
State of New Hampshire
Department of Health and Human Services

# State Fiscal Year 2024 Service Authorization Quality Study

*January 2025*

HSAG HEALTH SERVICES ADVISORY GROUP

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# Acknowledgements and Conflict of Interest Statement

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

Health Services Advisory Group, Inc. (HSAG) confirms that no one conducting the State Fiscal Year 2024 Quality Study activities had a conflict of interest with **AmeriHealth Caritas New Hampshire**, **New Hampshire Healthy Families**, and **WellSense Health Plan**.

# 1. Executive Summary

The New Hampshire Department of Health and Human Services (DHHS) asked Health Services Advisory Group, Inc. (HSAG), New Hampshire's external quality review organization, to conduct a quality study to determine how each managed care organization (MCO) in the New Hampshire Medicaid Care Management (MCM) Program defined the reasons for denied service authorizations included in the quarterly SERVICEAUTH.05 Reports. Until DHHS received clarification concerning the specifications each MCO used to define the denials, the number of denials reported by the three MCOs could not be compared.

HSAG collected information for the study by sending questionnaires and scheduling meetings with the three Medicaid MCOs in New Hampshire: **AmeriHealth Caritas New Hampshire** (**ACNH**), **New Hampshire Healthy Families** (**NHHF**), and **WellSense Health Plan** (**WS**).

## Methodology

The process HSAG used to conduct the Service Authorization Quality Study is included in Appendix A. To begin the study, HSAG investigated the 32 service categories listed in the SERVICEAUTH.05 Report. HSAG assigned this task to employees familiar with the New Hampshire MCM Program who have worked on various external quality review (EQR) projects in the State. Appendix B includes the names and qualifications of the HSAG staff members assigned to the Service Authorization Quality Study.

As HSAG began this study, HSAG's subcontractor, Horn Research, concurrently conducted individual semi-structured interview sessions with 30 people who were adults or parents/guardians of children enrolled in the New Hampshire MCM Program. The study results indicated that the categories of services most frequently mentioned as areas of difficulty in obtaining approval for the requests included durable medical equipment (DME) and medications. After reviewing the results of the semi-structured interviews, DHHS instructed HSAG to limit the investigation of denied services to the State Plan members who had a service authorization denial for DME and/or pharmacy during second quarter (Q2) and Q3 2023. HSAG began investigating the reasons for denied service authorization requests for DME and pharmacy at the end of January 2024.

## Findings

The study included a summary of information submitted in the SERVICEAUTH.05 Reports for Q2 and Q3 2023. The SERVICEAUTH.05 Report required submission of information for 32 services (DME, high-tech radiology/imaging studies, pharmacy, etc.). The summary completed by HSAG included the number of service authorization requests, approvals, and denials for each of the MCO's 1915b and State Plan members. Table 1 includes a summary of the information from those reports concerning the service authorizations that were requested and denied.

**Table 1—SERVICEAUTH.05 MCO 1915b and State Plan: Q2 and Q3 2023**

| Population | Quarter Report | Service Authorization Requests | Service Authorization Denials | Percent Denied |
|---|---|---|---|---|
| 1915b | 2 | 8,043 | 1,100 | 13.7% |
| State Plan | 2 | 45,122 | 8,880 | 19.7% |
| **Total** | **2** | **53,165** | **9,980** | **18.8%** |
| 1915b | 3 | 6,641 | 690 | 10.4% |
| State Plan | 3 | 41,047 | 7,469 | 18.2% |
| **Total** | **3** | **47,688** | **8,159** | **17.1%** |

The highest numbers of service authorization requests (45,122) and denials (8,880) occurred in Q2 for State Plan members. The lowest numbers of service authorization requests (6,641) and denials (690) occurred in Q3 for the 1915b population.

During Q2 2023, the MCOs processed a total of 53,165 requests for authorization for the 1915b and State Plan populations, and the statewide denial rate was 18.8 percent. In Q3 2023, the MCOs processed a total of 47,688 requests for authorization for the 1915b and State Plan populations, and the statewide denial rate was 17.1 percent, which was slightly lower than the Q2 percentage.

