

State of New Hampshire



Department of Health and Human Services

# **New Hampshire External Quality Review Technical Report**

## **SFY 2013–2014**

November 2014



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## ABBREVIATIONS AND ACRONYMS

### Commonly Used Abbreviations and Acronyms

Following is a list of abbreviations and acronyms used throughout this report.

- ◆ **AHRQ**—Agency for Healthcare Research and Quality
- ◆ **BBA**—federal Balanced Budget Act of 1997
- ◆ **BCCP**—Breast and Cervical Cancer Program
- ◆ **BMI**—Body Mass Index
- ◆ **CAHPS**<sup>®</sup>—Consumer Assessment of Healthcare Providers and Systems<sup>1</sup>
- ◆ **CAP**—corrective action plan
- ◆ **CCC**—Children with Chronic Conditions
- ◆ **CFR**—Code of Federal Regulations
- ◆ **CHIP**—Children’s Health Insurance Program
- ◆ **CMS**—Centers for Medicare & Medicaid Services
- ◆ **DHHS**—State of New Hampshire, Department of Health and Human Services
- ◆ **EPSDT**—Early and Periodic Screening, Diagnosis, and Treatment
- ◆ **EQR**—external quality review
- ◆ **EQRO**—external quality review organization
- ◆ **FCC**—Family Centered Care
- ◆ **FFS**—fee-for-service
- ◆ **FQHC**—Federally Qualified Health Centers
- ◆ **FSS**—final sample size
- ◆ **FTP**—file transfer protocol
- ◆ **HEDIS**<sup>®</sup>—Healthcare Effectiveness Data and Information Set<sup>2</sup>
- ◆ **HMO**—Health Maintenance Organization
- ◆ **HSAG**—Health Services Advisory Group, Inc.
- ◆ **ID**—Identification

<sup>1</sup> CAHPS<sup>®</sup> is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

<sup>2</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

- ◆ **IQAP**—Internal Quality Assurance Program
- ◆ **ISCAT**—Information System Capability Assessment Tool
- ◆ **MACPAC**—Medicaid and CHIP Payment and Access Commission
- ◆ **MCM**—Medicaid Care Management
- ◆ **MCO**—managed care organization
- ◆ **MMIS**—Medicaid Management Information Systems
- ◆ **NB**—no benefit
- ◆ **NCQA**—National Committee for Quality Assurance
- ◆ **NH Healthy Families**—New Hampshire Healthy Families
- ◆ **NR**—not reported
- ◆ **OMBP**—Office of Medicaid Business and Policy
- ◆ **PCPs**—primary care physicians
- ◆ **PIHP**—prepaid inpatient health plans
- ◆ **PIP**—performance improvement project
- ◆ **PMV**—performance measure validation
- ◆ **QAPI**—Quality Assessment and Performance Improvement
- ◆ **QI**—quality initiatives
- ◆ **QIP**—Quality Incentive Program
- ◆ **R**—report
- ◆ **RFP**—request for proposal
- ◆ **RHC**—Rural Health Centers
- ◆ **SFY**—state fiscal year

## 1. EXECUTIVE SUMMARY

### Overview of the SFY 2013–2014 External Quality Review (EQR) Activities

The federal Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires state Medicaid agencies that contract with Medicaid MCOs to use an external quality review organization (EQRO) to review the quality, timeliness, and access to care and services provided to Medicaid members by Medicaid MCOs. The BBA also requires states to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' MCOs. The data used to prepare the annual technical report are derived from activities conducted in accordance with the information found in the Code of Federal Regulations (CFR), 42 CFR 438.358. To meet these requirements, the State of New Hampshire, Department of Health and Human Services (DHHS) Office of Medicaid Business and Policy (OMBP) contracted with Health Services Advisory Group, Inc. (HSAG), to perform the EQR activities for the State. HSAG began working with DHHS in August 2013.

As stated in the Quality Strategy for the New Hampshire Medicaid Care Management Program dated July 8, 2014, “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.”<sup>3</sup> To meet those goals, DHHS contracted with three MCOs to provide Medicaid services to members beginning in December 2013: **Meridian Health Plan (Meridian)**, **New Hampshire Healthy Families (NH Healthy Families)**, and **Well Sense Health Plan (Well Sense)**. Because the MCOs only operated for seven months during state fiscal year (SFY) 2013–2014, some of the EQRO activities were planned or initiated but not completed during the fiscal year.

The SFY 2013–2014 EQR Technical Report describes how data from activities conducted in accordance with 42 CFR 438.364 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Medicaid recipients by the New Hampshire MCOs. The report contains an assessment of the MCOs’ strengths and weaknesses, as well as recommendations for improvement, and includes a comparison of the health plans that operated in the New Hampshire Medicaid Care Management Program.

One mandatory activity was completed during SFY 2013–2014 (i.e., MCO contractual compliance), and the other two mandatory activities were initiated (i.e., evaluation of MCO

<sup>3</sup> New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy. (2014). *Quality Strategy for the New Hampshire Medicaid Care Management Program*. Available at: <http://www.dhhs.nh.gov/ombp/quality/documents/quality-strategy.pdf>. Accessed on: Oct 3, 2014.

programs and projects and validation of MCO performance measures). Optional EQR activities initiated or completed included a CAHPS survey, encounter data validation, and performance measure reporting. Additional activities initiated or completed included focus groups, access reporting, and the CMS Adult Core Set Measures. This report includes the following for each EQR activity completed:

- ◆ Objectives
- ◆ Technical methods of data collection and analysis
- ◆ A description of the data obtained
- ◆ Conclusions drawn from the data

The SFY 2013–2014 EQR Technical Report includes the findings from the completed activities and a description of the status of the remaining activities as of June 30, 2014.

## Findings, Conclusions, and Recommendations Concerning the Quality of Care, Timeliness of Care, and Access to Care

HSAG, as the EQRO for New Hampshire, conducted EQR activities and analyzed the results of the completed activities as described in the next sections of this report. A complete description of each activity and a detailed explanation of the methodology, findings, and recommendations can be found in Sections 4–12 of this report.

## Managed Care Organization (MCO) Contractual Compliance

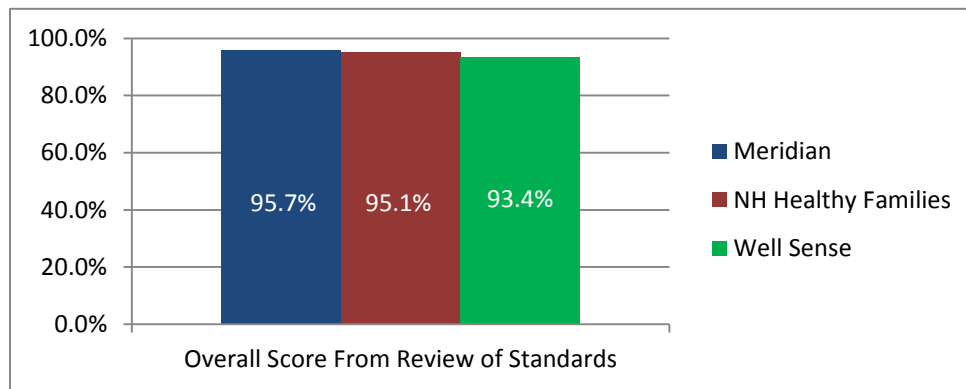
The BBA requires a state or its EQRO to conduct a review within a three-year period to determine a Medicaid MCO's compliance with the standards established by the state concerning access to care, structure and operations, and quality measurement and improvement. To meet this requirement, HSAG performed a comprehensive assessment of each MCO's internal quality assurance program (IQAP) during an on-site compliance review. The review included the three MCOs originally contracted to provide services in the New Hampshire Care Management Program: **Meridian**, **NH Healthy Families**, and **Well Sense**. HSAG completed the reviews in April and May 2014.

The overall score generated from the on-site review included 14 standards derived from the BBA and the New Hampshire Medicaid Care Management Program Agreement. The standards involved reviewing requirements for delegation, plans that the MCOs were required to create (e.g., Emergency Response Plan, Communications, et.), emergency and poststabilization care, care management/care coordination, wellness and prevention, behavioral health, enrollment and disenrollment, member services, cultural considerations, grievances and appeals, access, network management, utilization management, and quality management. All three MCOs achieved strong



overall compliance scores that ranged within 2.3 percentage points from the highest to the lowest score as shown in Figure 1-1.

**Figure 1-1—Overall Scores From the Review of 14 Standards**



In addition to the 14 standards, HSAG also evaluated checklists with requirements for access standards, the call center, culturally and linguistically appropriate services, the provider directory, the member handbook, identification card requirements, the MCO Web site, network management, notice requirements, and member rights. The overall checklist scores for the three MCOs were similar, with the MCOs achieving the following scores: **Meridian**—99.5 percent, **NH Healthy Families**—98.5 percent, and **Well Sense**—97.1 percent. The final ratings from the on-site review included scores generated from file reviews for grievances, denials, appeals, credentialing, and recredentialing. **Well Sense** was the only health plan with providers who were recredentialed during the review period. The overall file review scores for the three MCOs show that **Well Sense** achieved a nearly perfect score with 99.5 percent, and the other two MCOs scored 90.7 percent (**Meridian**) and 89.3 percent (**NH Healthy Families**).

Nearly all the recommendations generated from the compliance review for the three MCOs related to ensuring that policies, procedures, and plan documents included a few of the specific requirements found in the Medicaid Care Management Program Agreement between the MCOs and DHHS. HSAG also found that **Well Sense** must develop an after-hours provider inquiry line with the capability of informing callers about operating hours and instructions on how to verify enrollment for a member with an emergency or urgent medical or behavioral health condition. Credentialing files from **Meridian** and **NH Healthy Families** lacked validation of hospital affiliations, and a few files from these two MCOs failed to be processed within 30 days of receipt of a completed application for primary care providers (PCPs) and within 45 days for specialists. Two of the **NH Healthy Families** credentialing files did not contain proof of current malpractice insurance coverage on the date the file was approved by the Credentialing Committee.

The checklist review revealed that **Meridian** and **NH Healthy Families** lacked documentation to support at least one specialist located within 60 minutes or 45 miles of each member, **Well Sense** lacked documentation to support at least one tertiary or specialized service facility within 120 minutes or 80 miles of each member, **NH Healthy Families** did not include information

concerning the structure and operation of the MCO in the required documents, and **Well Sense** needed to include information about Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) on the searchable provider Web site and in the provider manual. Review of the appeals files revealed that **NH Healthy Families** and **Well Sense** must ensure that appeals are processed within 30 calendar days after receipt unless the MCO notifies the member that an extension is necessary to complete the appeal.

The scores achieved by the MCOs confirmed that their strengths include having policies and processes in place to monitor and evaluate the requirements established by the BBA and DHHS concerning the quality of care and services, the timeliness of care and services, and access to care and services. The review also validated that the MCOs have processes and mechanisms in place to identify issues and create targeted interventions to ensure that the New Hampshire Medicaid Care Management Program operates according to federal and State requirements. The complete description of the SFY 2013–2014 compliance activities is included in Section 4 of this report.

## Evaluation of MCO Programs and Projects

As described in 42 CFR 438.240(b)(1) and in accordance with 42 CFR 438.240(d), DHHS requires the MCOs to perform a minimum of four performance improvement projects (PIPs) annually with at least one PIP focusing on behavioral health. The MCOs have the freedom to choose the PIP topics; however, the topics need to be supported by quantitative and qualitative evidence to ensure that they will improve care for the membership in the New Hampshire Medicaid Care Management Program. When HSAG began conducting PIP activities in New Hampshire, three MCOs were involved in the process: **Meridian**, **NH Healthy Families**, and **Well Sense**. As the activities progressed, **Meridian** exited the New Hampshire Medicaid market, and the PIPs continued with the remaining two health plans.

Figure 1-2 shows the PIP topics chosen by **NH Healthy Families**, which represent key areas of focus for improvement. The health plan's PIP topics address the CMS' requirements related to quality outcomes: quality, timeliness of, and access to, care and services.

**Figure 1-2—NH Healthy Families PIP Topics**

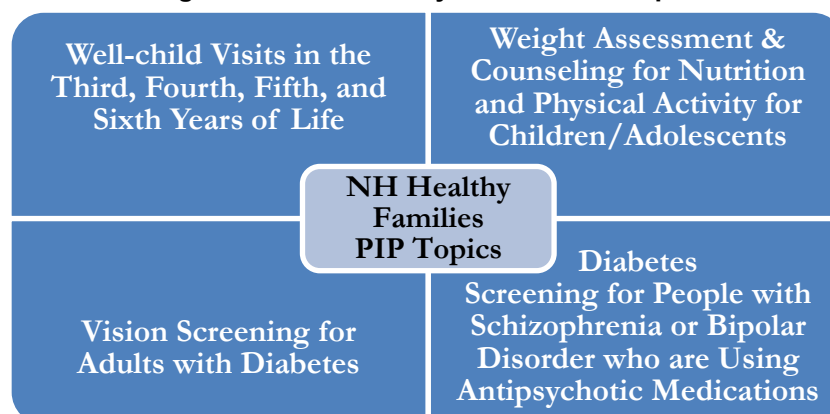
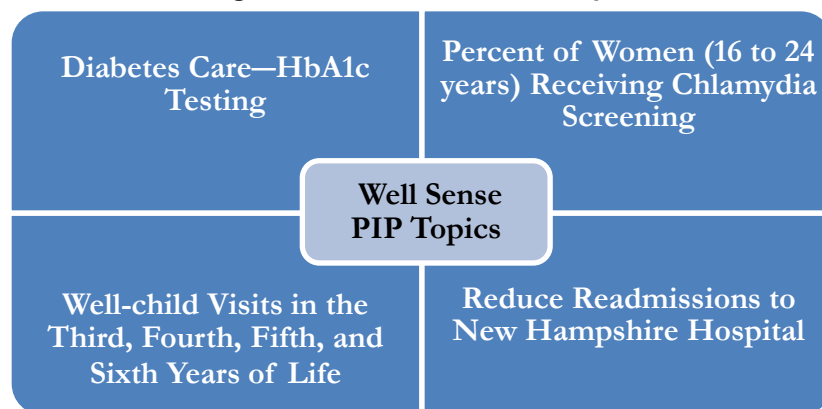


Figure 1-3 displays the PIP topics chosen by **Well Sense**, which represent key areas of focus for improvement. The health plan's PIP topics also addressed CMS' requirements related to quality outcomes: quality, timeliness of, and access to, care and services.

**Figure 1-3—Well Sense PIP Topics**



The MCOs also are required to perform four quality incentive program (QIP) projects each year with the topics defined by DHHS. The four QIPs defined by DHHS include:

- ◆ Timeliness of Prenatal Care, including the Prenatal and Postpartum Care—Timeliness of Prenatal Care (Healthcare Effectiveness Data and Information Set [HEDIS] measure component).
- ◆ Follow-up after Hospitalization for Mental Illness Within Seven Days of Discharge for beneficiaries age six and older at the time of discharge, including the hospitalizations in New Hampshire Hospital (HEDIS measure).
- ◆ Parental Satisfaction with Children Getting Appointments for Care (CAHPS measure).
- ◆ Satisfaction with Getting Appointments for Care (CAHPS Adult Survey).

HSAG classifies the progression of PIPs and QIPs in three stages: Design, Implementation, and Outcomes. During SFY 2013–2014, HSAG supplied the MCOs with a summary form to use in the submission of the PIP/QIP documentation to support the creation of the projects. Through the validation process, HSAG will assess the study methodology, verify study findings, and provide an overall evaluation of the validity and reliability of the PIPs/QIPs submitted by the MCO.

HSAG will perform an interim evaluation to assess and validate the design of the PIPs/QIPs. The interim evaluation will verify that the PIPs/QIPs are structured in a methodologically sound manner and that they will study what they are intended to study. HSAG's interim evaluation reports will include the background information on the areas evaluated, the methods used to conduct the evaluation, the findings/results, and a scored validation tool for each PIP/QIP. HSAG will also provide recommendations to strengthen the design of the projects and/or to improve any planned interventions that the MCO is considering.

