State of New Hampshire

Department of Health and Human Services

New Hampshire Care Management Report

State Fiscal Year (SFY) 2016

May 2016

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Acknowledgements

The preparation of this report was financed under a Contract with the State of New Hampshire, Department of Health and Human Services, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, e.g., the United States Department of Health and Human Services.

Executive Summary

Overview

On December 1, 2013, the New Hampshire Department of Health and Human Services (DHHS) implemented the Medicaid Care Management (MCM) program. Since 2013, DHHS has contracted with Health Services Advisory Group, Inc. (HSAG) to serve as the state's federally required external quality review organization (EQRO). In March 2016, at the request of DHHS, HSAG conducted a focus review of the two MCM programs, **New Hampshire Healthy Families** (**NHHF**) and **Well Sense Health Plan** (**Well Sense**), to examine the processes and methods employed by each managed care organization (MCO) to identify and assess members for care management and care coordination. If a member's assessment indicated that the person could benefit from care management, DHHS also wanted to review the process for the completing and updating the care treatment plan.

Methodology

HSAG requested a list of the names of members in care management from the MCOs. HSAG selected a sample of 10 member records to be part of an on-site care management record review. The eligible population included members enrolled in care management for 30 days or longer during the past six months, and the status of cases included open cases and closed cases. The MCOs were to provide a data file with all members enrolled in care management except those in the low intensity level requiring no care coordination.

Summary of Findings

Below is a summary of the findings from the on-site review.

- Both MCOs used nationally recognized care management information systems. **NHHF** used the TruCare Enterprise Care Management System and **Well Sense** used the CareEnhance Care Management System (CCMS®).[1] The systems were designed using clinical protocols to guide the care managers as they completed comprehensive assessments and the care treatment plans.
- Employees in the care management department included registered nurses, behavioral health specialists, social workers, and clerical staff. The average caseload ratio reported for the care managers at **NHHF** was 1:60. **Well Sense** reported a caseload ratio of 1:40–50 for complex cases and 1:70–80 for population-based cases.
- The MCOs used 15 data sources to identify members for care management, and the two MCOs completed 13 comprehensive assessments within 30 days of member identification.

[1] CCMS® is a registered trademark of McKesson.

- The development of the care treatment plan occurred the same day as the completion of the comprehensive assessment for 11 members and within 10 days for the remaining two members who agreed to complete the assessment.
- **NHHF** indicated that formal reassessments occurred for the foster children every three months and annually for the remaining population in care management. **Well Sense** indicated that formal reassessment occurred every six months for members in care management.
- A member remained in care management until goals were achieved, the member was no longer eligible for benefits with the MCO, the member decided to no longer participate in care management, or the MCO could no longer reach the member. Nine of the 20 cases were closed at the time of the audit.

Recommendations

- The MCOs need to ensure that the care management systems used by the MCOs (i.e., TruCare and CCMS) are continuously enhanced to include protocols and algorithms to evaluate and accommodate the needs of new populations served or additional services provided by the MCOs.
- In the future, new members will be added to the MCM population and additional services will be administered by the MCOs. Both MCOs need to begin planning staffing scenarios to meet the future care management needs of the MCM population.
- While no state standards for care management caseloads exist in New Hampshire, the caseload ratios maintained by **NHHF** and **Well Sense** appear consistent with industry research. Both MCOs need to ensure that the caseloads do not change significantly as they continue to provide care management services for the MCM population.
- Members frequently develop conditions that need to be care managed after enrollment, and current DHHS standards exist only for completing assessments at the time of enrollment. Timely requirements for completing member assessments also could be established by DHHS after enrollment when the MCO receives information that a member could benefit from care management (e.g., hospitalizations, frequent emergency room visits, predictive modeling, etc.).
- The files for the foster children indicated that it took numerous attempts to reach the New Hampshire Division for Children, Youth & Families (DCYF) workers to obtain permission to talk to the guardians of foster children in care management. Although it is necessary to speak to the DCYF worker to obtain contact information for the current guardian of the children in foster care, DHHS may consider working with NHHF and DCYF to determine if there is a way to expedite the process.
- Every file contained the name of the primary care providers (PCPs). There was not consistent identification, however, of the specialists involved in the member's care. Because the members included in the study had multiple comorbidities complicating their primary diagnosis, HSAG recommends that a specific field be created to list the names and specialty of the specialists involved in caring for the member.
- Both MCOs need to consider sending a copy of the care treatment plan goals and objectives to members and to the PCPs.

Overview

On December 1, 2013, DHHS implemented the MCM program, and since 2013, DHHS has contracted with HSAG to serve as the state's federally required EQRO. In March 2016, at the request of DHHS, HSAG conducted a focus review of the MCM care management/care coordination programs at **NHHF** and **Well Sense** to examine the processes and methods employed to:

- Identify members who are appropriate for care management.
- Assess the functional, medical, social, and behavioral health needs of members identified for care management.
- Develop care treatment plans that address the functional, medical, social, and behavioral health needs of the member from the results of a comprehensive assessment.
- Reassess the member, after an appropriate period of time or as the member's condition requires, and to revise the care treatment plan to address newly identified needs of the member or progress the member has made towards the care treatment goals.

To study the care management programs at each MCO, HSAG requested a list of the names of members in care management. From the MCO list, HSAG selected a sample of member records for the on-site care management record review. While on-site, HSAG reviewed the selected care management records to examine the processes used by the MCO for identification, assessment, care treatment plan development, and reassessment of members in care management.

In addition to the care management record review, HSAG assessed the operational structure of each MCO's care management program. Specifically, HSAG assessed the information systems used by MCOs to support care management activities, the level and types of care management staff employed by the MCOs, the caseload ratios of care managers to members maintained by each MCO, and the process used to care manage the members.

Background

Medicaid Care Management Program

In 2011, the New Hampshire legislature passed Senate Bill 147 requiring a comprehensive statewide Medicaid managed care program for all Medicaid enrollees. The DHHS implemented the MCM program on December 1, 2013. Beneficiaries enrolled in the program receive services through one of two MCOs: **NHHF** or **Well Sense**. The MCOs are responsible for coordinating and managing their members' care through a network of qualified providers.

The Agreement between DHHS and each MCO required the MCOs to "develop a strategy for coordinating all care for all members…(to include) coordination of primary care, specialty care, and all other MCO-covered services as well as services provided through the fee-for-service program and non-Medicaid community-based services."[2] The Agreement also requires each MCO to ensure that:

- Each member has access to an ongoing source of primary care appropriate to his or her needs.
- Appropriate prenatal care services are provided to members.
- Non-emergent transportation is arranged for members needing transportation to medically necessary services covered by the New Hampshire Medicaid program.
- Health education programs are developed for members concerning wellness, prevention, and care management.

MCOs are required to conduct a health needs assessment for all new members to determine the need for care management and to develop effective care coordination programs that assist members in the management of chronic and complex health conditions. Members demonstrating high utilization of services and those identified as special needs members are to receive assistance through care management.

Assessment of the MCM Care Management Programs

The contract between DHHS and HSAG requires HSAG to conduct studies on topics identified by DHHS. At the end of calendar year 2015, DHHS requested that HSAG conduct a focus study to determine the process each MCO used to identify, assess, and care manage members in care management.

The Case Management Society of America (CMSA) defines case management as "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes."[3] DHHS requested that HSAG review member files to determine how the MCOs identify, assess, and coordinate care for members who may benefit from care management. If the results of the assessment determine that a member needed assistance with care management, DHHS was interested in examining each MCO's process for developing a comprehensive care treatment plan for each member. DHHS and HSAG met to discuss the study and to determine the methodology that would be used to elicit the information needed to examine the care management process at the two MCOs.

[2] New Hampshire Department of Health and Human Services. (2015). *Amendment #8 to the Medicaid Care Management Contract.* Available at: http://www.dhhs.nh.gov/ombp/caremgt/contracts.htm. Accessed on: March 18, 2016.
[3] Case Management Society of America. (2010). Standards of Practice. Retrieved from http://www.cmsa.org/Individual/MemberResources/StandardsofPracticeforCaseManagement/tabid/69/Default.aspx. Accessed on: March 24, 2016.

Methodology

HSAG collaborated with DHHS to design the focus review of MCO care management programs that included an on-site review of care treatment plans maintained by the MCOs for members in care management. Further, DHHS requested that HSAG review the information systems used by MCOs to support care management activities, assess the level and types of care management staff employed by the MCOs, determine the caseload ratios of care managers to members at each MCO, and review the process of collecting information for completion of the comprehensive assessment and development of the care treatment plan. HSAG conducted pre-on-site and on-site activities during this focus review.

The External Quality Review Protocols established by the Centers for Medicare & Medicaid Services (CMS) defined the process that EQROs use to conduct focus studies.[4] HSAG followed the protocols for conducting focus studies, which are described in Appendix A.

Pre-On-Site Activities

Care Management Program Evaluation Guide

Prior to going on-site, HSAG and DHHS developed a Care Management Program Evaluation Guide (Evaluation Guide) that was used to collect the data from a review of the care management records at the MCOs. HSAG developed the Evaluation Guide using the care coordination requirements found in the Agreement between DHHS and the MCOs, the 2015 Health Plan Accreditation standards developed by the National Committee for Quality Assurance (NCQA), and standards from the Utilization Review Accreditation Commission (URAC) Case Management Accreditation Guide, Version 5.0. After reviewing the care management program descriptions developed by the two MCOs, HSAG determined that the two program descriptions contained references to the Standards of Practice developed by CMSA. Because both MCOs noted the CMSA Standards of Practice in their care management programs, HSAG also included CMSA standards in the guide.

The Evaluation Guide is included as Appendix B to this report, and includes the following care management topics:

- Member Identification
- Comprehensive Assessment
- Care Treatment Plan Development
- Reassessment of the Care Treatment Plan

[4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 8: Conducting Focused Studies of Health Care Quality, Version 2.0, September 2012.* Retrieved from http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/eqr-protocol-8.pdf. Accessed on: March 29, 2016.

Study Population

In December 2015, DHHS notified the MCOs of the care management focus study and provided a summary of the study to be conducted by HSAG. DHHS supplemented the preliminary information that was sent to the MCOs with an email that included the specifications for the data files that were to be sent to HSAG in advance of the on-site review. The data files were to contain specific information about each member in care management to allow HSAG to select a list of member records to be reviewed during the on-site activities. The file specifications sent to **NHHF** and **Well Sense** are included as Appendix C and Appendix D.

Members enrolled in care management for 30 days or longer during the past six months were to be included in the list of members sent to HSAG. The status of cases included open cases and closed cases. The files were separated into members enrolled in the MCO prior to July 1, 2015; and members enrolled on or after July 1, 2015. The MCOs were required to post their data files to the secure HSAG file transfer protocol (FTP) site on or before February 12, 2016. Both MCOs sent HSAG clarifying questions concerning the file specifications prior to posting the documents, and both MCOs posted the files to the HSAG FTP site as requested. Table 1 displays the number of members included in the data files submitted to HSAG and the different DHHS requirements for members enrolled prior to and after July 1, 2015.

Table 1—Number of Members Included in the Files Submitted by the MCOs

Members in Care Management	NHHF	Well Sense
Members enrolled in the MCO prior to July 1, 2015: ◆ No DHHS requirements for timely completion of the health needs assessment	36	713
DHHS requirements for completion of a health needs assessment for *members enrolled in the MCO on or after July 1, 2015*: ◆ Members who are pregnant or with special health care needs to be assessed within 30 calendar days ◆ All other members to be assessed within 90 calendar days or there must be documentation of three attempts to conduct the screen with a definition of how to overcome the barriers to complete the assessment within 120 days	165	221
Total Members	**201***	**934**

***NHHF moved to an Integrated Care Model (ICM) of case management in November 2015. The previous model identified six levels of care management, and the low intensity cases were managed without care plans. The current ICM requires care plans for all members. NHHF created the file for this study as the MCO was moving to the ICM program.

The members were to be identified by the level of care management that was being provided by the MCO. **NHHF** divided members into two stratification levels: Complex care management and care coordination. **Well Sense** divided members into three stratification levels: Complex care management, population-based care management, and social care management. The definitions of the stratification levels are included in Appendix E.

Files from **NHHF** included members with eligibility dates from December 1, 2013 (the beginning of the MCM program in New Hampshire), but the total number was considerably less than the total number of members submitted by **Well Sense**. Although the number of files varied significantly from **NHHF** and **Well Sense**, HSAG determined that the files contained a sufficient number of members from both MCOs to create the samples for the study.

On February 22, 2016, HSAG selected 10 members to be reviewed at each MCO during the on-site care management record review and 10 members as the oversample if files needed to be excluded from the study. HSAG posted the list of records in the respective **NHHF** and **Well Sense** folders on the secure HSAG FTP site. HSAG sent the agendas and the Evaluation Guide to the MCOs the same day that the lists were posted. Since HSAG reviewed only 10 care management cases at each MCO, caution must be used when applying these findings to the entire population of members in care management. The information provides an overview of findings from the review of the automated case files for the sampled population and may identify areas that require further investigation.

On-site Activities

The on-site reviews were held on March 8, 2016 at **Well Sense**'s Manchester office and March 9, 2016 at **NHHF**s' Bedford office. The sessions began with an opening conference and with introductions by the MCO staff members involved in the record review. Both MCOs elected to display the care management records electronically. Care management staff members at both MCOs participated in the sessions and were available to answer questions throughout the day. In addition to the care management record review, HSAG assessed the operational structure of each MCO's care management program.

Findings

The information obtained during the on-site reviews is presented by discussing the processes that are similar at both MCOs, and processes that differ at the two MCOs. The findings presented first are the assessments of the operational structure of each MCO's care management program.

Assessment of Operational Structure of the Care Management Programs

The assessment of operational structure of the care management programs includes a review of the number of members in care management/care coordination, information systems supporting care management, staffing, caseloads, and stratification levels for the members included in the study.

Members in Care Management/Care Coordination

Table 2 displays the number of members that **NHHF** and **Well Sense** indicated were in care management/care coordination at the time of the on-site review during discussions with HSAG.

Table 2—Members In Care Management/Care Coordination		
Number of Members	**NHHF**	**Well Sense**
Members in Care Management/Care Coordination	403	767
Members Pending Comprehensive Assessment	386	369

NHHF indicated that there were currently 403 members in care management/care coordination. The 386 members who were pending a comprehensive assessment included the members transitioning to the ICM of care management. **Well Sense** indicated that there were currently 767 members in care management/care coordination. There were 369 members who were pending a comprehensive assessment.

Information Systems Supporting Care Management

The MCOs used nationally recognized computer systems to document the information obtained for members in care management as shown in Table 3.

Table 3—Case Management Systems Used by the MCOs		
Name of Case Management Systems	**NHHF**	**Well Sense**
TruCare Enterprise Care Management System	X	
CareEnhance Care Management System (CCMS)		X

Both MCOs

Both MCOs' care management systems were designed using nationally recognized clinical protocols to guide the care managers as they interviewed the member, caregiver, parent, or guardian. Medical directors at **NHHF** and **Well Sense** also reviewed and approved the protocols used by the MCOs. The systems automatically documented the care manager's name, date, and time of entries into the system, and both systems prompted the care manager with the questions that were asked during the comprehensive assessment. The members' answers to the questions could also prompt screens that contained additional questions. For example, if the member answers that he or she has diabetes, the system would direct the care manager to a list of questions concerning an assessment of the status of the member's diabetes care and treatment.

NHHF

NHHF used the TruCare Enterprise Care Management System. The TruCare system allowed approved members of the care management team access to update member records and notes. The behavioral health care managers also had access to the TruCare system. Other department (e.g., member services, provider services, etc.) could view selected fields but could not update

information. The TruCare system also allowed members and providers the ability to view care plans on the secure Website established by **NHHF**. Members could view a Self-Management Care Plan that included the name of the care manager, goals, and tasks; but not the barriers and interventions defined by the care managers. Providers could display a care plan that included defined barriers and interventions, and the text notes written by the care managers. The TruCare system had the capability of printing the member's care treatment plan and generating reports.

Well Sense

Well Sense used a computer program designed by McKesson called CCMS. The CCMS system was also used by the inpatient utilization management, prior authorization, and pharmacy staff members. The behavioral health care managers also had access to the system. The system allowed approved members of the care management team access to update member records and notes. Other department (e.g., member services, provider services, etc.) could view selected fields but could not update information. **Well Sense** was in the process of developing the capability of printing the care plan from the CCMS system at the time of the on-site review. The CCMS system also allowed care managers and management staff to generate reports.

Staffing

At the time of the on-site reviews, the number of people devoted to care management/care coordination was 23 at **NHHF** and 30 at **Well Sense** as shown in Table 4.