DHHS requested that HSAG limit the service authorization study to State Plan members and focus on service authorizations requested and denied for DME and pharmacy during Q2 and Q3 2023. The information in the SERVICEAUTH.05 Report contained two categories of information for DME and two categories of information for pharmacy as shown below:

- DME
  - Adult excluding orthotics and prosthetics
  - Child (0–21 years) excluding orthotics and prosthetics
- Pharmacy
  - Behavioral health (BH) drugs (mental health and substance use disorder [SUD]) includes office-based (including injections)
  - Non-BH drugs (including injections)

In Q2 2023, the rate of denial for State Plan members for the two DME services ranged from 1.8 percent to 22.4 percent. The rate of denial for the two pharmacy services in Q2 ranged from 30.2 percent to 47.3 percent. All three MCOs denied fewer than 10 percent of requested services for DME for adults and children in Q3 2023. Denials for pharmacy, however, ranged from 30.2 percent to 47.3 percent.

After reviewing the information concerning the State Plan denials by MCO in Q2 and Q3 2023, HSAG investigated how each MCO determined the number submitted in each column in the report. The process to obtain information from the MCOs included multiple questionnaires and individual meetings with each MCO with the goal of defining the specifications used to compile the information submitted in the

SERVICEAUTH.05 Report. Appendix C includes the first questionnaire sent to the MCOs and their responses. Appendix D contains the second questionnaire sent to the MCOs, information from the virtual meeting, and the MCOs' responses.

The MCOs submitted two questionnaires and participated in virtual meetings. After compiling the information, HSAG identified consistencies in the processes the MCOs used to submit information for the SERVICEAUTH.05 Report. All three MCOs indicated that they:

- Used detail-level information, not header information, to count the number of authorization requests.
- Counted an authorization as requested even if the file was awaiting additional documentation from the provider.
- Included both non-urgent and expedited authorizations in the Requested column.
- Completed the request for additional information for DME within 14 calendar days of receipt.
- Counted all denials, including partial denials, in the Total Denied column.
- Considered an authorization request as pending if the request had not yet been approved or denied.
- Contacted the provider at least once for missing information.

Conversely, the MCOs' processes for follow-up on requested documentation for standard authorizations varied, including the number of attempts made and the time allotted to obtain additional information. The processes also varied for the type of authorization (i.e., DME and pharmacy) prior to deciding to approve or deny the request. All MCOs initiated the follow-up using a variety of methods such as telephone, fax, and electronic outreach via a portal.

- **ACNH** made two attempts to contact providers for missing information for pharmacy within 24 hours and within 48 hours for DME authorizations upon receipt of the request.
- **NHHF** made one attempt to contact providers for missing information for DME and pharmacy authorizations and completed the pharmacy authorizations within 24 hours.
- **WS** made one attempt to contact providers for missing information for DME within the 14-day period and within 24 hours for pharmacy authorizations. In addition, **WS** required a subcontractor to complete the authorizations and noted that the time for the decision by the subcontractor was generally half of the contract-required time.

As a final step in the study, HSAG requested detailed reasons for Q2 and Q3 2023 DME and pharmacy authorizations that the MCOs submitted as denied in the SERVICEAUTH.05 Report. In addition to the qualitative responses from each MCO on the questionnaires and interviews, HSAG reviewed the MCO-reported quantitative information concerning the numbers of denied authorizations for the focused service categories of DME and pharmacy and the reasons for the denials. The MCOs furnished information concerning the following:

- The total number of requested authorizations
- The total number of denied authorizations
- Classifications for the denied authorizations:

- Incomplete/incorrect paperwork submitted
- Not a New Hampshire Medicaid covered service
- Request was not medically necessary
- Out-of-network denial
- Other

With one exception, the most prevalent reason for denial from all MCOs for all four categories of services was that the request was not medically necessary. The exception, **WS**'s Q3 rate for the adult DME excluding orthotics and prosthetics service type, had seven total denials for the quarter, three of which were due to incomplete/incorrect paperwork. In both pharmacy services studied, from 77.7 percent to 100 percent of the cases denied in both quarters were denied for not meeting the medical necessity requirement.

## Conclusions, Limitations, and Recommendations

During the study, HSAG found that the three MCOs reported several similarities in the way they defined the numbers to submit for the quarterly SERVICEAUTH.05 Reports, including how each MCO calculated the requested and approved categories. The three MCOs reported different information in the Pending category of the SERVICEAUTH.05 Report and noted that some authorizations are not pended.

The study investigated more detailed reasons (i.e., not medically necessary, not a covered service, etc.) why the MCOs deny service authorization requests. Although the information obtained from the MCOs further defined the Total Denied column on the SERVICEAUTH.05 Report, future quality studies to determine what is included in the Request Determined Not Medically Necessary category may be necessary. Further study could investigate the reasons why the MCOs find the overwhelming majority of DME and pharmacy authorizations to be denied due to not meeting medical necessity. The high rate of pharmacy denials could be due to generic medications being available for requested brand-name medications or the medication not being on the formulary.

### *Limitations*

In addition, the study found some limitations in understanding the MCOs' processes for a cancelled request. **WS** reported that a request could be cancelled or nullified related to duplication or retraction of the request. Those requests which the MCO cancelled were not included in the Total Requested category, nor was it clear whether all MCOs removed the cancelled requests prior to counting them as approved or denied.

HSAG could not determine the case mix of the members assigned to each MCO to determine if a higher number of service authorizations was appropriate for one of the MCOs due to having members with more chronic conditions.

The SERVICEAUTH.05 Report is a snapshot of activity during a given moment in time. Authorizations could move from pended to denied or approved within a day, causing data mismatches in a retrospective review.

## Recommendations

HSAG provides the following recommendations from the information obtained as a result of this study for DHHS to consider:

- DHHS needs to develop specifications for each MCO to follow when submitting information for the SERVICEAUTH.05 Report.
- DHHS could consider including a Cancelled column on the SERVICEAUTH.05 Report to assist the MCOs in submitting this information on the report.
- HSAG confirmed that the MCOs could break down the Total Denied column into additional subcategories. Further refinement may be needed to identify specific reasons why the MCOs consider a service request not medically necessary.
- Further study could investigate the reasons that the MCOs find the overwhelming majority of DME and pharmacy authorizations to be denied due to not meeting medical necessity.
- Further study could determine if the high rate of pharmacy denials is due to generic medications being available for requested brand-name medications.
- DHHS could consider exploring the denials included in the Not a Covered Service category to determine if the same services are being requested by members enrolled in different MCOs.
- A future study could involve researching the denial decisions that were appealed by the member or provider to determine if the appeal overturned the original decision to deny.

# 2. Overview and Methodology

## Introduction

Since December 1, 2013, DHHS has operated the MCM Program, which is a statewide comprehensive risk-based capitated managed care program. Beneficiaries enrolled in the MCM Program receive services through one of three MCOs: **ACNH**, **NHHF**, and **WS**. All three health plans coordinate and manage their members' care through dedicated staff and a network of qualified providers.

The MCOs submit quarterly SERVICEAUTH.05 Reports with details concerning the number of requested service authorizations that the plans approved and denied. DHHS wanted to understand the specifications that each MCO used to determine the number of denied authorizations and therefore requested that HSAG conduct a quality study to investigate the information. HSAG examined the information submitted by the MCOs as denials in Q2 and Q3 2023 to determine the specifications each MCO used to submit information concerning their denied authorizations.

HSAG followed an 11-step process to complete the Service Authorization Quality Study which included the technical methods of data collection and analysis as shown in Appendix A. HSAG conducted the study from January to October 2024, and the process included multiple questionnaires and meetings with each MCO to define the logic used to compile the information submitted as denials for the SERVICEAUTH.05 Reports. Appendix B contains the names and qualifications of the HSAG employees assigned to conduct the study.