After 12 months, HSAG will evaluate the Implementation stage by reviewing the baseline data collection and analysis. In future years, once the PIPs/QIPs have progressed to a point of remeasurement, HSAG will validate the PIPs/QIPs through the Outcomes' stage to determine if changes in indicator rates were statistically significant over baseline. HSAG also will determine if the improvement was sustained through a subsequent measurement period. In addition to analyzing and reporting the MCO's PIP/QIP study indicator results, HSAG will provide a critical evaluation of the MCO's causal/barrier analyses and evaluate the effectiveness of the interventions. This critical review will determine if the MCO's barrier analysis was rigorous and sufficient to identify appropriate interventions with the potential to bring about real improvement.

The documentation supporting the design of the PIPs/QIPs will be submitted to HSAG in SFY 2014–2015 for validation. The complete description of the progress of the SFY 2013–2014 PIP/QIP activities is included in Section 5 of this report.

## Validation of MCO Performance Measures

Validation of the MCOs' performance measures is required by 42 CFR 438.358(b)(2), and CMS-established protocols to be used during the performance measure validation (PMV) activities. When HSAG began conducting PMV activities in March 2014, three MCOs were involved in the process: **Meridian**, **NH Healthy Families**, and **Well Sense**. As the activities progressed, **Meridian** exited the New Hampshire Medicaid managed care program, and the PMV activities continued with the remaining two health plans.

DHHS required the contracted MCOs to report a list of measures during the first year of operation, and 34 measures were validated by HSAG.<sup>4</sup> In general, these measures included ambulatory care visits, timely processing of appeals, appeals by reason type, timely claim processing, member communication, provider communication, details of pharmacy payments, polypharmacy monitoring, timely processing of prior authorization requests, and member-provider ratios. Section 6 of this report contains the list of performance measures validated for SFY 2013–2014.

In conducting the SFY 2013–2014 PMV activities, HSAG focused on the following objectives:

- ◆ Assessing the accuracy of the required performance measures reported by the MCOs
- ◆ Determining the extent to which the measures calculated by the MCOs follow DHHS' specifications and reporting requirements
- ◆ Conducting an information system readiness review for the MCOs in preparation for HEDIS 2015 reporting

<sup>4</sup> New Hampshire Department of Health and Human Services Office of Medicaid Business and Policy. (2014). *Quality Strategy for the New Hampshire Medicaid Care Management Program*. Retrieved from <http://www.dhhs.nh.gov/ombp/quality/documents/quality-strategy.pdf>

HSAG conducted the SFY 2013–2014 PMV activities based on the CMS protocol for conducting PMV. The PMV activities can be organized into three phases: pre-on-site, on-site, and post-on-site. At the time of preparing this technical report, HSAG initiated the pre-on-site activities. The 2013–2014 PMV activities and reports are scheduled to be completed by HSAG in November 2014, and the results will be reported in the SFY 2014–2015 New Hampshire EQR Technical Report. The complete description of the SFY 2013–2014 PMV activities is included in Section 6 of this report.

## Other EQR Activities in SFY 2013–2014

### CAHPS

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The CAHPS survey is recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting data. At the end of SFY 2012–2013, DHHS contracted with HSAG to conduct CAHPS surveys of their child Medicaid Fee-for-Service (FFS) and Children’s Health Insurance Program (CHIP) populations.

For purposes of this report, survey findings for the child Medicaid FFS and CHIP populations’ survey findings were compared to the 2013 National Committee for Quality Assurance (NCQA) CAHPS Child Medicaid national averages.<sup>5,6</sup> For each population, a measure was noted when the measure’s rate was at least 5 percentage points higher or lower than the NCQA national average.

- ◆ In 2013, a total of 2,042 CHIP members were surveyed, and 913 completed surveys were returned on behalf of CHIP members. After ineligible members were excluded, the response rate was 46.2 percent.<sup>7</sup> The CHIP 2013 top-box rates (e.g., a response value of 9 or 10 on a scale of 0 to 10, Usually/Always, or Yes) for the general child population were lower than the 2013 NCQA child Medicaid national averages for two of the nine comparable measures: *Rating of Health Plan* and *Rating of Specialist Seen Most Often*. Furthermore, the rate for *Rating of Specialist Seen Most Often* was lower than the NCQA national average by 5 percentage points or more. However, for the remaining seven comparable measures, the CHIP 2013 top-box rates for the general child population were higher than the 2013 NCQA child Medicaid average. For *Getting*

<sup>5</sup> Since NCQA does not publish separate benchmarking data for the CHIP population, NCQA national averages for the child Medicaid population are used for comparative purposes. Therefore, caution should be exercised when interpreting the results of the NCQA national average comparisons for the CHIP population.

<sup>6</sup> National data were obtained from Quality Compass®.

<sup>7</sup> The survey disposition and response rate results are based on the responses of parents/caretakers of CHIP beneficiaries in the general child and CCC supplemental populations.

*Needed Care*, *Getting Care Quickly*, and *Coordination of Care*, the measures were higher than the 2013 NCQA national average by 5 percentage points or more.

- ◆ The CHIP 2013 top-box rates for the Children with Chronic Conditions (CCC) population were lower than the 2013 NCQA child Medicaid national averages for five of the 14 comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Customer Service*. Of these five measures, the rate for the *Rating of Health Plan* was lower than the NCQA national average by 5 percentage point or more. For the CHIP CCC population, the 2013 top-box rates were higher than the 2013 NCQA child Medicaid national average for nine comparable measures. Of these nine measures, the rate for *Access to Specialized Services* CCC measure was higher than the 2013 NCQA national average by 5 percentage points or more.
- ◆ In 2013, a total of 3,490 child Medicaid FFS beneficiaries were surveyed, and 1,183 completed surveys were returned on behalf of child beneficiaries. After ineligible beneficiaries were excluded, the response rate was 34.6 percent.<sup>8</sup> For the Child Medicaid FFS general child population, the 2013 top-box rates for three of the nine comparable measures (*Rating of Health Plan*, *Rating of Specialist Seen Most Often*, and *Customer Service*) were lower than the 2013 NCQA child Medicaid national averages. Furthermore, the rates for two of these measures, *Rating of Health Plan* and *Customer Service*, were lower than the NCQA national average by 5 percentage points or more. However, for the remaining six comparable measures, rates for the Child Medicaid FFS general child population were higher than the 2013 NCQA national average. Moreover, of the six measures, rates for two measures (*Getting Needed Care* and *Coordination of Care*) were higher than the 2013 NCQA child Medicaid national average by 5 percentage points or more.
- ◆ The Child Medicaid FFS 2013 top-box rates for the CCC population were lower than the 2013 NCQA child Medicaid national average for seven of the 14 comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Customer Service*, *Access to Specialized Services*, and *FCC: Getting Needed Information*. Of these seven measures, the rates for *Rating of Health Plan* and *Customer Service* were below the NCQA national average by 5 percentage points or more. Rates for the remaining seven comparable measures were higher than the 2013 NCQA child Medicaid national average; however, the difference in rates was minor.

The complete list of results from the CAHPS survey is included in Section 7 of this report.

<sup>8</sup> The survey disposition and response rate results are based on the responses of parents/caretakers of child Medicaid FFS beneficiaries in the general child and CCC supplemental populations.



## **Focus Groups**

In support of HSAG's EQR of New Hampshire's Medicaid Care Management Program, HSAG selected Horn Research to perform the tasks associated with gathering qualitative information from Medicaid beneficiaries regarding their experience with the transition to the Medicaid Care Management Program. In conjunction with DHHS and HSAG, Horn Research identified four Key Points of Inquiry to explore during data collection efforts: Experience With Medicaid Care Management, Access to Care, Quality of Care and Care Management, and Information Needs. In May 2014, Horn Research conducted four focus groups and stakeholder interviews in Manchester, New Hampshire, and Laconia, New Hampshire, with targeted Medicaid MCO members.

### **Experience with Medicaid Care Management**

Participants said they had sufficient notification of the change to managed care but did not feel adequately prepared to decide between MCOs. Most participants selected the MCO that included their PCP in the network rather than the MCO that provided the best coverage for their needs. Overall, participants said they did not understand their MCO and did not know how to find out about or understand coverage details.

### **Access to Care**

Overall, participants said that access to their doctors has remained the same. The main concerns expressed about access were related to medications and specialists. Many participants said they had experienced challenges with medications not being covered under the new MCO and delays in receiving prescriptions and referrals to specialists due to the pre-authorization process.

### **Quality of Care and Care Management**

Participants were evenly divided on the assessment of the quality of their PCP but did not necessarily relate that assessment to their MCO. For those who required care coordination, most felt their care was coordinated adequately. Nearly all participants felt they had an active role in making decisions about their health care and their children's health care.

### **Information Needs**

In general, participants did not report receiving useful information from their MCO; in fact, most said they had not received any information. Information on physician quality and clear information on benefits and coverage were most frequently mentioned as information needs and desires. While a small number of participants were comfortable and preferred online resources, the majority of people said they preferred to receive information in hard-copy format.

### **Improvements to MCO and Medicaid**

In general, participants had difficulty distinguishing between the roles of the MCO and Medicaid, which resulted in some overlap in responses for improvements for each. Overall, participants

would like to see their MCO expand benefits to include more dental care and prescription medications. Participants would like Medicaid to expand eligibility to include more adults and to provide clearer information on eligibility rules.

The participants offered suggestions to improve the Medicaid Care Management Program and made recommendations in the following five categories: Improving Benefit and Coverage Information, Improving the Prescription Pre-Authorization Process, Expanding Physician Information, Tailoring Health Education Materials, and Expanding Health Benefits. The discussions surrounding these topics are highlighted in Section 8 of this report.

### ***Encounter Data Validation***

At the end of SFY 2013–2014, HSAG had not received encounter data. HSAG will develop a methodology for New Hampshire encounter data validation in collaboration with DHHS as data become available. The results from the SFY 2013–2014 encounter data validation activities will be included in the New Hampshire EQR Technical Report for SFY 2014–2015.

### ***Access Reporting***

HSAG continues to work with DHHS to determine the format and contents of the data to be used in developing the New Hampshire Medicaid access reports. At the end of fiscal year 2013–2014, HSAG received data files and began the data-mining process to determine the format and contents of the files. The results from the access reports covering SFY 2013–2014 for the New Hampshire Medicaid beneficiaries will be included in the New Hampshire EQR Technical Report for SFY 2014–2015.

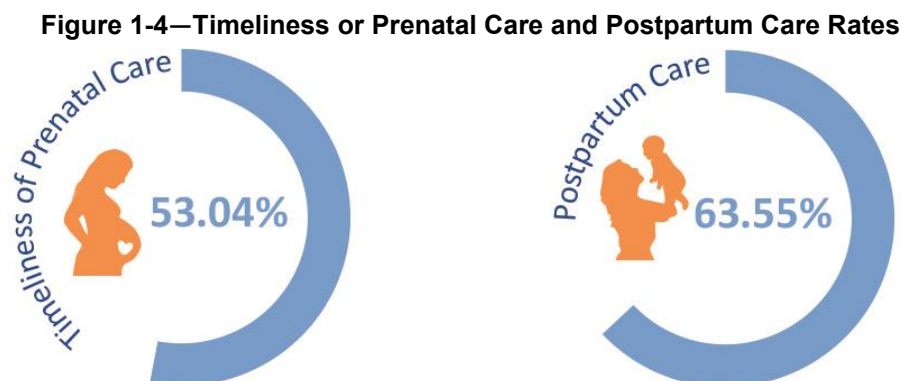
### ***CMS Adult Core Set Measures***

In December 2012, CMS initiated the Adult Medicaid Quality Grant Program to measure and improve the quality of care for Medicaid beneficiaries. The grant supports state Medicaid agencies in collecting, reporting, and analyzing data on the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid. New Hampshire was one of the 26 states to participate in the program.<sup>9</sup> During SFY 2013–2014, DHHS contracted with HSAG to produce the rates for the HEDIS *Prenatal and Postpartum Care* measure for the population included in the New Hampshire Adult Medicaid Quality Grant (i.e., FFS population).

<sup>9</sup> Department of Health and Human Services Centers for Medicare & Medicaid Services. (n.d.) *Adult Medicaid Quality Grants*. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Medicaid-Quality-Grants.html>



Figure 1-4 displays the rates achieved for the *Prenatal Care* and *Postpartum Care* measures.



The national benchmarks available for comparing the New Hampshire rates for the two components of this measure are from the 2013 HEDIS national Medicaid benchmarks for Health Maintenance Organizations (HMOs). Although this study was conducted using women in FFS Medicaid in New Hampshire and the HEDIS benchmarks are from women in HMOs, HSAG is presenting the 2013 HEDIS national Medicaid benchmarks to allow DHHS to compare the FFS beneficiary rates to the national Medicaid HMO member rates. DHHS exceeded the 2013 national average for the *Postpartum Care* measure component (63.05 percent) but was well below the 2013 national average for the *Timeliness of Prenatal Care* measure component (82.93 percent).

Key areas of focus for improving these measure rates should be provider education and member education. Providers should be further educated on HEDIS specifications and the numerator requirements for women to be counted as part of measure calculations. Beneficiary education regarding pregnancy also is important, as a healthy pregnancy begins even before a woman becomes pregnant. Beneficiaries should be knowledgeable about available health plans or clinics to provide prenatal care, vital prenatal care activities and tests, and postpartum care. As with all studies involving medical record procurement, the rate of records requested is influenced by available provider demographic information, the quality of the submitted documentation, and the willingness of the provider to release the requested documentation. Therefore, provider education is an important aspect in planning future studies.

The complete description of the SFY 2013–2014 CMS Adult Core Set Measures activities is included in Section 11 of this report.

### ***Performance Measure Reporting***

At the end of SFY 2013–2014, HSAG was working with DHHS to develop a list of the measures to be reported by the MCOs for the period of operation ending June 30, 2014. Also, HSAG had not received the necessary data from the MCOs to calculate performance measure rates at the end of SFY 2013–2014. Performance measure results and their comparisons will be included in the New Hampshire EQR Technical Report for SFY 2014–2015.

## 2. OVERVIEW OF THE MEDICAID CARE MANAGEMENT PROGRAM

### History of the New Hampshire Medicaid Care Management Program

In June 2011, the New Hampshire State Legislature passed SB 147 (Chapter 125, Laws of New Hampshire 2011), which required the State of New Hampshire, DHHS, OMBP, to develop a comprehensive statewide Care Management Program for all New Hampshire Medicaid members. DHHS released a request for proposal (RFP) for Medicaid Care Management Services on October 17, 2011. On May 9, 2012, New Hampshire's Executive Council voted to approve the contract with the vendors to implement care management for New Hampshire's Medicaid program. On August 24, 2012, CMS approved New Hampshire's State plan to implement Medicaid managed care statewide. The Care Management Program became operational and began providing services to Medicaid members on December 1, 2013.

The federal BBA, Public Law 105-33, requires State Medicaid agencies that contract with MCOs to use an EQRO to review the quality, timeliness of, and access to, care and services provided to Medicaid members by Medicaid MCOs. An EQRO may be contracted with states to conduct this work. After a competitive procurement process, DHHS awarded a contract to HSAG to conduct EQR services for the New Hampshire Medicaid Care Management Program. HSAG commenced services in August 2013.

### Demographics of the New Hampshire Medicaid Care Management Program

The demographics displayed in Table 2-1 and Table 2-2 below were derived from the New Hampshire Medicaid Care Management (MCM) Monthly Enrollment Report published by DHHS on June 2, 2014. Table 2-1 includes the overall enrollment in the three MCOs from the beginning of the Medicaid Care Management Program on December 1, 2013, until June 1, 2014. Table 2-1 also displays the number of beneficiaries receiving Medicaid but not enrolled in an MCO (i.e., Non-MCM).

**Table 2-1—Trend in Enrollment in Medicaid Care Management and Non-Medicaid Care Management as of June 1, 2014**

Trend in Overall Enrollment by Health Plan and Non-MCM June 1, 2014							
	12/1/2013	1/1/2014	2/1/2014	3/1/2014	4/1/2014	5/1/2014	6/1/2014
Meridian	25,231	26,329	27,209	28,614	29,258	30,090	30,336
NH Healthy Families	34,855	36,166	37,249	38,083	38,857	39,911	40,223
Well Sense	44,168	45,586	46,639	47,669	48,028	49,151	49,231
<b>Total MCM</b>	<b>104,254</b>	<b>108,081</b>	<b>111,097</b>	<b>114,366</b>	<b>116,143</b>	<b>119,152</b>	<b>119,790</b>
Non-MCM	26,147	25,186	22,772	18,775	17,708	17,450	16,306

Table 2-2 displays the population by eligibility categories for the three MCOs and the Medicaid beneficiaries in the non-MCM program.

**Table 2-2—Current Month Eligibility Category Groups by Health Plan and Non-MCM as of June 1, 2014**

Eligibility Category Groups by Health Plan and Non-MCM June 1, 2014						
	Low-Income Children (Age 0–18)	Children With Severe Disabilities (Age 0–18)	Foster Care & Adoption Subsidy (Age 0–25)	Low-Income Adults & BCCP* (Age 19–64)	Adults With Disabilities (Age 19–64)	Elderly & Elderly With Disabilities (Age 65+)
Meridian	20,892	235	374	3,720	4,277	838
NH Healthy Families	28,646	229	555	4,913	4,814	1,066
Well Sense	35,899	228	601	6,170	5,245	1,088
Non-MCM	3,001	983	459	1,758	4,513	5,592
Percent MCM	96.6%	41.3%	76.9%	89.4%	76.1%	34.9%
*Breast and Cervical Cancer Program						

The 10 counties in New Hampshire are grouped into two geographic regions. The two geographic regions include metropolitan counties (i.e., Rockingham, Hillsborough, and Strafford) and non-metropolitan counties (i.e., Belknap, Carroll, Cheshire, Coos, Grafton, Merrimack, and Sullivan). Figure 2-1 displays the membership in the metropolitan and non-metropolitan counties. As a percentage of the plan's total population, **Meridian** has the greatest percentage of members in the metropolitan counties, and **Well Sense** has the greatest percentage of members in the non-metropolitan counties.

**Figure 2-1—Geographic Region for Membership in Medicaid Care Management and Non-Medicaid Care Management as of June 1, 2014**

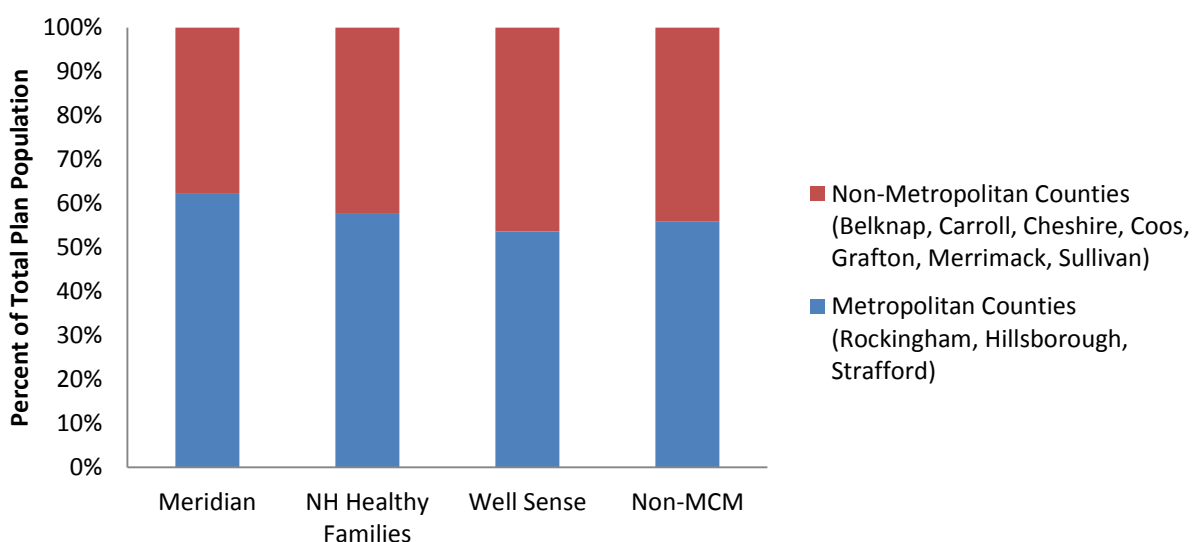
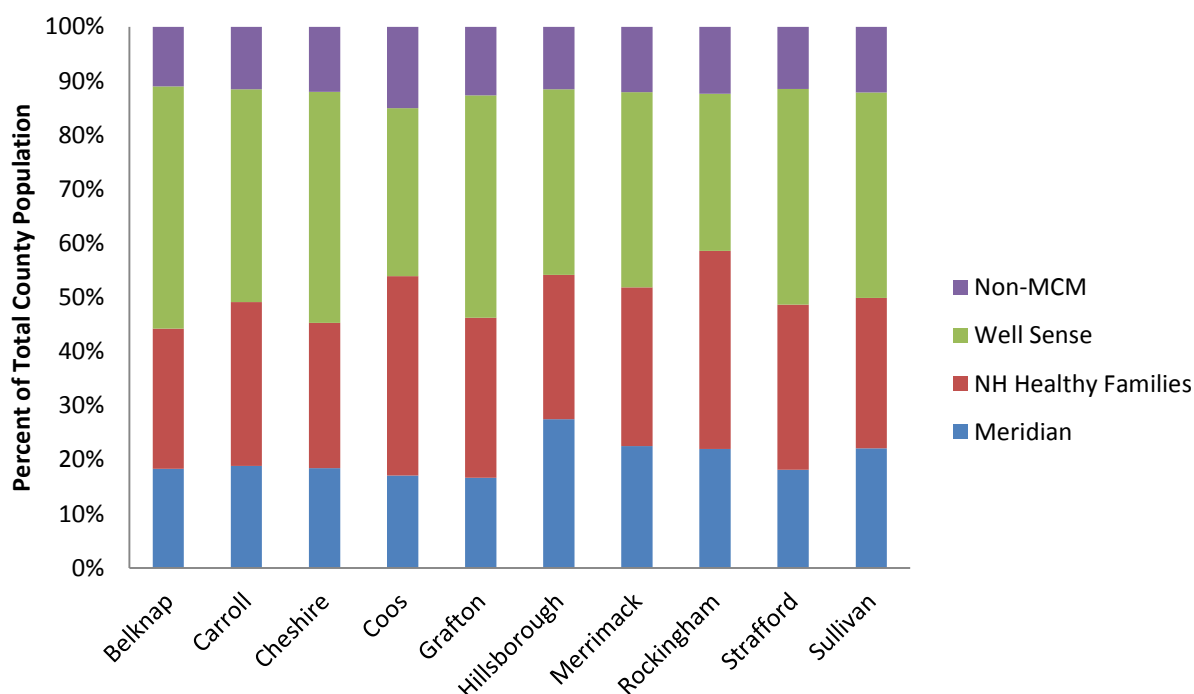


Figure 2-2 shows each of the 10 counties and the county membership in the three MCOs and in non-Medicaid Care Management. Although there is some variation of the number of members in each MCO in each county, overall the percentage of members in all three MCOs, or the Medicaid Care Management Program, is relatively consistent across all 10 counties. Coos County has the greatest percentage of members in Non-Medicaid Care Management.

**Figure 2-2—Membership in the Three MCOs and the Non-Medicaid Care Management Members by County as of June 1, 2014**



*Notes:*

Data subject to revision.

Members without full Medicaid benefits (e.g., Qualified Medicare Beneficiaries) are excluded.

New Heights is the data source for time lag between open Medicaid and MCM selection and plan transitions; all data are run as of the last of the month.

For all other reports, Medicaid Management Information Systems (MMIS) is the data source; all data are run as of the first week of the month.

County data exclude small numbers of out-of-state or unknown counties.

## Quality Strategy for the New Hampshire Medicaid Care Management Program

### Quality Strategy Background

The CMS Medicaid managed care regulations at 42 CFR 438.200 and 438.202, which implement Section 1932(c)(1) of the Social Security Act, define certain Medicaid state agency responsibilities. The regulations require Medicaid state agencies that operate Medicaid managed care programs to develop and implement a written Quality Assessment and Performance Improvement Strategy (herein referred to as “Quality Strategy”) to assess and improve the quality of health care services offered to their members. The written strategy must describe the standards that the state and its contracted MCOs and prepaid inpatient health plans (PIHPs) must meet. The Medicaid state agency must, in part:

- ◆ Conduct periodic reviews to examine the scope and content of its Quality Strategy and evaluate its effectiveness.
- ◆ Ensure compliance with standards established by the state that are consistent with federal Medicaid managed care regulations.
- ◆ Update the strategy periodically, as needed.
- ◆ Submit to CMS a copy of its initial strategy, a copy of the revised strategy whenever significant changes have occurred in the program, and regular reports describing the implementation and effectiveness of the strategy.

### Quality Strategy Goals and Objectives

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”<sup>10</sup> to the provision of health services for the State’s Medicaid beneficiaries. The State’s initial quality improvement objectives will be drawn from generally understood New Hampshire Medicaid opportunities for improvement. Moreover, DHHS seeks to improve the quality and timeliness of, and access to, care for the New Hampshire Medicaid population. To assess achievement of this objective, DHHS has identified a set of four QIPs and four PIPs that will be evaluated annually as part of the ongoing EQR activities. Figure 2-3 displays the four QIP topics selected to be evaluated as part of the DHHS Quality Strategy.

<sup>10</sup> New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy. (2014). *Quality Strategy for the New Hampshire Medicaid Care Management Program*. Available at: <http://www.dhhs.nh.gov/ombp/quality/documents/quality-strategy.pdf>. Accessed on: Oct 3, 2014.

**Figure 2-3—New Hampshire Medicaid MCO QIP Topics**



Each MCO selected PIPs to be tracked and evaluated as part of DHHS’ quality program. Figure 2-4 lists each MCO’s PIP topics.

**Figure 2-4—New Hampshire Medicaid MCO PIP Topics**

NH Healthy Families	Well Sense
<ul style="list-style-type: none"> <li>◆ Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</li> <li>◆ Vision Screening for Adults with Diabetes</li> <li>◆ Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications</li> <li>◆ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</li> </ul>	<ul style="list-style-type: none"> <li>◆ Diabetes Care—HbA1c</li> <li>◆ Percent of Women (16 to 24 years) Receiving Chlamydia Screening</li> <li>◆ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</li> <li>◆ Reduce Readmissions to New Hampshire Hospital</li> </ul>

After the Medicaid Care Management Program has been operational long enough for QIP and PIP outcomes to be assessed, DHHS will draw from the QIPs, PIPs, and other activities to identify additional Medicaid program priorities, strengths, and opportunities for improvement to enhance program goals.

In addition to the QIPs and PIPs, MCO quality assessment and performance improvement (QAPI) programs will include performance measurement for the above initiatives as well as the more than 300 DHHS required quality indicators and routine reporting on health plan operations. All performance data will be submitted to the State. As part of its ongoing compliance activities, HSAG assesses each MCO’s QAPI program to verify the programs’ completeness, comprehensiveness, and overall rigor so that the MCO may continually monitor, assess, and

improve the quality, access, and timeliness of care and services provided to Medicaid beneficiaries. The findings of HSAG's assessment of each MCO's QAPI program will be produced in the respective annual EQR technical report. The findings from HSAG's annual evaluation of MCOs' QIPs and PIPs also will be produced in each year's EQR technical report.



### 3. DESCRIPTION OF EQR ACTIVITIES—SFY 2013–2014

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#### Overview

HSAG prepared the New Hampshire EQR Technical Report following the guidelines established by 42 CFR 438.364, which defines the information that must be included for the activities described in the BBA and CMS protocols. The three activities that must be described in the annual report are compliance monitoring activities, evaluation of MCO programs and projects, and validation of performance measures. The information that is required to be included by CMS is the objectives of each activity, the technical methods of data collection and analysis, the description of the data obtained, and the conclusions drawn from the data. Other activities performed by the EQRO are to be delineated with a comparison of the MCOs' performance and an assessment of the MCOs' strengths and weaknesses and recommendations for improvement. The following section presents a list of the activities HSAG initiated or completed in New Hampshire during SFY 2013–2014.

#### Activities Conducted in SFY 2013–2014

HSAG conducted tasks associated with the three activities to be included in the reporting of EQR activities as required by 42 CFR 438.358. Those activities are listed below:

- ◆ MCO Contractual Compliance
- ◆ Evaluation of MCO Programs and Projects
- ◆ Validation of MCO Performance Measures

In addition to these three activities, HSAG provided technical assistance and project management and support for the following activities during SFY 2013–2014:

- ◆ CAHPS
- ◆ Focus Groups
- ◆ Encounter Data Validation
- ◆ Access Reporting
- ◆ CMS Adult Core Set Measures
- ◆ Performance Measure Reporting

## 4. MCO CONTRACTUAL COMPLIANCE

### Overview

The BBA requires a state or its EQRO to conduct a review within a three-year period to determine a Medicaid MCO's compliance with the standards established by the state concerning access to care, structure and operations, and quality measurement and improvement. To meet this requirement, HSAG performed a comprehensive assessment of each MCO's IQAP during an on-site compliance review in April and May of 2014. The review included the three MCOs originally contracted to provide services in the New Hampshire Care Management Program: **Meridian**, **NH Healthy Families**, and **Well Sense**.

The purpose of the SFY 2013–2014 Compliance Review was to determine the MCOs' compliance with 42 CFR 438 Subparts A–F of the BBA and the State contractual requirements. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012<sup>11</sup> to create the process, tools, and interview questions used for the SFY 2013–2014 Compliance Review. According to CMS' *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012,<sup>12</sup> the compliance review activity can be performed by the State Medicaid agency, an agent that is not an MCO, or the state's EQRO. For SFY 2013–2014, DHHS contracted with HSAG, its EQRO, to conduct on-site compliance reviews for the MCOs in the New Hampshire Care Management Program.

### Methodology

Before beginning the compliance review, HSAG developed data collection tools to document the findings of the review. The requirements in the tools were selected based on applicable federal and State regulations and laws, and the requirements set forth in the contract between DHHS and the MCOs, as they related to the scope of the review. HSAG conducted the review in three phases as shown in Figure 4-1.

<sup>11</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: Feb 19, 2013.

<sup>12</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: Feb 19, 2013.

**Figure 4-1—Phases of Activities Associated With the Review of MCO Contractual Compliance**

The **pre-on-site phase of the review activities** included:

- ◆ Developing the compliance review documents, to include the compliance review tool, file review tools, and checklists.
- ◆ Preparing and forwarding to each MCO a customized desk review form, instructions for completing the form, and directions for submitting the requested documentation to HSAG.
- ◆ Scheduling the on-site reviews.
- ◆ Developing the agenda for the 2½-day on-site review.
- ◆ Providing the detailed agenda and the data collection (compliance review) tool to each MCO to facilitate preparation for HSAG’s review.
- ◆ Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents submitted to HSAG by each MCO. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each MCO’s operations, identify areas needing clarification, and begin compiling information in preparation for the on-site review.
- ◆ Generating a list of 10 sample cases plus an oversample of five cases for each of the following file reviews: grievances, appeals, and denials.
- ◆ Generating a list of 30 sample cases plus an oversample of 10 cases for the credentialing and recredentialing file reviews.

The **on-site review activities** included:

- ◆ An opening conference, with introductions, and a review of the agenda and logistics for HSAG’s on-site review activities.
- ◆ A review of the documents HSAG requested that each MCO have available on-site.
- ◆ A review of the sample cases HSAG requested from each MCO.
- ◆ A review of the data systems each MCO used in its operations, which includes but is not limited to care management, grievance and appeal tracking, quality improvement tracking, and quality measure reporting.
- ◆ Interviews conducted with each MCO’s key administrative and program staff members.

- ◆ A closing conference during which HSAG reviewers summarized their preliminary findings.

HSAG documented the findings in the data collection (compliance review) tool, checklists, and file review tools. These documents serve as the comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the MCOs' performance into compliance for those requirements that HSAG assessed as less than fully compliant.

The **post-on-site review activities** included:

- ◆ Compiling and aggregating the review findings to produce a comprehensive compliance review report.
- ◆ Creating the Corrective Action Plan (CAP) template which contained the findings and recommendations for each element scored *Partially Met* or *Not Met*.
- ◆ Distributing the on-site review reports and the CAP documents to the MCOs in July 2014.

Because **Meridian** decided to withdraw from the New Hampshire Medicaid Care Management Program before the documents were distributed, **Meridian** will not be required to submit a CAP. **Well Sense** and **NH Healthy Families** will be submitting their CAPs to HSAG in SFY 2014–2015.

## MCO-Specific Findings and Comparisons

The compliance review included 14 standards that were created from the applicable federal and State standards. The standards contained elements that addressed the quality of care and services, the timeliness of care and services, and the access to care and services. The MCOs received a score for each of the 14 standards, and those ratings produced an overall score for the standards review.

The five standards displayed in Figure 4-2 address requirements for delegation and subcontracting, plans the MCOs are required to create (i.e., Program Management Plan; Early and Periodic Screening, Diagnosis, and Treatment [EPSDT]; Communications Plan; Emergency Response Plan), emergency and poststabilization care, care management/care coordination, and wellness and prevention. The number of elements in each standard ranged from 10 to 27. All three MCOs achieved 100 percent in the wellness and prevention standard. The lowest scores achieved by each of the three MCOs during the on-site compliance review were found in these five standards. **Well Sense** scored 73.1 percent in emergency and poststabilization care, and **Meridian** and **NH Healthy Families** scored 86.1 percent and 75 percent, respectively, in the standard requiring MCOs to create certain plans. This standard also represented the lowest average score for the 14 standards.

**Figure 4-2—Findings From Review of Standards: Delegation, Plans Required, Emergency Care, Care Management, and Wellness and Prevention**

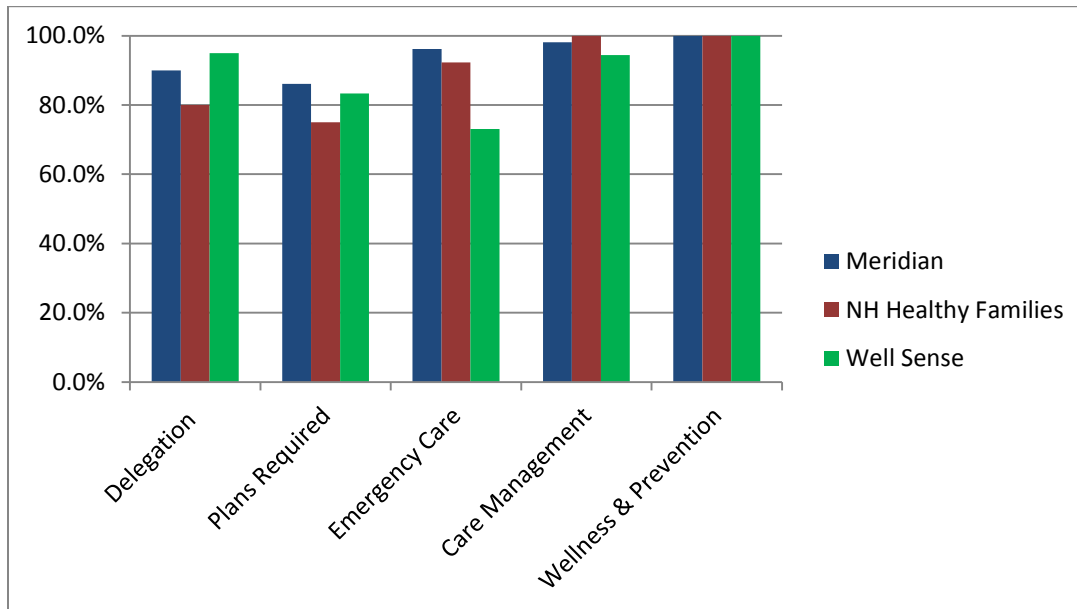


Figure 4-3 contains five standards that address requirements for behavioral health, member enrollment and disenrollment, member services, cultural considerations, and grievances and appeals. The number of elements in each standard ranged from 10 to 56. All three MCOs achieved 100 percent in the cultural considerations standard. Each score achieved in these five standards was above 90 percent for all three MCOs.

**Figure 4-3—Findings From Review of Standards: Behavioral Health, Enrollment and Disenrollment, Member Services, Cultural Considerations, and Grievances and Appeals**

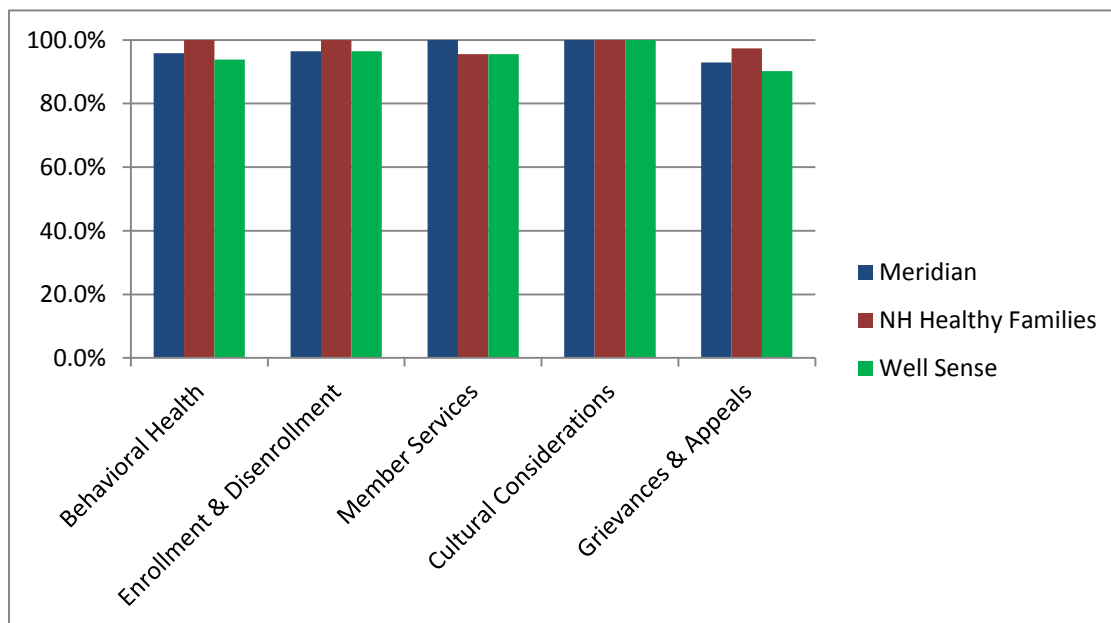


Figure 4-4 contains four standards that address requirements for access to care, network management/credentialing, utilization management, and quality management. The number of elements in each standard ranged from 18 to 34. All three MCOs achieved 100 percent in the quality management standard. Except for the standards with all three MCOs scoring 100 percent, the highest average score achieved by the three MCOs was in the access standards (97.9 percent).

**Figure 4-4—Findings From Review of Standards: Access, Network Management, Utilization, and Quality**

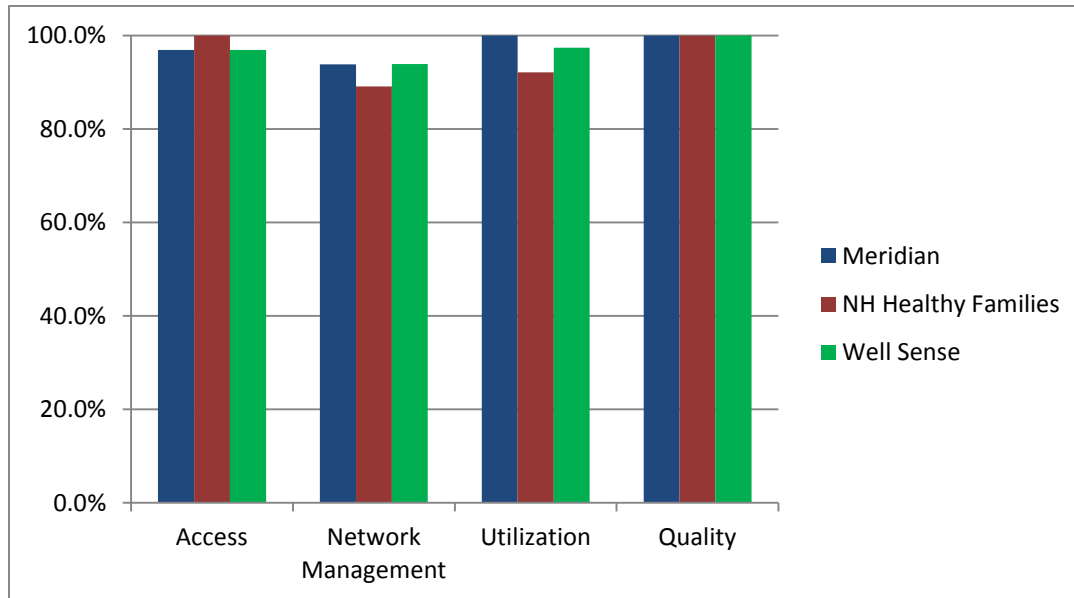
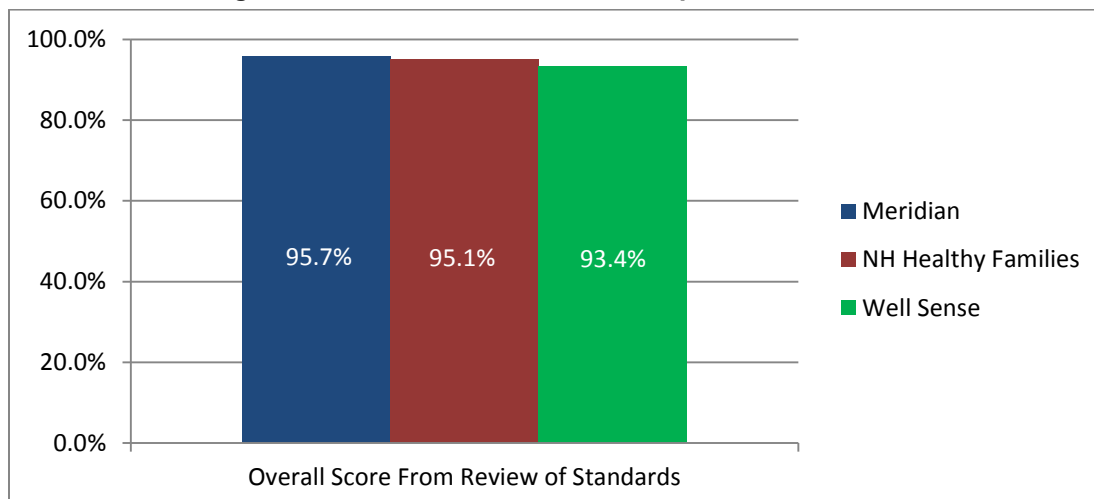


Figure 4-5 displays the overall score for the 14 compliance standards for each of the three MCOs. The scores ranged from 95.7 percent to 93.4 percent and confirm that the MCOs have policies and processes in place to monitor and evaluate the requirements established by the BBA and DHHS concerning the quality of care and services, the timeliness of care and services, and access to care and services. The review also validated that the MCOs had mechanisms in place to identify issues and create targeted interventions to ensure that the New Hampshire Medicaid Care Management Program operates according to federal and State requirements.

**Figure 4-5—Overall Score for 14 Compliance Standards**



In addition to the 14 standards, HSAG also evaluated checklists with requirements for access standards, the call center, culturally and linguistically appropriate services, the provider directory, the member handbook, identification card requirements, the MCO Web site, network management, notice requirements, and member rights. The overall checklist scores for the three MCOs were similar, with the MCOs achieving the following scores: **Meridian**—99.5 percent, **NH Healthy Families**—98.5 percent, and **Well Sense**—97.1 percent. **Meridian** scored 100 percent on all but one checklist, **NH Healthy Families** scored 100 percent on all but three checklists, and **Well Sense** scored 100 percent on all but four checklists.

The third rating from the on-site review was generated from file reviews for grievances, denials, appeals, credential, and recredentialing. The recredentialing file review was applicable only to **Well Sense**, and **Well Sense** scored nearly a perfect score (99.5 percent) in the file reviews. The overall file review score for **Meridian** was 90.7 percent, and 89.3 percent for **NH Healthy Families**.

## Opportunities for Improvement and Recommendations

HSAG reviewed the noncompliant elements and created the summary of findings, opportunities for improvement, and recommendations listed below for each of the three MCOs. Evidence of each MCO's corrective actions will be submitted to HSAG in August 2014, and a review of the noncompliant elements will be included in the on-site activities in SFY 2014–2015.

### **Meridian Health Plan**

During the on-site review at **Meridian**, HSAG reviewed documentation to support 14 standards with 292 applicable elements. **Meridian** met all requirements for 269 (92.1 percent) of the elements, partially met 21 (7.2 percent) of the elements, and failed to satisfy the requirements for 2 (0.7 percent) of the elements. HSAG reviewed 226 elements during the file reviews; **Meridian** missed 21 elements, achieving a score of 90.7 percent. **Meridian** missed only one item during the checklists review and achieved a nearly perfect score, with a rating of 99.5 percent.

All recommendations related to the review of policies, procedures, and plan documents required making revisions to include specific requirements found in the Medicaid Care Management Program Agreement with DHHS. None of the initial credentialing files contained validation of hospital affiliation, and one of the files failed to be processed within 30 days of receipt of a completed application for a PCP. Finally, the MCO's documentation of the required access standards could not validate at least one specialist located within 60 minutes or 45 miles of each member.



## **NH Healthy Families**

During the on-site review at **NH Healthy Families**, HSAG reviewed documentation to support 14 standards with 294 applicable elements. **NH Healthy Families** met all the requirements for 267 (90.8 percent) of the elements, partially met 25 (8.5 percent) of the elements, and failed to satisfy the requirements for 2 (0.7 percent) of the elements. HSAG reviewed 298 elements during the file reviews; **NH Healthy Families** missed 32 elements, achieving a rating of 89.3 percent. **NH Healthy Families** missed only three elements of the 204 items reviewed on the checklists and scored 98.5 percent.

All recommendations related to the review of policies, procedures, and plan documents required making revisions to include specific requirements found in the Medicaid Care Management Program Agreement with DHHS. The review of the appeals files revealed that the MCO must ensure that appeals are processed within 30 calendar days after receipt of the appeal unless the MCO notifies the member that an extension is necessary to complete the appeal. None of the initial credentialing files contained validation of hospital affiliation, five of the files failed to be processed within 30 days of receipt of a completed application for PCPs and within 45 days for specialists, and two files did not contain proof of current malpractice insurance coverage on the date the file was approved by the Credentialing Committee. The MCO's documentation of the required access standards could not validate at least one specialist located within 60 minutes or 45 miles of each member. Neither the member handbook nor the MCO's Web site included information on the structure and operation of the MCO plan and provider incentive plans, as required by the program agreement.

## **Well Sense**

During the on-site review at **Well Sense**, HSAG reviewed documentation to support 14 standards with 295 applicable elements. **Well Sense** met all requirements for 264 (89.5 percent) of the elements, partially met 23 (7.8 percent) of the elements, and failed to satisfy the requirements for 8 (2.7 percent) of the elements. HSAG reviewed 377 elements during the file reviews; **Well Sense** missed only two elements, achieving a nearly perfect score of 99.5 percent. **Well Sense** missed only six elements of the 204 items reviewed on checklists and scored 97.1 percent.

All but one recommendation related to the review of policies, procedures, and plan documents required making revisions to include specific requirements found in the Medicaid Care Management Program Agreement with DHHS. One recommendation involved developing an after-hours provider inquiry line with the capability of informing callers about operating hours and instructions on how to verify enrollment for a member with an emergency or urgent medical or behavioral health condition.

Review of the appeals files revealed that the MCO must ensure that each appeal is processed within 30 calendar days after receipt, unless the MCO notifies the member that an extension is



necessary to complete the appeal. The MCO's documentation of the required access standards could not validate the location of at least one tertiary or specialized service facility within 120 minutes or 80 miles of each member. Finally, the automated provider directory must include a search function for FQHCs and RHCs, and the provider Web site must contain information about FQHCs and RHCs.

## 5. EVALUATION OF MCO PROGRAMS AND PROJECTS

### Overview

As described in 42 CFR 438.240(b)(1), in accordance with 42 CFR 438.240(d), and as part of the State's quality strategy, DHHS requires the MCOs to perform a minimum of four PIPs annually with at least one PIP focusing on behavioral health. The MCOs have the freedom to choose the PIP topics; however, the topics need to be supported by quantitative and qualitative evidence to ensure that they will improve care for the membership in the New Hampshire Medicaid Care Management Program. When HSAG began conducting the PIP activities in New Hampshire, three MCOs were involved in the process: **Meridian**, **NH Healthy Families**, and **Well Sense**. As the activities progressed, **Meridian** exited the New Hampshire Medicaid market, and the PIP activities continued with the remaining two health plans.

The overview of HSAG's PIP validation activities in New Hampshire includes two key components of the quality improvement process as described below:

1. HSAG evaluates the technical structure to determine whether a PIP's design (e.g., study question(s), study population, study indicators, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic identification of barriers and the subsequent development of relevant interventions. This component evaluates how well the MCO improved its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results). The goal of HSAG's PIP validation is to ensure that the MCO and key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP.

The MCOs also are required to perform four QIPs each year with the topics defined by DHHS. The SFY 2013–2014 QIP topics are shown below:

- ◆ Timeliness of prenatal care including the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* (HEDIS measure component).
- ◆ Follow-up after Hospitalization for Mental Illness Within Seven Days of Discharge for beneficiaries age six and older at the time of discharge, including the hospitalizations in New Hampshire Hospital (HEDIS measure).
- ◆ Parental Satisfaction with Children Getting Appointments for Care (CAHPS measure).
- ◆ Satisfaction with Getting Appointments for Care (CAHPS Adult Survey).

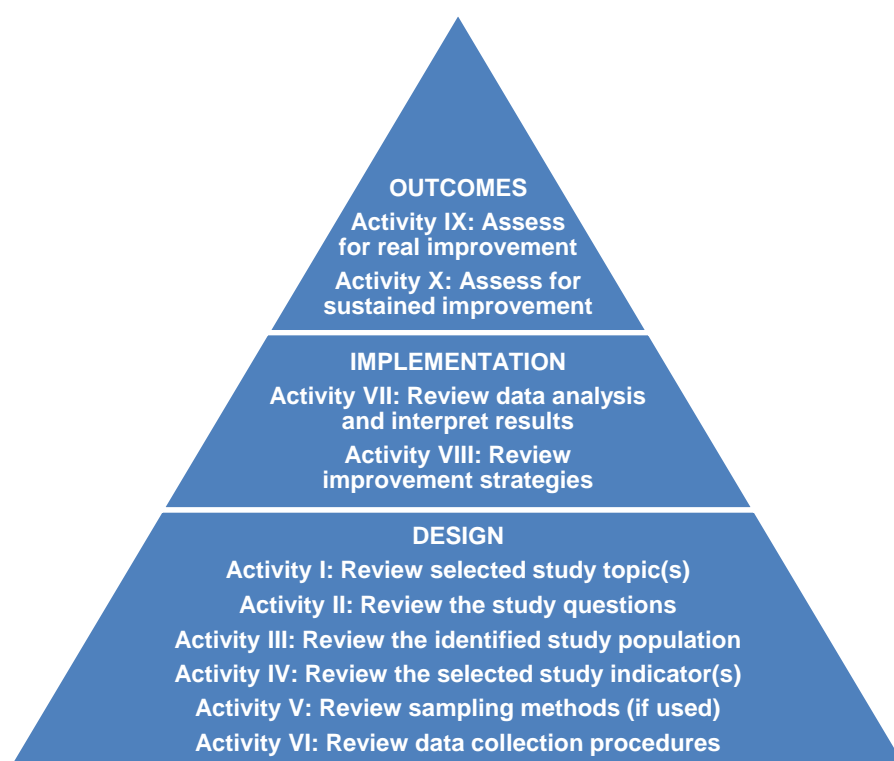
The documentation supporting the design of the four QIPs will be submitted to HSAG in SFY 2014–2015 for validation.

## Methodology

Included in the overall assessment of the MCO's QAPI program is a comprehensive review and validation of the PIPs implemented by the MCO when a review of performance measures shows the need for targeted improvement in a particular area. Additionally, HSAG will review and validate the findings for the QIP topics that have been selected by DHHS. Both PIPs and QIPs will serve as key tools to help DHHS achieve goals and objectives outlined in its quality strategy because they provide the framework for monitoring, measuring, and improving the delivery of health care for Medicaid recipients in the New Hampshire Care Management Program.

As shown in Figure 5-1, HSAG classifies the progression of PIPs and QIPs in three stages: Design, Implementation, and Outcomes.

**Figure 5-1—Three Phases of PIPs and QIPs**



The base of the pyramid depicts the foundation for the PIPs and QIPs in Activities I through VI. Those activities involve the creation of the topic to be studied, development of the study questions, and identification of the study population. The activities also require crafting the study indicators, producing the sampling methodology, and reviewing the data collection procedures.

The middle of the pyramid portrays Activities VII and VIII, the activities involved in the actual implementation of the design with the collection of data, data analysis, and the interpretation of the findings. Once the data analysis produces the findings of the study, the improvement strategies are reviewed to determine if there is a need to revise and refine the interventions.

The pinnacle of the pyramid, Activities IX and X, involves determining if the study produced real improvement. Once it is determined, through the use of statistical testing, that real improvement was achieved, the challenge is to sustain improvement over time.

During SFY 2013–2014, HSAG supplied the MCOs with a summary form to use in the submission of the PIP/QIP documentation to support the creation of the projects. Through the validation process, HSAG will assess the study methodology, verify study findings, and provide an overall evaluation of the validity and reliability of the PIPs/QIPs submitted by the MCO.

Each MCO will complete and submit to HSAG a PIP/QIP Summary Form for review and validation. HSAG will provide the MCOs with explicit instructions on how to submit the PIP/QIP. The MCO will be given the opportunity to contact HSAG with questions concerning the completion of the PIP/QIP Summary Form until the MCO submits its PIP/QIP to HSAG for validation. MCOs will use HSAG's secure file transfer protocol (FTP) site to upload all PIP/QIP information. HSAG staff members will ensure that the confidentiality and security of MCO PIP/QIP information is maintained in accordance with HSAG policy and federal regulation, 45 CFR 164.

### **HSAG PIP and QIP Validation**

HSAG will evaluate and score each of the 10 CMS PIP/QIP steps shown in Figure 5-1 using the PIP/QIP Validation Tool. Each evaluation element within a given activity will be given a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed* based on the PIP or QIP documentation and study indicator outcomes submitted by the MCO. HSAG will designate as critical elements some of the evaluation elements deemed pivotal to the PIP and QIP process. For a PIP/QIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score will result in an overall validation rating of *Not Met*. In addition to the validation status, HSAG will give each PIP and QIP an overall percentage score for all evaluation elements (including critical elements) and will designate a *Met*, *Partially Met*, or *Not Met* validation status for each PIP/QIP submitted for validation.

## ***Interim Evaluation and Report***

HSAG's six-month interim evaluation will include a review and assessment of each MCO's QAPI program strategy and a review of each MCO's PIPs and QIPs. During the interim evaluation, HSAG will assess and validate the first stage of the PIP (Design) to ensure it is structured in a methodologically sound manner and that it will study what it is intended to study. HSAG does not anticipate that the MCOs will include baseline rate information in the initial submission of PIPs/QIPs; however, future interim submissions will contain indicator rates.

HSAG's Interim Evaluation Report will include the background information concerning the areas evaluated, the methods used to conduct the evaluation, the findings/results, and a scored validation tool for each PIP/QIP. Further, this interim report will include a critical assessment of each PIP/QIP and whether the studies were consistent with the strategy detailed in the MCO's QAPI strategy. HSAG will also provide recommendations to strengthen the design of the PIP and/or to improve any planned interventions that the MCO is considering.

## ***Annual Validation***

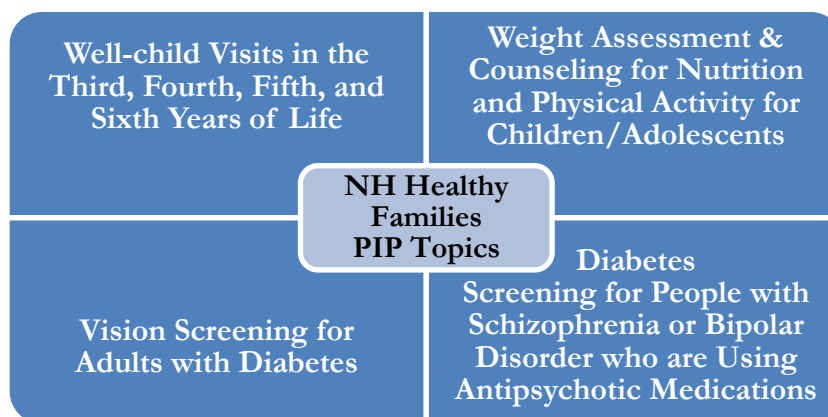
After 12 months, the MCOs will be required to submit the PIPs/QIPs to HSAG for an annual validation. HSAG will evaluate the progression to baseline data collection and analysis. In future years, once the PIP/QIP has progressed to a point of remeasurement, HSAG will validate the PIP/QIP through the Outcomes stage to determine if changes in indicator rates were statistically significant over baseline and the improvement is sustained with a subsequent measurement period. To ensure the results are comparable from year to year, HSAG will use the same approach and methods for the annual evaluation that it used to evaluate the PIPs/QIPs during the interim evaluation.

In addition to analyzing and reporting the MCO's PIP/QIP study indicator results, HSAG will provide a critical evaluation of the MCO's causal/barrier analyses and evaluate the effectiveness of interventions. This critical review will determine if the MCO's barrier analysis was rigorous and sufficient to identify appropriate interventions with the potential to bring about real improvement.

## MCO-Specific Topics

Figure 5-2 displays the PIP topics chosen by **NH Healthy Families**. The three non-behavioral health projects are vision screening for adults with diabetes, well care visits for 3–6-year-olds, and weight assessment and counseling for nutrition and physical activity for children/adolescents. The project with the behavioral health focus is diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications.

**Figure 5-2—PIP Topics for NH Healthy Families**

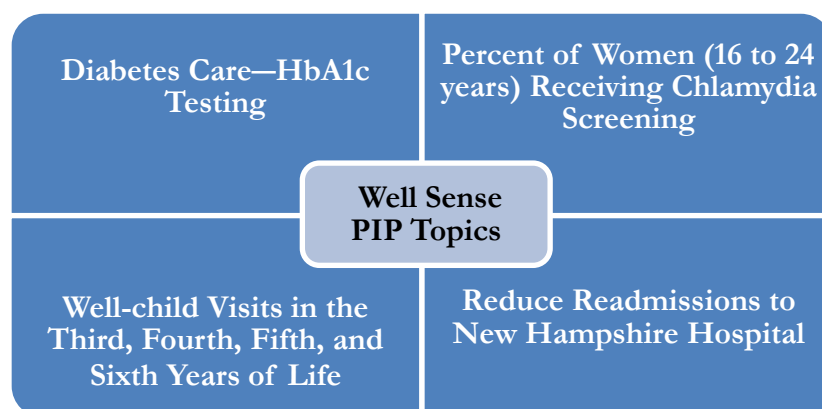


These PIP topics represent key areas of focus for improvement for **NH Healthy Families**. The health plan's PIP topics address CMS' requirements related to quality outcomes: quality, timeliness of, and access to, care and services.

- ◆ The focus of the *Comprehensive Diabetes Screening—Vision Screening* PIP is to increase the rate of diabetic members aged 18 to 75 years with diabetes who have an annual retinal eye exam.
- ◆ The focus of the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication* PIP is to increase the percentage of members aged 18 to 64 years with schizophrenia or bipolar disorder who are dispensed an antipsychotic medication and have a diabetes test during the measurement year.
- ◆ The focus of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* PIP is to increase the percentage of eligible members aged 3 to 17 years with evidence of BMI documentation.
- ◆ The focus of the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth years of Life* PIP is to increase the percentage of members aged 3 to 6 years who have one or more well-child visit(s) with a PCP during the measurement year.

Figure 5-3 displays the four PIP topics chosen by **Well Sense**. Three studies focus on non-behavioral health needs (e.g., diabetes care: HbA1c testing, well-child visits for 3–6-year-olds, and percent of women 16–24 years of age receiving chlamydia screening). The PIP with a behavior health focus involves reducing readmissions to New Hampshire Hospital.

**Figure 5-3—PIP Topics for Well Sense**



These PIP topics represent key areas of focus for improvement for **Well Sense**. The health plan's PIP topics addressed CMS' requirements related to quality outcomes—specifically, quality, timeliness of, and access to, care and services.

- ◆ The focus of the *Chlamydia Screening* PIP is to increase the percentage of women 16 to 24 years of age who are identified as sexually active and have at least one chlamydia test performed during the measurement year.
- ◆ The focus of the *Diabetes Care—HbA1c Testing* PIP is to increase the rate of diabetic members aged 18 to 75 years with diabetes who have an annual HbA1c test.
- ◆ The focus of the *Reducing Hospital Readmissions* PIP is to decrease the percentage of readmissions to New Hampshire Hospital within 30, 60, and 90 days.
- ◆ The focus of the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth years of Life* PIP is to increase the percentage of members aged 3 to 6 years who have one or more well-child visit(s) with a PCP during the measurement year.

The results of the PIP and QIP validations will be included in the information submitted in the SFY 2014–2015 EQR Technical Report.

## 6. VALIDATION OF MCO PERFORMANCE MEASURES

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### Overview

Validation of the MCOs' performance measures is required by the BBA in 42 CFR 438.358(b)(2), and CMS-established protocols to be used during the PMV. DHHS requires MCOs in the New Hampshire Care Management Program to submit performance measure data as part of their quality assessment and performance improvement programs. To ensure compliance with the BBA, DHHS contracted with HSAG to validate specific performance measures designated by DHHS during the first year of MCO operation in the State of New Hampshire.

When HSAG began conducting the PMV activities in March 2014, three MCOs were involved in the process: **Meridian**, **NH Healthy Families**, and **Well Sense**. As the activities progressed, **Meridian** exited the New Hampshire Medicaid market, and the PMV activities continued with the remaining two health plans. The following sections provide a summary of the activities associated with PMV in New Hampshire for SFY 2013–2014.

DHHS required the contracted MCOs to report a list of measures during the first year of their operations, of which 34 were validated by HSAG during SFY 2013–2014.<sup>13</sup> In general, these measures included ambulatory care visits, timely processing of appeals, appeals by reason type, timely claim processing, member communication, provider communication, details of pharmacy payments, polypharmacy monitoring, timely processing of prior authorization requests, and member-provider ratios.

In conducting the SFY 2013–2014 PMV activities, HSAG focused on the following objectives:

- ◆ Assessing the accuracy of the required performance measures reported by the MCOs
- ◆ Determining the extent to which the measures calculated by the MCOs follow DHHS' specifications and reporting requirements
- ◆ Conducting an information system readiness review for the MCOs in preparation for HEDIS 2015 reporting

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<sup>13</sup> These measures are listed in Exhibit O Amendment #1 NH Medicaid Care Management Quality and Oversight Reporting.



## Methodology

HSAG conducted the SFY 2013–2014 PMV activities based on CMS' PMV protocol. All PMV activities can be organized into three phases: pre-on-site, on-site, and post-on-site. At the time of preparing this technical report, HSAG had completed the pre-on-site activities.

### **Pre-On-site Activities**

HSAG provided a technical assistance session to the MCOs to help them prepare for the SFY 2013–2014 PMV. The session, delivered in Webinar format, assisted the MCOs in understanding HSAG's procedures and processes in conducting the PMV.

Based on the scope of the validation, HSAG assembled a validation team with the full complement of skills required for validating the specific performance measures and conducting the information system readiness review of each MCO. The team is composed of a lead auditor and several team members.

Working in collaboration with DHHS, HSAG customized the Information System Capability Assessment Tool (ISCAT) to collect the MCO-specific information consistent with New Hampshire's health service delivery model. HSAG prepared a documentation request to accompany the customized ISCAT and sent the request to the MCOs. The MCOs were required to complete the ISCAT and send supporting documentation to facilitate better understanding of their data systems and processes. These supporting documents included policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions.

Upon receiving the completed ISCAT and requested supporting documents, HSAG conducted a desk review of all materials and noted any issues or items that required further follow-up. Information included in the ISCAT was used by the validation team to complete the PMV tools.

Prior to the on-site visit with each MCO, HSAG prepared an agenda describing all on-site visit activities and indicating the type of staff needed for each session. The agenda will be forwarded to each MCO at least two weeks prior to the on-site visit. HSAG will conduct a pre-on-site conference call with the MCOs if requested in preparation for the on-site visit activities.

### **On-site Activities**

Two on-site visits will be conducted in September 2014, one for each MCO. During the on-site visit, HSAG's validation team will collect additional information to compile PMV findings using several methods, including interviews, system demonstration, review of data output files, observation of data processing, and review of data reports. The on-site objectives include:

- ◆ **Opening meetings**—Include introductions of the validation team and key MCO staff involved in the calculation or reporting of the performance measures. The purpose of the PMV, the required documentation, basic meeting logistics, and queries to be performed will be discussed.
- ◆ **Review of ISCAT and supporting documentation**—This session is designed to be interactive with key MCO staff so that the validation team can obtain a complete picture of all the steps taken to generate responses to the ISCAT and evaluate the degree of compliance with written documentation. The validation team will conduct interviews to confirm findings from the documentation review, discuss outstanding issues, and ascertain that written policies and procedures are used and followed in daily practice.
- ◆ **Evaluation of data systems and processes**—Multiple sessions will be conducted to determine whether the MCO's systems are capable of handling claims, membership, provider, appeals, prior authorization, and call center files for the health care services to be offered to members in the New Hampshire Medicaid Care Management Program. More specifically, MCO's system capability in the following areas will be assessed for data completeness and accuracy for measures to be validated during the SFY 2013–2014 validation cycle as well as for HEDIS 2015 reporting:
  - Claims/encounter processing
  - Member enrollment/disenrollment
  - Capitation reconciliation
  - Encounter data submission
  - Provider and vendor data processing
  - Call center data processing
  - Prior authorization data processing
  - Grievance and appeal data processing

The system readiness review also includes interviews with appropriate staff members, system demonstrations, and the review of appropriate internal reports to identify if the MCO has controls within each data system that will be used for HEDIS 2015 reporting. HSAG also must verify that the controls are functioning appropriately to ensure all transactions are accounted for and processed accurately.

- ◆ **Closing conference**—At the end of each on-site visit, the validation team will summarize its preliminary findings and revisit the documentation requirements for any post-on-site activities.

## Post-On-site Activities

The validation team will review any final performance measure rates submitted by the MCOs and follow up with each MCO concerning any outstanding issues identified during the ISCAT documentation review and the on-site visits. Any issues identified from the rate review will be communicated to the MCO as a corrective action as soon as possible so that the rates can be revised before the PMV report is issued.

HSAG will prepare a PMV report for each MCO, documenting the validation findings. Based on all validation activities, the validation team will determine the audit result for each performance measure. CMS' PMV Protocol identifies three possible validation finding designations for performance measures which are defined in Table 6-1.

**Table 6-1—Three Audit Designations for Performance Measures**

Audit Designation Categories for Performance Measures	
<b>Report (R)</b>	Measure was compliant with the State's specifications, and the rate can be reported.
<b>Not Reported (NR)</b>	This designation is assigned to measures for which: (1) the MCO rate was materially biased, or (2) the MCO was not required to report.
<b>No Benefit (NB)</b>	Measure was not reported because the MCO did not offer the benefit required by the measure.

According to the protocol, the validation designation for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not compliant based on the review findings. Consequently, an error for a single audit element may result in a designation of NR because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the measure could be given a designation of R.

Any corrective actions that cannot be implemented in time will be noted in the audit findings report as recommendations. If the corrective action is closely related to accurate rate reporting, the validation team may render a particular measure as NR.

In addition to the validation findings of the performance measures, HSAG will also present its information system readiness review findings in the PMV report and evaluate whether each of the data systems/processes examined is compliant with industry standards. Recommendations will be provided to each MCO to assist in preparing its HEDIS 2015 reporting activities.

Table 6-2 includes the performance measures that will be validated by HSAG for SFY 2013–2014. The table specifies the reporting reference identification, the measure, the indicators for each measure, and the measurement period being validated.

**Table 6-2—Measures to Be Validated by HSAG for SFY 2013–2014**

Performance Measures to Be Validated for SFY 2013–2014 PMV Validation Cycle			
Reporting Reference ID	Measure	Indicator	Measurement Period to Be Validated
AMBCARE.01	Ambulatory Care: Physician/APRN/Clinic Visits	by Age Group A. < 12 months B. 12–24 months C. 25 months–6 years D. 7–11 years E. 12–19 years F. 20–44 years G. 45–64 years H. ≥65 years	1st Quarter 2014
AMBCARE.02	Ambulatory Care: Physician/APRN/Clinic Visits	by Geographic Region A. Metropolitan Counties B. Non-Metropolitan Counties C. Non-NH/Unknown	1st Quarter 2014
AMBCARE.03	Ambulatory Care: Physician/APRN/Clinic Visits	by Eligibility Group A. Low-Income Children B. Children With Severe Disabilities C. Children in Foster Care and Adoption Subsidy D. Low-Income Adults Non-Expansion E. Low-Income Adults Expansion F. Adults with Disabilities G. Aged Adults	1st Quarter 2014
AMBCARE.04	Ambulatory Care: Emergency Department Visits	by Age Group A. < 12 months B. 12–24 months C. 25 months– 6 years D. 7–11 years E. 12–19 years F. 20–44 years G. 45–64 years H. ≥65 years	1st Quarter 2014
AMBCARE.05	Ambulatory Care: Emergency Department Visits	by Geographic Region A. Metropolitan Counties B. Non-Metropolitan Counties C. Non-NH/Unknown	1st Quarter 2014

Table 6-2—Measures to Be Validated by HSAG for SFY 2013–2014

Performance Measures to Be Validated for SFY 2013–2014 PMV Validation Cycle			
Reporting Reference ID	Measure	Indicator	Measurement Period to Be Validated
AMBCARE.06	Ambulatory Care: Emergency Department Visits	by Eligibility Group A. Low-Income Children B. Children With Severe Disabilities C. Children in Foster Care and Adoption Subsidy D. Low-Income Adults Non-Expansion E. Low-Income Adults Expansion F. Adults with Disabilities G. Aged Adults	1st Quarter 2014
AMBCARE.07	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care	by Age Group A. < 12 months B. 12–24 months C. 25 months–6 years D. 7–11 years E. 12–19 years F. 20–44 years G. 45–64 years H. ≥65 years	1st Quarter 2014
AMBCARE.08	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care	by Geographic Region A. Metropolitan Counties B. Non-Metropolitan Counties C. Non-NH/Unknown	1st Quarter 2014
AMBCARE.09	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care	by Eligibility Group A. Low-Income Children B. Children With Severe Disabilities C. Children in Foster Care and Adoption Subsidy D. Low-Income Adults Non-Expansion E. Low-Income Adults Expansion F. Adults with Disabilities G. Aged Adults	1st Quarter 2014
APPEALS.01	Resolution of Appeals	Standard Appeals Within 30 Calendar Days	1st Quarter 2014
APPEALS.02		Extended Standard Appeals Within 44 Calendar Days	1st Quarter 2014
APPEALS.03		Expedited Appeals Within 3 Calendar Days	1st Quarter 2014
APPEALS.04		All Appeals Within 45 Calendar Days	1st Quarter 2014

**Table 6-2—Measures to Be Validated by HSAG for SFY 2013–2014**

Performance Measures to Be Validated for SFY 2013–2014 PMV Validation Cycle			
Reporting Reference ID	Measure	Indicator	Measurement Period to Be Validated
APPEALS.09	Appeals by Reason Type	Denial or Limited Authorization	1st Quarter 2014
APPEALS.10		Reduction, Suspension, or Termination of Previously Authorized Service	1st Quarter 2014
APPEALS.11		Denial of Payment	1st Quarter 2014
APPEALS.12		Failure to Provide Timely Service	1st Quarter 2014
APPEALS.13		Untimely Service Authorization	1st Quarter 2014
APPEALS.14		Failure of MCO to Act Within NH DHHS Contract Time Frames	1st Quarter 2014
CLAIM.01	Timely Professional and Facility Medical Claim Processing	within 30 Calendar Days of Receipt	April 2014 rates (daily calculation, summarized monthly)
CLAIM.06	Claims Quality Assurance: Claims Payment Accuracy		April 2014 monthly sampled percentage
INPUTIL.01	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members (Quarterly Rate)		1st Quarter 2014
MEMCOMM.06	Member Communications: Reasons for Telephone Inquiries	Report each as separate measure. A: Benefit Question Non-Rx B: Rx-Question C: Billing Issue D: Finding/Changing a PCP E: Finding a Specialist F: Complaints About Health Plan G: Enrollment Status H: Material Request I: Information/Demographic Update J: Giveaways K: Other	April 2014 rate
PHARMPAY.01	Mean Pharmacy Payments PMPY by Age Group	A. <=5 B. 6–13 C. 14–18 D. 19–44 E. 45–64 F. >=65 G. Total	1st Quarter 2014

**Table 6-2—Measures to Be Validated by HSAG for SFY 2013–2014**

Performance Measures to Be Validated for SFY 2013–2014 PMV Validation Cycle			
Reporting Reference ID	Measure	Indicator	Measurement Period to Be Validated
PHARMPAY.03	Median Pharmacy Payments PMPY by Age Group	A. <=5 B. 6–13 C. 14–18 D. 19–44 E. 45–64 F. >=65 G. Total	1st Quarter 2014
POLYPHARM.01	Polypharmacy Monitoring for All Medications by Age Group	For each number of claims (0, 1, 2, 3, 4, 5+), report numerator, denominator, and rate by age: 0–18, 19–44, 45–64, Total	1st Quarter 2014
POLYPHARM.02	Polypharmacy Monitoring for Behavioral Health Medications: All Children	For each number of claims (0, 1, 2, 3, 4, 5+), report numerator, denominator, and rate by age: 0–5, 6–18, Total 0–18	1st Quarter 2014
POLYPHARM.03	Polypharmacy Monitoring for Behavioral Health Medications: Children Receiving Foster Care Services	For each number of claims (0, 1, 2, 3, 4, 5+), report numerator, denominator, and rate by age: 0–5, 6–18, Total 0–18	1st Quarter 2014
PHARMUTLMGT.01	Pharmacy Utilization Management: Adherence to State PDL		1st Quarter 2014

**Table 6-2—Measures to Be Validated by HSAG for SFY 2013–2014**

Performance Measures to Be Validated for SFY 2013–2014 PMV Validation Cycle			
Reporting Reference ID	Measure	Indicator	Measurement Period to Be Validated
PROVCOMM.06	Provider Communications: Reasons for Telephone Inquiries	Report each as separate measure. A. Verifying Member Eligibility B. Billing/Payment C. Service Authorization D. Change of Address, Name, Contact Info, etc. E. Changing Service Mix Offered by Provider F. Changing Panel Size G. Voluntary Termination H. Enrollment/Credentialing I. Complaints About Health Plan J. Other	April 2014 rate
PROVRATIO.01	Member to Provider Ratio by Geographic Region: MCO Designated Primary Care Providers	Report as separate measure A. Metropolitan counties B. Non-metropolitan counties C. Non-NH/Unknown	1st Quarter 2014
PROVRATIO.02	Member to Provider Ratio by Geographic Region: Pediatricians	Report as separate measure A. Metropolitan counties B. Non-metropolitan counties C. Non-NH/Unknown	1st Quarter 2014
PROVRATIO.03	Member to Provider Ratio by Geographic Region: Maternity Providers	Report as separate measure A. Metropolitan counties B. Non-metropolitan counties C. Non-NH/Unknown	1st Quarter 2014
SERVICEAUTH.03	Medical Services, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests		1st Quarter 2014

The SFY 2013–2014 PMV activities and reports are scheduled to be completed by HSAG in November 2014. The results of the PMV activities will be reported in the SFY 2014–2015 New Hampshire EQR Technical Report.



## 7. CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS)

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### Overview

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The CAHPS survey is recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting data. At the end of SFY 2012–2013, DHHS contracted with HSAG to conduct CAHPS surveys of its child Medicaid FFS and CHIP populations.

### Methodology

The technical method of data collection was through administration of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set to statewide samples of the child Medicaid FFS and CHIP populations. The children included as eligible for the survey were 17 years of age or younger as of December 31, 2012. A mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to the mailed surveys) was used. The parents or caretakers of child beneficiaries completed the surveys from September to November 2013. All beneficiaries sampled received an English version of the survey.

The CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and CCC measurement set includes a set of standardized items (83 core questions). These survey questions were categorized into 16 measures of satisfaction. These measures include four global rating questions, five composite measures, two individual item measures, and five CCC composite measures/items. The global ratings reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). The individual item measures are individual questions that look at a specific area of care (e.g., *Health Promotion and Education* and *Coordination of Care*).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response).

For each of the composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of three categories: (1) “Never,” “Sometimes,” “Usually,” or “Always;” (2) “Not at all,” “A little,” “Some,” or “A lot;” or (3) “No” or “Yes.” A positive or top-box response for the composites was defined as a response of “Usually/Always” or “A lot/Yes.” The percentage of top-box responses is referred to as a global proportion for the composite scores.

For each of the individual items, the percentage of respondents who chose a positive response was calculated. CAHPS individual item response choices fell into one of two categories: (1) “Never,” “Sometimes,” “Usually,” or “Always;” or (2) “No” or “Yes.” A positive or top-box response for the individual items was defined as a response of “Usually/Always” or “Yes.” The percentage is referred to as a question summary rate (or top-box response).

For purposes of this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Caution should be exercised when interpreting results for those measures with less than 100 respondents. CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Additionally, for purposes of this report, the child Medicaid FFS and CHIP populations’ survey findings were compared to 2013 NCQA CAHPS Child Medicaid national averages.<sup>14,15</sup> For each population, a measure was noted when the measure’s rate was at least 5 percentage points higher or lower than the NCQA national average.

It is important to note that the CAHPS 5.0 Medicaid Health Plan Surveys were released by the Agency for Healthcare Research and Quality (AHRQ) in 2012. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child CAHPS Health Plan Surveys in August 2012, which are referred to as the CAHPS 5.0H Adult and Child Health Plan Surveys. As a result of the transition from the CAHPS 4.0H to the CAHPS 5.0H Child Medicaid Health Plan Surveys and changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2013 NCQA CAHPS national averages were not available for these measures; thus, comparisons to NCQA national data could not be performed.

For both CHIP and FFS, the results for two populations are reported: general child and CCC. The general child population represents results from child members selected as part of the simple random sample, which represents the general population of children. A series of questions included in the survey was used to identify children with chronic conditions (i.e., CCC screener questions). The survey responses for child members in both the general child sample and the CCC supplemental sample were analyzed to determine which child members had chronic conditions (i.e., CCC population). Based on parents’/caretakers’ responses to the CCC screener questions, these completed surveys were used to calculate the CCC CAHPS results presented in this report.

<sup>14</sup> Since NCQA does not publish separate benchmarking data for the CHIP population, NCQA national averages for the child Medicaid population are used for comparative purposes. Therefore, caution should be exercised when interpreting the results of the NCQA national average comparisons for the CHIP population.

<sup>15</sup> National data were obtained from Quality Compass®.

## Findings

### CHIP

In 2013, a total of 2,042 CHIP beneficiaries were surveyed, and 913 completed surveys were returned on behalf of CHIP beneficiaries. After ineligible beneficiaries were excluded, the response rate was 46.2 percent.<sup>16</sup> In 2013, the average NCQA response rate for the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set was 26.9 percent, which was lower than the CHIP response rate. Table 7-1 and Table 7-2 show the 2013 general child and 2013 CCC CAHPS results, respectively, for the CHIP population.<sup>17,18</sup>

**Table 7-1—CHIP General Child CAHPS Results**

CAHPS Measure	2013 General Child Top-Box Rates
<b>Global Ratings</b>	
Rating of Health Plan	65.4%
Rating of All Health Care	66.7%
Rating of Personal Doctor	75.0%
Rating of Specialist Seen Most Often	64.5%
<b>Composite Measures</b>	
Getting Needed Care	91.1%
Getting Care Quickly	94.7%
How Well Doctors Communicate	97.6%
Customer Service	87.7%
Shared Decision Making	56.0%
<b>Individual Item Measures</b>	
Coordination of Care	85.2%
Health Promotion and Education	69.0%

The CHIP 2013 top-box rates for the general child population were lower than the 2013 NCQA child Medicaid national averages for two of the nine comparable measures: *Rating of Health Plan* and *Rating of Specialist Seen Most Often*. Furthermore, the rate for *Rating of Specialist Seen Most Often* was lower than the NCQA national average by 5 percentage points or more. However, for the

<sup>16</sup> The survey disposition and response rate results are based on the responses of parents/caretakers of CHIP beneficiaries in the general child and CCC supplemental populations.

<sup>17</sup> The top-box rates presented in Table 7-1 are based on results of the general child population. The top-box rates presented in Table 7-2 are based on results of the CCC population.

<sup>18</sup> As previously noted, due to changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2013 NCQA national average data were not available and comparisons could not be performed.

remaining seven comparable measures, the CHIP 2013 top-box rates for the general child population were higher than the 2013 NCQA child Medicaid average. For *Getting Needed Care*, *Getting Care Quickly*, and *Coordination of Care*, the measures were higher than the 2013 NCQA national average by 5 percentage points or more.

**Table 7-2—CHIP CCC CAHPS Results**

CAHPS Measure	2013 CCC Top-Box Rates
<b>Global Ratings</b>	
Rating of Health Plan	59.0%
Rating of All Health Care	61.2%
Rating of Personal Doctor	73.0%
Rating of Specialist Seen Most Often	67.1%
<b>Composite Measures</b>	
Getting Needed Care	90.1%
Getting Care Quickly	95.4%
How Well Doctors Communicate	97.4%
Customer Service	86.7% <sup>+</sup>
Shared Decision Making	63.4%
<b>Individual Item Measures</b>	
Coordination of Care	82.7%
Health Promotion and Education	75.6%
<b>CCC Composites and Items</b>	
Access to Specialized Services	85.7% <sup>+</sup>
FCC: Personal Doctor Who Knows Child	93.9%
Coordination of Care for Children with Chronic Conditions	78.0%
Access to Prescription Medicines	94.6%
FCC: Getting Needed Information	91.4%
<i>CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting results for those measures with less than 100 respondents.</i>	

The CHIP 2013 top-box rates for the CCC population were lower than the 2013 NCQA child Medicaid national averages for five of the 14 comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Customer Service*. Of these five measures, the rate for the *Rating of Health Plan* was lower than the NCQA national average by 5 percentage point or more. For the CHIP CCC population, the 2013 top-box rates were higher than the 2013 NCQA child Medicaid national average for nine comparable measures; of these, the rate for the *Access to Specialized Services* CCC measure was higher than the 2013 NCQA national average by 5 percentage points or more.

## Child Medicaid FFS

In 2013, a total of 3,490 child Medicaid FFS beneficiaries were surveyed, and 1,183 completed surveys were returned on behalf of the child beneficiary. After ineligible beneficiaries were excluded, the response rate was 34.6 percent.<sup>19</sup> In 2013, the average NCQA response rate for the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set was 26.9 percent, which was lower than the child Medicaid FFS' response rate. Table 7-3 and Table 7-4 show the 2013 general child and 2013 CCC CAHPS results, respectively, for child Medicaid FFS.<sup>20,21</sup>

**Table 7-3—Child Medicaid FFS General Child CAHPS Results**

CAHPS Measure	2013 General Child Top-Box Rates
<b>Global Ratings</b>	
Rating of Health Plan	61.0%
Rating of All Health Care	68.7%
Rating of Personal Doctor	76.2%
Rating of Specialist Seen Most Often	67.2%
<b>Composite Measures</b>	
Getting Needed Care	89.8%
Getting Care Quickly	93.5%
How Well Doctors Communicate	96.5%
Customer Service	81.4% <sup>+</sup>
Shared Decision Making	63.1%
<b>Individual Item Measures</b>	
Coordination of Care	86.7%
Health Promotion and Education	73.1%
CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting results for those measures with less than 100 respondents.	

For the Child Medicaid FFS general child population, the 2013 top-box rates for three of the nine comparable measures (*Rating of Health Plan*, *Rating of Specialist Seen Most Often*, and *Customer Service*) were lower than the 2013 NCQA child Medicaid national averages. Furthermore, the rates for two of these measures, *Rating of Health Plan* and *Customer Service*, were lower than the NCQA national average by 5 percentage points or more. However, for the remaining six comparable measures, the

<sup>19</sup> The survey disposition and response rate results are based on the responses of parents/caretakers of child Medicaid FFS beneficiaries in the general child and CCC supplemental populations.

<sup>20</sup> The top-box rates presented in Table 7-3 are based on results of the general child population. The top-box rates presented in Table 7-4 are based on results of the CCC population.

<sup>21</sup> As previously noted, due to changes to the *Shared Decision Making* composite measure and *Health Promotion and Education* individual item measure, 2013 NCQA national average data were not available and comparisons could not be performed.

rates for the Child Medicaid FFS general child population were higher than the 2013 NCQA national average. Moreover, rates for *Getting Needed Care* and *Coordination of Care* were higher than the 2013 NCQA child Medicaid national average for by 5 percentage points or more.

**Table 7-4—Child Medicaid FFS CCC CAHPS Results**

CAHPS Measure	2013 CCC Top-Box Rates
<b>Global Ratings</b>	
Rating of Health Plan	56.0%
Rating of All Health Care	63.0%
Rating of Personal Doctor	73.8%
Rating of Specialist Seen Most Often	65.9%
<b>Composite Measures</b>	
Getting Needed Care	85.1%
Getting Care Quickly	92.2%
How Well Doctors Communicate	94.8%
Customer Service	75.2%
Shared Decision Making	63.1%
<b>Individual Item Measures</b>	
Coordination of Care	81.3%
Health Promotion and Education	72.5%
<b>CCC Composites and Items</b>	
Access to Specialized Services	76.0%
Family-Centered Care (FCC): Personal Doctor Who Knows Child	91.1%
Coordination of Care for Children with Chronic Conditions	77.5%
Access to Prescription Medicines	91.3%
FCC: Getting Needed Information	90.1%

The Child Medicaid FFS 2013 top-box rates for the CCC population were lower than the 2013 NCQA child Medicaid national average for seven of the 14 comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Customer Service*, *Access to Specialized Services*, and *FCC: Getting Needed Information*. Of these seven measures, the rates for *Rating of Health Plan* and *Customer Service* were below the NCQA national average by 5 percentage points or more. Rates for the remaining seven comparable measures were higher than the 2013 NCQA child Medicaid national average; however, the difference in rates was minor.

## Opportunities for Improvement and Recommendations

HSAG performed a comparison of the CHIP and Child Medicaid FFS populations' 2013 CAHPS survey results to the 2013 NCQA CAHPS Child Medicaid national averages to determine potential areas for improvement. Based on these comparisons, the following areas were identified as opportunities for improvement for CHIP and FFS for both the general child and CCC populations.

### CHIP

For the CHIP general child population, HSAG recommends that CHIP focus quality improvement efforts on *Rating of Specialist Seen Most Often*. For the CCC population, HSAG recommends that CHIP focus quality improvement initiatives on enhancing beneficiaries' experiences with *Rating of Health Plan*. HSAG recommends CHIP focus quality improvement in these areas, since the measures' rates were 5 percentage points or more below NCQA's 2013 CAHPS child Medicaid national averages. The following are recommendations of best practices and other proven strategies that can be used or adapted by the program to target improvement in each of these areas.

### Rating of Specialist Seen Most Often

**Planned Visit Management**—The program should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons.

**Skills Training for Specialists**—The program can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

**Telemedicine**—Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine, such as live, interactive videoconferencing, allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there is a shortage of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a



case conference with the specialist at the end of the teleconference visit. Furthermore, the local provider is more involved in the consultation process and more informed about the care the patient is receiving.

## Rating of Health Plan

**Alternatives to One-on-One Visits**—The program should engage in efforts that assist providers in examining and improving their systems’ abilities to manage patient demand. As an example, the State could test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of health care services and appointments.

Alternatives to traditional one-on-one, in-office visits can assist in improving physician availability and ensuring patients receive immediate medical care and services.

**Health Plan Operations**—It is important for programs to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to beneficiaries) that provide the health care “products.” The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable staff to provide high-quality, patient-centered care. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health system.

**Promote Quality Improvement Initiatives**—Implementation of organization-wide quality improvement (QI) initiatives is most successful when program staff members at every level are involved. Methods for achieving this can include aligning QI goals to the mission and goals of the program, establishing program-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, progress of QI initiatives should be monitored and reported internally to assess the effectiveness of these efforts.

## Child Medicaid FFS

For the Child Medicaid FFS general child and CCC populations, HSAG recommends that efforts focus on improving *Rating of Health Plan* and *Customer Service*, since these rates were below the NCQA’s 2013 CAHPS child Medicaid national averages by 5 percentage points or more. The following are recommendations of best practices and other proven strategies that can be used or adapted by the program to target improvement in each of these areas.

## Rating of Health Plan

**Alternatives to One-on-One Visits**—The program should engage in efforts that assist providers in examining and improving their systems’ abilities to manage patient demand. As an example, the health plan could test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of health care services and appointments.



Alternatives to traditional one-on-one, in-office visits can assist in improving physician availability and ensuring patients receive immediate medical care and services.

**Health Plan Operations**—It is important for programs to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan’s health care “products.” The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.

**Promote Quality Improvement Initiatives**—Implementation of organization-wide QI initiatives is most successful when program or health plan staff members at every level are involved. Methods for achieving this can include aligning QI goals to the mission and goals of the program/health plan organization, establishing program-level and plan-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, progress of QI initiatives should be monitored and reported internally to assess the effectiveness of these efforts.

## Customer Service

**Call Centers**—An evaluation of current program and call center hours and practices can be conducted to determine if the hours and resources meet beneficiaries’ needs. If it is determined that the call center is not meeting beneficiaries’ needs, an after-hours customer service center can be implemented to assist beneficiaries after normal business hours and/or on weekends. Additionally, asking beneficiaries to complete a short survey at the end of each call can assist in determining if beneficiaries are receiving the help they need and identify potential areas for customer service improvement.

**Creating an Effective Customer Service Training Program**—The program should consider implementing a training program to meet the needs of its unique work environment. Recommendations from employees, managers, and business administrators could be used and serve as guidance when constructing the training program. The customer service training program could be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and service recovery to ensure staff members feel competent in their ability to deal with difficult patient/beneficiary encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job.

**Customer Service Performance Measures**—Establishing customer service standards can assist in addressing areas of concern and serve as domains to evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified, as needed.

## 8. FOCUS GROUPS

### Overview

In support of the HSAG's EQR of New Hampshire's Medicaid Care Management Program, HSAG selected Horn Research to perform the tasks associated with gathering qualitative information from Medicaid beneficiaries regarding their experience with the transition to the Medicaid Care Management Program. In conjunction with DHHS and HSAG, Horn Research identified four Key Points of Inquiry to explore during data collection efforts: *Experience with Medicaid Care Management, Access to Care, Quality of Care and Care Management, and Information Needs*. During SFY 2013–2014, Horn Research conducted four focus groups and stakeholder interviews in Manchester, New Hampshire, and Laconia, New Hampshire, with targeted Medicaid MCO members during May 2014.

### Methodology

DHHS provided Horn Research a “blind” list of all Medicaid beneficiaries in Hillsborough County and Belknap County with identification numbers, managed care provider (e.g., **Meridian**, **NH Healthy Families**, or **Well Sense**), gender, age, and eligibility category (e.g., adult with disability, child with disability, low-income adult, or low-income child). From this list, Horn Research selected a random sample of beneficiaries that was proportionately representative of the eligibility categories reflected in the New Hampshire Medicaid population.

Multiple recruitment efforts, including letters, e-mails, and telephone calls, were employed to encourage participation and resulted in all groups being filled to capacity. However, due to illness, work constraints, and child care issues, a number of participants were unable to attend the focus groups as scheduled causing a lower-than-anticipated turnout. These individuals were offered the opportunity to participate in a telephone interview to ensure that their opinions were reflected in the survey results. A total of 36 individuals participated in the project.

### Findings

When all focus groups and telephone interviews were completed, the information was analyzed by identifying, coding, and categorizing primary patterns in the data. The consistent patterns found in the analysis of the data and the representative sample support the validity of the information gathered, but they should not be assumed to be *statistically* representative of the whole population. The information provided should be used to identify salient issues relevant to the population, provide contextual information for the larger assessment process, and identify avenues for further research.

## ***Experience With Medicaid Care Management***

In order to understand their knowledge of and engagement with Medicaid Care Management and their MCO, participants were asked to describe how they chose their MCO, what they liked best and least about their MCO, and any problems they have experienced. Participants said they had sufficient notification of the change to managed care but did not feel adequately prepared to decide between MCOs. Most participants selected the MCO that included their PCP in the network rather than the MCO that provided the best coverage for their needs. Overall, participants said they did not understand their MCO and did not know how to find out about or understand coverage details. Several participants said they experienced significant delays in receiving their benefit cards.

## ***Access to Care***

A key to understanding how well the Medicaid Care Management Program is performing is to identify whether participants have experienced improved or diminished access to doctors, specialists, medications, and ancillary services. Overall, participants said that access to their doctors has remained the same. The main concerns expressed about access were related to medications and specialists. Many participants said they had experienced challenges with medications not being covered under the new MCO and delays in receiving prescriptions and referrals to specialists due to the pre-authorization process. Participants expressed concern about reduced access to dental care as a component of preventive care. They did not understand that dental benefits are provided by the State Medicaid system and not the MCOs.

## ***Quality of Care and Care Management***

Focus groups provided valuable insight into the quality of care, and coordination of care, participants received. Participants were asked to assess the quality of their providers and care coordination, describe their role in their health care, and share whether they feel they are or can be active participants in coordinating their care. Participants were evenly divided on the assessment of the quality of their PCP, but did not necessarily relate that assessment to their MCO. For those who required care coordination, most felt their care was coordinated adequately. Nearly all participants felt they had an active role in making decisions about their care and their children's health care.

## ***Information Needs***

The focus groups also explored the information that participants most want to receive from their MCOs, including information about health education, providers, and benefits/coverage and how they would prefer to receive it. In general, participants did not report receiving useful information from their MCO; in fact, most said they had not received any information. Information on

physician quality and clear information on benefits and coverage were most frequently mentioned as information needs and desires. While a small number of participants were comfortable and preferred online resources, the majority of people said they preferred to receive information in hard-copy format.

### ***Improvements to MCO and Medicaid***

Participants were asked to suggest one improvement they would make to their MCO and to Medicaid overall. In general, participants had difficulty distinguishing between the roles of the MCO and Medicaid, which resulted in some overlap in responses for improvements for each. Overall, participants would like to see their MCO expand benefits to include more dental care and prescription medications. Participants would like Medicaid to expand eligibility to include more adults and to provide clearer information on eligibility rules.

## **Opportunities for Improvement and Recommendations**

The participants offered suggestions to improve the Medicaid Care Management Program and made recommendations that were grouped in the following five categories.

### ***Improve Benefit and Coverage Information***

A clear and concise overview of plan benefits provided in easy-to-understand language would be a positive improvement for beneficiaries. Including a comprehensive list of covered medications would also assist beneficiaries in more effectively deciding which MCO best meets their needs.

### ***Improve Prescription Pre-authorization Process***

Streamlining the process to review beneficiaries' medical history before requiring testing of cheaper medications and reducing or eliminating pre-authorization for medications required for long-term and/or permanent health conditions would be beneficial. Additionally, reducing the time frame for pre-authorizations would be a favorable improvement. Some of the issues expressed by participants regarding pre-authorization may have been due to the requirement for MCOs to honor pre-authorizations for prescriptions during the first 90 days of enrollment. This requirement may have resulted in members needing approval for medications previously used within the 90-day period. This issue may not persist once members transition to their MCO's formulary management. Exploring participants' experience with prescription medications in future focus group activities would be beneficial.

***Expand Physician Information***

Additional information on physician philosophy, experience, and specialties, along with routine information such as whether physicians are currently accepting new Medicaid patients, location, and hours, would improve beneficiaries' ability to effectively select PCPs and specialists. Developing quality metrics and an option for user reviews may also improve beneficiaries' knowledge of options.

***Tailor Health Education Materials***

A more consistent effort to specifically tailor health education materials to beneficiaries based on history and needs could more effectively engage beneficiaries in proactively improving their health.

***Expansion of Health Benefits***

Participants agreed they would like to see an expansion of health benefits to include more services and prescription coverage. In particular, expanding preventive health benefits to include preventive dental care for adults could reduce long-term health costs.

## 9. ENCOUNTER DATA VALIDATION

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### Overview

The BBA of 1997 established guidelines for quality assessment and performance improvement activities to be performed by states administering a Medicaid managed care program. CMS acknowledged the importance of using encounter data for managing Medicaid managed care programs and drafted protocols to be used in the encounter data validation process.<sup>22</sup> Encounter data can be instrumental in assessing and improving the quality of care rendered to Medicaid beneficiaries. In order for encounter data to be used to examine the New Hampshire Medicaid Care Management Program, however, the data must be reliable, valid, complete, and accurate. One of the tasks required by HSAG's EQRO contract with DHHS involves validating the encounter data submitted by the New Hampshire Medicaid MCOs. During SFY 2013–2014, HSAG met with DHHS to begin discussing the encounter data validation activities and preparing for the receipt of New Hampshire Medicaid Care Management Program encounter data.

### Methodology

At the end of SFY 2013–2014, HSAG had not received encounter data. HSAG will develop a methodology for the New Hampshire encounter data validation in collaboration with DHHS as data become available. The results from the SFY 2013–2014 encounter data validation activities will be included in the New Hampshire EQR Technical Report for SFY 2014–2015.

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<sup>22</sup> Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2012). *Validation of Encounter Data Reported by the MCO, Version 2.0*. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: Feb 19, 2013.

## 10. ACCESS REPORTING

### Overview

As stated in the *Monitoring Access to Care in New Hampshire's Medicaid Program* report dated May 2013, “pursuant to 42 U.S.C. 1396a(a)(30)(A), the New Hampshire Medicaid program must provide for methods and procedures relative to the utilization of and payment for covered care and services as are necessary to safeguard against unnecessary utilization of care and services and assure that payments are consistent with efficiency, economy, and quality of care”<sup>23</sup> One of the tasks required by HSAG's EQRO contract with DHHS involves producing the Medicaid program's access to care report for the State. To accomplish this task, HSAG will receive data and begin evaluating access to care from the first quarter of 2013 to the present. During SFY 2013–2014, HSAG met with DHHS to prepare for the receipt of the data and began discussing the contents and format of the report.

### Methodology

Information furnished by the Medicaid and CHIP Payment and Access Commission (MACPAC) will be used to develop the New Hampshire Medicaid access report. The Medicaid analysis of access to care will follow MACPAC's three-pronged approach: beneficiary characteristics, provider capacity, and service utilization rates.<sup>24</sup> The beneficiary characteristics will include the number of beneficiaries in the New Hampshire Medicaid program, demographics, enrollment data, trends in enrollment, and geographic dispersion.<sup>25</sup> To determine the sufficiency of the capacity of the network, HSAG will evaluate the number of providers and facilities available to furnish services to the New Hampshire Medicaid population. The utilization rates will be determined by examining the data to determine the services accessed by Medicaid beneficiaries.

HSAG continues to work with DHHS to determine the format and contents of the data to be used in developing the New Hampshire Medicaid access reports. At the end of fiscal year 2013–2014, HSAG received data files and began the data-mining process to determine the format and contents of the files. The results from the access reports covering SFY 2013–2014 for the New Hampshire Medicaid beneficiaries will be included in the New Hampshire SFY 2014–2015 EQR Technical Report.

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<sup>23</sup> New Hampshire Department of Health and Human Services Office of Medicaid Business and Policy. *Monitoring Access to Care in New Hampshire's Medicaid Program*. (2013). Available at: <http://www.dhhs.nh.gov/ombp/documents/medicaid-report-may2013.pdf>. Accessed on: October 3, 2014.

<sup>24</sup> Ibid.

<sup>25</sup> Ibid.



## 11. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) ADULT CORE SET MEASURES

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### Overview

In December 2012, CMS initiated the Adult Medicaid Quality Grant Program to measure and improve the quality of care for Medicaid beneficiaries. The grant supports state Medicaid agencies in collecting, reporting, and analyzing data on the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid. New Hampshire was one of the 26 states to participate in the program.<sup>26</sup> During SFY 2013–2014, DHHS contracted with HSAG to produce the rates for the HEDIS *Prenatal and Postpartum Care* measure for the population included in the New Hampshire Adult Medicaid Quality Grant (i.e., FFS population).

### Methodology

According to HEDIS specifications, the *Timeliness of Prenatal Care* measure component is defined as the percentage of deliveries that received a prenatal care visit as a member of the MCO in the first trimester or within 42 days of enrollment in the MCO. The postpartum care measure is defined as the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.<sup>27</sup>

The *Prenatal and Postpartum Care* measure was calculated using the hybrid methodology, which requires both administrative and medical record data. The hybrid method used administrative data to identify Medicaid beneficiaries meeting denominator criteria (i.e., the eligible population) and numerator compliance, when applicable. A sample was drawn from the eligible population, and medical records for beneficiaries in the sample were procured and reviewed, unless administrative data had shown beneficiaries to be numerator-positive. Medical record review was conducted by trained HSAG nurses using an HSAG-designed, Web-based data collection tool. Medical record review results were combined with the portion of the sample identified as meeting numerator criteria through administrative data to determine the final rate.

### Sampling

A base sample size of 411 beneficiaries was selected and a 5 percent oversample was applied. Oversamples were rounded up to the nearest whole number. The sample for this measure was calculated in accordance with the systematic sampling methodology presented in *HEDIS 2013*

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<sup>26</sup> Department of Health and Human Services Centers for Medicare & Medicaid Services. (n.d.) *Adult Medicaid Quality Grants*. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Medicaid-Quality-Grants.html>. Accessed on: October 3, 2014.

<sup>27</sup> National Committee for Quality Assurance. *HEDIS 2013, Volume 2: Technical Specifications for Health Plans*. Washington, DC: NCQA Publication, 2012.

*Volume 2: Technical Specifications for Health Plans.*<sup>28</sup> This methodology specifies that samples should be selected systematically using a random starting observation.

## Findings

Table 11-1 displays the *Prenatal and Postpartum Care* measure results from the hybrid data collection methodology. Measure rate calculations were based on calendar year 2012 data using HEDIS 2013 Technical Specifications.

**Table 11-1—Prenatal and Postpartum Care Results**

Data Element	Timeliness of Prenatal Care	Postpartum Care
<b>Administrative Data Calculations</b>		
Eligible population	3,887	3,887
Number of numerator events by administrative data in eligible population (before exclusions)	1,155	1,749
Administrative rate (before exclusions)	29.71%	45.00%
Final sample size (FSS)	432	432
Number of numerator events by administrative data in FSS	111	206
Administrative rate on FSS	25.69%	47.69%
<b>Exclusions</b>		
Number of sample records excluded because of valid data errors	4	4
Number of medical records excluded	0	0
<b>Hybrid Data Calculations</b>		
Denominator	428	428
Numerator events by administrative data	110	205
Numerator events by medical records	117	67
Reported rate <sup>29</sup>	53.04%	63.55%
<b>Confidence Intervals</b>		
Lower 95% confidence interval	48.19%	58.87%
Upper 95% confidence interval	57.65%	67.99%

<sup>28</sup> Ibid.

<sup>29</sup> Reported rate is calculated as follows: (Numerator events by administrative data + Numerator events by medical records)/Denominator.

The overall reported rate for the *Timeliness of Prenatal Care* measure component is 53.04 percent. The overall reported rate for the *Postpartum Care* measure component is 63.55 percent.

**Figure 11-1—Overall Reported Rates for Timeliness of Prenatal Care and Postpartum Care**



The administrative rate for the *Postpartum Care* measure component was higher than the administrative rate for the *Timeliness of Prenatal Care* measure component. The number of events found due to medical record review increased the *Timeliness of Prenatal Care* measure component rate by approximately 27 percent and the *Postpartum Care* measure component rate by approximately 16 percent.

The *Postpartum Care* measure component rates were also stratified by two categories: (1) Metro versus Non-Metro, and (2) Race. Table 11-2 and Table 11-3 display the *Postpartum Care* measure component results stratified by Metro versus Non-Metro and Race, respectively.

**Table 11-2—Postpartum Care Results: Metro Versus Non-Metro Stratification**

Data Element	Metro	Non-Metro	Out of State	Total
Numerator	146	120	6	272
Denominator	226	191	11	428
Reported rate	64.60%	62.83%	54.55%	63.55%
Lower 95% confidence interval	58.15%	55.71%	20.57%	58.87%
Upper 95% confidence interval	70.62%	69.42%	79.43%	67.99%

The number of beneficiaries located in metro counties (i.e., urban) and non-metro (i.e., rural) counties are fairly consistent, while only a small number are located out of state.

Table 11-3 displays the race category breakouts for this measure. The overall reported rate for the *Postpartum Care* measure component is 63.55 percent.

**Table 11-3—Postpartum Care Results: Race Stratification**

Data Element	White	Black or African-American	Hispanic	Other	Unknown	Total
Numerator	252	7	9	3	1	272
Denominator	395	8	17	6	2	428
Reported rate	63.80%	87.50%	52.94%	50.00%	50.00%	63.55%
Lower 95% confidence interval	58.93%	58.33%	26.27%	1.66%	0.00%	58.87%
Upper 95% confidence interval	68.41%	100.00%	73.73%	81.67%	94.30%	67.99%

## Opportunities for Improvement and Recommendations

The national benchmarks available for comparing the New Hampshire rates for the two components of this measure are from the 2013 HEDIS national Medicaid benchmarks for HMOs. Although this study was conducted using women in FFS Medicaid in New Hampshire and the HEDIS benchmarks are from women in HMOs, HSAG is presenting the 2013 HEDIS national Medicaid benchmarks to allow DHHS to compare the FFS beneficiary rates to the national Medicaid HMO member rates listed below:

- ◆ *Timeliness of Prenatal Care*—82.93 percent
- ◆ *Postpartum Care*—63.05 percent

DHHS exceeded the 2013 national average for the *Postpartum Care* measure component (63.05 percent), but was well below the 2013 national average for the *Timeliness of Prenatal Care* measure component (82.93 percent).

Key areas of focus for improving these measure rates should be provider education and beneficiary education. Providers should be further educated on HEDIS specifications and the numerator requirements for beneficiaries to be counted as part of measure calculations. Beneficiary education regarding pregnancy also is important, as a healthy pregnancy begins even before a woman becomes pregnant. Beneficiaries should be knowledgeable about available health plans or clinics to provide prenatal care, vital prenatal care activities and tests, and postpartum care. Some recommendations have been provided below for DHHS' consideration in developing strategies and interventions to improve prenatal and postpartum care. As with all studies involving medical record procurement, the rate of records requested is influenced by available provider demographic information, the quality of the submitted documentation, and the willingness of the

provider to release the requested documentation. Therefore, provider education is an important aspect in planning future studies.

### ***Timeliness of Prenatal Care Recommendations***

- ◆ Encourage proactive outreach to all women newly enrolled in Medicaid with pregnancy as their eligibility category (e.g., placing welcome calls, informing them of clinics or providers in their area).
- ◆ Ensure all clinicians are informed about the HEDIS requirement to document the initiation of prenatal care before 13 weeks.
- ◆ Educate physicians' office staff concerning the importance of checking gestational age when scheduling first prenatal visits.
- ◆ Address high unintended pregnancy rates by having providers ask all women about their pregnancy intentions as a routine part of primary care. One of the most effective ways to influence getting prenatal care is to talk about early prenatal care before a woman becomes pregnant.<sup>30</sup>
- ◆ Promote early prenatal care by targeting outreach and education efforts to low-income communities, as well as low-income women of reproductive age.<sup>31</sup>

### ***Postpartum Care Recommendations***

- ◆ Scheduling and follow-up:
  - Schedule postpartum visits 4 to 5 weeks after delivery, or prior to delivery, within 4 weeks of the expected date of delivery.<sup>32</sup>
  - Conduct active outreach for missed appointments or “no shows.”
  - Track postpartum appointments—scheduled, utilized, cancelled, and no shows. For missed appointments or “no shows,” staff should conduct active outreach to patients to reschedule the appointment.<sup>33,34</sup>

<sup>30</sup> Bellanca H. Oregon CCO “Timeliness to prenatal care” metric. Available at: <http://transformationcenter.org/wp-content/uploads/2013/10/1-prenatal-care-metric-explanation.pdf>. Accessed on: September 4, 2014.

<sup>31</sup> Ibid.

<sup>32</sup> Affinity Health Plan. Keys to Quality—Strategies to Increase Postpartum Visit Adherence. 2010. Available at: [https://www.affinityplan.org/uploadedFiles/Affinity/Providers/QM\\_Updates/Postpartum%20Visit.pdf](https://www.affinityplan.org/uploadedFiles/Affinity/Providers/QM_Updates/Postpartum%20Visit.pdf). Accessed on: September 4, 2014.

<sup>33</sup> Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid. *Improving the Management of Postpartum Visits*. MassHealth Physician Bulletin 95 July 2013. Available at: <http://www.mass.gov/eohhs/docs/masshealth/bull-2013/phy-95.pdf>. Accessed on: September 4, 2014.

<sup>34</sup> Affinity Health Plan. Keys to Quality—Strategies to Increase Postpartum Visit Adherence. 2010.

- Piggyback postpartum visits with infant appointments if the mother and the baby are patients at the same office/clinic site.<sup>35</sup>
- ◆ Engaging patients:
  - Provide counseling and education during the prenatal period that emphasizes the importance of postpartum care.<sup>36</sup>
  - Provide information on community resources or supports.<sup>37</sup>
  - Ensure patients know they will need a postpartum check-up during the prenatal period and make sure they know who they should see for this check-up.<sup>38</sup>

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<sup>35</sup> Ibid.

<sup>36</sup> Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid. *Improving the Management of Postpartum Visits*. MassHealth Physician Bulletin 95 July 2013. Available at: <http://www.mass.gov/eohhs/docs/masshealth/bull-2013/phy-95.pdf>. Accessed on: September 4, 2014.

<sup>37</sup> Ibid.

<sup>38</sup> Affinity Health Plan. Keys to Quality—Strategies to Increase Postpartum Visit Adherence. 2010.

## 12. PERFORMANCE MEASURE REPORTING

### Overview

Calculation of the MCOs' performance measures is an activity defined by the BBA in 42 CFR 438.358(c)(3) and the CMS-established protocols that are used during the calculation of the measures.<sup>39</sup> DHHS requires the MCOs in the New Hampshire Care Management Program to submit performance measure data as part of their quality assessment and performance improvement programs. New Hampshire will use the information to measure, compare, and monitor the performance of the MCOs over time. DHHS contracted with HSAG to provide a comparison of performance measures designated by DHHS during the first year of operation in the State of New Hampshire. The comparison may include rates from the MCOs in the New Hampshire Care Management Program, the Medicaid fee-for-service population, the commercial populations, the CMS Adult Core Set Measures, and national Medicaid benchmarks established by NCQA.

### Methodology

The performance measures reported by the MCOs and the specifications for calculating the performance measures will be defined by DHHS. At the end of SFY 2013–2014, HSAG was working with DHHS to develop a list of the measures to be reported by the MCOs for the period of operation ending June 30, 2014. The SFY 2013–2014 performance measure results and their comparisons will be included in the New Hampshire SFY 2014–2015 EQR Technical Report.

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<sup>39</sup> Department of Health and Human Services Centers for Medicare & Medicaid Services. *EQR Protocol 6: Calculation of Performance Measures: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: Feb 19, 2013.