Table 4—Staff Assigned to Care Management

Staff Members	NHHF	Well Sense
Care Managers: Registered Nurses	7	7
Open Positions for Registered Nurse		1
Care Managers: Social Workers (Licensed)		6
Program Specialists: Social Workers (Licensed and Non-licensed)	4	
Open Position for Program Specialist	1	
Program Coordinators (Medical)	4	4
Behavioral Health (Licensed)	5	10
Behavioral Health Service Manager (Licensed)	1	
Program Coordinators (Behavioral Health)	1	2
Total Staff	**23**	**30**

Both MCOs

Both MCOs employed registered nurses, social workers, and non-licensed staff in their care management departments.

NHHF

At the time of the on-site review, **NHHF** had seven registered nurses in the care management department, and three were certified case managers. Three of the registered nurses functioned as the director, supervisor, and manager for the care management department. **NHHF** employed social workers as program specialists who were licensed or unlicensed to assist in completing the assessments. **NHHF** employed four social workers at the time of the on-site review and had one open position for a program specialist.

Behavioral health care management was coordinated by the Cenpatico staff at **NHHF**. Staff members from Cenpatico and **NHHF** were physically located in the same area of the Bedford, New Hampshire office to allow for more efficient communication and coordination of services. The behavioral health care managers were masters' prepared and licensed in a behavioral health specialty. There were five Cenpatico care managers at **NHHF**, which included one care manager devoted to children in foster care. One additional licensed social worker provided assistance as a behavioral health services manager working with the foster children.

NHHF and Cenpatico employed five non-licensed program coordinators to assist in completing paperwork and locating members whose contact information changed while they were in care management.

NHHF used multi-disciplinary teams to manage members in care management. The teams were comprised of medical directors, registered nurses, social workers, behavioral health specialists, program specialists, and a behavioral health services manager. **NHHF** also employed Member Connections Representatives who assisted care managers by going to members' homes if the care managers no longer had valid contact information for a member. The multi-disciplinary teams met weekly to discuss cases.

Well Sense

Seven registered nurses coordinated the members in care management at **Well Sense**, and there was one open position for a registered nurse at the time of the on-site review. One registered nurse was working on obtaining case management certification. **Well Sense** employed six master's level social workers to oversee the cases in care coordination and social care management. The social workers also assisted the registered nurses in coordinating the social and behavioral health needs for members. Four non-licensed program coordinators assisted the care managers.

Behavioral health care management was coordinated by Beacon Health Strategies (Beacon) for members at **Well Sense**. Members from the medical and behavioral health teams were physically located in the same area of the Manchester, New Hampshire office to allow for more efficient communication and coordination of services. The behavioral health care managers were masters' prepared and licensed in a behavioral health specialty. Beacon employed ten licensed staff members including four technical assistants, one program director, one operations manager, one clinical manager, one case manager, one substance use disorder case manager, and one person who functioned as liaison between **Well Sense** and the New Hampshire Hospital. Two non-licensed program coordinators assisted the behavioral health care managers.

Well Sense used multi-disciplinary teams to manage members in care management. The multi-disciplinary teams at **Well Sense** were comprised of medical directors, registered nurses, social workers, behavioral health specialists, and pharmacists. The teams met every other week to discuss cases or more frequently, if needed.

Caseloads

Both MCO reported that the ratios of care managers to members varied from day-to-day. At the time of the on-site review, the MCOs reported the caseloads as shown in Table 5.

Table 5—Average Caseloads

Caseloads	NHHF	Well Sense
Overall Average Caseloads	1:60	
Average Caseloads for Complex Cases		1:40–50
Average Caseloads for Population-based Cases		1:70–80

The caseloads for handling members in care management were similar for both MCOs. **NHHF** gave one caseload ratio: one care manager for every 60 members. **Well Sense** provided separate ratios for their complex cases (one care manager for every 40–50 members) and for population-based cases (one care manager for every 70–80 cases).

Stratification of the Members Included in the Sample

Table 6 displays the stratification of the members selected for the 10 members included in the file reviews for **NHHF** and **Well Sense**.

Table 6—Stratification of Sampled Population

Stratification Levels	NHHF	Well Sense
Complex Care Management	5	4
Population Based Care Management	NA	2
Integrated Social Care Management	NA	4
Care Coordination	5	NA
Total Cases	**10**	**10**

As previously mentioned, **NHHF** included members in the study from complex care management and care coordination. **Well Sense** included members in the study from complex care management, population based care management, and integrated social care management.

Identification of Members for Care Management

The following section describes the processes used by the MCOs to identify members who may benefit from care management.

Member Identification

The early identification of members who need assistance with care management benefits the member by improving self-management of acute and chronic conditions. Early identification also benefits the MCOs by improving health outcomes for their population and assisting members in using medical resources more effectively and efficiently.

New member outreach begins at both MCOs as soon as they receive new enrollment data from the State. The enrollment information may identify a member who could be considered for care management (e.g., members with special health care needs; aged, blind, and disabled; etc.), and the MCOs also made outreach calls to conduct a screening to determine if additional members may benefit from care management. Once a member was enrolled, there were multiple methods used to identify the need for care management as shown in Table 7.

Table 7—Methods Used by the MCOs to Identify Members for Care Management

Methods Used to Identify Members	Members in the Study	
	NHHF	Well Sense
Health Risk Assessment	0	1
Prior Authorizations/Utilization Management	0	2
Claims/Predictive Modeling	2	3
Daily Inpatient Census Reports/Discharge Reports/Readmission Reports	5	1
Self-Referrals (Member or Guardian)	3	2
Vendors (e.g., Transportation, Vision, Durable Medical Equipment, Home Health, etc.)	0	1
Emergency Room Visits		
Pharmacy Data		
Results from Laboratory or Radiology Studies		
Nurse Advise Line		
Health Care Providers		
Disease Management		
Hospital Staff Referrals		
State Enrollment Data		
MCO Staff (e.g., Member Services, Provider Services, Quality, etc.)		

Both MCOs

The new member calls at both MCOs were made by non-clinical staff, and a short screening form was used to identify members who could benefit from care management. If the screening form indicated that the member may benefit from care management, the member information was forwarded to the care management staff or the call was transferred directly to a care manager.

NHHF

NHHF reviewed inpatient census reports and discharge reports to determine if those members may need assistance with care management. **NHHF** identified five members in the study from those reports.

NHHF identified three members in the study from self-referrals: Two members self-referred, and one child was referred by her guardian. Claims or predictive modeling assisted in identifying two members included in the study. **NHHF** used a predictive modeling system that generated reports to identify people whose score indicates that they may need assistance in managing their care due to gaps in care or utilization trends. The predictive modeling system at **NHHF**, Impact Pro, used algorithms that combined data from claims, diagnostic related groups (DRGs), procedures, pharmacy, diagnoses, laboratory studies, and any other available utilization data to identify a stratification level assigned to each member. The predictive modeling system generated monthly reports, and care managers used the information to evaluate members in care management and other members who may benefit from care management.

Well Sense

One member in the study completed the health risk assessment form mailed in the new member welcome packet, and the information on the form indicated that the member may benefit from care management.

The prior authorization and utilization management staff at **Well Sense** referred two members in the study to care management. **Well Sense** reviewed inpatient census reports and discharge reports to determine if any members needed assistance with care management and identified one member in the study from those reports. One member self-referred to care management and one parent referred her son.

Claims or predictive modeling assisted in identifying the three members included in the study, and the transportation vendor referred one member to care management after the member filed a complaint with the vendor. **Well Sense** used a predictive modeling system that generated reports to identify people whose score indicates that they may need assistance in managing their care due to gaps in care or utilization trends. The predictive modeling system at **Well Sense**, the Registry, used algorithms that combined data from claims, DRGs, procedures, pharmacy, diagnoses, laboratory studies, and any other available utilization data to identify a stratification level assigned to each member. The predictive modeling systems generated monthly reports, and care managers used the information to evaluate members in care management and other members who may benefit from care management.

Completion of the Comprehensive Assessment

Once a member was identified as possibly benefiting from care management, care managers at both MCOs began attempts to contact the member to complete the comprehensive assessment.

Completing the Comprehensive Assessment

NHHF and **Well Sense** made initial attempts by telephone. If the member could not be reached, a letter was sent to the home address asking the member to call the care manager. Many time the case management files contained documentation of multiple attempts to reach a member before initially connecting with the member. The number of days between identification and completion of the comprehensive assessment for the cases reviewed is shown in Table 8.

Table 8—Number of Days Between Identification and the Comprehensive Assessment

Days	NHHF	Well Sense
0–7 Days	4	4
8–14 Days	1	1
15–30 Days	2	1
Greater Than 30 Days	1	1
Patient Refused to Complete	2	3
Total	**10**	**10**

Both MCOs

Interviews with staff at **NHHF** and **Well Sense** confirmed that care managers attempt to complete the comprehensive assessments within 30 days of notification that a member may benefit from care management. At **NHHF** and **Well Sense**, the study revealed that care managers made frequent attempts to call the members. If telephone numbers were incorrect in the system, staff members called other entities that could have updated contact information. For example, if the member was recently discharged from a hospital or facility, care managers called the hospital or facility. Or, care managers called the PCP to determine if the PCP's records indicated a different telephone number for the member. When a member could not be reached by telephone, letters were sent to the member's last know home address.

The file reviews at both MCOs confirmed that if the member/guardian was not reached within the first two weeks after being identified as benefiting from care management, care managers were calling the members at least once or twice a week to complete the comprehensive assessment.

NHHF

NHHF completed four comprehensive assessments within seven days of referral to care management. One member was assessed 8–14 days, and two members were assessed 15–30 days. The **NHHF** member who was assessed in greater than 30 days enrolled in the MCO in 2014 and was in foster care. It took 75 days to complete the assessment, however, and this member's care management record contained evidence of multiple attempts to find or reach the member.

NHHF made numerous attempts to contact the DCYF case worker to obtain permission to talk to the parents or guardians. Once permission was granted, it also took multiple attempts to speak with the parents or guardians of the child in foster care. In another file for a child in foster care, **NHHF**

indicated that the care manager had logged 256 phone contacts with persons associated with the case.

Two members refused to complete the assessment and requested assistance only with care coordination services from the care managers. Because one of the two members was on the waiting list for a transplant, the care manager completed a brief care treatment plan and maintained contact with the member to ensure that the member did not need assistance with medical needs.

NHHF employed Connection Representatives to visit the member's last known address to determine if they could find a current address for a member.

Well Sense

Well Sense completed four comprehensive assessments within seven days of referral to care management. One member was assessed 8–14 days, and one member was assessed 15–30 days. The **Well Sense** member who was assessed in greater than 30 days was in a minor child, and it took 62 days to reach the mother to complete the assessment. The member enrolled in the MCO in November 2015. **Well Sense** called the mother multiple times and left voice messages to encourage her to complete the assessment. There was evidence in the file that the case managers spoke to the mother six times before completion of the comprehensive assessment.

Three members refused to complete the assessment. One member requested assistance only with care coordination services from the care manager. One member was pregnant, and the care manager followed the case until the woman completed her postpartum visit. One member was recently diagnosed with a chronic condition and requested only educational materials to learn about the condition.

Well Sense dispatched an employee to the member's last known address to determine if they could find a current address for a member.

Development of the Care Treatment Plan

After the completion of the comprehensive assessment, the TruCare system at **NHHF** and the CCMS system at **Well Sense** assisted the care manager in the development of the care treatment plan.

Member Files and Development Timelines

Table 9 displays the number of member files that contained a care treatment plan and the number of days it took to develop the plan after the completion of the comprehensive assessment.

Table 9—Number of Days from Assessment to Development of Care Treatment Plan

Days to Completed Care Treatment Plan	NHHF	Well Sense
Same Day	7	4
2 Days	0	1
10 Days	0	1
Total Number of Care Treatment Plans Developed	**7**	**6**

Table 9—Number of Days from Assessment to Development of Care Treatment Plan		
Days to Completed Care Treatment Plan	**NHHF**	**Well Sense**
Patient Refused to Complete Comprehensive Assessment	2	3
Patient Refused to Complete Care Treatment Plan	1	1
Total Members In the Study	**10**	**10**

Both MCOs

A review of the notes from member calls included the members' decision to be in care management, or to refuse the offer of care management assistance. One member in each MCO declined the opportunity to complete the care treatment plan and to be in care management.

NHHF

Although **NHHF** completed eight comprehensive assessments, one of those members disengaged with the care management process prior to the development of the care treatment plan. **NHHF** completed all seven of the care treatment plans the same day as the comprehensive assessment.

Well Sense

Well Sense completed seven comprehensive assessments, and one of those members also disengaged prior to the development of the care treatment plan. **Well Sense** completed four care treatment plans the same day as the comprehensive assessment. One care treatment plan was completed two days after the completion of the comprehensive assessment, and one care treatment plan was completed 10 days after the completion of the comprehensive assessment.

At **Well Sense**, the social workers completed a separate care plan to document the goals and progress of the social needs of the member. The social worker frequently interacted with the medical and/or behavioral health care manager to ensure that everyone managing the care for the member coordinated efforts and shared current information about the member.

Elements in the Care Treatment Plans

Table 10 lists the elements found in the care treatment plans for the members in the study.

Table 10—Number of Elements Found in the Care Treatment Plans		
Care Treatment Plan Elements	**NHHF**	**Well Sense**
Member or Caregiver Participated in the Development of the Care Treatment Plan	7	6
Verification of Benefits	7	6
Diagnoses to Include Comorbid Conditions	7	6
Member's Benefit Category	7	6
PCP Identified	7	6
Current Medications	7	6
Medical Needs	7	6
Physical/Functional Status/Activities of Daily Living	7	6
Depression Screening	7	6
Behavioral Health Needs	7	6
History of Substance Use	7	6
Assessment of Cognitive Functioning	7	6
Social Needs (Including Living Arrangement, Transportation, Caregiver Support, etc.)	7	6
Cultural/Linguistic Preferences	7	6
Visual and Hearing Needs	7	6
Time Delimited Goals and Objectives	7	6
Potential Barriers Noted and Interventions to Overcome Barriers	7	6
Member/Parent/Guardian Involvement	7	6
Coordination with Community/State Agencies Noted	4	3
PCP Notified in Writing of Member's Enrollment in Care Management	4	2

Every member's file did not need to include coordination with community and/or State agencies, but every file should have included notification in writing to the PCP that the member was in care management.

Both MCOs

The TruCare system and the CCMS system used algorithms (i.e., step-by-step guide formulated to evaluate members based on prior answers to a set of pre-determined questions) to create the care treatment plans. Once the MCOs compiled the information about the member from the comprehensive assessment, the system generated the care treatment plan. From the information generated by the TruCare system and CCMS, the care manager and the member selected the goals and objectives to improve his/her health status that were most important to the member. The care treatment plans also defined barriers and interventions to overcome the barriers.

The care management files at both MCOs contained a list of the members' current medical and behavioral health diagnoses. The MCOs checked member benefit categories for every member who was included in the review. Because members had different benefits in different eligibility categories (e.g., the New Hampshire Health Protection Program, Waiver Programs, etc.) care management staff from both MCOs checked and documented the benefit coverage for each of the members in care management.

All 13 files contained the name of the member's current PCP. Because the members in the study frequently had comorbidities, specialists were often involved in the care of the member. The list of specialists could be found in some of the member files, but they were not displayed as prominently as the name of the PCP.

Current medications were displayed in each of the member's files. Both systems had a separate screen to enter the member's current medications. After the member told the care managers about the medications they were taking, however, the care managers at both MCOs checked pharmacy lists to determine if the medications provided by the member were accurate and complete. The medication information found in the system was collected from the member's responses, caregiver responses, and from pharmacy claims.

The care plans contained a physical and behavioral health status. Depending on the answers reported by the members, additional screens may be generated to ask in-depth questions about a particular response. Both MCOs use the Patient Health Questionnaire 2-Question Screen (PHQ2) to identify members who may be suffering from depression, and members who screened positive for depression were referred to Cenpatico at **NHHF** and Beacon at **Well Sense**.

The social assessments found in the care plans at both MCOs documented an assessment of living arrangements, caregiver support, financial issues, history of abuse or violence, transportation needs, legal issues, community support needs, food insecurities, and financial needs to include utility assistance. Both MCOs offered cell phones to members who did not have a consistent form of communication, and one file contained documentation of additional minutes being provided on a member's cell phone to assist in communication with providers and the care manager.

The documentation in the care management files confirmed that there was interaction with social service agencies in the community. Members were referred to the visiting nurses association, shelters, food banks, Women Infants and Children (WIC), legal aid, and community mental health centers. If a member who was currently smoking decided that one of his/her goals was to stop smoking, the member was referred to a program to assist in stop smoking efforts.

Cultural preferences and linguistic limitations also were documented in the member files. Although the comprehensive assessments assessed visual and hearing needs, none of the members needed assistance in those areas.

The PCPs did not participate in the development of the care treatment plan in either of the MCOs. Both MCOs, however, indicated that they occasionally received calls from PCPs to discuss members in care management.

NHHF

Four of the seven files contained documentation that the PCP received a letter informing him/her of the member being enrolled in care management. The TruCare system had the capability of printing the care treatment plans, however, only two letters to providers included a copy of the plan. Providers and members could access the care treatment plans on the **NHHF** secure Website, but sending the document to providers and members would ensure that they received a written copy of the care treatment plan.

The files of the foster children also contained evidence of an Education Care Plan addendum. Case managing the foster population frequently involved balancing interactions between DCYF, the biological parents, and the foster parents. The case management of foster children was handled by an employee of Cenpatico at **NHHF**.

Cultural preferences and linguistic limitations were documented in the members' files. One member spoke an Arabic language and required the assistance of a telephonic interpreter whenever the case manager spoke to the member.

Although not every member needed coordination with community or State agencies, four member files at **NHHF** contained evidence of conversations with those agencies. Three members were in foster care, and the care manager from Cenpatico maintained contact with the DCYF case worker. **NHHF** also was in contact with one foster child's probation officer. The other member needed assistance with housing, food, and finances.

Well Sense

Two of the six files contained documentation that the PCP received a letter informing him/her of the member being enrolled in care management. **Well Sense** could not print the care plans at the time of the review, and staff indicated that they were developing that functionality. Sending the information to providers and members would ensure that they received a written copy of the care treatment plan.

Although not every member needed coordination with community or State agencies, three member files at **Well Sense** contained evidence of conversations with those agencies. Two members needed assistance with housing, food, and finances. The third member was a complex newborn whose file contained multiple contacts with community and State agencies.

Reassessment of the Care Treatment Plan

After the creation of a care treatment plan, the plan needs to be continually updated with current information about the member.

Frequency of Reassessments

Table 11 displays the frequency of formal reassessment of the care treatment plans at **NHHF** and **Well Sense**.

Table 11—Frequency of Formal Reassessments of the Care Treatment Plan		
Frequency	**NHHF**	**Well Sense**
Every Three Months for Children in Foster Care	X	
Every Six Months		X
Annually	X	

Both MCOs

After the care managers completed a telephone call with the member, the care manager scheduled the next call with the member by entering the date in the TruCare system or CCMS. The frequency of calls depended on the severity of the case. Reports were generated daily by the TruCare and CCMS systems to advise the care managers of calls scheduled for that day.

During the on-site review, the documentation produced by both MCOs confirmed that care managers continually reassessed the members' physical and behavioral health status along with the current social needs. The notes generated by the care managers indicated that interview questions during every conversation with members assisted in gathering the information needed to obtain insights about the person that extended beyond the medical or behavioral health diagnoses.

The files produced evidence that the goals, objectives, interventions, and barriers also were constantly reviewed and updated by the care managers. Goals may be achieved or goals may change if a member's status changes during the course of care management. The member's adherence to or non-compliance with the established care management care plan also could trigger a revision to the stated goals and objectives.

NHHF

In one member's file, there was evidence of the Member Connection representative and the care manager conducting face-to-face visits with the member. **NHHF** indicated that formal reassessments occurred annually if the member remained in care management for that length of time. The care manager for the foster children at **NHHF** stated that formal reassessments for that population were completed every three months.

Well Sense

In two members' files, there was evidence of the care managers conducting face-to-face visits with the members. **Well Sense** indicated that a formal reassessment occurred every six months if the member remained in care management for that length of time.

Case Closure

The MCO staff members at **NHHF** and **Well Sense** confirmed that a member remained in care management until goals were achieved, the member was no longer eligible for benefits with the

MCO, the member decided to no longer participate in care management, or the MCO could no longer reach the member. Prior to closing the case, **NHHF** and **Well Sense** talked to the member or sent correspondence to members requesting that they call the case manager.

Open and Closed Cases

Table 12 displays the status of the cases (i.e., open or closed) included in the study.

Table 12—Number of Care Management Cases Remaining Open and Closed		
Open and Closed Cases	**NHHF**	**Well Sense**
Open Cases	6	5
Closed Cases: Loss of Contact with Member	2	2
Closed Cases: Member Reached Goals	2	2
Closed Cases: Member no Longer Wanted to be in Care Management	0	1
Total Members In the Study	**10**	**10**

Both MCOs

The main reason for closing the cases in the study was loss of contact with the member or the member not returning the MCOs' calls.

NHHF

The specific reasons for closing the four cases in the study included loss of contact with two members, and two members meeting their goals.

Well Sense

The specific reasons for closing the five cases in the study included loss of contact with one member, one member deciding that she no longer needed care management, and the completion of postpartum visits for two members. One member whose pregnancy triggered care management stayed in care management after the postpartum visit, but she eventually failed to return the calls to the care manager.

Recommendations

The information presents recommendations generated from the findings of the study, best practices, and current industry standards.

- "A care management information system is designed to facilitate the practice of care management by supporting the information needs of care managers. (Care managers) collect, process, transmit, and disseminate data that represent information for the care management process, decision making, and outcome analysis. (The system) should provide the care manager with an electronic record-keeping system that totally replaces the paper-based records of the

past, while enhancing functionality through ticklers, alerts, summary-level information, business process analyses, (and) report generation."[5]

- The TruCare system used by **NHHF** and the CCMS system used by **Well Sense** were appropriate for the MCO's care management activities and provided the components and capabilities defined as essential for care management information systems by Matraian, McGonigle, and Pavlekovsky.[6] The MCOs need to ensure that the systems are continuously enhanced to include algorithms to evaluate and accommodate the needs of new populations served or services provided by the MCOs.

- The number of staff devoted to care management needs to be constantly assessed to ensure that the MCOs have the correct number of employees with the credentials needed to support effective and efficient care management.
  - In the future, additional members will be added to the MCM population and additional services will be administered by the MCOs. Care management is a labor-intensive endeavor that will require additional staff to maintain the staffing ratios currently experienced at **NHHF** and **Well Sense**. Both MCOs need to begin planning staffing scenarios to meet the future care management needs of the MCM population.
- The CMSA conducted research in 2008 and found that caseloads ranged from 2 cases to 365 cases.[7] The Health Intelligence Network published the caseload statistics in May of 2012 from information obtained from 153 health care organizations as shown in Table 13.[8]

Table 13—Average Caseloads and Industry Standards

Caseloads	NHHF	Well Sense	Industry Standard
Average 1–49 Cases			31.1%
Average 50-99 Cases	100%	100%	42.2%
Average 100–149 Cases			15.6%
Average 150–250 Cases			11.1%

  - While no state standards for care management caseloads exist in New Hampshire, the caseload ratios maintained by **NHHF** and **Well Sense** appear consistent with industry research. Both MCOs need to ensure that the caseloads do not change significantly as they continue to provide care management services for the MCM population.
- Members frequently develop conditions that need to be care managed after enrollment, and that was the case with many of the members in the study. Seven of the 20 members had been enrolled in their MCO since the beginning of the program in December of 2013 and had been in

[5] Mastrian, K., McGonigle, D., & Pavlekovsky, K. (2007). Tips, tools & techniques. *Professional Case Management, 12*(3), 182. Retrieved March 22, 2016 from EBSCOHost database.
[6] Ibid.
[7] Stricker, P. (2008). *What is an "average" caseload?* CMSA eNewsletter, Spring 2014. Retrieved from http://www.naylornetwork.com/cmsatoday/printerFriendly-v2.asp?issueID=30163. Accessed on: March 22, 2016.
[8] Healthcare Intelligence Network. (2012). *2012 Healthcare Benchmarks-Healthcare Case Management*. Retrieved March 23, 2016 from http://www.hin.com/chartoftheweek/2012_case_manager_average_caseload_printable.html. Accessed on: March 18, 2016.

and out of care management multiple times. In New Hampshire, timely requirements for completing member assessments are required only at the time of enrollment.

  - Timely requirements for completing member assessments also could be established by DHHS after enrollment when the MCO receives information that a member could benefit from care management (e.g., hospitalizations, frequent emergency room visits, predictive modeling, etc.).

- The files for the foster children indicated that it took numerous attempts for **NHHF** to reach the DCYF workers to obtain permission to talk to the guardians of foster children in care management.
  - Although it is necessary to speak to the DCYF worker to obtain contact information for the current guardian of the children in foster care, DHHS may consider working with NHHF and DCYF to determine if there is a way to expedite the process.
- Both MCOs identified the PCP for all 15 members who completed the comprehensive assessment. There was not consistent identification, however, of the specialists involved in the member's care. If the MCOs did identify the specialists involved in the care, the names of the providers were frequently in fields that could not be easily retrieved by the care managers (e.g., in notes documenting conversations with the members, etc.).
  - Because the members included in the study had multiple comorbidities complicating their primary diagnosis, HSAG recommends that a specific field be created to list the names and specialty of the specialists involved in caring for the member. Many times during the review it was evident that the care furnished to the members was being provided by specialists, not the PCP.
- None of the members in the study received a copy of their care treatment plan.
  - Both MCOs need to consider sending the care treatment plan goals and objectives to every member. Members need a reference tool to ensure that they can identify the areas that could improve their health status. The information sent to the members needs to be in language that is easily understood by the member, and it should include goals that are actionable and achievable.
- Only six PCPs of the 15 members were notified in writing of the members' enrollment in care management.
  - Both MCOs need to notify PCPs when members are enrolled in care management and send the care treatment plan to the member's PCP. It is essential that every member in care management receives consistent information about the management of their health care. Consistent information from the care manager and the PCP's office can only be accomplished if the PCP receives a copy of the plan.

Conclusion

The DHHS and MCOs recognize that there are opportunities for improvement in the care management process. Both MCOs have information systems to facilitate the practice of care management, and the focus study generated recommendations concerning enhancements to the process. The biggest areas of concern, however, include ensuring that the PCP is notified when

members enter care management and maintaining the staffing levels to ensure that every member who could benefit from care management receives the opportunity to be enrolled in care management. The current staffing ratios are consistent with industry standards. As more members and services are added to the MCM Program, however, both MCOs will be challenged to hire the staff needed to maintain those ratios to ensure effective care management for the Medicaid members.

Appendix A: External Quality Review Protocols for Conducting Focus Studies

The External Quality Review Protocols established by CMS defined the process that EQROs use to conduct focus studies.[9] The protocol for conducting focus studies lists eight specific activities that must be completed.

- Selecting a study topic—The study topic was the care management/care coordination process at the two MCOs.
- Defining the study question—The study question for this project is as follows: How do the MCOs select members for care management, and how do the MCOs develop and manage the care treatment plan for members in care management?
- Development of study variables—The study variables included the processes established by each of the two MCOs to identify members for care management and how the MCOs developed the care treatment plan for the members. HSAG developed a Case Management Program Evaluation Guide to assist in the collection of data.
- Identification of the sample of members included in the study—The sample of members was selected from the program designation of members receiving Medicaid services in New Hampshire: Foster care, long-term care, Medicaid expansion, members receiving Social Security Income, and the low-income non-expansion population. Each MCO also defined the levels of care management used to identify the intensity of needs for each member. **NHHF** used two designations: Complex care management and care coordination. **Well Sense** used three designations: Complex care management, population-based care management, and integrated social care management.
- HSAG sent the MCOs file specifications to assist in determine the members eligible to be included in the study. The files specifications are included as Appendix C and Appendix D to this report. Both MCOs uploaded data files to HSAG's secure FTP site.
- Sampling methodology—DHHS and HSAG determined that a sample of 10 files would be sufficient to obtain the information for the study. A health analyst at HSAG selected members from each program designation and from each level of care management for each of the MCO samples. An oversample of 10 members was also provided to the MCOs.
- Reliability in the collection of data—Reliability refers to "the extent to which results are consistent over time and an accurate representation of the total population under study."[10] One health analyst from HSAG performed the reviews, and the same evaluation guide was used to evaluate the cases at both MCOs. HSAG conducted the reviews on successive days in the first full week in March 2016. Since HSAG reviewed only 10 care management cases at each MCO, caution must be used when applying these findings to the entire population of members in care

[9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 8: Conducting Focused Studies of health Care Quality, Version 2.0, September 2012.* Retrieved from http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/eqr-protocol-8.pdf. Accessed on: April 22, 2015.

[10] Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report, 8*(4), 597. Retrieved March 22, 2016 from EBSCOhost database.

management. The information provides an overview of findings from the review of the automated case files for the sampled population and may identify areas that require further investigation.

- Analysis of data—The same health analyst who conducted the reviews performed the analysis of the data obtained during the on-site reviews with assistance from additional HSAG staff members.
- Interpretation of data—The same health analyst who conducted the reviews interpreted the data. Other members of the HSAG staff reviewed the results of the study and offered recommendations for improving the care management processes at the two New Hampshire MCM Program MCOs.

Appendix B: Care Management/Care Coordination Evaluation Guide

Case Management Program Evaluation		
Section I: Identification		
1. Member Information	**MCO Name:** ☐ **NHHF** ☐ **Well Sense** A. Member Name: _____ B. Member Medicaid ID: _____ C. Member MCO Identification Number: _____ D. Date Member Identified as Needing an Assessment: _____ E. Date Assessment Performed: _____ F. Date Treatment Plan Completed: _____ G. Date of Enrollment in MCO: _____ H. Date of Enrollment in Case Management: _____ I. Member's Case Management Program (e.g., Complex, Population-based, Integrated, etc.) _____	
Observations:		
2. Identifying Members	The MCO uses methods to identify members who may benefit from case management. Check all that apply. ☐ A. New member calls ☐ B. Mailings to new members ☐ C. Claims and encounters ☐ D. Referrals from providers ☐ E. Referrals from member services ☐ F. Member referrals ☐ G. Emergency room visits or hospital discharge data ☐ H. Pharmacy data ☐ I. Utilization management data ☐ J. Laboratory results ☐ K. Referrals from disease management data	☐ Yes ☐ No

Case Management Program Evaluation		
Section I: Identification		
NCQA 2015 Health Plan Standards: Q17.B(2); QI17.C.; Q17.D.; QI18.B.	☐ L. Other: _____	
Observations:		
3. Identifying Members with Complex Needs *Amendment #8 to the Medicaid Care Management (MCM) Contract: Section 10.8.3* *NCQA 2015 Health Plan Standards: Q17.B(2)*	The MCO has a way to identify members with chronic care coordination, high risk/high cost, and complex member management needs. Check all the conditions that the MCO identified. ☐ A. Diabetes ☐ B. Congestive Heart Failure (CHF) ☐ C. Chronic Obstructive Pulmonary Disease (COPD) ☐ D. Asthma ☐ E. Coronary Arterial Disease (CAD) ☐ F. Obesity ☐ G. Mental/Behavioral Health Illness ☐ H. Wound Care ☐ I. Pregnancy ☐ J. Substance Use ☐ K. Other: _____ ☐ L. Other: _____	☐ Yes ☐ No
Observations:		
4. Identifying Members with Special Needs *Amendment #8 to the MCM Contract: Section 10.9.2* *42 CFR 438.208(b)(3)* *42 CFR 438.208(c)(1)(i)*	The MCO has a way to identify members with special health care needs. ☐ A. A member with at least two chronic conditions ☐ B. A member with one chronic condition and is at risk for another chronic condition ☐ C. A member with one serious and persistent mental health condition ☐ D. A member with substance use disorder ☐ E. A member living with HIV/AIDS ☐ F. A member who is a child in foster care ☐ G. A member who is a child and a client of Division of Children, Youth, & Families (DCYF) receiving services	☐ Yes ☐ No

Case Management Program Evaluation		
Section I: Identification		
42 CFR 438.240(b)(4)	through a court order ☐ H. A member who is homeless ☐ I. Other: _____	
Observations:		
5. Disease Management Identification Methodology *NCQA 2015 Health Plan Standards: Q18.C.*	The MCO utilizes a disease management methodology to identify members in need of various levels of health coaching and care intervention. Check all that apply. ☐ A. Grouper ☐ B. Predictive modeling ☐ C. Proprietary screening algorithms ☐ D. Other: _____	☐ Yes ☐ No
Observations:		

Case Management Program Evaluation		
Section II: Comprehensive Assessment		
1. Date of the Assessment *Amendment #8 to the MCM Contract: Section 10.7.2*	The MCO conducts a Health Needs Assessment for all new members within the following timeframes from the date of enrollment in the MCO: a) 30 calendar days for pregnant women, and children and adults with special health care needs b) 90 calendar days for all other members Member is Pregnant: ☐ Yes ☐ No Member has Special Needs: ☐ Yes ☐ No Date of Enrollment: _____ Date of Assessment: _____ Calendar days between Enrollment and Assessment: _____	☐ Yes ☐ No
Observations:		
2. Completion of the Assessment *42 CFR 438.208(c)(2)*	List the credentials of the person completing the Health Needs Assessment. _____	☐ Yes ☐ No
Observations:		
3. Comprehensive Assessment *URAC 5.0 CM12(i); CM14(a)*	The file includes documentation of how the information was collected to complete a comprehensive assessment. Check all that apply. ☐ A. Interview with the member ☐ B. Discussion with the family or caregivers ☐ C. Discussion with the PCP ☐ D. Discussion with specialists treating the member ☐ E. Consultation with members of an interdisciplinary health care team ☐ F. Review of medical records ☐ G. Review of the member's encounters/claims, pharmacy, or utilization data ☐ H. Other: _____	☐ Yes ☐ No
Observations:		

Case Management Program Evaluation		
Section II: Comprehensive Assessment		
4. Physical Health Needs Assessed *NCQA 2015 Health Plan Standards: Q17.F(1-4)* *URAC 5.0 CM12(a-f)* *URAC 5.0 CM13(a)*	The comprehensive assessment included documentation of the member's physical needs. Check all that apply. ☐ A. Medical history for physical health ☐ B. Current physical health diagnoses ☐ C. Physical/functional status ☐ D. Developmental disabilities ☐ E. Comorbid conditions ☐ F. Current medications ☐ G. Activities of daily living ☐ H. Assessment of neurological/cognitive issues (i.e., Alzheimer's, dementia, etc.) ☐ I. Member's physical health status expectations and goals ☐ J. Identification of current PCP and specialists involved in caring for the member's physical needs ☐ K. Other: _____	☐ Yes ☐ No
Observations:		
5. Ongoing Source of Primary Care *Amendment #8 to the MCM Contract: Section 10.3.1.1.* *42 CFR 438.208(b)(1)*	The comprehensive assessment included the identification of the PCP who is the ongoing source of primary care services appropriate for the member's needs.	☐ Yes ☐ No
Observations:		
6. Person Responsible for Coordinating the Member's Health Care Services *Amendment #8 to the MCM Contract: Section 10.8.1*	The comprehensive assessment included the identification of the person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.	☐ Yes ☐ No
Observations:		

Case Management Program Evaluation		
Section II: Comprehensive Assessment		
7. Mental/Behavioral Health Needs Assessed *NCQA 2015 Health Plan Standards: Q17.F.4* *URAC 5.0 CM12(g-i)*	The comprehensive assessment included documentation of the member's mental/behavioral health needs. Check all that apply. ☐ A. Medical history for mental/behavioral health ☐ B. Current mental/behavioral health diagnoses ☐ C. Evaluation of cognitive functioning ☐ D. History of substance abuse ☐ E. Member's mental health status expectations and goals ☐ F. Identification of current providers involved in caring for the member's mental/behavioral health needs	☐ Yes ☐ No
Observations:		
8. Social Issues Assessed *Amendment #8 to the MCM Contract: Sections 10.5; 10.10* *NCQA 2015 Health Plan Standards: Q17.G(3,5,8,10)* *URAC 5.0 CM12(h)*	The comprehensive assessment included documentation of the member's social needs. Check all that apply. ☐ A. Activities of daily living ☐ B. Current living arrangements (e.g., environmental and residential issues) ☐ C. Caregiver/support systems ☐ D. Strengths, abilities, weaknesses, and coping skills ☐ E. Financial issues ☐ F. History of abuse, violence, or trauma (interpersonal violence) ☐ G. Educational level or vocational issues ☐ H. Hobbies or leisure activities ☐ I. Health literacy ☐ J. Non-emergent transportation needs ☐ K. Legal issues ☐ L. Community support needs ☐ M. Food insecurities ☐ N. Utility assistance ☐ O. Transportation	☐ Yes ☐ No
Observations:		

Case Management Program Evaluation		
Section II: Comprehensive Assessment		
9. Linguistic Needs *NCQA 2015 Health Plan Standards: Q17.F(7); Q17.G(6)* *URAC 5.0 CM12(j)*	The comprehensive assessment included an evaluation of the member's cultural and linguistic needs, preferences, or limitations.	☐ Yes ☐ No
Observations:		
10. Visual and Hearing Needs *NCQA 2015 Health Plan Standards: Q17.F(8);QI17.G(7)*	The comprehensive assessment included an evaluation of the member's visual and hearing needs, preferences, or limitations.	☐ Yes ☐ No
Observations:		
11.Caregiver Resources *NCQA 2015 Health Plan Standards: Q17.F(9); Q17G(8)*	The comprehensive assessment included an evaluation of caregiver resources and involvement and life-planning activities.	☐ Yes ☐ No
Observations:		

Case Management Program Evaluation		
Section III: Development of the Care Treatment Plan		
1. Development of Care Treatment Plan *NCQA 2015 Health Plan Standards: Q17.F(12)*	The MCO develop a care treatment plan. Date of Enrollment: _____ Date identified for Case Management: _____ Date of Care Treatment Plan: _____ Date Member Entered in Case Management: _____ Primary Diagnosis/Condition: _____	☐ Yes ☐ No
Observations:		
2. Over- and/or Under-Utilization *42 CFR 438.240(b)(3)*	The care treatment plan included documentation of a review of the member's over- and/or under-utilization of resources.	☐ Yes ☐ No
Observations:		
3. Individualized Interventions *URAC 5.0 CM14(b)*	The care treatment plan contains specific individualized, member-level interventions to meet the member's assessed needs.	☐ Yes ☐ No
Observations:		
4. Goals and Objectives *NCQA 2015 Health Plan Standards: Q17.F(12)* *URAC 5.0 CM14(b)*	The care treatment plan goals and objectives are time-limited, prioritized, and measurable.	☐ Yes ☐ No
Observations:		

Case Management Program Evaluation		
Section III: Development of the Care Treatment Plan		
5. Care Management Services *URAC 5.0 CM14(b)(vi)*	The MCO arranged or provided professional care management services performed collaboratively by a team of professionals (which may include physicians, physician assistants, nurses, specialists, pediatricians, pharmacists, behavior health specialists, and/or social workers) appropriate for the member's condition and health care needs.	☐ Yes ☐ No
Observations:		
6. Coordination of Care *Amendment #8 to the MCM Contract: Section 10.2* *URAC 5.0 CM14(b)(vi)*	There is evidence that the MCO facilitated the coordination of the member's care and ensured communication between the member, PCP, specialty care providers, and all other MCO-covered services as well as services provided through the fee-for-service program and non-Medicaid community-based services.	☐ Yes ☐ No
Observations:		
7. Member Participation *Amendment #8 to the MCM Contract: Section 10.3.1.1.* *URAC 5.0 CM14(b)(vi)*	There is evidence that the member assisted in the development of the care treatment plan.	☐ Yes ☐ No
Observations:		
8. PCP Notification *Amendment #8 to the MCM Contract: Section 10.3.1.1.* *URAC 5.0 CM14(b)(vi)*	There is evidence that the PCP assisted in the development of the care treatment plan.	☐ Yes ☐ No
Observations:		
9. Evidence-based Clinical Guidelines *NCQA 2015 Health Plan Standards: QI17.E(1)* *URAC 5.0 CM1(d)*	Documentation in the file indicates that the MCO developed the care treatment plan using best practices or evidence-based clinical guidelines.	☐ Yes ☐ No

Case Management Program Evaluation		
Section III: Development of the Care Treatment Plan		
Observations:		
10. Evaluating Barriers *NCQA 2015 Health Plan Standards: Q17.F(13)*	The care treatment plan evaluated barriers to achieving the goals and provided suggestions to assist the member in overcoming the barriers.	☐ Yes ☐ No
Observations:		
11. Coordination with State Agencies *Amendment #8 to the MCM Contract: Section 10.10* *URAC 5.0 CM15(a)(iii)(b)*	The care treatment plan includes coordination and integration with social services and community care. ☐ A. Juvenile Justice and Adult Community Corrections ☐ B. DHHS Social Services (WIC, Head Start, Community Action Programs, housing, etc.) ☐ C. Community Service Organizations ☐ D. Public Health Agencies ☐ E. Schools ☐ F. Court System ☐ G. ServiceLink Resource Network ☐ H. Housing ☐ I. Other: _____	☐ Yes ☐ No ☐ NA
Observations:		
12. Time Period for Reevaluation *NCQA 2015 Health Plan Standards: QI17.H(3,5)*	The care treatment plan defines the specific length of time established to reevaluate the member's progress.	☐ Yes ☐ No
Observations:		

Case Management Program Evaluation		
Section IV: Reassessment of the Care Treatment Plan		
1. Reassessment of Care Treatment Plan *NCQA 2015 Health Plan Standards: QI17.H(3,5)*	There is evidence that the goals and objectives have been reassessed since the member was placed in case management. Use NA if the time established for the first reassessment is in the future and skip this section. Date member placed in case management: _____ Date if most current review: _____ Date of prior review(s): _____	☐ Yes ☐ No ☐ NA–Date of Reassessment: _____
Observations:		
2. Date of Reassessment *NCQA 2015 Health Plan Standards: QI17.H(3,5)*	The reassessment occurred at the time scheduled in the care treatment plan. Date scheduled for most recent reassessment: _____ Date most recent reassessment occurred: _____	☐ Yes ☐ No
Observations:		
3. Processes Used to Revise the Care Treatment Plan *NCQA 2015 Health Plan Standards: QI17.H(5); QI17.J(6)*	The care management team used processes to revise the care treatment plan. Check all that apply. ☐ A. Face-to-face interview with the member ☐ B. Telephonic interview with member ☐ C. Interviews with family or caregivers ☐ D. Discussions with the PCP ☐ E. Discussions with specialists treating the member ☐ F. Consultation with other members of the interdisciplinary health care team ☐ G. Review of the member's medical records ☐ H. Review of encounter/claims, pharmacy, or utilization data ☐ I. OTHER: _____	☐ Yes ☐ No
Observations:		

Case Management Program Evaluation		
Section IV: Reassessment of the Care Treatment Plan		
4. Monitoring *NCQA 2015 Health Plan Standards: QI17.H(5);* *QI17.J(6)*	There is evidence in the file that there is continuous monitoring of the member to determine the member's achievement towards meeting the goals and objectives established in the care treatment plan.	☐ Yes ☐ No
Observations:		
5. Evaluating and Overcoming Barriers *NCQA 2015 Health Plan Standards: QI17.H(2)*	The reassessment of the care treatment plan included evaluating barriers to achieving the goals and the effectiveness of the suggestions to overcome the barriers.	☐ Yes ☐ No
Observations:		
6. Member Involvement in the Care Plan Revisions *URAC 5.0 CM15(a)(iv)*	The member was consulted prior to establishing the care treatment plan revisions.	☐ Yes ☐ No
Observations:		
7. PCP Involvement in the Care Plan Revisions *URAC 5.0 CM15(a)(iv)*	The PCP was consulted prior to establishing the care treatment plan revisions.	☐ Yes ☐ No
Observations:		
8. PCP Advised *URAC 5.0 CM15(a)(iv)*	There is evidence in the file that the PCP was notified of the revisions to the care treatment plan for the member.	☐ Yes ☐ No
Observations:		

Case Management Program Evaluation		
Section IV: Reassessment of the Care Treatment Plan		
9. Coordination of Care *Amendment #8 to the MCM Contract: Section 10.10* *URAC 5.0 CM15(a)(iii)(b)*	During the time of reassessment of the Care Treatment Plan, there is evidence that the MCO facilitated the coordination of the member's care and included coordination and integration with social services and community care.	☐ Yes ☐ No
Observations:		

Appendix C: New Hampshire Healthy Families File Specifications

Care Management Data File Specifications for New Hampshire Healthy Families	
Information concerning member selection: **A. Look-back Period: Six Months** **B. Members Enrolled in Care Management for 30 Days or Longer** **C. Include Open and Closed Cases** **D. Include Members Enrolled in All Levels of Care Management with the Exception of Low Intensity Levels (e.g., Only Sending Educational Materials to Member, etc.) Requiring no Care Coordination** **E. Include the Specific Reason or Diagnosis that Triggered Enrollment in Care Management (e.g., Pregnancy, Diabetes, Hypertension, COPD, CHF, etc.)** **F. SEND TWO FILES: One File with Members Enrolled in the MCO Prior to July 1, 2015 and One File with Members Enrolled On or After July 1, 2015** **G. Data Files are to be Posted to the HSAG FTP Site in the Focus Group Information Folder On or Before February 12, 2016**	
1	Medicaid Identification Number
2	Date of Enrollment in NHHF
3	Member's Last Name
4	Member's First Name
5	Member's Middle Initial
6	Address: City
7	Address: Zip Code
8	Date of Birth
9	Program Designation: Foster Care (Yes or No)
10	Program Designation: Long Term Care (Yes or No)
11	Program Designation: Medicaid Expansion (Yes or No)
12	Program Designation: SSI (Yes or No)
13	Program Designation: Low Income Non-expansion Population (Yes or No)
14	Specific Reason Member was Enrolled in Care Management as Defined by the MCO's Eligibility Determination (e.g., Pregnancy, Diabetes, Hypertension, COPD, CHF, etc.)
15	Method Used to Identify the Member for Care Management (e.g., Claims, New Member Call, Provider Referral, etc.)
16	Date of Enrollment in Care Management
17	Date care management file closed (If Applicable)
18	Currently in Integrated Care Management: Complex Care Management (Yes or No)
19	Currently in Integrated Care Management: Care Coordination (Yes or No)

Appendix D: Well Sense File Specifications

Care Management Data File Specifications for Well Sense	
Information concerning member selection: **A. Look-back Period: Six Months** **B. Members Enrolled in Care Management for 30 Days or Longer** **C. Include Open and Closed Cases** **D. Include Members Enrolled in All Levels of Care Management with the Exception of Low Intensity Levels (e.g., Only Sending Educational Materials to Member, etc.) Requiring no Care Coordination** **E. Include the Specific Reason or Diagnosis that Triggered Enrollment in Care Management (e.g., Pregnancy, Diabetes, Hypertension, COPD, CHF, etc.)** **F. SEND TWO FILES: One File with Members Enrolled in the MCO Prior to July 1, 2015 and One File with Members Enrolled On or After July 1, 2015** **G. Data Files are to be Posted to the HSAG FTP Site in the Focus Group Information Folder On or Before February 12, 2016**	
1	Medicaid Identification Number
2	Date of Enrollment in Well Sense
3	Member's Last Name
4	Member's First Name
5	Member's Middle Initial
6	Address: City
7	Address: Zip Code
8	Date of Birth
9	Program Designation: Foster Care (Yes or No)
10	Program Designation: Long Term Care (Yes or No)
11	Program Designation: Medicaid Expansion (Yes or No)
12	Program Designation: SSI (Yes or No)
13	Program Designation: Low Income Non-expansion Population (Yes or No)
14	Specific Reason Member was Enrolled in Care Management as Defined by the MCO's Eligibility Determination (e.g., Pregnancy, Diabetes, Hypertension, COPD, CHF, etc.)
15	Method Used to Identify the Member for Care Management (e.g., Claims, New Member Call, Provider Referral, etc.)
16	Date of Enrollment in Care Management
17	Date Care Management File Closed (if applicable)
18	Currently in Complex Care Management (Yes or No)
19	Currently in Population-Based Care Management (Yes or No)
20	Currently in Integrated Social Care Management (Yes or No)

Appendix E: Stratification of Members

NHHF

NHHF used two levels of stratification to identify the members included in the study: Complex care management and care coordination.

- Complex care management is a high level of care management services for members with complex needs, including members classified as children or adults with special health care needs (SHCN); those with catastrophic, high-cost, high-risk, or comorbid conditions; those who have been non-adherent in less intensive programs; or those who are frail, elderly, disabled, or at the end of life.[11]
- Care Coordination is appropriate for members with primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services. Care coordination typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor medical or behavioral health concerns arise.[12]
- **NHHF** also contacted members discharged from an inpatient facility within 72 hours of discharge to assist with transition of care.

Well Sense

Well Sense used three levels of stratification to identify the members included in the study: Complex care management, population-based care management, and integrated social care management.

- Complex care management is the most intense level of care management at **Well Sense** targeting the most complex, highest-risk members, including those with SHCN. This level of care management involves a multidisciplinary approach to the comprehensive assessment of the member's condition, consensual face-to-face member meetings, coordination of care through the health care continuum, and determination of available benefits and resources, including family support and community resources.[13]
- Population-based care management is the intermediate level of care management which includes arranging services for members with specific medical, behavioral, and social needs and interventions for specified diagnoses, including, but not limited to diabetes and asthma. This involves the assessment of the member's condition telephonically, coordination of care, and

[11] Granite State Health Plan. (2015).*Granite State Health Plan Care Management Program Description*.
[12] Ibid.
[13] Boston Medical Center. (2015). *Boston Medical Center HealthNet Plan and Well Sense Health Plan Care Management Program.*

determination of available benefits and resources, including family support and community resources.[14]

- Integrated social care management provides a multi-disciplinary, co-managed approach to support the member's psychosocial care needs. A social care manager collaboratively assesses the needs of the member and the member's family/caregivers when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for services to meet the specific member's needs.[15]
- **Well Sense** also provided a Transition to Home level of care management for members discharged from an inpatient stay.

[14] Ibid.
[15] Ibid.