## Goal of the Study

DHHS created the SERVICEAUTH.05 Report for the MCOs to use to submit quarterly information concerning service authorizations. To assist the MCOs in completing the reports, DHHS provided instructions for each of the columns noted in Table 2.

**Table 2—Columns Included in the SERVICEAUTH.05 Report**

| MCO | Data Period (YYYY-Q#) | Service Category | 1915b/ State Plan | Requested | Approved | Total Denied | Percent Denied | Out-of-Network Denials | Pending |
|---|---|---|---|---|---|---|---|---|---|

The specifications created by DHHS for the Total Denied column are shown below:

> Enter the total number of denied service authorizations (including Out-of-Network) for each service category and population (1915b/State Plan). Indicate with a zero (0) if no service authorizations were denied for a particular field.

Without a specific definition of "denied," DHHS recognized that the numbers in the Total Denied column may include the following categories:

- Not meeting medical necessity;
- Out-of-network;
- Incomplete documentation or information submitted by the provider;
- Incorrect forms;
- Not a Medicaid covered service; or
- Other

The goal of the study was to determine how each MCO defined the "denied" service authorizations included in the SERVICEAUTH.05 Reports. DHHS asked HSAG to evaluate the information submitted by the MCOs for the SERVICEAUTH.05 Reports for Q2 and Q3 2023. The reports listed the number of service authorizations separately for the 1915b members and the State Plan members.

To begin the study, HSAG summarized the information in the Q2 and Q3 2023 SERVICEAUTH.05 Reports for the State Plan and 1915b Plan members. Table 3 displays a summary of the requested, approved, and total denied authorizations, by service category, provided by each MCO for the 1915b Plan members during Q2 2023.

**Table 3—SERVICEAUTH.05 MCO 1915b Plan: Q2 2023**

| Service Category | Requested | | | Approved | | | Total Denied | | |
|---|---|---|---|---|---|---|---|---|---|
| | ACNH | NHHF | WS | ACNH | NHHF | WS | ACNH | NHHF | WS |
| ABA Services | 24 | 41 | 103 | 24 | 36 | 103 | 0 | 5 | 0 |
| Adult Day Care | 0 | 0 | 9 | 0 | 0 | 9 | 0 | 0 | 0 |
| Audiology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Community Mental Health Center (excluding pharmacy) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DME Adult excluding Orthotics and prosthetics | 88 | 2 | 408 | 78 | 2 | 378 | 10 | 0 | 30 |
| DME Child (0–21 years) excluding Orthotics and prosthetics | 28 | 41 | 405 | 25 | 38 | 365 | 1 | 3 | 40 |
| EPSDT Special Requests (0–21 years)—Service requests for which state plan & administrative rules are silent on coverage (For all service authorizations in this service category, complete the tab EPSDT Special Requests) | 0 | 4 | 0 | 0 | 4 | 0 | 0 | 0 | 0 |
| Genetic Counseling and Testing | 0 | 4 | 15 | 0 | 4 | 13 | 0 | 0 | 2 |

| Service Category | Requested | | | Approved | | | Total Denied | | |
|---|---|---|---|---|---|---|---|---|---|
| | ACNH | NHHF | WS | ACNH | NHHF | WS | ACNH | NHHF | WS |
| High Tech Radiology/Imaging Studies | 403 | 27 | 1,214 | 286 | 23 | 1,162 | 117 | 4 | 52 |
| Home Health Services excluding LNA, Personal Care Attendant, and Private Duty Nursing | 0 | 11 | 254 | 0 | 11 | 252 | 0 | 0 | 2 |
| Hospice | 0 | 1 | 17 | 0 | 1 | 17 | 0 | 0 | 0 |
| Inpatient Hospital (Exclude SUD, Maternity, Surgical, Mental Health) | 28 | 38 | 671 | 24 | 31 | 616 | 1 | 7 | 55 |
| Inpatient Hospital Maternity (Non-SUD) and NICU (including neonatal abstinence syndrome) | 0 | 0 | 12 | 0 | 0 | 12 | 0 | 0 | 0 |
| Inpatient Hospital Mental Health and SUD | 0 | 4 | 78 | 0 | 4 | 78 | 0 | 0 | 0 |
| Inpatient Hospital Surgical (Non-SUD) | 2 | 4 | 38 | 2 | 4 | 36 | 0 | 0 | 2 |
| LNA Services | 0 | 11 | 122 | 0 | 11 | 121 | 0 | 0 | 1 |
| Medical Supplies such as syringes, saline, gauze | 0 | 12 | 209 | 0 | 12 | 192 | 0 | 0 | 12 |
| Orthotics and prosthetics | 0 | 6 | 139 | 0 | 6 | 138 | 0 | 0 | 1 |
| Other | 2 | 6 | 104 | 2 | 3 | 100 | 0 | 3 | 3 |
| Other SUD Services (non-Methadone) | 0 | 0 | 103 | 0 | 0 | 103 | 0 | 0 | 0 |
| Outpatient Surgeries (all settings) | 0 | 2 | 87 | 0 | 2 | 84 | 0 | 0 | 3 |
| Pain Management | 0 | 0 | 53 | 0 | 0 | 50 | 0 | 0 | 3 |
| Personal Care Attendant | 1 | 14 | 74 | 1 | 14 | 7 | 0 | 0 | 1 |
| Pharmacy: BH Drugs (Mental Health & SUD); includes office-based (including injections) | 24 | 12 | 260 | 16 | 7 | 188 | 8 | 5 | 72 |
| Pharmacy: Non-BH Drugs (including injections) | 111 | 65 | 1,059 | 54 | 48 | 568 | 57 | 17 | 491 |
| Physician/Medical services | 124 | 12 | 350 | 104 | 11 | 328 | 20 | 1 | 22 |
| Private Duty Nursing | 10 | 15 | 66 | 8 | 15 | 65 | 0 | 0 | 1 |
| Psychology including testing and neuropsychological testing | 0 | 0 | 10 | 0 | 0 | 10 | 0 | 0 | 0 |
| PT/OT/ST | 48 | 49 | 488 | 39 | 43 | 478 | 8 | 6 | 10 |
| Sleep Study | 60 | 0 | 24 | 54 | 0 | 24 | 6 | 0 | 0 |
| SUD Services—Intensive Outpatient | 0 | 245 | 38 | 0 | 227 | 38 | 0 | 18 | 0 |

| Service Category | Requested | | | Approved | | | Total Denied | | |
|---|---|---|---|---|---|---|---|---|---|
| | ACNH | NHHF | WS | ACNH | NHHF | WS | ACNH | NHHF | WS |
| SUD Services—residential | 0 | 0 | 54 | 0 | 0 | 54 | 0 | 0 | 0 |
| **Statewide Total** | **8,043** | | | **6,863** | | | **1,100** | | |

ABA=applied behavior analysis; EPSDT=Early and Periodic Screening, Diagnostic, and Treatment; LNA=licensed nursing assistant; NICU=neonatal intensive care unit; PT=physical therapy; OT=occupational therapy; ST= speech therapy

Statewide, there were 8,043 requests for service authorizations, and the overall denial rate for the 1915b population in Q2 2023 was 13.7 percent. Table 4 displays the summary of the requested, approved, and total denied authorizations, by service category, provided by each MCO for the State Plan members during Q2 2023.

**Table 4—SERVICEAUTH.05 MCO State Plan: Q2 2023**

| Service Category | Requested | | | Approved | | | Total Denied | | |
|---|---|---|---|---|---|---|---|---|---|
| | ACNH | NHHF | WS | ACNH | NHHF | WS | ACNH | NHHF | WS |
| ABA Services | 91 | 324 | 186 | 86 | 286 | 186 | 4 | 38 | 0 |
| Adult Day Care | 3 | 12 | 1 | 3 | 12 | 1 | 0 | 0 | 0 |
| Audiology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Community Mental Health Center (excluding pharmacy) | 28 | 0 | 0 | 28 | 0 | 0 | 0 | 0 | 0 |
| DME Adult excluding Orthotics and prosthetics | 558 | 493 | 74 | 506 | 484 | 64 | 49 | 9 | 10 |
| DME Child (0–21 years) excluding Orthotics and prosthetics | 83 | 192 | 67 | 79 | 185 | 52 | 3 | 7 | 15 |
| EPSDT Special Requests (0–21 years)—Service requests for which state plan & administrative rules are silent on coverage (For all service authorizations in this service category, complete the tab EPSDT Special Requests) | 0 | 192 | 0 | 0 | 185 | 0 | 0 | 7 | 0 |
| Genetic Counseling and Testing | 0 | 192 | 45 | 0 | 185 | 28 | 0 | 7 | 7 |
| High Tech Radiology/Imaging Studies | 2,007 | 3,519 | 2,557 | 1,395 | 2,564 | 2,400 | 612 | 955 | 157 |
| Home Health Services excluding LNA, Personal Care Attendant, and Private Duty Nursing | 43 | 480 | 243 | 38 | 476 | 240 | 5 | 4 | 3 |
| Hospice | 16 | 31 | 14 | 11 | 31 | 14 | 5 | 0 | 0 |

| Service Category | Requested | | | Approved | | | Total Denied | | |
|---|---|---|---|---|---|---|---|---|---|
| | ACNH | NHHF | WS | ACNH | NHHF | WS | ACNH | NHHF | WS |
| Inpatient Hospital (Exclude SUD, Maternity, Surgical, Mental Health) | 1,065 | 1,957 | 646 | 856 | 1,894 | 557 | 138 | 63 | 88 |
| Inpatient Hospital Maternity (Non-SUD) and NICU (including neonatal abstinence syndrome) | 43 | 367 | 212 | 41 | 367 | 209 | 1 | 0 | 3 |
| Inpatient Hospital Mental Health and SUD | 0 | 943 | 201 | 0 | 755 | 200 | 0 | 187 | 1 |
| Inpatient Hospital Surgical (Non-SUD) | 147 | 159 | 51 | 121 | 157 | 50 | 20 | 2 | 1 |
| LNA Services | 17 | 24 | 45 | 17 | 24 | 44 | 0 | 0 | 1 |
| Medical Supplies such as syringes, saline, gauze | 0 | 193 | 37 | 0 | 189 | 31 | 0 | 3 | 6 |
| Orthotics and prosthetics | 0 | 114 | 113 | 0 | 111 | 102 | 0 | 3 | 11 |
| Other | 5 | 1,066 | 98 | 3 | 1,018 | 85 | 2 | 48 | 11 |
| Other SUD Services (non-Methadone) | 0 | 0 | 723 | 0 | 0 | 723 | 0 | 0 | 0 |
| Outpatient Surgeries (all settings) | 190 | 273 | 202 | 160 | 227 | 187 | 25 | 45 | 15 |
| Pain Management | 2 | 352 | 94 | 2 | 252 | 81 | 0 | 100 | 13 |
| Personal Care Attendant | 9 | 45 | 3 | 9 | 45 | 3 | 0 | 0 | 0 |
| Pharmacy: BH Drugs (Mental Health & SUD); includes office-based (including injections) | 804 | 1,142 | 1,180 | 424 | 698 | 824 | 380 | 444 | 356 |
| Pharmacy: Non-BH Drugs (including injections) | 2,014 | 4,558 | 2,513 | 1,135 | 2,627 | 1,364 | 879 | 1,931 | 1,149 |
| Physician/Medical services | 4,716 | 641 | 598 | 4,189 | 625 | 540 | 453 | 16 | 56 |
| Private Duty Nursing | 2 | 29 | 9 | 2 | 29 | 9 | 0 | 0 | 0 |
| Psychology including testing and neuropsychological testing | 0 | 69 | 58 | 0 | 50 | 58 | 0 | 19 | 0 |
| PT/OT/ST | 1,267 | 2,207 | 947 | 1,204 | 1,851 | 927 | 55 | 356 | 20 |
| Sleep Study | 260 | 212 | 69 | 216 | 208 | 65 | 44 | 3 | 4 |
| SUD Services—Intensive Outpatient | 1 | 0 | 295 | 0 | 0 | 295 | 0 | 0 | 0 |
| SUD Services—residential | 248 | 0 | 436 | 212 | 0 | 436 | 31 | 0 | 0 |
| **Statewide Total** | **45,122** | | | **36,047** | | | **8,880** | | |

ABA=applied behavior analysis; EPSDT=Early and Periodic Screening, Diagnostic, and Treatment; LNA=licensed nursing assistant; NICU=neonatal intensive care unit; PT=physical therapy; OT=occupational therapy; ST= speech therapy

Statewide, there were 45,122 requests for service authorizations, and the overall denial rate for the State Plan population in Q2 2023 was 19.7 percent. Table 5 displays the summary of the requested, approved, and total denied authorizations, by service category, provided by each MCO for the 1915b Plan members during Q3 2023.

**Table 5—SERVICEAUTH.05 MCO 1915b Plan: Q3 2023**

| Service Category | Requested | | | Approved | | | Total Denied | | |
|---|---|---|---|---|---|---|---|---|---|
| | ACNH | NHHF | WS | ACNH | NHHF | WS | ACNH | NHHF | WS |
| ABA Services | 26 | 62 | 36 | 26 | 47 | 36 | 0 | 15 | 0 |
| Adult Day Care | 0 | 0 | 10 | 0 | 0 | 10 | 0 | 0 | 0 |
| Audiology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Community Mental Health Center (excluding pharmacy) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DME Adult excluding Orthotics and prosthetics | 143 | 0 | 618 | 122 | 0 | 572 | 21 | 0 | 45 |
| DME Child (0–21 years) excluding Orthotics and prosthetics | 39 | 51 | 372 | 32 | 48 | 347 | 7 | 3 | 25 |
| EPSDT Special Requests (0–21 years)—Service requests for which state plan & administrative rules are silent on coverage (For all service authorizations in this service category, complete the tab EPSDT Special Requests) | 7 | 0 | 0 | 4 | 0 | 0 | 3 | 0 | 0 |
| Genetic Counseling and Testing | 0 | 0 | 7 | 0 | 0 | 6 | 0 | 0 | 1 |
| High Tech Radiology/Imaging Studies | 411 | 29 | 922 | 320 | 25 | 859 | 91 | 4 | 63 |
| Home Health Services excluding LNA, Personal Care Attendant, and Private Duty Nursing | 0 | 6 | 229 | 0 | 6 | 218 | 0 | 0 | 11 |
| Hospice | 0 | 0 | 6 | 0 | 0 | 6 | 0 | 0 | 0 |
| Inpatient Hospital (Exclude SUD, Maternity, Surgical, Mental Health) | 27 | 15 | 671 | 24 | 13 | 592 | 1 | 2 | 79 |
| Inpatient Hospital Maternity (Non-SUD) and NICU (including neonatal abstinence syndrome) | 0 | 5 | 17 | 0 | 5 | 16 | 0 | 0 | 1 |
| Inpatient Hospital Mental Health and SUD | 0 | 3 | 22 | 0 | 3 | 22 | 0 | 0 | 0 |
| Inpatient Hospital Surgical (Non-SUD) | 0 | 0 | 34 | 0 | 0 | 33 | 0 | 0 | 1 |
| LNA Services | 0 | 10 | 129 | 0 | 10 | 126 | 0 | 0 | 3 |

| Service Category | Requested | | | Approved | | | Total Denied | | |
|---|---|---|---|---|---|---|---|---|---|
| | ACNH | NHHF | WS | ACNH | NHHF | WS | ACNH | NHHF | WS |
| Medical Supplies such as syringes, saline, gauze | 0 | 7 | 318 | 0 | 7 | 270 | 0 | 0 | 42 |
| Orthotics and prosthetics | 60 | 5 | 118 | 58 | 5 | 117 | 2 | 0 | 1 |
| Other | 34 | 0 | 107 | 29 | 0 | 100 | 5 | 0 | 6 |
| Other SUD Services (non-Methadone) | 0 | 0 | 97 | 0 | 0 | 97 | 0 | 0 | 0 |
| Outpatient Surgeries (all settings) | 2 | 1 | 27 | 2 | 1 | 22 | 0 | 0 | 5 |
| Pain Management | 0 | 0 | 51 | 0 | 0 | 48 | 0 | 0 | 3 |
| Personal Care Attendant | 0 | 7 | 51 | 0 | 7 | 51 | 0 | 0 | 0 |
| Pharmacy: BH Drugs (Mental Health & SUD); includes office-based (including injections) | 41 | 6 | 78 | 24 | 4 | 52 | 17 | 2 | 26 |
| Pharmacy: Non-BH Drugs (including injections) | 122 | 41 | 221 | 92 | 26 | 112 | 30 | 15 | 109 |
| Physician/Medical services | 86 | 10 | 278 | 78 | 10 | 264 | 8 | 0 | 14 |
| Private Duty Nursing | 14 | 14 | 72 | 14 | 14 | 71 | 0 | 0 | 1 |
| Psychology including testing and neuropsychological testing | 0 | 2 | 1 | 0 | 1 | 1 | 0 | 1 | 0 |
| PT/OT/ST | 23 | 38 | 322 | 19 | 33 | 310 | 4 | 5 | 12 |
| Sleep Study | 162 | 1 | 28 | 160 | 1 | 28 | 2 | 0 | 0 |
| SUD Services—Intensive Outpatient | 0 | 213 | 27 | 0 | 209 | 27 | 0 | 4 | 0 |
| SUD Services—residential | 2 | 0 | 47 | 2 | 0 | 47 | 0 | 0 | 0 |
| **Statewide Total** | **6,641** | | | **5,941** | | | **690** | | |

ABA=applied behavior analysis; EPSDT=Early and Periodic Screening, Diagnostic, and Treatment; LNA=licensed nursing assistant; NICU=neonatal intensive care unit; PT=physical therapy; OT=occupational therapy; ST= speech therapy

Statewide, there were 6,641 requests for service authorizations, and the overall denial rate for the 1915b population in Q3 2023 was 10.4 percent. Table 6 displays the summary of the requested, approved, and total denied authorizations, by service category, provided by each MCO for the State Plan members during Q3 2023.

**Table 6—SERVICEAUTH.05 MCO State Plan: Q3 2023**

| Service Category | Requested | | | Approved | | | Total Denied | | |
|---|---|---|---|---|---|---|---|---|---|
| | ACNH | NHHF | WS | ACNH | NHHF | WS | ACNH | NHHF | WS |
| ABA Services | 95 | 361 | 55 | 85 | 328 | 51 | 5 | 33 | 4 |
| Adult Day Care | 7 | 28 | 0 | 3 | 28 | 0 | 4 | 0 | 0 |
| Audiology | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Community Mental Health Center (excluding pharmacy) | 19 | 0 | 0 | 18 | 0 | 0 | 0 | 0 | 0 |
| DME Adult excluding Orthotics and prosthetics | 186 | 476 | 135 | 167 | 471 | 128 | 17 | 5 | 7 |
| DME Child (0–21 years) excluding Orthotics and prosthetics | 61 | 173 | 24 | 54 | 162 | 23 | 6 | 11 | 1 |
| EPSDT Special Requests (0–21 years)—Service requests for which state plan & administrative rules are silent on coverage (For all service authorizations in this service category, complete the tab EPSDT Special Requests) | 21 | 21 | 0 | 19 | 20 | 0 | 2 | 1 | 0 |
| Genetic Counseling and Testing | 9 | 182 | 58 | 0 | 162 | 50 | 9 | 20 | 8 |
| High Tech Radiology/Imaging Studies | 1,787 | 3,046 | 1,977 | 1,346 | 2,255 | 1,863 | 441 | 791 | 114 |
| Home Health Services excluding LNA, