/violation; failure to meet telephone inquiries performance standards is an example of Category 5 violation with a lesser fine of $1,000/violation.

Convening Cross-MCO Quality Activities
The State will convene Quality Assurance and Improvement meetings with the Medical Directors and Quality Improvement Directors shortly after implementation. These quarterly meetings will routinely bring the State and all three MCOs quality teams together, take a population perspective on NH Medicaid program, and, to the greatest degree possible, harmonize of quality initiatives across the NH Medicaid program.

EQRO Technical Review and Report
The State's EQRO Technical Report will include an assessment of each MCOs strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries, recommendations for improving the quality of health care services furnished by each MCO, comparative information about all of the State's MCOs, and an assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year, after the first year of NH Medicaid Care Management program operations. This information will be used to inform any needed benefit changes, NH Medicaid Care Management Contract amendments, additional MCO quality improvement activities, sanctions or other program changes. Additionally, the EQRO report will be used to inform the State of any needed oversight or regulatory support to improve managed care health care delivery.

B. And C. Proposed Progress Toward Meeting Quality Objectives
The State will routinely perform the following mandatory quality assurance activities:

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

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

IV. Review of Quality Strategy

A. Public Input

The quality strategy was designed prior to implementation of the Medicaid Care Management program. During this time, the State looked to 42 CFR 438.200, the CMS State Quality Strategy Tool Kit for State Medicaid and Children's Health Insurance Agencies, the quality strategies of other states and DHHS staff to develop an initial draft framework. The State distributed and posted the draft quality strategy and modified the strategy in response to public comments, stakeholder feedback and the Medicaid Care Management contract Amendment One. The State will submit its final Quality Strategy to CMS prior to program launch.

After the implementation of the Care Management program, the State will participate in each MCO's advisory committees composed of representatives from the provider community (primary care and specialty care), members, family caregivers of MCO members, the advocacy community, and MCO staff. These committees will provide a forum for beneficiaries and providers to be actively engaged in MCO quality improvements, raise issues and concerns, discuss possible solutions, and provide advice and recommendations on a wide range of issues. Additionally, the State's EQRO will conduct formal focus group discussions to elicit beneficiary feedback without the presence of either DHHS or MCO representatives.

The State will conduct Quality Assurance and Improvement meetings with the Medical Directors and Quality Improvement Directors shortly after implementation. These quarterly meetings will routinely bring the State and all three MCOs quality teams together, take a population perspective on NH Medicaid program, and, to the greatest degree possible, harmonize quality initiatives across the NH Medicaid program.

In addition to input from these committees, the quality strategy and supporting reports and documents will be placed on the DHHS NH Medicaid Care Management website at: http://www.dhhs.nh.gov/ocom/care-management.htm and be available for ongoing public review and comment.

B. Strategy Assessment Timeline

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

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

Quality Strategy Activity	Date Complete
Post Draft Quality Strategy for Step One for Public Comment	July 15, 2012
Post Final Quality Strategy	October 1, 2013
Monitor Quality Performance Results	Continuously
Post Draft Quality Strategy for Step Two and Step Three for Public Comment	60 days prior to implementation
Post Final Updated Quality Strategy	30 days prior to implementation
Monitor Quality Performance Results	Continuously
Post Triennial Update Draft Quality Strategy for Public Comment	60 days prior to Agreement Year
Post Final Updated Quality Strategy	30 days prior to Agreement Year
Monitor Quality Performance Results	Continuously

V. Achievements and Opportunities

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

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

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

Members	Step 1	Step 2	Step 3	Excluded/ FFS
OAA/ANB/APTD/MEAD/TANF/Poverty Level - Non-Duals[2]	X			
Foster Care - With Member Opt Out	X			
Foster Care - Mandatory Enrollment (w/CMS waiver)		X		
HC-CSD (Katie Becket) - With Member Opt Out	X			
CHIP (transition to Medicaid expansion)	X			
TPL (non-Medicare) except members with VA benefits	X			
Auto eligible and assigned newborns	X			
Breast and Cervical Cancer Program (BCCP)	X			
Medicare Duals - With Member Opt Out	X			
Medicare Duals - Mandatory Enrollment (w/CMS waiver)		X		
ACA Expansion Group			X	
Members with VA Benefits				X
Family Planning Only Benefit (in development)				X
Initial part month and retroactive/PE eligibility segments (excluding auto eligible newborns)				X
Spend-down				X
QMB/SLMB Only (no Medicaid)				X

Covered Services Matrix	Step 1	Step 2	Step 3	Excluded/ FFS
Maternity & Newborn Kick Payments	X			

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

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Covered Services Matrix	Step 1	Step 2	Step 3	Excluded/ FFS
Inpatient Hospital	X			
Outpatient Hospital	X			
Inpatient Psychiatric Facility Services Under Age 22	X			
Physicians Services	X			
Advanced Practice Registered Nurse	X			
Rural Health Clinic & FQHC	X			
Prescribed Drugs	X			
Community Mental Health Center Services	X			
Psychology	X			
Ambulatory Surgical Center	X			
Laboratory (Pathology)	X			
X-Ray Services	X			
Family Planning Services	X			
Medical Services Clinic (mostly methadone clinic)	X			
Physical Therapy	X			
Occupational Therapy	X			
Speech Therapy	X			
Audiology Services	X			
Podiatrist Services	X			
Home Health Services	X			
Private Duty Nursing	X			
Adult Medical Day Care	X			
Personal Care Services	X			
Hospice	X			
Optometric Services Eyeglasses	X			

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Covered Services Matrix	Step 1	Step 2	Step 3	Excluded/ FFS
Furnished Medical Supplies & Durable Medical Equipment	X			
Non-Emergent Medical Transportation	X			
Ambulance Service	X			
Wheelchair Van	X			
Fluoride Varnish by Primary Care Physicians	X			
Acquired Brain Disorder Waiver Services		X		
Developmentally Disabled Waiver Services		X		
Choices for Independence Waiver Services		X		
In Home Supports Waiver Services		X		
Skilled Nursing Facility		X		
Skilled Nursing Facility Atypical Care		X		
Inpatient Hospital Swing Beds, SNF		X		
Intermediate Care Facility Nursing Home		X		
Intermediate Care Facility Atypical Care		X		
Inpatient Hospital Swing Beds, ICF		X		
Glencliff Home		X		
Developmental Services Early Supports and Services		X		
New Substance Abuse Benefit Allowing MLDACs		X		
Home Based Therapy – DCYF		X		
Child Health Support Service – DCYF		X		
Intensive Home and Community Services – DCYF		X		
Placement Services – DCYF		X		
Private Non-Medical Institutional For Children – DCYF		X		
Crisis Intervention – DCYF		X		
Intermediate Care Facility MR				X

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Covered Services Matrix	Step 1	Step 2	Step 3	Excluded/ FFS
Medicaid to Schools Services				X
Dental Benefit Services				X

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Appendix B: Medicaid Quality Indicators

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NH Medicaid Care Management Quality and Oversight Information

Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
101	N/A	MCOs	Beneficiary	Beneficiary Demographics	Cultural Considerations	Community demographic, cultural and epidemiologic profile: Beneficiary Counts by preferred Spoken language	NH DHHS	NH 101	All	July	3 months after go-live	September 30th
102	N/A	MCOs	Beneficiary	Beneficiary Demographics	Cultural Considerations	Community demographic, cultural and epidemiologic profile: Beneficiary Counts by preferred written language	NH DHHS	NH 101	All	July	3 months after go-live	September 30th
103	N/A	MCOs	Beneficiary	Beneficiary Demographics	Cultural Considerations	Community demographic, cultural and epidemiologic profile: Beneficiary Counts by Ethnicity	NH DHHS	NH 101	All	July	3 months after go-live	September 30th
104	N/A	MCOs	Beneficiary	Beneficiary Demographics	Cultural Considerations	Community demographic, cultural and epidemiologic profile: Beneficiary Counts by Race	NH DHHS	NH 101	All	July	3 months after go-live	September 30th
200	A	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults	CAHPS 5.0H Core Survey - Adults	CAHPS 5.0H	Adult - CORE	>=18	Fielded for 70 days beginning 7 months after go-live; normal NCQA schedule thereafter	11 months after go-live	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
200	B	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults with Chronic Conditions	CAHPS Supplement: Chronic Conditions - In the last 6 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment? (CC9, Screening Question)	CAHPS	Adult - SUPP - Q08 - CC09	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
200	C	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults with Chronic Conditions	CAHPS Supplement: Chronic Conditions - In the last 6 months, how often was it easy to get the medical equipment you needed through your health plan? (CC10)	CAHPS	Adult - SUPP - Q08 - CC10	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
200	D	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults with Chronic Conditions	CAHPS Supplement: Chronic Conditions - In the last 6 months, did you have any health problems that needed special therapy, such as physical, occupational, or speech therapy? (CC11, Screening Question)	CAHPS	Adult - SUPP - Q08 - CC11	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
200	E	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults with Chronic Conditions	CAHPS Supplement: Chronic Conditions - In the last 6 months, how often was it easy to get the special therapy you needed through your health plan? (CC12)	CAHPS	Adult - SUPP - Q08 - CC12	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
200	F	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults with Chronic Conditions	CAHPS Supplement: Chronic Conditions - Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks. In the last 6 months, did you need someone to come into your home to give you home health care or assistance? (CC13, Screening Question)	CAHPS	Adult - SUPP - Q08 - CC13	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
200	G	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults with Chronic Conditions	CAHPS Supplement: Chronic Conditions - In the last 6 months, how often was it easy to get home health care or assistance through your health plan? (CC14)	CAHPS	Adult - SUPP - Q08 - CC14	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
200	H	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults with Chronic Conditions	CAHPS Supplement: Behavioral Health - In the last 6 months, did you need any treatment or counseling for a personal or family problem? (MH2, Screening Question)	CAHPS	Adult - SUPP - Q08 - MH2	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
200	I	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults with Chronic Conditions	CAHPS Supplement: Behavioral Health - In the last 6 months, how often was it easy to get the treatment or counseling you needed through your health plan? (MH3)	CAHPS	Adult - SUPP - Q08 - MH3	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
200	J	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults	CAHPS Supplement: Coordination of Care from Other Health Providers - In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers? (OHP3, Screening Question)	CAHPS	Adult - SUPP - Q14 - OPH3	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
200	K	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults	CAHPS Supplement: Coordination of Care from Other Health Providers - In the last 6 months, who helped to coordinate your care? (OHP4.)	CAHPS	Adult - SUPP - Q14 - OPH4	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
200	L	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults	CAHPS Supplement: Coordination of Care from Other Health Providers - How satisfied are you with the help you received to coordinate your care in the last 6 months? (OHP5)	CAHPS	Adult - SUPP - Q14 - OPH5	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
200	M	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults	CAHPS Supplement: Quality Improvement Customer Service - Were any of the following a reason you did not get the information or help you needed from your health plan's customer service? (CS1)	CAHPS	Adult - SUPP - Q23 - CS1	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
200	N	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults	CAHPS Supplement: Quality Improvement Transportation - Some health plans help with transportation to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your health plan to get help with transportation? (T1, Screening Question)	CAHPS	Adult - SUPP - Q27 - T1	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
200	O	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults	CAHPS Supplement: Quality Improvement Transportation - In the last 6 months, when you phoned to get help with transportation from your health plan, how often did you get it? (T2, Screening Question)	CAHPS	Adult - SUPP - Q27 - T2	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
200	P	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Adults	CAHPS Supplement: HEDIS Set - Have you had a flu shot since September 1, of last year?	CAHPS	Adult - SUPP - Q28 - H16	>=18	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
201	A	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Children	CAHPS 5.0H Core and Children with Chronic Conditions Survey - Children	CAHPS 5.0H	Child - CORE and CORE W CCC	>=18	Fielded for 70 days beginning 7 months after go-live; normal NCQA schedule thereafter	11 months after go-live	June 30th
201	B	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Children	CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor? (OHP1, Screening Question)	CAHPS	Children - SUPP - Q17 - OHP1	0-17	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
201	C	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Children	CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers? (OHP2)	CAHPS	Children - SUPP - Q17 - OHP2	0-17	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
201	D	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Children	CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers? (OHP3, Screening Question)	CAHPS	Children - SUPP - Q17 - OHP3	0-17	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
201	E	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Children	CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - In the last 6 months, who helped to coordinate your child's care? (OHP4)	CAHPS	Children - SUPP - Q17 - OHP4	0-17	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
201	F	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Children	CAHPS Supplement: Quality Improvement Coordination of Care from Other Health Providers - How satisfied are you with the help you got to coordinate your child's care in the last 6 months? (OHP5)	CAHPS	Children - SUPP - Q17 - OHP5	0-17	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
201	G	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Children	CAHPS Supplement: Quality Improvement Customer Service - Were any of the following a reason you did not get the information or help you needed from customer service at your child's health plan? (CS1)Summary Counts for each of the following:a) You had to call several times before you could speak with someone (Yes/No) b) The information customer service gave you was not correct (Yes/No)c) Customer service did not have the information you needed (Yes/No)d) You waited too long for someone to call you back (Yes/No)e) No one called you back (Yes/No)f) Some other reason (Yes/No) Please specify:_____	CAHPS	Children - SUPP - Q26 - CS1	0-17	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
201	H	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Children	CAHPS Supplement: Transportation - Some health plans help with transportation for your child to get to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your child's health plan to get help with transportation for your child? (T1, Screening Question)	CAHPS	Children - SUPP - Q30 - T1	0-17	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
201	I	MCOs & EQRO for Statewide	Beneficiary	Satisfaction	Children	CAHPS Supplement: Transportation - In the last 6 months, when you phoned your child's health plan to get help with transportation, how often did you get it? (T2, Screening Question)	CAHPS	Children - SUPP - Q30 - T2	0-17	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th
202	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	CAHPS Adult Survey - Flu Shots for Adults Ages 50-64 (analytic breakout)	CAHPS	CMS Adult 1	50-64	Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	11 months after go-live	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
210	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Acute Care	Appropriate Testing for Children With Pharyngitis	NCQA	HEDIS: CWP	2-18	July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.	6/30/2015	June 30th
211	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Acute Care	Appropriate Treatment for Children With Upper Respiratory Infection	NCQA	HEDIS: URI	3 months-18 years old	July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.	6/30/2015	June 30th
212	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Acute Care	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	NCQA	HEDIS: AAB	18-64	CY	6/30/2015	June 30th
215	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Antidepressant Medication Management - Effective Acute Phase Treatment - Adults	NCQA	HEDIS: AMM	18-64, >=65, Total	May 1 of the year prior to the measurement year to Oct 31 of the measurement year.	6/30/2016	June 30th
215	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Antidepressant Medication Management - Effective Acute Phase Treatment - Adults - BIP Sub-population	NCQA	HEDIS: AMM	>=18	May 1 of the year prior to the measurement year to Oct 31 of the measurement year.	6/30/2016	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
216	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Antidepressant Medication Management - Effective Continuation Phase Treatment - Adults	NCQA	HEDIS: AMM	18-64, >=65, Total	May 1 of the year prior to the measurement year to Oct 31 of the measurement year.	6/30/2016	June 30th
216	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Antidepressant Medication Management - Effective Continuation Phase Treatment - Adults - BIP Sub-population	NCQA	HEDIS: AMM	>=18	May 1 of the year prior to the measurement year to Oct 31 of the measurement year.	6/30/2016	June 30th
217	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Adherence to Antipsychotics for Individuals with Schizophrenia - Adults Age 19-64	NCQA	HEDIS: SAA	19-64	CY	6/30/2015	June 30th
217	B	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Adherence to Antipsychotics for Individuals with Schizophrenia - Adults Age 19-64 - BIP Sub-population	NCQA	HEDIS: SAA	19-64	CY	6/30/2015	June 30th
218	A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Follow up appointment within 7 calendar days of discharge from New Hampshire Hospital	NH DHHS	NH 340	All	Quarterly	4 months after go-live	Within 30 days of the end of the quarter
219	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Follow Up After Hospitalization For Mental Illness - 7 days	NCQA	HEDIS: FUH	6-20, >=21, Total	January 1 through December 1 of the measurement year	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
219	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Follow Up After Hospitalization For Mental Illness - 7 days - BIP Sub-population	NCQA	HEDIS: FUH	>=6	January 1 through December 1 of the measurement year	6/30/2015	June 30th
220	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Follow Up After Hospitalization For Mental Illness - 30 days	NCQA	HEDIS: FUH	6-20, >=21, Total	January 1 through December 1 of the measurement year	6/30/2015	June 30th
220	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Follow Up After Hospitalization For Mental Illness - 30 days - BIP Sub-population	NCQA	HEDIS: FUH	>=6	January 1 through December 1 of the measurement year	6/30/2015	June 30th
221	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Follow Up Care for Children Prescribed ADHD Medication - Initiation	NCQA	HEDIS: ADD	6-12	A year starting March-April 1 of the year prior to the measurement year and ending February 28 of the measurement year.	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
222	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	NCQA	HEDIS: ADD	6-12	A year starting March-April 1 of the year prior to the measurement year and ending February 28 of the measurement year.	6/30/2015	June 30th
223	A-D	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation	NCQA	NH 223 / HEDIS: IET	13 - 17, 18-64, >=65, Total	CY	6/30/2015	June 30th
223	E	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation - BIP Sub-population	NCQA	NH 223 / HEDIS: IET	>=18	CY	6/30/2015	June 30th
224	A-D	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement	NCQA	NH 224 / HEDIS: IET	13 - 17, 18-64, >=65, Total	CY	6/30/2015	June 30th
224	E	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement - BIP Sub-population	NCQA	NH 224 / HEDIS: IET	>=18	CY	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
225	N/A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Percent of Beneficiary receipt of discharge plan upon discharge from New Hampshire Hospital	NH DHHS	NH 340	All	Quarterly	4 months after go-live	Within 30 days of the end of the quarter
226	N/A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Percent of contact with the Beneficiary within 3 calendar days of Beneficiary discharge from New Hampshire Hospital	NH DHHS	NH 340	All	Quarterly	4 months after go-live	Within 30 days of the end of the quarter
227	A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Percent of continuously enrolled children using behavioral health medications who received a psychiatric consultation for behavioral health medications - children	NH DHHS	NH 358	0-18	CY	6/30/2015	June 30th
227	B	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Percent of continuously enrolled children using behavioral health medications who received a psychiatric consultation for behavioral health medications - children receiving foster care services	NH DHHS	NH 358	0-18	CY	6/30/2015	June 30th
228	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Screening for Clinical Depression and Follow-up Plan	CMS	CMS Adult 6	18-64, >=65, Total	CY	6/30/2015	June 30th
228	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Screening for Clinical Depression and Follow-up Plan - BIP Sub-population	CMS	CMS Adult 6	>=18	CY	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
229	N/A	MCOs	Healthcare Processes and Outcomes	Outcomes	Behavioral Health	Homelessness Hospital discharges: Number of discharges to homeless shelters and homelessness.	NH DHHS	NH 446	All	Agreement year	7/31/2014	Within 30 days of the end of an agreement year
230	N/A	MCOs	Healthcare Processes and Outcomes	Outcomes	Behavioral Health	Readmission to NH Hospital at 30 days	NH DHHS	NH 360	All	June 1 of the prior SFY to June 30 of the measurement year. A 13 month period.	9/1/2014	September 1st
231	N/A	MCOs	Healthcare Processes and Outcomes	Outcomes	Behavioral Health	Readmission to NH Hospital at 180 days	NH DHHS	NH 360	All	January 1 of the of the prior SFY to June 30 of the measurement year. An 18 month period	9/1/2015	September 1st
233	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual HIV/AIDS Medical Visits, Two With a Minimum of 180 Days Between Each Visit - Adults	NCQA / CMS	CMS Adult 16	18-64, >=65, Total	CY	6/30/2015	June 30th
233	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual HIV/AIDS Medical Visits, Two With a Minimum of 180 Days Between Each Visit - Adults - BIP Sub-population	NCQA / CMS	CMS Adult 16	>=18	CY	6/30/2015	June 30th
235	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual Monitoring for Patients on Persistent Medications - Adults - ACE or ARB	NCQA	HEDIS: MPM	18-64, >=65, Total	CY	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
235	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual Monitoring for Patients on Persistent Medications - Adults - ACE or ARB - BIP Sub-population	NCQA	HEDIS: MPM	>=18	CY	6/30/2015	June 30th
236	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual Monitoring for Patients on Persistent Medications - Adults - Anticonvulsants	NCQA	HEDIS: MPM	18-64, >=65, Total	CY	6/30/2015	June 30th
236	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual Monitoring for Patients on Persistent Medications - Adults - Anticonvulsants - BIP Sub-population	NCQA	HEDIS: MPM	>=18	CY	6/30/2015	June 30th
237	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual Monitoring for Patients on Persistent Medications - Adults - Digoxin	NCQA	HEDIS: MPM	18-64, >=65, Total	CY	6/30/2015	June 30th
237	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual Monitoring for Patients on Persistent Medications - Adults - Digoxin - BIP Sub-population	NCQA	HEDIS: MPM	>=18	CY	6/30/2015	June 30th
238	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual Monitoring for Patients on Persistent Medications - Adults - Diuretics	NCQA	HEDIS: MPM	18-64, >=65, Total	CY	6/30/2015	June 30th
238	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual Monitoring for Patients on Persistent Medications - Adults - Diuretics - BIP Sub-population	NCQA	HEDIS: MPM	>=18	CY	6/30/2015	June 30th
239	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual Monitoring for Patients on Persistent Medications - Adults - Total Rate	NCQA	HEDIS: MPM	18-64, >=65, Total	CY	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
239	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual Monitoring for Patients on Persistent Medications - Adults - Total Rate - BIP Sub-population	NCQA	HEDIS: MPM	>=18	CY	6/30/2015	June 30th
240	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual HIV/AIDS Medical Visits, Two With a Minimum of 90 Days Between Each Visit - Adults	NCQA / CMS	CMS Adult 16	18-64, >=65, Total	CY	6/30/2015	June 30th
240	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Annual HIV/AIDS Medical Visits, Two With a Minimum of 90 Days Between Each Visit - Adults - BIP Sub-population	NCQA / CMS	CMS Adult 16	>=18	CY	6/30/2015	June 30th
241	A-C	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Rate of Maintenance Medication Gaps Greater Than 20 Days Between Refills by Age Group	NH DHHS	NH 241	0-5, 6-18, 19-64	Quarterly	2/28/2014	2 months after the end of the quarter
245	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening	NCQA	HEDIS: CMC	18-75	CY	6/30/2015	June 30th
246	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Controlling High Blood Pressure - Age 18 to 85	NCQA	HEDIS: CBP	18-64, 65-85, Total	CY	6/30/2015	June 30th
246	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Controlling High Blood Pressure - Age 18 to 85 - BIP Sub-population	NCQA	HEDIS: CBP	18-85	CY	6/30/2015	June 30th

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250	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Comprehensive Diabetes Care - HbA1c Testing	NCQA / CMS	HEDIS: CDC	18-64, 65-75, Total	CY	6/30/2015	June 30th
250	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Comprehensive Diabetes Care - HbA1c Testing - BIP Sub-population	NCQA / CMS	HEDIS: CDC	18-75	CY	6/30/2015	June 30th
250	E-G	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Comprehensive Diabetes Care - HbA1c Testing - Disabled Sub-population	NCQA / CMS	HEDIS: CDC	18-64, 65-75, Total	CY	6/30/2015	June 30th
250	H-J	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Comprehensive Diabetes Care - HbA1c Testing - Metropolitan Counties	NCQA / CMS	HEDIS: CDC	18-64, 65-75, Total	CY	6/30/2015	June 30th
250	K-M	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Comprehensive Diabetes Care - HbA1c Testing - Non-metropolitan Counties	NCQA / CMS	HEDIS: CDC	18-64, 65-75, Total	CY	6/30/2015	June 30th
251	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Comprehensive Diabetes Care - HbA1c Control (>9%)	NCQA	HEDIS: CDC	18-75	CY	6/30/2015	June 30th
252	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Comprehensive Diabetes Care - LDL-C Screening	NCQA / CMS	HEDIS: CDC	18-64, 65-75, Total	CY	6/30/2015	June 30th
252	D	EQRO	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Comprehensive Diabetes Care - LDL-C Screening - BIP Sub-population	NCQA / CMS	HEDIS: CDC	18-75	CY	6/30/2015	June 30th
253	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Comprehensive Diabetes Care - Eye Exam	NCQA	HEDIS: CDC	18-75	CY	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
254	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Comprehensive Diabetes Care - Medical Attention for Nephropathy	NCQA	HEDIS: CDC	18-75	CY	6/30/2015	June 30th
255	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Screening	Annual Pediatric hemoglobin A1C Testing - Children Age 5 to 17 With Type I or II Diabetes	CMS	CMS Child 22	5-17	CY	6/30/2015	June 30th
259	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Outcomes	Chronic Care	Diabetes Short-Term Complications Admission Rate per 100,000 - Adults	AHRQ / CMS	CMS Adult 8	18-64, >=65, Total	CY	6/30/2015	June 30th
259	D	EQRO	Healthcare Processes and Outcomes	Outcomes	Chronic Care	Diabetes Short-Term Complications Admission Rate per 100,000 - Adults - BIP Sub-population	AHRQ / CMS	CMS Adult 8	>=18	CY	6/30/2015	June 30th
260	A-D	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Use of Appropriate Medications for People with Asthma - Age 5 to 64	NCQA	NH 260 / HEDIS: ASM	5-11, 12-18, 19-50, 51-64, Total	CY	6/30/2015	June 30th
261	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Medication Management for People with Asthma - At Least 50% of Treatment Period - Age 5 to 18	NCQA / CMS	HEDIS: MMA	5-18	CY	6/30/2015	June 30th
262	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Medication Management for People with Asthma - At Least 75% of Treatment Period - Age 5 to 18	NCQA / CMS	HEDIS: MMA	5-18	CY	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
263	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Outcomes	Chronic Care	Annual Percent of Asthma Patients With One or More Asthma-Related Emergency Room Visits - Age 2 to 20	Alabama Medicaid / CMS	CMS Child 20	2-20	CY	6/30/2015	June 30th
264	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Outcomes	Chronic Care	Asthma Admission Rate per 100,000 - Adults	AHRQ / CMS	CMS Adult 11	18-64, >=65, Total	CY	6/30/2015	June 30th
264	D	EQRO	Healthcare Processes and Outcomes	Outcomes	Chronic Care	Asthma Admission Rate per 100,000 - Adults - BIP Sub-population	AHRQ / CMS	CMS Adult 11	>=18	CY	6/30/2015	June 30th
267	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	Chronic Care	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	NCQA	HEDIS: SPR	>=40	CY	6/30/2015	June 30th
268	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Outcomes	Chronic Care	Chronic Obstructive Pulmonary Disease (COPD) Admission Rate per 100,000 - Adults	AHRQ / CMS	CMS Adult 9	18-64, >=65, Total	CY	6/30/2015	June 30th
268	D	EQRO	Healthcare Processes and Outcomes	Outcomes	Chronic Care	Chronic Obstructive Pulmonary Disease (COPD) Admission Rate per 100,000 - Adults - BIP Sub-population	AHRQ / CMS	CMS Adult 9	>=18	CY	6/30/2015	June 30th
270	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Outcomes	Chronic Care	Congestive Heart Failure Admission Rate per 100,000 - Adults	AHRQ / CMS	CMS Adult 10	18-64, >=65, Total	CY	6/30/2015	June 30th
270	D	EQRO	Healthcare Processes and Outcomes	Outcomes	Chronic Care	Congestive Heart Failure Admission Rate per 100,000 - Adults - BIP Sub-population	AHRQ / CMS	CMS Adult 10	>=18	CY	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
271	A-D	MCOs & EQRO for Statewide	Network	Access	Service Use	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions Overall PQI Composite per 100,000 beneficiaries - Adults	AHRQ / DHHS	PQI 90	18-44, 45-64, >=65, Total	Quarterly	Four months after the completion of the first full quarter after go-live	4 months after the end of the quarter
271	E-H	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Outcomes	Chronic Care	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions Overall PQI Composite per 100,000 beneficiaries - Adults	AHRQ / DHHS	PQI 90	18-44, 45-64, >=65, Total	CY	6/30/2015	June 30th
280	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Quality Assurance and Improvement	General	Care Transition - Transition Record Transmitted to Health Care Professional - Adults	AMA-PCPI/ NCQA / CMS	CMS Adult 24	18-64, >=65, Total	CY	6/30/2015	June 30th
280	D	EQRO	Healthcare Processes and Outcomes	Quality Assurance and Improvement	General	Care Transition - Transition Record Transmitted to Health Care Professional - Adults - BIP Sub-population	AMA-PCPI/ NCQA / CMS	CMS Adult 24	>=18	CY	6/30/2015	June 30th
300	A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Resolution of appeals - duration of time - Percentage of appeals resolutions that meet contract standards (17.9.1.1 - 17.9.1.4) - Standard appeals - within 30 calendar days	NH DHHS	NH 300	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
300	B	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Resolution of appeals - duration of time - Percentage of appeals resolutions that meet contract standards (17.9.1.1 - 17.9.1.4) - Extended appeals - within 44 calendar days	NH DHHS	NH 300	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
300	C	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Resolution of appeals - duration of time - Percentage of appeals resolutions that meet contract standards (17.9.1.1 - 17.9.1.4) - Expedited appeals- within 3 calendar days	NH DHHS	NH 300	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
300	D	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Resolution of appeals - duration of time - Percentage of appeals resolutions that meet contract standards (17.9.1.1 - 17.9.1.4) - Maximum - within 45 calendar days	NH DHHS	NH 300	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
301	A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Resolution of appeals - disposition type - Percentage of appeals by disposition outcome - Member abandoned appeal	NH DHHS	NH 301	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
301	B	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Resolution of appeals - disposition type - Percentage of appeals by disposition outcome - Appeal upheld	NH DHHS	NH 301	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
301	C	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Resolution of appeals - disposition type - Percentage of appeals by disposition outcome - Appeal Reversed	NH DHHS	NH 301	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
301	D	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Resolution of appeals - disposition type - Percentage of appeals by disposition outcome - Appeal elevated to State Fair Hearing	NH DHHS	NH 301	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
302	A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Type of Appeals - Percentage of Appeals initiated by Action (17.4) - Denial or limited authorization	NH DHHS	NH 302	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
302	B	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Type of Appeals - Percentage of Appeals initiated by Action (17.4) - Reduction, suspension, or termination of previously authorized service	NH DHHS	NH 302	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
302	C	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Type of Appeals - Percentage of Appeals initiated by Action (17.4) - Denial of payment	NH DHHS	NH 302	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
302	D	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Type of Appeals - Percentage of Appeals initiated by Action (17.4) - Failure to provide timely service	NH DHHS	NH 302	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
302	E	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Type of Appeals - Percentage of Appeals initiated by Action (17.4) - Untimely service authorization	NH DHHS	NH 302	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
302	F	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Type of Appeals - Percentage of Appeals initiated by Action (17.4) - Failure of MCO to act within NH DHHS contract timeframes (17.4.1.6)	NH DHHS	NH 302	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
303	A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Timeliness of Notice Delivery - Percentage of notices delivered to beneficiaries within timeframe stipulated in contract - Notice for Denial of Payment - delivered on date of action	NH DHHS	NH 303	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
303	B	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Timeliness of Notice Delivery - Percentage of notices delivered to beneficiaries within timeframe stipulated in contract - Notice for Denial of Service Authorization - 14 calendar days after request for authorization	NH DHHS	NH 303	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
303	C	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Timeliness of Notice Delivery - Percentage of notices delivered to beneficiaries within timeframe stipulated in contract - Notice for Denial of Service Authorization under permissible extensions - 28 calendar days after request for authorization	NH DHHS	NH 303	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
303	D	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Timeliness of Notice Delivery - Percentage of notices delivered to beneficiaries within timeframe stipulated in contract - Notice for circumstances that warrant expedited notices - 3 business days after request for authorization	NH DHHS	NH 303	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
304	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Percent of grievance dispositions made within 45 calendar days	NH DHHS	NH 304	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
330	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Frequency of Ongoing Prenatal Care (<21% of Expected Number of Visits)	NCQA	HEDIS: FPC	All	CY	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
330	B	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Frequency of Ongoing Prenatal Care (21-40% of Expected Number of Visits)	NCQA	HEDIS: FPC	All	CY	6/30/2015	June 30th
330	C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Frequency of Ongoing Prenatal Care (41-60% of Expected Number of Visits)	NCQA	HEDIS: FPC	All	CY	6/30/2015	June 30th
330	D	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Frequency of Ongoing Prenatal Care (61-80% of Expected Number of Visits)	NCQA	HEDIS: FPC	All	CY	6/30/2015	June 30th
330	E	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Frequency of Ongoing Prenatal Care (>= 81% of Expected Number of Visits)	NCQA	HEDIS: FPC	All	CY	6/30/2015	June 30th
331	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Prenatal and Postpartum Care - Timeliness of Prenatal Care	NCQA	HEDIS: PPC	All	CY	6/30/2015	June 30th
332	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Prenatal and Postpartum Care - Postpartum Care - Total	NCQA	HEDIS: PPC	All	CY	6/30/2015	June 30th
332	B	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Prenatal and Postpartum Care - Postpartum Care – Metropolitan Counties	NCQA	HEDIS: PPC	All	CY	6/30/2015	June 30th
332	C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Prenatal and Postpartum Care - Postpartum Care – Non-metropolitan Counties	NCQA	HEDIS: PPC	All	CY	6/30/2015	June 30th
332	D	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Prenatal and Postpartum Care - Postpartum Care – Ethnicity: Hispanic	NCQA	HEDIS: PPC	All	CY	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
332	E	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Prenatal and Postpartum Care - Postpartum Care – Ethnicity: Non-Hispanic	NCQA	HEDIS: PPC	All	CY	6/30/2015	June 30th
332	F	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Prenatal and Postpartum Care - Postpartum Care – Race: White	NCQA	HEDIS: PPC	All	CY	6/30/2015	June 30th
332	G	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Prenatal and Postpartum Care - Postpartum Care – Race: Black	NCQA	HEDIS: PPC	All	CY	6/30/2015	June 30th
332	H	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Prenatal and Postpartum Care - Postpartum Care – Race: Other	NCQA	HEDIS: PPC	All	CY	6/30/2015	June 30th
333	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Outcomes	Perinatal	Behavioral Health Risk Assessment for Pregnant Women	AMA - Convened Physician Consortium for Performance Improvement (CPCI) / CMS	CMS TBD	All	Agreement year	12/31/2015	December 31st
334	N/A	DHHS	Healthcare Processes and Outcomes	Outcomes	Perinatal	Mothers who reported smoking during pregnancy	NH DHHS	NH 334	All	Agreement year	12/31/2014	December 31st
335	N/A	DHHS	Healthcare Processes and Outcomes	Prevention	Perinatal	Rate of Early Term Elective Delivery	TJC PC-01 / CMS	CMS Adult 14	All	CY	6/30/2015	June 30th
335	N/A	DHHS	Healthcare Processes and Outcomes	Prevention	Perinatal	Cesarean rate for nulliparous singleton vertex (AKA Cesarean rate for low-risk first birth women)	California Maternal Quality Care Collaborative / CMS	CMS Child 4	All	CY	6/30/2015	June 30th

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336	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Perinatal	Appropriate Use of Antenatal Steroids	Providence St. Vincent Medical Center, TJC-03 / CMS	CMS Adult 15	All	CY	6/30/2015	June 30th
337	N/A	DHHS	Healthcare Processes and Outcomes	Outcomes	Perinatal	Percent of live births weighing less than 2,500 grams	CDC / CMS	CMS Child 3	N/A	CY	6/30/2015	June 30th
340	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Screening	Breast Cancer Screening - Age 42-69	NCQA	HEDIS: BCS	42-64, 65-69, Total	2 CY	6/30/2016	June 30th
340	D	EQRO	Healthcare Processes and Outcomes	Prevention	Screening	Breast Cancer Screening - Age 42-69 - BIP Sub-population	NCQA	HEDIS: BCS	42-69	2 CY	6/30/2016	June 30th
341	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Screening	Cervical Cancer Screening - Age 24-64	NCQA	HEDIS: CCS	24-64	3 CY	6/30/2017	June 30th
341	B	EQRO	Healthcare Processes and Outcomes	Prevention	Screening	Cervical Cancer Screening - Age 24-64 - BIP Sub-population	NCQA	HEDIS: CCS	24-64	3 CY	6/30/2017	June 30th
341	C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Screening	Cervical Cancer Screening - Age 24-64 - Disabled Sub-population	NCQA	HEDIS: CCS	24-64	3 CY	6/30/2017	June 30th
341	D	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Screening	Cervical Cancer Screening - Age 24-64 - Metropolitan Counties	NCQA	HEDIS: CCS	24-64	3 CY	6/30/2017	June 30th
341	E	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Screening	Cervical Cancer Screening - Age 24-64 – Non-metropolitan Counties	NCQA	HEDIS: CCS	24-64	3 CY	6/30/2017	June 30th

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342	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Screening	Chlamydia Screening in Women - Age 16 to 24	NCQA	HEDIS: CHL	16-20, 21-24, Total	CY	6/30/2015	June 30th
342	D	EQRO	Healthcare Processes and Outcomes	Prevention	Screening	Chlamydia Screening in Women - Age 16 to 24 - BIP Sub-population	NCQA	HEDIS: CHL	16-24	CY	6/30/2015	June 30th
343	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Adult BMI Assessment	NCQA	HEDIS: BAA	18-64, 64-74, Total	CY	6/30/2015	June 30th
343	D	EQRO	Healthcare Processes and Outcomes	Prevention	Well-Care	Adult BMI Assessment - BIP Sub-population	NCQA	HEDIS: BAA	18-74	CY	6/30/2015	June 30th
344	A-D	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Developmental Screening in the First Three Years of Life	CAHMI / CMS	CMS Child 8	1, 2, 3, Total	Birthday - 12 months	6/30/2016	June 30th
345	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile documentation	NCQA	HEDIS: WCC	3-11, 12-17, Total	CY	6/30/2015	June 30th
346	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	NCQA	NH 346 / HEDIS: WCC	3-11, 12-17, Total	CY	6/30/2015	June 30th

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347	A-C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	NCQA	NH 347 / HEDIS: WCC	3-11, 12-17, Total	CY	6/30/2015	June 30th
350	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Well-Child Visits in the first 15 Months of Life (0 visit)	NCQA	HEDIS: W15	15 months	CY	6/30/2015	June 30th
350	B	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Well-Child Visits in the first 15 Months of Life (1 visit)	NCQA	HEDIS: W15	15 months	CY	6/30/2015	June 30th
350	C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Well-Child Visits in the first 15 Months of Life (2 visits)	NCQA	HEDIS: W15	15 months	CY	6/30/2015	June 30th
350	D	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Well-Child Visits in the first 15 Months of Life (3 visits)	NCQA	HEDIS: W15	15 months	CY	6/30/2015	June 30th
350	E	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Well-Child Visits in the first 15 Months of Life (4 visits)	NCQA	HEDIS: W15	15 months	CY	6/30/2015	June 30th
350	F	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Well-Child Visits in the first 15 Months of Life (5 visits)	NCQA	HEDIS: W15	15 months	CY	6/30/2015	June 30th
350	G	MCOs & EQRO for Statewide	Network	Access	Service Use	Well-Child Visits in the first 15 Months of Life (6 or more visits) - Total	NCQA	HEDIS: W15	15 months	CY	6/30/2015	June 30th
350	G	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Well-Child Visits in the first 15 Months of Life (6 or more visits) - Total	NCQA	HEDIS: W15	15 months	CY	6/30/2015	June 30th

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350	H	MCOs & EQRO for Statewide	Network	Access	Service Use	Well-Child Visits in the first 15 Months of Life (6 or more visits) - Metropolitan Counties	NCQA	HEDIS: W15	15 months	CY	6/30/2015	June 30th
350	I	MCOs & EQRO for Statewide	Network	Access	Service Use	Well-Child Visits in the first 15 Months of Life (6 or more visits) - Non-Metropolitan Counties	NCQA	HEDIS: W15	15 months	CY	6/30/2015	June 30th
351	A	MCOs & EQRO for Statewide	Network	Access	Service Use	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - Total Population	NCQA	HEDIS: W34	3-6	CY	6/30/2015	June 30th
351	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - Total Population	NCQA	HEDIS: W34	3-6	CY	6/30/2015	June 30th
351	B	MCOs & EQRO for Statewide	Network	Access	Service Use	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - Metropolitan Counties	NCQA	HEDIS: W34	3-6	CY	6/30/2015	June 30th
351	C	MCOs & EQRO for Statewide	Network	Access	Service Use	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life - Non-Metropolitan Counties	NCQA	HEDIS: W34	3-6	CY	6/30/2015	June 30th
352	A	MCOs & EQRO for Statewide	Network	Access	Service Use	Adolescent Well Care Visits - Total Population	NCQA	HEDIS: AWC	12-21	CY	6/30/2015	June 30th
352	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Adolescent Well Care Visits - Total Population	NCQA	HEDIS: AWC	12-21	CY	6/30/2015	June 30th
352	B	MCOs & EQRO for Statewide	Network	Access	Service Use	Adolescent Well Care Visits - Metropolitan Counties	NCQA	HEDIS: AWC	12-21	CY	6/30/2015	June 30th
352	C	MCOs & EQRO for Statewide	Network	Access	Service Use	Adolescent Well Care Visits - Non-Metropolitan Counties	NCQA	HEDIS: AWC	12-21	CY	6/30/2015	June 30th

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353	A	MCOs & EQRO for Statewide	Network	Access	Service Use	Access to (use of) Preventive/Ambulatory Health Services - Adults	NCQA	NH 353 / HEDIS: AAP	20-44, 45-64, >=65, Total	CY	6/30/2015	June 30th
353	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Access to (use of) Preventive/Ambulatory Health Services - Adults	NCQA	NH 353 / HEDIS: AAP	20-44, 45-64, >=65, Total	CY	6/30/2015	June 30th
353	B	MCOs & EQRO for Statewide	Network	Access	Service Use	Access to (use of) Preventive/Ambulatory Health Services - Adult Total: Metropolitan Counties	NCQA	NH DHHS 385 / HEDIS AAP	>=20	CY	6/30/2015	June 30th
353	C	MCOs & EQRO for Statewide	Network	Access	Service Use	Access to (use of) Preventive/Ambulatory Health Services - Adult Total: Non-Metropolitan Counties	NCQA	NH DHHS 385 / HEDIS AAP	>=20	CY	6/30/2015	June 30th
354	A	MCOs & EQRO for Statewide	Network	Access	Service Use	Children and Adolescents' Access To PCP - Age 12 Months - 19 Years	NCQA	HEDIS: CAP	12-24 months, 25 months-6 years, 7-11, 12-19, Total	CY	6/30/2015	June 30th
354	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Well-Care	Children and Adolescents' Access To PCP - Age 12 Months - 19 Years	NCQA	HEDIS: CAP	12-24 months, 25 months-6 years, 7-11, 12-19, Total	CY	6/30/2015	June 30th
355	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Combo 2	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th

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355	B	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Combo 3	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Combo 4	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	D	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Combo 5	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	E	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Combo 6	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	F	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Combo 7	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	G	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Combo 8	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	H	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Combo 9	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	I	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Combo 10	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	J	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - DTaP	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th

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355	K	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - IPV	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	L	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - MMR	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	M	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - HiB	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	N	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Hepatitis B	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	O	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - VZV	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	P	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Pneumococcal Conjugate	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	Q	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Hepatitis A	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	R	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Rotavirus	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th
355	S	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Childhood Immunization Status - Influenza	NCQA	HEDIS: CIS	2	CY	6/30/2015	June 30th

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356	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Immunizations for Adolescents - Combination 1	NCQA	HEDIS: IMA	13	CY	6/30/2015	June 30th
356	B	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Immunizations for Adolescents - Meningococcal	NCQA	HEDIS: IMA	13	CY	6/30/2015	June 30th
356	C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Immunizations for Adolescent - Tdap/Td	NCQA	HEDIS: IMA	13	CY	6/30/2015	June 30th
357	N/A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Prevention	Immunization	Human Papillomavirus (HPV) Vaccine for Female Adolescents	NCQA	NQF 1407	13	CY	6/30/2015	June 30th
370	N/A	CMS	Healthcare Processes and Outcomes	Outcomes	Acute Care	Pediatric central-line associated bloodstream infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CDC / CMS	CMS Child 19	0-17	CY	6/30/2015	June 30th
416	A	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Individuals Eligible for EPSDT (Line 1a)	CMS	416 L1a	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY (April 1 is the due date for CMS)
416	B	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Individuals Eligible for EPSDT for 90 Continuous Days (Line 1b)	CMS	416 L1b	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY (April 1 is the due date for CMS)

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416	C	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Individuals Eligible for EPSDT under a CHIP Medicaid Expansion (Line 1c)	CMS	416 L1c	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY(April 1 is the due date for CMS)
416	D	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Months of Eligibility (Line 3a)	CMS	416 L3a	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY (April 1 is the due date for CMS)
416	E	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Screens Received (Line 6)	CMS	416 L6	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY (April 1 is the due date for CMS)
416	F	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total eligible received at least one initial or periodic Screen (Line 9)	CMS	416 L9	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY (April 1 is the due date for CMS)

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416	G	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Eligibles referred to corrective treatment with the screening provider or referred to another provider for further needed diagnostic or treatment services. (Line 11)	CMS	416 L11	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY(April 1 is the due date for CMS)
416	H	DHHS	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Eligibles receiving any dental services (Line 12a)	CMS	416 L12a	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY (April 1 is the due date for CMS)
416	I	DHHS	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Eligibles receiving preventive dental services (Line 12b)	CMS	416 L12b	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY (April 1 is the due date for CMS)
416	J	DHHS	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Eligibles receiving dental treatment services (Line 12c)	CMS	416 L12c	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY(April 1 is the due date for CMS)

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416	K	DHHS	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Eligibles receiving a sealant on a permanent molar tooth by MCO and FFS (Line 12d)	CMS	416 L12d	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY (April 1 is the due date for CMS)
416	L	DHHS	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Eligibles receiving diagnostic dental services (Line 12e)	CMS	416 L12e	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY (April 1 is the due date for CMS)
416	M	DHHS	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Eligibles receiving oral health services by a non-dentist provider (Line 12f)	CMS	416 L12f	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY (April 1 is the due date for CMS)
416	N	DHHS	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Eligibles receiving any dental or oral health service (Line 12g)	CMS	416 L12g	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY(April 1 is the due date for CMS)
416	O	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total Eligibles enrolled in Managed Care (Line 13)	CMS	416 L13	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY (April 1 is the due date for CMS)

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416	P	MCOs & EQRO for Statewide	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	EPSDT performance via Form-CMS 416 procedures: Total number of Screening Blood Lead Tests (Line 14)	CMS	416 L14	Total <21, <0, 1-2, 3-5, 6-9, 10-14, 15-18, 19-20	Federal FY	3/18/2015	March 18th of the next Federal FY (April 1 is the due date for CMS)
417	N/A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	EPSDT	MCO EPSDT Plan that includes written policies and procedures for conducting outreach and education, tracking and follow-up to ensure compliance with the EPSDT periodicity schedules	DHHS	N/A	0-20	Agreement year	90 days prior to go-live	May 1st
420	A	MCOs & EQRO for Statewide	Network	Access	Beneficiary Request	Beneficiary Requests for Assistance Accessing MCO Designated Primary Care Providers - Total Population	NH DHHS	NH 420	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
420	B	MCOs & EQRO for Statewide	Network	Access	Beneficiary Request	Beneficiary Requests for Assistance Accessing MCO Designated Primary Care Providers - Metropolitan Counties	NH DHHS	NH 420	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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420	C	MCOs & EQRO for Statewide	Network	Access	Beneficiary Request	Beneficiary Requests for Assistance Accessing MCO Designated Primary Care Providers - Non-metropolitan Counties	NH DHHS	NH 420	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
421	A	MCOs & EQRO for Statewide	Network	Access	Beneficiary Request	Beneficiary Requests for Assistance Accessing Physician/APRN Specialist (non-MCO Designated Primary Care) Providers - Non-metropolitan Counties	NH DHHS	NH 421	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
421	B	MCOs & EQRO for Statewide	Network	Access	Beneficiary Request	Beneficiary Requests for Assistance Accessing Physician/APRN Specialist (non-MCO Designated Primary Care) Providers - Metropolitan Counties	NH DHHS	NH 421	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
421	C	MCOs & EQRO for Statewide	Network	Access	Beneficiary Request	Beneficiary Requests for Assistance Accessing Physician/APRN Specialist (non-MCO Designated Primary Care) Providers - Total Population	NH DHHS	NH 421	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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422	A	MCOs & EQRO for Statewide	Network	Access	Beneficiary Request	Beneficiary Requests for Assistance Accessing Other Providers (non-Physician/APRN) - Metropolitan Counties	NH DHHS	NH 422	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
422	B	MCOs & EQRO for Statewide	Network	Access	Beneficiary Request	Beneficiary Requests for Assistance Accessing Other Providers (non-Physician/APRN) - Non-metropolitan Counties	NH DHHS	NH 422	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
422	C	MCOs & EQRO for Statewide	Network	Access	Beneficiary Request	Beneficiary Requests for Assistance Accessing Other Providers (non-Physician/APRN) - Total Population	NH DHHS	NH 422	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
425	A	MCOs & EQRO for Statewide	Network	Access	Network Adequacy	Beneficiary to provider ratio - MCO Designated Primary Care providers - Statewide	NH DHHS	NH 425	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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425	B	MCOs & EQRO for Statewide	Network	Access	Network Adequacy	Beneficiary to provider ratio - MCO Designated Primary care providers - Metropolitan Counties	NH DHHS	NH 425	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
425	C	MCOs & EQRO for Statewide	Network	Access	Network Adequacy	Beneficiary to provider ratio - MCO Designated Primary Care providers - Non-Metropolitan Counties	NH DHHS	NH 425	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
426	A	MCOs & EQRO for Statewide	Network	Access	Network Adequacy	Child to Pediatrician Provider Ratio - Total	NH DHHS	NH 426	0-18	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
426	B	MCOs & EQRO for Statewide	Network	Access	Network Adequacy	Child to Pediatrician Provider Ratio - Metropolitan Counties	NH DHHS	NH 426	0-18	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
426	C	MCOs & EQRO for Statewide	Network	Access	Network Adequacy	Child to Pediatrician Provider Ratio - Non-Metropolitan Counties	NH DHHS	NH 426	0-18	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
427	A	MCOs & EQRO for Statewide	Network	Access	Network Adequacy	Female Age 19 to 64 to OB/GYN Provider Ratio - Total	NH DHHS	NH 427	19-64	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
427	B	MCOs & EQRO for Statewide	Network	Access	Network Adequacy	Female Age 19 to 64 to OB/GYN Provider Ratio - Metropolitan Counties	NH DHHS	NH 427	19-64	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
427	C	MCOs & EQRO for Statewide	Network	Access	Network Adequacy	Female Age 19 to 64 to OB/GYN Provider Ratio - Non-Metropolitan Counties	NH DHHS	NH 427	19-64	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
430	A	MCOs & EQRO for Statewide	Network	Access	Service Use	Access to (use of) Preventive/Ambulatory Health Services - Total Population	NCQA	DHHS 430 / HEDIS AAP & CAP	All	CY	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
430	B	MCOs & EQRO for Statewide	Network	Access	Service Use	Access to (use of) Preventive/Ambulatory Health Services - Metropolitan Areas	NCQA	DHHS 430 / HEDIS AAP & CAP	All	CY	6/30/2015	June 30th
430	C	MCOs & EQRO for Statewide	Network	Access	Service Use	Access to (use of) Preventive/Ambulatory Health Services - Non-Metropolitan Areas	NCQA	DHHS 430 / HEDIS AAP & CAP	All	CY	6/30/2015	June 30th
431	A	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Physician/APRN/Clinic Utilization per 1,000 beneficiaries - Total Population	NH DHHS / HEDIS	NH 431 / HEDIS AAP & CAP	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	Within 4 months after the end of the quarter
431	A	MCOs & EQRO for Statewide	Network	Access	Service Use	Physician/APRN/Clinic Utilization per 1,000 beneficiaries - Total Population	NH DHHS / HEDIS	NH 431 / HEDIS AAP & CAP	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	Within 4 months after the end of the quarter
431	B	MCOs & EQRO for Statewide	Network	Access	Service Use	Physician/APRN/Clinic Utilization per 1,000 beneficiaries - Metropolitan Areas	NH DHHS / HEDIS	NH 431 / HEDIS AAP & CAP	All	Quarterly	Four months after the completion of the first full quarter after go-live	4 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
431	C	MCOs & EQRO for Statewide	Network	Access	Service Use	Physician/APRN/Clinic Utilization per 1,000 beneficiaries - Non-Metropolitan Areas	NH DHHS / HEDIS	NH 431 / HEDIS AAP & CAP	All	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
431	D	MCOs & EQRO for Statewide	Network	Access	Service Use	Physician/APRN/Clinic Utilization per 1,000 beneficiaries - Children, Children and Families Aid Categories	NH DHHS / HEDIS	NH 431 / HEDIS CAP	0-18	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
431	E	MCOs & EQRO for Statewide	Network	Access	Service Use	Physician/APRN/Clinic Utilization per 1,000 beneficiaries - Children, Blind and Disabled Aid Categories	NH DHHS / HEDIS	NH 431 / HEDIS CAP	0-18	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
431	F	MCOs & EQRO for Statewide	Network	Access	Service Use	Physician/APRN/Clinic Utilization per 1,000 beneficiaries - Children, Foster Care Aid Categories	NH DHHS / HEDIS	NH 431 / HEDIS CAP	All	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
431	G	MCOs & EQRO for Statewide	Network	Access	Service Use	Physician/APRN/Clinic Utilization per 1,000 beneficiaries - Adults, families and Children Aid Categories	NH DHHS / HEDIS	NH 431 / HEDIS AAP	19-64	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
431	H	MCOs & EQRO for Statewide	Network	Access	Service Use	Physician/APRN/Clinic Utilization per 1,000 beneficiaries - Adults, Blind and Disabled Aid Categories	NH DHHS / HEDIS	NH 431 / HEDIS AAP	19-64	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
431	I	MCOs & EQRO for Statewide	Network	Access	Service Use	Physician/APRN/Clinic Utilization per 1,000 beneficiaries - Adults, Aged Aid Category	NH DHHS / HEDIS	NH 431 / HEDIS AAP	>=65	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
432	A	MCOs & EQRO for Statewide	Network	Access	Service Use	Ambulatory Care: Emergency Dept. Visits/1000 - Total Population	NH DHHS / HEDIS	NH 432 / HEDIS AMB	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
432	B	MCOs & EQRO for Statewide	Network	Access	Service Use	Ambulatory Care: Emergency Dept. Visits/1000 by Metropolitan Counties	NH DHHS / HEDIS	NH 432	All	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
432	C	MCOs & EQRO for Statewide	Network	Access	Service Use	Ambulatory Care: Emergency Dept. Visits/1000 by Non-Metropolitan Counties	NH DHHS / HEDIS	NH 432	All	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
432	D	MCOs & EQRO for Statewide	Network	Access	Service Use	Ambulatory Care: Emergency Dept. Visits/1000 - Children, Children and Families Aid Categories	NH DHHS / HEDIS	NH 432	0-18	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
432	E	MCOs & EQRO for Statewide	Network	Access	Service Use	Ambulatory Care: Emergency Dept. Visits/1000 - Children, Blind and Disabled Aid Categories	NH DHHS / HEDIS	NH 432	0-18	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
432	F	MCOs & EQRO for Statewide	Network	Access	Service Use	Ambulatory Care: Emergency Dept. Visits/1000 - Children, Foster Care Aid Categories	NH DHHS / HEDIS	NH 432	N/A	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
432	G	MCOs & EQRO for Statewide	Network	Access	Service Use	Ambulatory Care: Emergency Dept. Visits/1000 - Adults, Children and Families Aid Categories	NH DHHS / HEDIS	NH 432	19-64	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
432	H	MCOs & EQRO for Statewide	Network	Access	Service Use	Ambulatory Care: Emergency Dept. Visits/1000 - Adults, Blind and Disabled Aid Categories	NH DHHS / HEDIS	NH 432	19-64	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
432	I	MCOs & EQRO for Statewide	Network	Access	Service Use	Ambulatory Care: Emergency Dept. Visits/1000 Beneficiary Months - Adults, Aged Aid Categories	NH DHHS / HEDIS	NH 432	>=65	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
433	A	MCOs & EQRO for Statewide	Network	Access	Service Use	ED Utilization for Primary Care - Total Population	NH DHHS	NH 433	All	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
433	B	MCOs & EQRO for Statewide	Network	Access	Service Use	ED Utilization for Primary Care - Metropolitan Areas	NH DHHS	NH 433	All	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
433	C	MCOs & EQRO for Statewide	Network	Access	Service Use	ED Utilization for Primary Care - Non-Metropolitan Areas	NH DHHS	NH 433	All	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
433	D	MCOs & EQRO for Statewide	Network	Access	Service Use	ED Utilization for Primary Care - Children, Child/Families Aid Categories	NH DHHS	NH 433	0-18	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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433	G	MCOs & EQRO for Statewide	Network	Access	Service Use	ED Utilization for Primary Care - Adults, Child/Family Aid Categories	NH DHHS	NH 433	>=19	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
433	H	MCOs & EQRO for Statewide	Network	Access	Service Use	ED Utilization for Primary Care - Adults, Blind/Disabled Aid Categories	NH DHHS	NH 433	>=19	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
440	N/A	EQRO	Network	Access	Network Adequacy	Timely access to service delivery - Behavioral health care appointment for routine office visit within 10 days	NH DHHS	NH 440	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
441	N/A	EQRO	Network	Access	Network Adequacy	Timely access to service delivery - behavioral health care visit within 48 hours for urgent care	NH DHHS	NH 441	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
442	N/A	EQRO	Network	Access	Network Adequacy	Timely access to service delivery - Follow up visit with seven days after discharge from inpatient and institutional care	NH DHHS/ HEDIS	NH 442	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
443	N/A	EQRO	Network	Access	Network Adequacy	Timely access to service delivery - non-urgent symptomatic office visits within 10 calendar days	NH DHHS	NH 443	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
444	N/A	EQRO	Network	Access	Network Adequacy	Timely access to service delivery - preventive office visits within 30 calendar days	NH DHHS	NH 444	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
445	N/A	EQRO	Network	Access	Network Adequacy	Transitional Care Within Two Days of Discharge with a home care nurse or a registered counselor	NH DHHS	NH 445	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
450	N/A	MCOs & EQRO for Statewide	Network	Network Profile	Board Certification	Board Certification - Percent of Family Medicine Physicians	NCQA	NH 450 / HEDIS: BCR	N/A	CY	6/30/2015	June 30th
451	N/A	MCOs & EQRO for Statewide	Network	Network Profile	Board Certification	Board Certification - Percent of Geriatricians	NCQA	NH 451 / HEDIS: BCR	N/A	CY	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
452	N/A	MCOs & EQRO for Statewide	Network	Network Profile	Board Certification	Board Certification - Percent of Internal Medicine Physicians	NCQA	NH 452 / HEDIS: BCR	N/A	CY	6/30/2015	June 30th
453	N/A	MCOs & EQRO for Statewide	Network	Network Profile	Board Certification	Board Certification - Percent of OB/GYNs	NCQA	NH 453 / HEDIS: BCR	N/A	CY	6/30/2015	June 30th
454	N/A	MCOs & EQRO for Statewide	Network	Network Profile	Board Certification	Board Certification - Percent of Other Physician Specialists	NCQA	NH 454 / HEDIS: BCR	N/A	CY	6/30/2015	June 30th
455	N/A	MCOs & EQRO for Statewide	Network	Network Profile	Board Certification	Board Certification - Percent of Pediatricians	NCQA	NH 455 / HEDIS: BCR	N/A	CY	6/30/2015	June 30th
500	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Emergency Dept. Visits/1000 Member Months - Total Population	NCQA	HEDIS: AMB	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	CY	6/30/2015	June 30th
501	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Emergency Dept. Visits/1000 Member Months - Medicaid/Medicare Dual-Eligibles	NCQA	HEDIS: AMB	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	CY	6/30/2015	June 30th
502	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Emergency Dept. Visits/1000 Member Months - Disabled	NCQA	HEDIS: AMB	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	CY	6/30/2015	June 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
503	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Emergency Dept. Visits/1000 Member Months - Other Low Income	NCQA	HEDIS: AMB	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	CY	6/30/2015	June 30th
505	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Discharges/1000 - Total Inpatient - Total Medicaid	NH DHHS / HEDIS	NH 505 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
506	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Discharges/1000 - Total Inpatient - Medicaid/Medicare Dual-Eligibles	NH DHHS / HEDIS	NH 506 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
507	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Discharges/1000 - Total Inpatient - Medicaid Disabled Eligibility Group	NH DHHS / HEDIS	NH 507 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
508	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Discharges/1000 - Total Inpatient - Medicaid Other Low-Income Eligibility Group	NH DHHS / HEDIS	NH 508 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
509	A-D	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Discharges/1000 - Maternity - Total Medicaid	NH DHHS/ HEDIS	NH 509 / HEDIS IPU	10-19, 20-44, 45-64, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
510	A-D	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Discharges/1000 - Maternity - Medicaid/Medicare Dual-Eligibles	NH DHHS/ HEDIS	NH 510 / HEDIS IPU	10-19, 20-44, 45-64, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
511	A-D	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Discharges/1000 - Maternity - Medicaid Disabled Eligibility Group	NH DHHS/ HEDIS	NH 511 / HEDIS IPU	10-19, 20-44, 45-64, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
512	A-D	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Discharges/1000 - Maternity - Medicaid Other Low-Income Eligibility Group	NH DHHS/ HEDIS	NH 512 / HEDIS IPU	10-19, 20-44, 45-64, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
513	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Discharges/1000 - Surgery - Total Medicaid	NH DHHS / HEDIS	NH 513 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
514	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Discharges/1000 - Surgery - Medicaid/Medicare Dual-Eligibles	NH DHHS / HEDIS	NH 514 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
515	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Discharges/1000 - Surgery - Medicaid Disabled Eligibility Group	NH DHHS / HEDIS	NH 515 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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516	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Discharges/1000 - Surgery - Medicaid Other Low-Income Eligibility Group	NH DHHS / HEDIS	NH 516 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
517	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - General Hospital/Acute Care - Discharges/1000 - Medicine - Total Medicaid	NH DHHS / HEDIS	NH 517 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
518	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - General Hospital/Acute Care - Discharges/1000 - Medicine - Medicaid/Medicare Dual-Eligibles	NH DHHS / HEDIS	NH 518 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
519	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - General Hospital/Acute Care - Discharges/1000 - Medicine - Medicaid Disabled Eligibility Group	NH DHHS / HEDIS	NH 519 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
520	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - General Hospital/Acute Care - Discharges/1000 - Medicine - Medicaid Other Low-Income Eligibility Group	NH DHHS / HEDIS	NH 520 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
525	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Total Inpatient - Total Medicaid	NH DHHS / HEDIS	NH 525 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
526	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Total Inpatient - Medicaid/Medicare Dual-Eligibles	NH DHHS / HEDIS	NH 526 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
527	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Total Inpatient - Medicaid Disabled Eligibility Group	NH DHHS / HEDIS	NH 527 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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528	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Total Inpatient - Medicaid Other Low-Income Eligibility Group	NH DHHS / HEDIS	NH 528 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
529	A-D	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Maternity - Total Medicaid	NH DHHS/ HEDIS	NH 529 / HEDIS IPU	10-19, 20-44, 45-64, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
530	A-D	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Maternity - Medicaid/Medicare Dual-Eligibles	NH DHHS/ HEDIS	NH 530 / HEDIS IPU	10-19, 20-44, 45-64, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
531	A-D	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Maternity - Medicaid Disabled Eligibility Group	NH DHHS/ HEDIS	NH 531 / HEDIS IPU	10-19, 20-44, 45-64, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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532	A-D	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Maternity - Medicaid Other Low-Income Eligibility Group	NH DHHS/ HEDIS	NH 532 / HEDIS IPU	10-19, 20-44, 45-64, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
533	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Surgery - Total MedicaID	NH DHHS / HEDIS	NH 533 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
534	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Surgery - Medicaid/Medicare Dual-Eligibles	NH DHHS / HEDIS	NH 534 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
535	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Surgery - Medicaid Disabled Eligibility Group	NH DHHS / HEDIS	NH 535 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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536	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Surgery - Medicaid Other Low-Income Eligibility Group	NH DHHS / HEDIS	NH 536 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
537	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Medicine - Total Medicaid	NH DHHS / HEDIS	NH 537 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
538	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Medicine - Medicaid/Medicare Dual-Eligibles	NH DHHS / HEDIS	NH 538 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
539	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Medicine - Medicaid Disabled Eligibility Group	NH DHHS / HEDIS	NH 539 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter

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540	A-I	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Inpatient Utilization - GH/Acute Care - Average Length of Stay - Medicine - Medicaid Other Low-Income Eligibility Group	NH DHHS / HEDIS	NH 540 / HEDIS IPU	<1, 1-9, 10-19, 20-44, 45-64, 65-74, 75-84, >=85, Total	Quarterly	Four months after the completion of the first full quarter after go-live	Within 4 months after the end of the quarter
541	A-C	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Plan All-Cause Rate of Readmissions Within 30 Days - Adults	NCQA / CMS	CMS Adult 7	18-64, >=65, Total	CY	6/30/2015	June 30th
541	D	EQRO	Operations and Finance	Service Utilization	General	Plan All-Cause Rate of Readmissions Within 30 Days - Adults - BIP Sub-population	NCQA / CMS	CMS Adult 7	>=18	CY	6/30/2015	June 30th
545	N/A	MCOs & EQRO for Statewide	Operations and Finance	Service Utilization	General	Use of Imaging Studies for Low Back Pain	NCQA	HEDIS: LBP	All	CY	6/30/2015	June 30th
550	A-G	MCOs	Operations and Finance	Service Utilization	Pharmacy	Mean pharmacy payments per Beneficiary per month by Age Group	NH DHHS	NH 550	<=5, 6-13, 14-18, 19-44, 45-64, >=65, Total	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
551	A	MCOs	Operations and Finance	Service Utilization	Pharmacy	Mean pharmacy payments per Beneficiary per month - Low income children	NH DHHS	NH 551	<=18	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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551	B	MCOs	Operations and Finance	Service Utilization	Pharmacy	Mean pharmacy payments per Beneficiary per month - Children with Disabilities in Home Care	NH DHHS	NH 551	<=18	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
551	C	MCOs	Operations and Finance	Service Utilization	Pharmacy	Mean pharmacy payments per Beneficiary per month - Children in Foster Care	NH DHHS	NH 551	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
551	D	MCOs	Operations and Finance	Service Utilization	Pharmacy	Mean pharmacy payments per Beneficiary per month - Low Income Adult	NH DHHS	NH 551	19-64	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
551	E	MCOs	Operations and Finance	Service Utilization	Pharmacy	Mean pharmacy payments per Beneficiary per month - Adults with Disabilities - Non-Duals	NH DHHS	NH 551	19-64	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
551	F	MCOs	Operations and Finance	Service Utilization	Pharmacy	Mean pharmacy payments per Beneficiary per month - Elderly - Non-Duals	NH DHHS	NH 551	>=65	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
551	G	MCOs	Operations and Finance	Service Utilization	Pharmacy	Mean pharmacy payments per Beneficiary per month - Medicare Duals	NH DHHS	NH 551	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
552	A-G	MCOs	Operations and Finance	Service Utilization	Pharmacy	Median Beneficiary pharmacy cost by age group	NH DHHS	NH 552	<=5, 6-13, 14-18, 19-44, 45-64, >=65, Total	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
553	A	MCOs	Operations and Finance	Service Utilization	Pharmacy	Median Beneficiary pharmacy cost - Low income children	NH DHHS	NH 553	>=18	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
553	B	MCOs	Operations and Finance	Service Utilization	Pharmacy	Median Beneficiary pharmacy cost - Children with Disabilities in Home Care	NH DHHS	NH 553	0-18	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
553	C	MCOs	Operations and Finance	Service Utilization	Pharmacy	Median Beneficiary pharmacy cost - Children in Foster Care	NH DHHS	NH 553	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
553	D	MCOs	Operations and Finance	Service Utilization	Pharmacy	Median Beneficiary pharmacy cost - Low Income Adult	NH DHHS	NH 553	19-64	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
553	E	MCOs	Operations and Finance	Service Utilization	Pharmacy	Median Beneficiary pharmacy cost - Adults with Disabilities - Non-Duals	NH DHHS	NH 553	19-64	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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553	F	MCOs	Operations and Finance	Service Utilization	Pharmacy	Median Beneficiary pharmacy cost - Elderly - Non-Duals	NH DHHS	NH 553	>=65	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
553	G	MCOs	Operations and Finance	Service Utilization	Pharmacy	Median Beneficiary pharmacy cost - Medicare Duals	NH DHHS	NH 553	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
554	A-G	MCOs	Operations and Finance	Service Utilization	Pharmacy	Pharmacy prescriptions filled per Beneficiary per month by age group	NH DHHS	NH 554	0-5, 6-18, 19-44, 45-64, >=65, Total	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
555	A	MCOs	Operations and Finance	Service Utilization	Pharmacy	Pharmacy prescriptions filled per Beneficiary per month - Low income children	NH DHHS	NH 555	0-18	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
555	B	MCOs	Operations and Finance	Service Utilization	Pharmacy	Pharmacy prescriptions filled per Beneficiary per month - Children with Disabilities in Home Care	NH DHHS	NH 555	0-18	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
555	C	MCOs	Operations and Finance	Service Utilization	Pharmacy	Pharmacy prescriptions filled per Beneficiary per month - Children in Foster Care	NH DHHS	NH 555	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
555	D	MCOs	Operations and Finance	Service Utilization	Pharmacy	Pharmacy prescriptions filled per Beneficiary per month - Low Income Adult	NH DHHS	NH 555	19-64	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
555	E	MCOs	Operations and Finance	Service Utilization	Pharmacy	Pharmacy prescriptions filled per Beneficiary per month - Adults with Disabilities - Non-Duals	NH DHHS	NH 555	19-64	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
555	F	MCOs	Operations and Finance	Service Utilization	Pharmacy	Pharmacy prescriptions filled per Beneficiary per month - Elderly - Non-Duals	NH DHHS	NH 555	>=65	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
555	G	MCOs	Operations and Finance	Service Utilization	Pharmacy	Pharmacy prescriptions filled per Beneficiary per month - Medicare Duals	NH DHHS	NH 555	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
560	N/A	MCOs	Operations and Finance	Service Utilization	Pharmacy	Utilization Controls - Adherence to State PDL	NH DHHS	NH 560	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
561	N/A	MCOs	Operations and Finance	Service Utilization	Pharmacy	Utilization Controls - generic utilization adjusted for preferred PDL brands	NH DHHS	NH 561	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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562	N/A	MCOs	Operations and Finance	Service Utilization	Pharmacy	Utilization Controls - generic substitution - The percent of generic claims among claims where generics were available (defined as generics plus multi-source claims).	NH DHHS	NH 562	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
563	N/A	MCOs	Operations and Finance	Service Utilization	Pharmacy	Utilization Controls - generic utilization -The percent of generic claims among all claims	NH DHHS	NH 563	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
600	N/A	MCOs	Operations and Finance	Operations	Claims Processing	Percent of clean professional and facility claims paid or denied within thirty (30) days of receipt	NH DHHS	NH 600	All	Calculated Daily Reported Monthly	45 days after go-live	15 calendar days after end of month
601	N/A	MCOs	Operations and Finance	Operations	Claims Processing	Percent of days per month that clean professional and facility claim payments met 30 day standard	NH DHHS	NH 601	All	Monthly	45 days after go-live	15 calendar days after end of month
602	N/A	MCOs	Operations and Finance	Operations	Claims Processing	Percent of clean professional and facility claims paid within sixty (60) days of receipt	NH DHHS	NH 602	All	Calculated Daily Reported Monthly	105 days after go-live	75 calendar days after end of month
603	N/A	MCOs	Operations and Finance	Operations	Claims Processing	Percent of days per month that clean professional and facility claim payments met 60 day standard	NH DHHS	NH 603	All	Monthly	45 days after go-live	15 calendar days after end of month

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604	N/A	MCOs	Operations and Finance	Operations	Claims Processing	Percent of pharmacy electronic systems transactions that are processed in less than one (1) second (standard is 95% or more)	NH DHHS	NH 604	All	Monthly	45 days after go-live	15 calendar days after end of month
605	N/A	MCOs	Operations and Finance	Operations	Claims Processing	Claims Processing Accuracy: Percentage of professional and facility claims that are accurately processed in their entirety (see definition 27.5.1).	NH DHHS	NH 605	All	Monthly	45 days after go-live	15 calendar days after end of month
606	N/A	MCOs	Operations and Finance	Operations	Claims Processing	Claims Payment Accuracy: Percentage of professional and facility claims paid or denied correctly (see definition 27.4.1).	NH DHHS	NH 606	All	Monthly	45 days after go-live	15 calendar days after end of month
607	N/A	MCOs	Operations and Finance	Operations	Claims Processing	Claims Financial accuracy: Inaccuracy of dollars paid to providers on professional and facility claims (see definition 27.3.1).	NH DHHS	NH 607	All	Monthly	45 days after go-live	15 calendar days after end of month
608	N/A	MCOs	Operations and Finance	Operations	Claims Processing	Interest paid on professional and facility claims paid > 30 days of receipt	NH DHHS	NH 608	All	Monthly	45 days after go-live	15 calendar days after end of month

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620	N/A	MCOs	Operations and Finance	Operations	Prior Authorizations	Medical service, equipment, and supply prior authorization determination timeframe: urgent within 72 hours for a new request	NH DHHS	NH 620	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
621	N/A	MCOs	Operations and Finance	Operations	Prior Authorizations	Medical service, equipment, and supply prior authorization determination timeframe: routine within 15 calendar days for a new request	NH DHHS	NH 621	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
622	N/A	MCOs	Operations and Finance	Operations	Prior Authorizations	Medical service, equipment, and supply prior authorization determination timeframe: urgent within 24 hours for a continuation request	NH DHHS	NH 622	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
623	N/A	MCOs	Operations and Finance	Operations	Prior Authorizations	Pharmacy prior authorization response timeframe: within 24 hours	NH DHHS	NH 623	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
700	N/A	TBD	Healthcare Processes and Outcomes	Community Based Services and Supports	Adults with Disabilities	Various-TBD	TBD	TBD	TBD	TBD	TBD	TBD

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750	N/A	TBD	Healthcare Processes and Outcomes	Community Based Services and Supports	Children in Foster Care	Various-TBD	TBD	TBD	TBD	TBD	TBD	TBD
800	N/A	TBD	Healthcare Processes and Outcomes	Community Based Services and Supports	Children with Disabilities	Various-TBD	TBD	TBD	TBD	TBD	TBD	TBD
850	N/A	TBD	Healthcare Processes and Outcomes	Community Based Services and Supports	Elderly Adults	Various-TBD	TBD	TBD	TBD	TBD	TBD	TBD
1002	N/A	MCOs	Beneficiary	Satisfaction	Behavioral Health	Behavioral Health Satisfaction Survey: The MCO shall conduct and submit to DHHS an analytic narrative report that interprets the results from the SAMHSA consumer satisfaction survey for members with behavioral health conditions	SAMHSA	NH 1002		Fielded for 70 days beginning 7 months after go-live; normal HEDIS schedule thereafter	First year under contract. 6/30/2015 from the MCOs	June 30th
1003	N/A	EQRO	Beneficiary	Satisfaction	General	Beneficiary Focus Group Studies regarding satisfaction with MCO and FFS provided healthcare. Minutes and analysis of focus group meetings.	NH DHHS	N/A		Bi-Annually, Annually	2/28/2014	February 28 and August 31

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1004	N/A	EQRO	Beneficiary	Satisfaction	General	Beneficiary Experience - Administer and/or validate Medicaid beneficiary experience survey including satisfaction with MCO provision of care, quality of care, and access to care provide appropriate comparators, including FFS populationOne aggregate report to include a sub-section for each of the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population, must include trends and analysis of opportunities for improvement	NH DHHS	N/A		Annually	9/30/2014	September 30th
1005	N/A	EQRO	Healthcare Processes and Outcomes	Quality Assurance and Improvement	State Innovation Model	State Innovation Model Reporting Support	TBD	TBD	TBD	TBD	TBD	TBD
1006	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Behavioral Health	A plan to decrease the likelihood of discharge to a shelter or homelessness for subsequent agreement year (subject to DHHS review and approval).	NH DHHS	N/A		Agreement year and after any modification	Within 1 month after go-live	Within 30 days of the end of a SFY

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1007	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Behavioral Health	Consent for Primary Care - Behavioral Health Coordination: A plan to improve the likelihood of consent of the subsequent agreement year (subject to DHHS review and approval).	NH DHHS	N/A		Agreement year and after any modification	Within 1 month after go-live	Within 30 days of the end of a SFY
1008	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Behavioral Health	Olmstead Plan Support addressing Critical Mental Health Needs - Community tenure strategies to address admissions and readmissions at NH Hospital for adults; Assessment of the availability, use and need for Assertive Community Treatment Teams by region and statewide; Community residential capacity by region and statewide; Community tenure strategies to address admissions and readmissions at NH Hospital for children	NH DHHS	N/A		Agreement year and after any modification	Within 1 month after go-live	Within 30 days of the end of a SFY
1009	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Behavioral Health	Quality Improvement Initiative Plan: Plan for use of reimbursement of child psychiatric consultation for behavioral health medications in children	NH DHHS	N/A		Agreement year and after any modification	Within 1 month after go-live	Within 30 days of the end of a SFY

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1010	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Behavioral Health	Reductions in Readmission Plan - a plan to reduce barriers identified and improve community tenure in the subsequent agreement year.	NH DHHS	N/A		Agreement year and after any modification	Within 1 month after go-live	Within 30 days of the end of a SFY
1012	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Claims Processing	Contingency plan for business continuity shall be developed and tested to ensure continuous operation of the MCIS.	NH DHHS	N/A		Agreement year and after any modification	Within 3 months after go-live	September 30th
1013	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Claims Processing	Contingency plan for confirmation of 5010 compliance and companion guide shall be developed and tested to ensure continuous operation of the MCIS.	NH DHHS	N/A		Agreement year and after any modification	Within 3 months after go-live	September 30th
1014	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Claims Processing	Contingency plan for confirmation of IRS publication 1075 shall be developed and tested to ensure continuous operation of the MCIS.	NH DHHS	N/A		Agreement year and after any modification	Within 3 months after go-live	September 30th
1015	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Claims Processing	Contingency plan for data security including preventive, detective, corrective controls and HIPPA compliance shall be developed and tested to ensure continuous operation of the MCIS.	NH DHHS	N/A		Agreement year and after any modification	Within 3 months after go-live	September 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1016	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Claims Processing	Contingency plan for disaster recovery shall be developed and tested to ensure continuous operation of the MCIS.	NH DHHS	N/A		Agreement year and after any modification	Within 3 months after go-live	September 30th
1017	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Claims Processing	Contingency plan for ICD-10 implementation and compliance plan shall be developed and tested to ensure continuous operation of the MCIS.	NH DHHS	N/A		Agreement year and after any modification	Within 3 months after go-live	September 30th
1018	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Claims Processing	Contingency plan for joint interface shall be developed and tested to ensure continuous operation of the MCIS.	NH DHHS	N/A		Agreement year and after any modification	Within 3 months after go-live	September 30th
1019	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Claims Processing	Contingency plan for risk management shall be developed and tested to ensure continuous operation of the MCIS.	NH DHHS	N/A		Agreement year and after any modification	Within 3 months after go-live	September 30th
1020	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Cultural Considerations	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 the service area community assessment.	NH DHHS	N/A		Agreement year and after any modification	9/30/2014	September 30th

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1022	N/A	EQRO	Healthcare Processes and Outcomes	Quality Assurance and Improvement	General	Validate MCO Adult and Pediatric quality measures and EQRO generated aggregate and calculate additional quality measures and assist the State in Grant related reporting of the measure	NH DHHS	N/A		Quarterly	11/30/2013	2 months after the end of the quarter
1023	N/A	EQRO	Healthcare Processes and Outcomes	Quality Assurance and Improvement	State Innovation Model	Validate MCO calculated State Innovations Grant Measures	TBD	TBD	TBD	TBD	TBD	2 months after the end of the quarter

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1024	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	General	Narrative Report on status of Quality Assessment and Performance Improvement (QAPI) program including: Annual objectives and goals, outcome measures, quantitative assessments, incorporate appropriate comparators which must be approved by DHHS prior to use, demonstrate program impact, success and opportunities using detailed, data driven assessments using statistically sound measurement and analysis, under and/or over-utilization, and an assessment of the quality and appropriateness of care for Beneficiaries with special needs. The MCO shall report the status and results including but not limited to: Brief description of each PIP, PIP goals and progress toward each goal, Sufficiently detailed, data driven assessments using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.	NH DHHS	N/A		Agreement year with quarterly updates	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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1025	N/A	EQRO	Healthcare Processes and Outcomes	Quality Assurance and Improvement	General	Convene MCO/DHHS quarterly meetings; coordinate, harmonize MCO quality work and support the National Quality Strategy; Support DHHS leadership to plan for and conduct conducting quarterly business meetings. Provide minutes from meetings.	NH DHHS	N/A		Quarterly	11/30/2013	2 months after the end of the quarter
1026	N/A	EQRO	Healthcare Processes and Outcomes	Quality Assurance and Improvement	General	Develop Quality Forums to include annual meeting topics related to MCO best practices; healthcare delivery innovation; quality improvement strategies, organize 1 annual conference, arrange for conference site, speakers, registration, materials, and conference evaluation and other logistics.	NH DHHS	N/A		Annually	9/30/2014	September 30th

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1027	N/A	EQRO	Healthcare Processes and Outcomes	Quality Assurance and Improvement	General	MCO Quality Performance Measure - Validation of MCO performance measures required by DHHS Quality Strategy and MCO Contract. Data file to update the NH Medicaid Quality Indicators website; One aggregate report to include a sub-section for each MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid FFS population.	NH DHHS	N/A		Quarterly	11/30/2013	2 months after the end of the quarter

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1028	N/A	EQRO	Healthcare Processes and Outcomes	Quality Assurance and Improvement	General	MCO and NH Medicaid Statewide Overview - Assessment of MCP QAPI Plans, MCO strengths and weaknesses; Recommendations for improving MCO healthcare services; Comparative reporting about all MCOs; Assessment of degree to which MCOs have addressed prior year's EQR recommendations; Provision of comparative analysis for MCOs and FFS One aggregate report to include a subsection for each of the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population. Must include trends and analysis of opportunities for improvement	NH DHHS	N/A		Annually	9/30/2014	September 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1029	N/A	EQRO	Healthcare Processes and Outcomes	Quality Assurance and Improvement	General	Projects - Evaluation of MCOs' DHHS-QIP and CMS required PIPs; Recommendations for improvement.Mid- year report updating project status; one aggregate report to include a sub-section for each the MCOs, and comparative report across the MCOs and reporting on the statewide Medicaid population.	NH DHHS	N/A		Bi-Annually, Annually	2/28/2014	February 28 and August 31
1030	N/A	EQRO	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Summary report referred to in Contract 17.1.9	NH DHHS	N/A		Quarterly	11/30/2013	2 months after the end of the quarter
1031	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Pharmacy	Quality Improvement Initiative Plan - Maintenance medication adherence to eliminate gaps in refills - Annual Plan	NH DHHS	N/A		Agreement year and after any modification	9/30/2014	September 30th
1032	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Pharmacy	Quality Improvement Initiative Plan - Polypharmacy for physical and behavioral health medication - Annual Plan	NH DHHS	N/A		Agreement year and after any modification	9/30/2014	September 30th
1033	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Pharmacy	Quality Improvement Initiative Plan: Use of reimbursement of child psychiatric consultation for behavioral health medications in children - Annual Plan	NH DHHS	N/A		Agreement year and after any modification	9/30/2014	September 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1034	N/A	EQRO	Network	Access	General	Beneficiary access to healthcare measuring and monitoring: Maintenance of the DHHS access report with an analysis of risk and opportunities for improvement	NH DHHS	N/A		Quarterly	11/30/2013	2 months after the end of the quarter
1035	N/A	MCOs	Network	Network Profile	General	Provider access anticipated needs, including, but not limited to number, mix and geographic distribution to meet anticipated Beneficiary needs - Annual Network Filing	NH DHHS	N/A		Agreement Year	2 months before go-live	May 1 Prior to Agreement Year
1036	N/A	MCOs	Network	Network Profile	General	Report on any corrective actions needed restore provider network adequacy to meet federal and state standards.	NH DHHS	N/A		Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1037	N/A	MCOs	Network	Network Profile	General	Report on data to support access to a choice of primary care providers, and access to women's health, family planning and special services,	NH DHHS	NH 1037		Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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1038	N/A	MCOs	Network	Network Profile	General	Report on data to support accessibility to providers for Beneficiaries with disabilities	NH DHHS	NH 1038		Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1039	N/A	MCOs	Network	Network Profile	General	Corrective Action Plan if there is a failure to comply with timely access provisions of the NH Medicaid Care Management Contract	NH DHHS	N/A		As needed	As needed	As needed
1040	N/A	MCOs	Network	Network Profile	General	Report any MCO provider network exceptions requested and the DHHS response	NH DHHS	N/A		As needed	As needed	As needed
1041	N/A	MCOs	Network	Access	Service Use	Provider participation report: Reports by geographic location, categories of service, provider type categories, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze provider service capacity in terms of realized Beneficiary access to health care	NH DHHS	N/A		Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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1043	N/A	MCOs	Network	Engagement and Communications	Provider Advisory Board	Provider Engagement: The MCO shall provide a narrative report on provider engagement through the Provider Advisory Board (PAB) meetings including, but not limited to, PAB Beneficiary composition, meeting times and locations, agendas, MCO program impact attributable to the PAB.	NH DHHS	N/A		Agreement Year	9/30/2014	September 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1044	N/A	MCOs	Network	Network Profile	General	Comprehensive Annual Provider Network Filing: The MCO shall report an overview of its provider network needed to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area, any transition plans needed to address any significant changes in the provider network (Network Adequacy Filing in accordance with NH Insurance Department Regulations and DHHS guidance)	NH DHHS	N/A		Agreement Year	30 days prior to go-live	June 1st
1046	N/A	MCOs	Network	Network Profile	Satisfaction	Provider Satisfaction Survey: The MCO shall conduct and submit to DHHS an analytic narrative report that interprets the results from an annual provider satisfaction survey, approved by DHHS and administered by a third party.	NH DHHS	N/A		Semi-annually	9/30/2014	September 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1047	N/A	EQRO	Network	Network Profile	Satisfaction	Provider Experience - Administer and/or validate MCO provider surveys One aggregate report to include a sub-section for each of the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid FFS population, must include trends and analysis of opportunities for improvement	NH DHHS	N/A		Semi-annually	9/30/2014	September 30th
1048	N/A	EQRO	Network	Training	EQRO	Report on EQRO provider training, including date and location, subject of the training, number in attendance, training evaluation including a distinct section on Behavioral Health/Mental Health Service Provider training	NH DHHS	N/A		Agreement Year	9/30/2014	September 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1049	N/A	MCOs	Network	Training	MCO	Report on MCO provider training, including date and location, subject of the training, number in attendance, training evaluation including a distinct section on Behavioral Health/Mental Health Service Provider training	NH DHHS	N/A		Agreement Year	9/30/2014	September 30th
1050	N/A	EQRO	Operations and Finance	Fraud, Waste and Abuse	General	EQRO will design and implement systems that monitor service utilization, claims and encounter data for evidence of fraud, EQRO will report immediately to DHHS Program Integrity when determination of suspected fraud is made. Monthly summary reports with immediate reporting to DHHS as circumstances warrant.	NH DHHS	N/A		Monthly	8/15/2013	15 calendar days after end of month
1051	N/A	MCOs	Operations and Finance	Fraud, Waste and Abuse	General	Comprehensive FWA log including all audits, in progress and complete	NH DHHS	N/A		Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1052	N/A	MCOs	Operations and Finance	Fraud, Waste and Abuse	General	Comprehensive FWA log including all FWA related to providers, including all communications regarding FWA, number of records requested, providers audited	NH DHHS	N/A		Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1053	N/A	MCOs	Operations and Finance	Fraud, Waste and Abuse	General	Comprehensive FWA log including amounts recovered/owed, provider training or corrective action to mitigate future FWA.	NH DHHS	N/A		Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1054	N/A	MCOs	Operations and Finance	Fraud, Waste and Abuse	General	Comprehensive FWA log including appeals, hearings related to FWA.	NH DHHS	N/A		Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1055	N/A	MCOs	Operations and Finance	Fraud, Waste and Abuse	General	Comprehensive FWA log including claims targeted for review and recovery, including claims analysis.	NH DHHS	N/A		Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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1056	N/A	MCOs	Operations and Finance	Fraud, Waste and Abuse	General	Comprehensive FWA log including number of complaints of FWA warranting investigation including, but not limited to provider name and specialty, NPI, complaint source and nature, dollar amount	NH DHHS	N/A		Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1057	N/A	MCOs	Operations and Finance	Fraud, Waste and Abuse	General	Comprehensive Annual FWA Summary Narrative Report including MCO internal recommendations as applicable based on summary analysis to mitigate FWA	NH DHHS	N/A		Agreement Year	9/30/2014	September 30th
1058	N/A	MCOs	Operations and Finance	Operations	Claims Processing	Provide results of review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims. Describe in detail any corrective action plans needed to address claims payment accuracy issues.	NH DHHS	N/A		Monthly	45 days after go-live	15 calendar days after end of month
1059	N/A	EQRO	Operations and Finance	Operations	Encounter Data	Recommendations for encounter data improvement	NH DHHS	N/A		Weekly	8/15/2013	One week after receipt of data

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1060	N/A	EQRO	Operations and Finance	Operations	Encounter Data	Process plan development for MMIS encounter data validation and integration.	NH DHHS	N/A		One time	TBD	TBD
1061	N/A	EQRO	Operations and Finance	Operations	Encounter Data	Encounter data validation report	NH DHHS	N/A		Weekly	8/15/2013	One week after receipt of data
1062	N/A	EQRO	Operations and Finance	Operations	General	Contract Compliance - Review and report on MCOs' compliance with Federal, State and Care Management contracts. Assessment of regulatory and operational compliance; One aggregate report to include a sub-section for each of the MCOs, a comparative report across the MCOs and reporting on the statewide NH Medicaid population.	NH DHHS	N/A		Annually	8/31/2014	September 30th

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1063	N/A	MCOs	Operations and Finance	Operations	Prior Authorizations	Service Utilization and Controls: Annual narrative report which shall include, but not be limited to, an assessment of the impact of utilization controls on Beneficiary, provide and program quality and costs; any unintended consequences; an assessment of any under-utilization and/or over-utilization; opportunities for improvement; impact of Beneficiary and/or providers on changes to utilization controls	NH DHHS	NH 1063		Agreement Year	9/30/2014	September 30th
1064	N/A	MCOs	Operations and Finance	Third Party Liability	Accident and Trauma	Accident and Trauma - Provide DHHS with a log including but not limited to: Detailed information contained on medical/pharmacy claims for any cases identified as possible accident and trauma per contract section 25.1.4	NH DHHS	NH 1064		Monthly & data as needed on demand	45 days after go-live	15 calendar days after end of month

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1065	A	MCOs	Operations and Finance	Third Party Liability	Cost Avoidance	Cost Avoidance - Monthly accumulation of claims cost avoided for other insurance per contract section 25.1.2	NH DHHS	NH 1065		Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1065	B	MCOs	Operations and Finance	Third Party Liability	Cost Avoidance	Cost Recovery- Monthly claim specific log of number of claims cost billed, amount not collected and the amount denied per contract section 25.1.5	NH DHHS	NH 1065		Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1067	N/A	TBD	Healthcare Processes and Outcomes	Quality Assurance and Improvement	State Innovation Model	State Innovations Grant Measures	TBD	TBD	TBD	TBD	TBD	2 months after the end of the quarter
1070	A-I	MCOs	Operations and Finance	Service Utilization	General	Average claims/service payment per Beneficiary per month by rate cell	NH DHHS	NH 1070	N/A	Agreement Year	12/31/2014	December 31st
1075	N/A	MCOs	Operations and Finance	Operations	General	MCO Staffing Contingency Plan	NH DHHS	N/A	N/A	N/A	Within 1 month after contract	N/A
1076	N/A	MCOs	Operations and Finance	Operations	General	MCO Emergency Response Plan	NH DHHS	N/A	N/A	N/A	60 days prior to go-live	May 1st
1077	N/A	MCOs	Operations and Finance	Operations	General	MCO Payment Reform Plan	NH DHHS	N/A	N/A	N/A	90 days prior to go-live	April 1st
1078	N/A	MCOs	Operations and Finance	Operations	General	MCO Project Management Plan	NH DHHS	N/A	N/A	N/A	60 days prior to go-live	May 1st

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1079	N/A	MCOs	Operations and Finance	Operations	General	MCO Communications Plan	NH DHHS	N/A	N/A	N/A	60 days prior to go-live	May 1st
1080	N/A	MCOs	Operations and Finance	Operations	General	MCO Program Integrity Plan	NH DHHS	N/A	N/A	N/A	Approved prior to go-live	N/A
1081	N/A	MCOs	Operations and Finance	Operations	General	MCO Step 1 Program Implementation Plan	NH DHHS	N/A	N/A	N/A	14 days after contract approval	N/A
1082	N/A	MCOs	Operations and Finance	Operations	General	MCO Step 2 Program Implementation Plan	NH DHHS	N/A	N/A	N/A	180 days prior to go-live of Step 2	N/A
1083	N/A	MCOs	Operations and Finance	Operations	General	MCO Recipient Explanation of Medicaid Benefits process	NH DHHS	N/A	N/A	N/A	Prior to go-live	As needed
1083	N/A	MCOs	Operations and Finance	Operations	Grievance and Appeals	MCO description of its Grievance System and all grievance process policies and procedures and related notices to members regarding the grievance process.	NH DHHS	N/A	N/A	N/A	Prior to go-live	As needed
1084	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	General	MCO Health Risk Assessment Tool	NH DHHS	N/A	N/A	N/A	Prior to go-live	As needed

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1085	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	General	Annual report on the number and percent of members who completed a Health Risk Assessment and the percentage of members eligible for chronic care management, high cost/high risk care management, complex care management and/or the MCO's special needs program who completed a health risk assessment	NH DHHS	N/A	All	Agreement Year	9/30/2014	September 30th
1086	N/A	MCOs	Operations and Finance	Operations	General	MCO Member Handbook	NH DHHS	N/A	N/A	N/A	90 days prior to go-live	As needed
1087	N/A	MCOs	Operations and Finance	Operations	General	MCO ID Card	NH DHHS	N/A	N/A	N/A	90 days prior to go-live	As needed
1088	N/A	MCOs	Operations and Finance	Operations	General	MCO Provider Directory	NH DHHS	N/A	N/A	N/A	90 days prior to go-live	As needed
1089	N/A	MCOs	Operations and Finance	Operations	General	MCO Informational Materials Intended for Members	NH DHHS	N/A	N/A	N/A	2 weeks prior to distribution	2 weeks prior to distribution
1090	N/A	MCOs	Operations and Finance	Operations	General	MCO Marketing Materials	NH DHHS	N/A	N/A	N/A	15 business days prior to distribution	15 business days prior to distribution

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1091	N/A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Pharmacy	MCO formulary and pharmacy prior authorization criteria and other point of service edits, including but not limited to, prospective drug utilization review edits and dosage limits	NH DHHS	N/A	N/A	N/A	60 days prior to go-live	60 days prior to implementation of any changes
1092	N/A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Pharmacy	MCO policies and procedures related to its maintenance drug policy, specialty pharmacy programs, and any new pharmacy service program proposed by the MCO	NH DHHS	N/A	N/A	N/A	60 days prior to go-live	60 days prior to implementation of any changes
1093	N/A	MCOs	Operations and Finance	Operations	General	MCO Provider Training Materials	NH DHHS	N/A	N/A	N/A	2 weeks prior to distribution	2 weeks prior to distribution
1094	N/A	MCOs	Operations and Finance	Operations	General	Report on the percentage of board-certified PCPs in the MCO provider network and the percentage of board certified specialty physicians, by specialty	NH DHHS	N/A	N/A	N/A	Upon request by DHHS	Upon request by DHHS
1095	N/A	MCOs	Operations and Finance	Operations	General	MCO certification that it is conversant with the requirements of the ADA, that it is in compliance with the law	NH DHHS	N/A	N/A	N/A		As needed

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1096	N/A	MCOs	Operations and Finance	Operations	General	MCO certification that it has assessed its provider network and certifies that the providers meet ADA requirements to the best of the MCO's knowledge. The MCO shall survey its providers of their compliance with the ADA using a standard survey document that will be developed by the State	NH DHHS	N/A	N/A	N/A		As needed
1097	N/A	MCOs	Operations and Finance	TPL	Accident and Trauma	MCO accident questionnaire guidelines and procedures	NH DHHS	N/A	N/A	N/A	90 days prior to go-live	April 1st
1098	N/A	MCOs	Operations and Finance	Operations	Grievance and Appeals	MCO utilization management policies, procedures, and criteria	NH DHHS	N/A	N/A	N/A	90 days prior to go-live	April 1st
1100	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Tabular Summary of MCO appeals resolutions - Resolution Type by Category of Service	NH DHHS	NH 1100	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1102	N/A	MCOs	Operations and Finance	Network	General	Provider Termination Log	NH DHHS	NH 1102	All	As needed or weekly	Upon first provider termination	Within 15 Calendar Days of Notice of Termination
1200	N/A	MCOs	Operations and Finance	Fraud, Waste and Abuse	Pharmacy	Lock-in to Pharmacy Log	NH DHHS	NH 1200	All	Monthly	60 calendar days after go-live	30 calendar days after end of month

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1201	N/A	MCOs	Operations and Finance	Fraud, Waste and Abuse	Pharmacy	Lock-in to Prescriber Log	NH DHHS	NH 1201	All	Monthly	60 calendar days after go-live	30 calendar days after end of month
1202	N/A	MCOs	Operations and Finance	Fraud, Waste and Abuse	Pharmacy	Lock-in Beneficiary Disenrollment Summary	NH DHHS	NH 1202	All	Monthly	60 calendar days after go-live	30 calendar days after end of month
1203	N/A	MCOs	Operations and Finance	Fraud, Waste and Abuse	Pharmacy	Lock-in Beneficiary Enrollment Summary	NH DHHS	NH 1203	All	Monthly	60 calendar days after go-live	30 calendar days after end of month
1204	N/A	MCOs	Operations and Finance	Fraud, Waste and Abuse	Pharmacy	Lock-in Beneficiary Activity Summary	NH DHHS	NH 1204	All	Monthly	60 calendar days after go-live	30 calendar days after end of month
1300	N/A	MCOs	Beneficiary	Engagement and Communications	Consumer Board	Narrative Report on Beneficiary Engagement through the Consumer Advisory Board (CAB) and Regional Beneficiary meetings	NH DHHS	NH 1300	All	Agreement year	9/30/2014	September 30th
1400	A-E	DHHS	Beneficiary	Beneficiary Demographics	Enrollment	Enrollment by age groups by MCOs/FFS	NH DHHS	NH 1400	0-18, 19-44, 45-64, >=65, Total	Weekly in first 3 months, then quarterly	7/15/2013	1 week after end of each week/quarter
1401	N/A	DHHS	Beneficiary	Beneficiary Demographics	Enrollment	Enrollment by counties by MCOs/FFS	NH DHHS	NH 1401	All	Weekly in first 3 months, then quarterly	7/15/2013	1 week after end of each week/quarter
1402	N/A	DHHS	Beneficiary	Beneficiary Demographics	Enrollment	Enrollment by MCO Rate Cell by MCOs	NH DHHS	NH 1402	All	Weekly in first 3 months, then quarterly	7/15/2013	1 week after end of each week/quarter
1403	N/A	DHHS	Beneficiary	Beneficiary Demographics	Enrollment	Enrollment by Medicare Dual Status by MCOs/FFS	NH DHHS	NH 1403	All	Weekly in first 3 months, then quarterly	7/15/2013	1 week after end of each week/quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1404	N/A	DHHS	Beneficiary	Beneficiary Demographics	Enrollment	Enrollment by Opt Out Reason by Rate Cell	NH DHHS	NH 1404	All	Weekly in first 3 months, then quarterly	7/15/2013	1 week after end of each week/quarter
1405	N/A	DHHS	Beneficiary	Beneficiary Demographics	Enrollment	Enrollment by Opt Out Status by Rate Cell	NH DHHS	NH 1405	All	Weekly in first 3 months, then quarterly	7/15/2013	1 week after end of each week/quarter
1406	N/A	DHHS	Beneficiary	Beneficiary Demographics	Enrollment	Report Beneficiaries disenrolled by rate cell and MCO	NH DHHS	NH 1406	All	Weekly in first 3 months, then quarterly	7/15/2013	1 week after end of each week/quarter
1407	N/A	DHHS	Beneficiary	Beneficiary Demographics	Enrollment	Report Beneficiaries re-enrolled after a loss of Medicaid eligibility by MCO	NH DHHS	NH 1407	All	Weekly in first 3 months, then quarterly	7/15/2013	1 week after end of each week/quarter
1408	N/A	DHHS	Beneficiary	Beneficiary Demographics	Enrollment	Report new Beneficiaries enrolled by MCO	NH DHHS	NH 1408	All	Weekly in first 3 months, then quarterly	7/15/2013	1 week after end of each week/quarter
1409	N/A	DHHS	Beneficiary	Beneficiary Demographics	Enrollment	Report the reason for each disenrollment by MCO	NH DHHS	NH 1409	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter
1410	N/A	DHHS	Beneficiary	Beneficiary Demographics	Enrollment	Report the reason for each new enrollment by MCO	NH DHHS	NH 1410	All	Weekly in first 3 months, then quarterly	7/15/2013	1 week after end of each week/quarter
1411	N/A	DHHS	Beneficiary	Beneficiary Demographics	Enrollment	Report total Beneficiaries enrolled by MCO	NH DHHS	NH 1411	All	Weekly in first 3 months, then quarterly	7/15/2013	1 week after end of each week/quarter
1420	N/A	MCOs	Beneficiary	Engagement and Communications	Direct Communication	Beneficiary Communications - Beneficiary calls warm transferred to NH DHHS queue by NH DHHS program	NH DHHS	NH 1420	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1421	N/A	MCOs	Beneficiary	Engagement and Communications	Direct Communication	Beneficiary Communications - New Beneficiary welcome calls	NH DHHS	NH 1421	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter
1422	N/A	MCOs	Beneficiary	Engagement and Communications	Direct Communication	Beneficiary Communications - Returned calls by the next business day	NH DHHS	NH 1422	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter
1425	N/A	MCOs	Beneficiary	Engagement and Communications	Website	Beneficiary Communications Website - Number of Beneficiary logins to MCO Beneficiary website portal	NH DHHS	NH 1425	All	Agreement year	9/30/2014	September 30th
1426	N/A	MCOs	Beneficiary	Engagement and Communications	Website	Beneficiary Communications Website - Number of individual requests for additional information from MCO Beneficiary website.	NH DHHS	NH 1426	All	Agreement year	9/30/2014	September 30th
1440	N/A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Consent for Behavioral Health/ Medical Information for Care Coordination - count of reasons for failure to obtain of consent	NH DHHS	NH 1440	All	Agreement year	7/31/2014	Within 30 days of the end of a SFY
1450	N/A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Non-Emergent Transportation	Number of NEMT requests made and mode delivered	NH DHHS	NH 1450	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1451	N/A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Non-Emergent Transportation	Number of NEMT requests authorized and delivered	NH DHHS	NH 1451	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1452	N/A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Non-Emergent Transportation	Number of NEMT requests made and services delivered by types of medical services – Out-of-State	NH DHHS	NH 1452	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1453	N/A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Non-Emergent Transportation	Number of NEMT requests made and services delivered by types of medical services -In-State	NH DHHS	NH 1453	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1454	N/A	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Non-Emergent Transportation	Number of wheelchair requests authorized and delivered	NH DHHS	NH 1454	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1460	A-C	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Pharmacy	Monitoring of polypharmacy among all medications	NH DHHS	NH 1460	0-18, 19-44, 45-64	Quarterly The measure will be calculated every month, report 3 months of data to DHHS every quarter	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1461	A-B	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Monitoring of polypharmacy for behavioral health medications - Children receiving foster care services	NH DHHS	NH 1441	0-5, 6 to 18	QuarterlyThe measure will be calculated every month, report 3 months of data to DHHS every quarter	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1461	A-B	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Pharmacy	Monitoring of polypharmacy for behavioral health medications - Children receiving foster care services	NH DHHS	NH 1461	0-5, 6 to 18	Quarterly The measure will be calculated every month, report 3 months of data to DHHS every quarter	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1462	A-B	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Behavioral Health	Monitoring of polypharmacy for behavioral health medications in children	NH DHHS	NH 1442	0-5, 6 to 18	Quarterly The measure will be calculated every month, report 3 months of data to DHHS every quarter	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1462	A-B	MCOs	Healthcare Processes and Outcomes	Healthcare Processes	Pharmacy	Monitoring of polypharmacy for behavioral health medications in children	NH DHHS	NH 1462	0-5, 6 to 18	QuarterlyThe measure will be calculated every month, report 3 months of data to DHHS every quarter	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1470	N/A	MCOs	Healthcare Processes and Outcomes	Quality Assurance and Improvement	Grievance and Appeals	Log of all grievances - detailed on grievance and any corrective action or response to the grievance	NH DHHS	NH 1470	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1480	N/A	MCOs	Network	Engagement and Communications	Direct Communication	Provider Communications: After hours voice mail follow up	NH DHHS	NH 1480	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter
1481	N/A	MCOs	Network	Engagement and Communications	Direct Communication	Provider Communications: Inbound provider call utilization - calls abandoned	NH DHHS	NH 1481	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter
1482	N/A	MCOs	Network	Engagement and Communications	Direct Communication	Provider Communications: Inbound provider call utilization - mean call time	NH DHHS	NH 1450	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter
1483	N/A	MCOs	Network	Engagement and Communications	Direct Communication	Provider Communications: Inbound provider call utilization - mean hold time in queue	NH DHHS	NH 1450	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1484	N/A	MCOs	Network	Engagement and Communications	Direct Communication	Provider Communications: Inbound provider call utilization - percent of calls answered within 30 seconds	NH DHHS	NH 1450	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter
1485	N/A	MCOs	Network	Engagement and Communications	Direct Communication	Provider Communications: Inbound provider call utilization - reason for the call	NH DHHS	NH 1450	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter
1490	N/A	MCOs	Operations and Finance	Operations	Call Center	Beneficiary Communications: Inbound Beneficiary call utilization - within 30 seconds	NH DHHS	NH 1450	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter
1491	N/A	MCOs	Operations and Finance	Operations	Call Center	Beneficiary Communications: Inbound Beneficiary call utilization - average (mean) call time	NH DHHS	NH 1450	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter
1492	N/A	MCOs	Operations and Finance	Operations	Call Center	Beneficiary Communications: Inbound Beneficiary call utilization - calls abandoned	NH DHHS	NH 1450	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter
1493	N/A	MCOs	Operations and Finance	Operations	Call Center	Beneficiary Communications: Inbound Beneficiary call utilization - mean hold time in queue	NH DHHS	NH 1450	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter
1494	N/A	MCOs	Operations and Finance	Operations	Call Center	Beneficiary Communications: Inbound Beneficiary call utilization - reason for the call	NH DHHS	NH 1450	All	Weekly in first 3 months, then quarterly	2 weeks after go-live	1 week after end of each week/quarter

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Ref #	Sub Ref #	Info Generated By	Topic Area	Domain	Sub-Domain	Name	Definition Steward	Measure ID	Age Group(s)	Measure Data Period	Date of Initial Required Submission	Delivery Date for Measure/ Report After Initial Period
1500	N/A	EQRO	Healthcare Processes and Outcomes	Quality Assurance and Improvement	General	Recommend to DHHS and design additional quality studies focused on Beneficiaries	NH DHHS	N/A	All	Annually	9/30/2014	September 30th
1600	N/A	MCOs	Operations and Finance	Operations	Prior Authorizations	Prior Authorization Approvals Summary	NH DHHS	NH 434	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1601	N/A	MCOs	Operations and Finance	Operations	Prior Authorizations	Prior Authorization Denial Detail Listing	NH DHHS	NH 434	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1602	N/A	MCOs	Operations and Finance	Operations	Prior Authorizations	Prior Authorization Denials Summary	NH DHHS	NH 434	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter
1700	N/A	MCOs	Operations and Finance	Service Utilization	Pharmacy	Total pharmacy payment amount	NH DHHS	NH 444	All	Quarterly	2 months after the end of the first full or partial quarter after go-live	2 months after the end of the quarter

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42 CFR Subpart D: Reference and Summarized Content	Contract Provision (NH Medicaid Care Management Contract Section Reference)
438.204 - Elements of state quality strategy	
• The State and the MCOs must assess the quality and appropriateness of care and services to all enrollees and individuals with special health care needs	• 20.4.2, 20.1.3, 20.1.13
• The State and the MCOs must identify race, ethnicity and primary language spoken.	• 16.1.5, 16.1.13
• The State must regular monitor MCO compliance with quality standards, including:	
• National measures,	• 20.5
• Annual, external independent review,	• 18.1.4
• The State's information systems, and	• 22
• Standards at least as stringent as those in the Federal regulations, for access to care, structure and operation, and quality measurement and improvement.	• 21.1.1, 26
Access Standards	
438.206 - Availability of services	
• The MCO must maintain and monitor a delivery network supported by written agreements and is sufficient to provide adequate access to services covered under the contract to the population to be enrolled.	• 19.1.1
• The MCO must provide female enrollees direct access to women's health specialists.	• 18.4.1
• The MCO must provide for a second opinion.	• 18.7
• The MCO must provide out of network services when not available in network.	• 18.6
• The MCO must provide assurance that the costs to enrollees out-of-network are no greater than in-network.	• 18.6.3
• The MCO must demonstrate that providers are credentialed.	• 19.3
• The MCO must demonstrate that both the MCO and its providers furnish services with timely access and cultural competence.	• 19.1.4; 16.1.2
438.207 - Assurances of adequate capacity and services	
• The MCO must provide documentation that demonstrates it has capacity to serve the expected enrollment, submit the documentation in a format specified by the State at time of contracting and any time there is a significant change.	• 19.1.1, 32.7.1
438.208 - Coordination and continuity of care	
• The MCOs must implement procedures to deliver primary care and coordinate health care services to enrollees.	• 10.1; 10.2; 10.3; 10.9

• The State must implement procedures to identify persons with special health care needs. For individuals with special health care needs: • The MCOs must implement mechanisms for assessing enrollees identified as having special needs to identify ongoing special conditions and developing a treatment plan. • The MCOs must have a mechanism to allow persons identified with special health care needs to access specialty care directly (standing referral).	• 10.8.2 • 10.8 • 10.8.1
438.210 - Coverage and authorization of services • The MCOs must define the amount, duration and scope of services provided. • The MCOs must specify "medically necessary services." • The MCOs must have a service authorization process.	• 8.2.1, 8.2.4, 8.2.5, 21.1.1 • 21.2 • 21
Structure and Operation Standards	
438.214 – Provider selection • The MCOs must implement written policies and procedures for selection and retention of providers. • The State must establish a uniform credentialing and recredentialing policy. MCO must follow a documented process for credentialing and recredentialing. • The MCOs cannot discriminate against providers that serve high-risk populations. • The MCOs must exclude providers who have been excluded from participation in Federal health care programs.	• 19.3 • 19.3 • 19.1.2, 32.3.1 • 19.3.8
438.218 - Information Requirements • The State and MCOs must meet the requirements of 42CFR438.10	• 14.2.3, 15.1.2, 15.1.12
438.224 - Confidentiality • The MCOs must comply with all state and federal confidentiality rules.	• 28.1.4, 28.1.6, 21.1.6, 22.5.11.9, 22.5.17.1, 32.4.6
438.226 - Enrollment and disenrollment • The MCOs must comply with the enrollment and disenrollment standards in 42CFR438.56.	• 14
438.228 - Grievance systems • The MCOs must comply with grievance system requirements in 42CFR438 Subpart F. • The State will conduct random reviews of enrollee notification through its EQRO.	• 17 • 20.3, 20.3-Included into EQRO Scope of Work in development

438.230 - Subcontractual relationships and delegation • The MCOs are accountable for any functions or responsibilities that it delegates. • The MCOs must have a written agreement that regularly monitors and specifies the activities and report responsibilities that are delegated and specifies the revocation of the agreement if the subcontractor's performance is inadequate.	• 5.1 • 5.3
Measurement and Improvement Standards	
438.236 - Practice guidelines • The MCOs must adopt practice guidelines that are based on valid and reliable evidence or a consensus of health care professionals in the field; consider the needs of the population, are adopted in consultation with health care professionals, and are reviewed and updated periodically • The MCOs must disseminate guidelines. • The MCOs must apply guidelines to coverage decisions.	• 20.7 • 20.2.3 • 20.2.4
438.240 - Quality assessment and performance improvement (QAPI) program • Each MCO must have an ongoing QAPI program. • The MCOs conduct general performance measurement, including the detection of both under-utilization and over-utilization and an assessment of the quality and appropriateness of care furnished to enrollees with special health care needs. • The MCOs must measure and report to the State its performance using standard performance measures required by the state. Submit data specified by the State to measure performance. • The MCOs must have an ongoing program of performance improvement projects that focus on clinical and nonclinical areas. Projects should be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects should include: Measurement of performance using objective quality indicators, implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the intervention, planning and initiation of activities for increasing or sustaining improvement. Each plan must report to the State the results of each project. • The State must review at least annually, the impact and effectiveness of the each program.	• 20.1.3 • 20.1.3, 20.1.4.4, 20.1.5, 20.1.13 • 20.1.6, 20.5 • 20.1.11 • 20.4, 20.1.7, 20.1.4, 20.3 • Also included in EQRO Scope of Work

438.242 - Health information systems	
• The MCOs must have a system in place that collects, analyzes, integrates, and reports data and supports the plan's compliance with the quality requirements.	• 22
• The MCOs collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system.	• 22.5.3
• The MCOs must ensure that data from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic and consistency, collecting service information in standardized formats, make all data available to the State and CMS.	• 22.5.10.5, 22.5.10.6, 23.2, 23.2.24, 32.7.2, 32.7.5
• Make the data available to the State and CMS.	• 23.1.1, 22.5.10, 22.5.15, 32.6.2

Appendix E: NH Medicaid Care Management Program Routine Quality Reports

General reporting requirements:

Unless otherwise specified within the NH Medicaid contract, the following standard reporting requirements apply. The MCOs must hold subcontractors accountable to the Quality Strategy requirements for any data and reporting. *Last Updated 7.2.12. Consult with the Department for any recent updates prior to use.*

Distribution and Presentation:

- Daily reports must be available at 8:00 am Eastern Time, Tuesday through Sunday.
- Monthly reports must be available no later than the 10th calendar day of each month for the previous month's data.
- Quarterly reports must be available no later than the 10th calendar day following the end of the quarter.
- Annual reports must be available no later than the 30th calendar day following the end of the defined year (e.g. fiscal, calendar, quality, etc).
- Periodic reports must be aggregated into a consolidated report, i.e. all monthly reports distributed as a single monthly report, and presented to the DHHS account manager and the DHHS program subject matter contact.
- All reports must be provided in an electronic file that allows text and visual displays of information to be exported, edited and used by DHHS (e.g. graphs in PowerPoint, executive summaries exported into other documents, etc.)

Analysis:

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

Baselines:

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

n.b. Reports noted are exclusive of the plans and reports exclusive to the initial implementation of the NH Medicaid Care Management program.

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
Program Management and Planning: Program Management	Description of MCO program management and measurement including, but not limited to, • A framework of processes to be used by the MCO and NH DHHS for managing and monitoring all aspects of the Care Management Program, • Sufficient detailed, data driven assessment using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities, and • Documentation of approval change history.	Annually	2; 7.4.1
Program Management and Planning: Communications	Description of MCO communications, including, but not limited to, • The objectives, tasks, activities, time allocation, deliverables, dependencies and responsible party regarding the implementation and operations of the Care Management Program, • The audience, purpose of the communication, paths of communication, means of communication, time line and evaluation of effectiveness of messages, and • Documentation of approvals and change history.	Annually	2; 7.4.2
Program Management and Planning: 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.	Annually	7.5
Payment Reform Initiative	Overview of the MCO Payment Reform Initiative, including, but not limited to: • Brief description of the Payment Reform Initiative inclusive of program goals, member health outcomes, and providers affected, • Executive summary of annual findings, • Incorporating and use of sufficiently detailed, data driven assessment using statistically sound measurement and analysis to accurately demonstrate program impact, successes and opportunities, • Year I shall address implementation of the Payment Reform Initiative inclusive of measurable implementation milestones, subsequent years shall address program results, • Comment and compliance with the requirements set forth in Section 9.1.5, including, but not limited to, rates paid, federal regulation, requests for program information, • For each provider group within the program:	Annually	9

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
	covered services not furnished by provider groups with the program, the type of incentive arrangement, the percentage of withhold or bonus, panel size and methodology used for assignment or pooling, adequate coverage of stop loss coverage if at financial risk.		
MCO Payment Reform Plan Implementation Milestones	Describe the progress made toward implementation of the MCO Payment Reform Plan, including, but not limited to: • Brief description of the payment reform initiatives inclusive of program goals, member health outcomes, and providers affected, • Executive summary of progress toward implementation, any correction or challenges being encounter and how those challenges are being addressed, • Sufficient detail to accurately assess progress toward each implementation goal, an analysis of any challenges or corrective action and how those challenges or changes will be addressed.	Quarterly, Annually	9.1.4
Care Management: Care Management Plan	Overview of the MCO comprehensive care management and as assessment of MCO care management, with comprehensive care coordination across its health plan, other payers, fee-for-service Medicaid, community services and other health and social service providers; promoting and assuring service accessibility; centered on individual member and care giver needs with member and family involvement; community centered; culturally appropriate care; specifically including, but not limited to: • Care coordination, • Non-emergent transport, • Wellness and prevention, • Member health education, • Complex care member management, • Members with special needs. The Care Management Plan must include all of the elements addressed in each sub-section of Section 10. For any delegated tasks, the MCO must provide the reason for delegation, the tasks being delegated, how the determination and assurance of quality operations and/or services was made. Any delegated activities must be comprehensively compliant with the reporting in the Quality Strategy and specifically with the Care Management Plan and reporting.	Annually	10

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
	For each Agreement year after Year I, the MCO shall include in the Care Management Plan a quantitative, data driven and, to the extent possible, statistically valid assessment of the prior years successes and new opportunities to improve the Care Management program, member health outcomes, and member and family experience of care. Any measures not otherwise specified in the NH Medicaid MCO contract and used for Care Management assessment must have prior approved from DHHS and should draw from national quality measurement experience to the greatest extent possible.		
Care Management: Systems of Care for Children	Report on activities that ensure member and family involvement in the development of a system of care for children with serious emotional disturbance.	Quarterly, Annually	10.1.3
Care Management: NEMT	Report on Non-Emergent Transportation (NEMT) to include, but not be limited to: • Types of NEMT used, • Number of members transported via NEMT, and • Requested, completed and not provided when requested NEMT events.	Monthly	10.4
EPSDT Services: EPSDT Plan	The MCO Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) Plan.	Annually	11
Behavioral Health: Community Based Services Utilization	Report by region of the ratio of community based services to office-based services.	Biannually	12.1.5.7
Behavioral Health: CANS and ANSA Training and Utilization	Report on use of the Child and Adolescent Needs and Strengths Assessment (CANS) and the Adult Needs and Strengths Assessment (ANSA) by community mental health workers to include: • Number of community mental health providers needing training, • Number of providers trained and certified, • Number of members receiving community mental health services, • Number of member receiving either CANS or ANSA each quarter, and • An assessment of Training and Utilization successes and opportunities with comment on opportunity improvement*.	Quarterly	12.1.6
Behavioral Health: Olmstead Plan Support	Report on the MCO activities related to the NH Olmstead Plan, "Addressing the Critical Mental Health Needs of NH Citizens: A Strategy for Resolution" including at minimum, • An assessment of the availability, use and need for Assertive Community Treatment Teams, by region and statewide, • Community residential capacity, by region and statewide, and • Community tenure strategies to address admissions and readmissions at New	Annually	12.1.8

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
	Hampshire hospital, for children and adults.		
Behavioral Health: Mental Health Service Providers Training Plan and Reporting	The MCO shall submit a plan for and report on how the MCO shall support the community mental health system hire, train and retain qualified staff, including, but not limited to: • Type of training provided with participant list, summary of activity and evaluation of the training, • How evidence based practices are sustained and/or expanded upon, including specific comment on each of the practices listed in 12.1.10.3, • Suicide prevention and post-intervention training, and • An assessment of training strengths and opportunities with how those opportunities will address in the subsequent Agreement Year. For any delegated tasks, the MCO must provide the reason for delegation, the tasks being delegated, how the determination and assurance of quality operations and/or services was made. Any delegated activities must be comprehensively compliant with the reporting in the Quality Strategy and specifically with the Mental Health Service Providers Training Plan and reporting.	Annually	12.1.10
Behavioral Health: Consent for Primary Care – Behavioral Health Coordination	The MCO shall report on Consent for Primary Care – Behavioral Health Coordination, including, but not limited to: • All instances in which consent was not given, and • If possible the reason for refusal of consent, • A plan to improve the likelihood of consent for the subsequent Agreement year, subject to review and approval from DHHS*.	Annually	12.2.12
Behavioral Health: Homelessness	The MCO shall report on homelessness, specifically discharge from New Hampshire Hospital to including, but not limited to: • Number of discharges to homeless shelters and homelessness, • The reasons for discharge to the shelters or homelessness, • The efforts made by the MCO to arrange appropriate placements, and • A plan to decrease the likelihood of discharge to a shelter or homelessness for the subsequent Agreement year, subject to prior review and approval from DHHS.	Annually	12.1.15.1
Behavioral Health: Reductions in Readmission Plan	The MCO shall submit a plan for and report on how the MCO shall reduce readmission to New Hampshire Hospital, including, but not limited to:	Annually for Plan, Quarterly Readmissions	12.1.16

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
	• The development of a discharge plan, • Member receipt of the discharge plan, • Contact with the member within 3 calendar days of discharge, • A follow up appointment within 7 calendar days, • An assessment of the barriers to discharge and a plan to reduce the barriers and improve community tenure in the subsequent Agreement year, subject to prior review and approval from DHHS.	Reporting	
Pharmacy Management: Service Operations	The MCO shall report on pharmacy services operations standards and must maintain response times of: • 95% of electronic systems transactions less than one (1) second, • 24 hours to a request for prior authorization, • Call Center customer services (e.g. inbound calls received, speed to answer, hold times, total call time, calls abandoned, etc.).	Quarterly	13.1.8; 13.1.9
Pharmacy Management: Utilization Controls	The MCO shall report on pharmacy utilization controls including but not limited to: • Prior authorizations, number, approved, denied, partially approved, • Generic utilization, including, but not limited to the percentage of generics/ all drugs, the percentage of generics / all drugs for which a generic is available and the brand is not required by the NH PDL, percentage of generics/ all drugs for which a generic is available, • Mail order pharmacy use if any, • Rankings by various parameters (e.g. claim count, payment amount, average payment) for, but not limited to: Top X member, Top X drug, Top X therapeutic class use, Top X ingredient, Top X prescriber, Top X pharmacy, • PDL utilization by various parameters (e.g. member, prescribers, therapeutic class, etc.).	Quarterly	13
Pharmacy Management: Summary of Pharmacy Costs	The MCO shall report on pharmacy costs, including but not limited to: • Total pharmacy claims and dollars paid, voided/reversed, denied, • Number of members accessing pharmacy services, by member characteristics such as age, eligibility group, gender, etc., • Average, median and range of the number of prescriptions per user, • Average, median and range of prescription claims and net cost in dollars per user, and	Quarterly	13

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
	by member characteristics such as age, eligibility group, gender, etc., • Drugs subject to a maximum allowable cost (MAC), the cost avoidance of MAC application, • Co-payment required/not required, collected/not collected, • Over the counter drug use by various parameters.		
Pharmacy Management: Quality Improvement Initiatives	The MCO shall report on MCO Pharmacy Quality Improvement initiatives, including at minimum: • Polypharmacy for physical and behavioral health medications, • Maintenance medication adherence to eliminate gaps in refills, • Use and reimbursement of child psychiatric consultation for behavioral health medications in children, and • Other MCO initiated programs. For each initiative, the MCO must provide objective outcomes and at the end of each Agreement year, a sufficient detailed, data driven assessment using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.	Annually for Assessment, Quarterly Reporting on Pharmacy Quality Improvement progress	13.1.10
Pharmacy Management: Rebate Billing Support	The MCO shall provide pharmacy data file transfers to support all DHHS rebate billings and report on the: • Date of file delivery, • Accuracy and completeness of the file transferred, any absent date elements, the reason for the absence data, and the date the data will be provided, • Any additional information or corrective actions needed to comprehensively support DHHS rebate filing.	Weekly	13.1.11; 13.1.12
Pharmacy Management: Third Party Liability Recoveries	The MCO shall report on any pharmacy costs billed to other payers or recovered from other payers, including, but not limited to: • The name of the member, • The name of the drug, • Dispensing date, • Amount allowed, • Amount due from TPL • Amount recovered.	Quarterly	13.1.12
Pharmacy Management: Lock-In	The MCO shall report on any programs with pharmacy or medication related restrictions, including, but not limited to: • Number of members locked-in to a pharmacy, prescribers, or both, • For each member locked in: the drug(s),	Monthly	24.1.22; 24.1.25

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
	prescribers(s) or pharmacy restriction, the lock-in date span, the reason/criterion met for the restriction, the date of last and the date of next review.		
Member Enrollment and Disenrollment	The MCO shall report on: • New members enrolled and the reason for each new enrollment, • Members re-enrolled after a loss of Medicaid eligibility, • Members disenrolled and the reason for each disenrollment, and • Total members enrolled.	Monthly	14
Member Services: Member Communications	The MCO shall report on: • Number of new member welcome calls, including, but not limited to the total number of calls made, the number of successful calls, the number of unsuccessful attempts, • Number of initial enrollment letters and member handbooks mailed and received back as undeliverable, • MCO member website with additional information on website use including, but not limited to, Number of hits to the website, time spent on the website, document downloads, requests for additional information, email use – number, proportion of contacts via email and reasons for email, email response statistics, maintenance and update events • Inbound member call center utilization, (e.g. calls received, reason for the call, speed to answer, hold times, total call time, calls abandoned, voice messages left during and after business hours, etc.), • Transferred member calls including, but not limited to the number of warm transfers, the program transferred to, any follow undertaken, etc., • After hours voice mail follow up, including, but not limited to the number and reason for the after hours calls, the date and time of the call, and the date and time of the returned calls by the next business day,	Monthly	15.1.3; 15.1.4; 15.1.12; 15.4.5. 22.5.11
Member Services: Member Engagement	The MCO shall report on member engagement through the Consumer Advisory Board (CAB) and Regional member meetings including, but not limited to, • CAB member composition, or • The number of members attending regional meetings, and • Meeting times and locations,	Annually	15.7; 20.1.1

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
	• Agendas, • MCO program impact attributable to the CAB and/or regional meetings.		
Member Services: Member Satisfaction Survey	The MCO shall conduct and submit the results from an annual CAHPS survey with all available CAHPS measures and sections, including, but not limited to supplements, children with chronic conditions, and mobility impairment.	Annually	15.7.3; 20.5
Cultural Considerations: Race, Ethnicity and Primary Language	The MCO shall report on the following activities related to the culturally appropriate delivery of services: • Member race, ethnicity and primary spoken and written language of its members, • Community demographic, cultural and epidemiologic profile to address the cultural and linguistic characteristics of each of the MCO's services areas, • Utilization of interpreter services for health plan service and medical services provided by its provider network, including, but not limited to the number of interpreters used and the number declined, • Activities undertaken as a part of the 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 the service area community assessment.	Annually	16.1.5; 16.1.7; 16.1.13.8; 16.1.13.11
Grievance and Appeals:	The MCO shall report on all actions, grievances, and appeals, including, but not limited to all matters handled by delegated entities including but not limited to: • Number of grievances, categories of grievance, member or provider characteristics grieving, any corrective action or response to the grievance (e.g. quality improvement project, operations changes, etc.), the date of filing and date of MCO response, (Quarterly), • Grievances alleging discrimination related to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental disability (three days of MCO receipt), • Number of and types of appeals (e.g. routine, expedited), the service/decision being appealed, characteristics of the appealing member, the MCO action, any corrective action or response to the appeal (e.g. quality improvement project, operations changes, etc.), the date filed and date of MCO, response including, but not limited to any	Quarterly, Three (3) business days	17.1.9; 26.2.2.4

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
	requested extensions and the reason for the extension, whether benefit continuation was required during the appeals timeframe, whether an upheld denial or partial denial continued to Fair Hearing with the date and decision from the Fair Hearing, (Quarterly).		
Access: Provider Network Adequacy	The MCO shall report on the adequacy of its provider network including but not limited to: • An assessment of the member demographics and anticipated medical services need including, but not limited to a community level assessment of services available and community level barriers to medical services, • Provider access anticipated needs, including, but not limited to number, mix and geographic distribution to meet anticipated member needs, • Provider participation report: provider participation reports by geographic location, categories of service, provider type categories, and any other codes necessary to determine the adequacy and extent of participation and service delivery and analyze provider service capacity in terms of realized member access to health care, • Any MCO provider network exceptions requested and the DHHS response, • Timely access to service delivery NH Medicaid Care Management contract standards for transition care after hospital or institutional discharge; preventive, routine, urgent and emergent care; • Data to support access to a choice of primary care provides, and access to women's health, family planning and special services, • Data to support accessibility to providers for members with disabilities, • Description of the number and type of services provided out of network, • Any corrective actions needed restore provider network adequacy to meet federal and state standards.	Quarterly	18; 18.1.2; 18.2; 19.1.1; 22.5.18; 22.5.19
Access: Provider Network Adequacy	The MCO shall report on Monitoring Access to Care in New Hampshire's Medicaid Program: MCO Access, to include all of the metrics measured and trended in the State's access reporting to CMS, including but not limited to: • Quarterly enrollment by age, aid categories, metropolitan/non-metropolitan counties; • Primary care providers/pediatricians/OB-	Quarterly, Annually	

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
	Gyn, member to provider ratios; • Numbers of visits, total visits/1000 members, seasonally adjusted, by aid categories and by metropolitan/non-metropolitan counties; • Emergency department utilization, total visits/1000 members, by aid categories, seasonally adjusted and by metropolitan/non-metropolitan counties; • Inpatient utilization, total admissions/1000 members, by aid categories, seasonally adjusted and by metropolitan/non-metropolitan counties; • Ambulatory sensitive condition admissions, total admissions/1000 members, seasonally adjusted; • Well-Child, Adolescent, adult preventive or other ambulatory services, total visits/1000 members, by metropolitan/non-metropolitan counties; • Member requests for assistance accessing providers, total requests/1000 members, by metropolitan/non-metropolitan counties.		
Network Management: Network Overview	The MCO shall report an overview of its provider network for inclusion into the provider directory, the MCO website, to DHHS, to include but not be limited to for each provider: • Provider type (hospital, pharmacy, physician, lab, etc), • Provider Name, • Practice Name, • Specialty, • Board Certification, Medicare certification, CLIA certification, JCAHO accreditation, etc as appropriate for the provider type, • Address, telephone, ADA compliant, website, • Hours of operation (e.g. Office hours including, but not limited to after hours, 24 hours pharmacy, etc.), • Service limitations (e.g. specialty pharmacy only, DME – oxygen supplier only, etc). The MCO shall report an overview of its provider network including but not limited to aggregate information on the data elements list above and including, but not limited to, the following data elements: • Number of providers terminated and number of providers newly enrolled by specialty,	Annually	18.2; 19.2.16; 19.2.18; 22.5.19

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
	location, number of members affected, • Geographic location of providers (by provider type) and members, • Any transition plans needed to address any significant changes in the provider network, • Provider Quality Report Card: provider dashboard or "report card" reports of provider service quality including but not limited to provider sanctions, timely fulfillment of service authorizations, count of service authorizations, etc.		
Network Management: Provider Communications	The MCO shall report on: • Provider training, including, but not limited to the date and location, subject of the training, number in attendance, training evaluation, and include in this report presentation the Behavioral Health: Mental Health Service Providers Training Reporting, • Provider relations strategy, including, but not limited to the provider relations staff information, provider relations activates, and the impact of those activities, • Inbound provider call utilization, (e.g. inbound calls received, reason for the call, speed to answer, hold times, total call time, calls abandoned, voice messages left during and after business hours, etc.), • After hours voice mail follow up, including, but not limited to the number and reason for the after hours calls, the date and time of the call, and the date and time of the returned calls by the next business day, • Number of hits on the MCO provider website with additional information on website use including, but not limited to but not limited to the number and proportion of utilization controls managed through the website, e-prescribing, document downloads, requests for additional information, email use – number, proportion of contacts via email and reasons for email, email response statistics, maintenance and update events.		12.1.10; 19.2.13; 19.2.15; 19.4.1; 22.5.11
Network Management: Provider Engagement	The MCO shall report on provider engagement through the Provider Advisory Board (PAB) meetings including, but not limited to, • PAB member composition, • Meeting times and locations, • Agendas, • MCO program impact attributable to the PAB.	Annually	19.4.1; 20.1.1
Network Management:	The MCO shall conduct and submit to DHHS the results from an annual provider satisfaction survey,	Annually	19.4.2

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
Provider Satisfaction Survey	approved by DHHS and administered by a third party.		
Quality: QAPI Program Summary	The MCO shall have a Quality Assessment and Performance Improvement (QAPI) program summary including, but not limited to: • Annual objectives and goals, • Outcome measures to the greatest extent possible in addition to structure and process measures, • Quantitative assessments to the greatest extent possible in addition to any qualitative assessments, • Incorporate appropriate comparators which must be approved by DHHS prior to use, • Sufficiently detailed, data driven assessments using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities, • Under and/or over-utilization, • An assessment of the quality and appropriateness of care for members with special needs.	Annually, Quarterly	20.1.7; 20.1.13; 20.4
Quality: Performance Improvement Projects	The MCO shall conduct a minimum of four (4) performance improvement projects (PIP) each Agreement year that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. At least one of these projects shall have a behavioral health focus. The MCO shall report the status and results including but not limited to: • Brief description of each PIP, PIP goals and progress toward each goal, • Sufficiently detailed, data driven assessments using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.	Quarterly	20.1.11
Quality: Quality Measures	The MCO shall at minimum report on the following quality measure sets, including any additions made to these data set and any additional quality measures specified by DHHS: • CMS CHIPRA Child Quality Measures, • CMS Adult Quality Measures, • NCQA Medicaid Accreditation HEDIS/CAHPS Measures, including all available CAHPS measures and sections, including supplements, children with chronic conditions, and mobility impairment, • The measure contained in NH Medicaid Care Management Contract Exhibit O.	Annually	20.5.1

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
Quality: Performance Incentives	The MCO shall report the status and results of each annual Quality Incentive Program (QIP) initiatives including but not limited to: • Brief description of each QIP, QIP goals and progress toward each goal, • Sufficiently detailed, data driven assessments using statistically sound measurement and analysis to accurately demonstrate program impact, success and opportunities.	Quarterly	20.6
Utilization Management: Service Utilization and Controls	The MCO shall report on services utilization and controls including but not limited to: • Prior authorizations, number requested, service requested (e.g. DME, hospitalization, service limit override, etc) approved, denied, partially approved, • Utilization controls decision making time frames for routine, urgent, continuation/extended, post service delivery • Sites and types of services, (e.g. acute hospital, home health, transplants, readmissions, high risk obstetric cases, etc.) by total number and normalized (e.g. number of services/ x members, number of services / PMPM), • Service utilization by various parameters (e.g. members eligibility group, member age, service provider, geographic site, etc.), • Rankings and trends by various parameters (e.g. utilization counts, payment amounts, average payments, etc.), • Annual reporting shall include, but not be limited to, an assessment of the impact of utilization controls on member, provide and program quality and costs; any unintended consequences; an assessment of any under-utilization and/or over-utilization; opportunities for improvement; impact of member and/or providers on changes to utilization controls.	Quarterly, Annually	20.1.5; 21; 21.3
MCIS: Data Transmissions from DHHS to MCO	DHHS shall provide a data transmissions to the MCOs to include: • Provider extract (every two weeks), • Recipient eligibility (daily), • Recipient refresh data extract (every two weeks), • Capitation payment data (monthly), • Third party coverage (daily).	See specific transmission adjacent	22.5.8; 25.1.1
MCIS: Data Transmissions from the MCOs to DHHS	The MCO Managed Care Information System (MCIS) shall provide a data file to DHHS to include: • Member benefit plan enrollment data (daily), • Member encounter data including, but not	See specific transmission adjacent	22.5.9; 23.2.21; 25.1.5

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
	limited to paid, denied, adjustment transactions by pay period (weekly/monthly), • Member supplement including, but not limited to primary care provider assigned and group affiliation (weekly/monthly), • Financial transaction data (weekly/monthly), • Third party coverage data (monthly), • Provider network file (monthly), • Coordination of benefits data (monthly).		
MCIS: Maintenance of Critical Systems	The following contingency plans shall be developed and tested to ensure continuous operation of the MCIS: • Disaster recovery plan, • Business continuity plan, • Data Security plan including preventive, detective, corrective controls and HIPPA compliance), • Joint interface plan, • Risk management plan, • Confirmation of 5010 compliance and companion guide, • Confirmation of IRS publication 1075, • ICD-10 implementation and compliance plan.	Annually and after any modification	22.5.12.5; 22.5.12.6; 22.5.17.2
MCIS: Encounter Data Quality	The MCO shall provide complete and accurate encounter data to DHHS. The MCO shall implement review procedures to validate encounter data submitted by providers. The MCO shall meet the following standards: • Completeness: 99%, • Accuracy: 98-100%, • Timeliness: 100%, • Error resolution: 100% (15 days).	See specific transmission adjacent	23.2.24
Fraud, Waste and Abuse: Comprehensive	The MCO shall report fraud, waste and abuse (FWA) information to DHHS including but not limited to, • All audits, in progress and complete, • Number of complaints of FWA warranting investigation including, but not limited to provider name and specialty, NPI, complaint source and nature, dollar amount, • All FWA related to providers, including all communications regarding FWA, number of records requested, providers audited, • Claims targeted for review and recovery, including claims analysis, • Appeals, hearings related to FWA, • Amounts recovered/owed, • Provider training or corrective action to mitigate future FWA, • Recommendations for to mitigate FWA (annual report) including, but not limited to	Annually, Quarterly	24; 24.1.4; 24.1.12; 24.1.13; 24.1.15; 24.1.19; 24.1.26

Program and Report Name	Brief Description	Frequency	MCO Contract Reference (Section)
	lock-in for medical services.		
Third Party Liability: Cost Avoidance	The MCO shall report the number of claims cost avoided by the MCO's claims system, including, but not limited to the amount of funds, the amounts billed, the amounts not collected, and the amounts denied.	Monthly	25; 25.1.2; 25.1.3; 25.1.5
Third Party Liability: Accident and Trauma	The MCO shall provide DHHS with a report including but not limited to: • Detailed claim for accident and trauma cases, • Accident questionnaire, • MCO intent to pursue and recover.	Monthly	25.1.4; 25.4.2; 25.4.4
Administrative Quality Assurance Standards	The MCO shall routinely measure the accuracy of claims processing and report results to DHHS including but not limited to: • Adjudication of claims: 95% of clean claims within thirty (30) days of receipt, 100% of all claims within sixty (60) days, and any interest paid on claims > 30 days, • Financial accuracy: 99%, • Payment accuracy: 97%, • Claims accuracy: 95%, • A review of a statistically valid sample of paid and denied claims determined with a ninety-five percent (95%) confidence level, +/- three percent (3%), assuming an error rate of three percent (3%) in the population of managed care claims, • Corrective action plans needed to address claims payment accuracy issues.	Monthly	27; 27.1.1; 27.2.1; 27.3; 27.4; 27.5
Privacy and Security of Members	The MCO shall report any suspicion of any violation of personal health information with one (1) day of receipt of any information suggesting any violation to DHHS.	One (1) day	28
Finance: MCO Audits	The MCO shall provide DHHS a copy of its audited financial statements.	Annually	29.7
Termination Plan	MCO must prepare a Transition Plan that is acceptable to and approved by DHHS to be implemented between receipt of notice and the termination date.	Care Management program start	30.1.1
Additional Reports Anticipated in Step 2			
Behavioral Health: Consumer Assessment of Health and Satisfaction	NH Public Mental Health Consumer Survey, Data Infrastructure Grant Mental Health Consumer Survey or Mental Health Sickness Indicator Profile (MHSIP) Consumer Survey	Annually	Step 2
Developmental Services: Consumer and Family Assessment of Health and Satisfaction	National Care Indicators Adult Consumer, Adult Family, Family Guardian, and Child Family Surveys.	Biennially	Step 2
Elderly and Adult Services: Experience of Care	CMS Participant Experience Survey	Annually	Step 2

Appendix F: Abbreviations and Acronyms

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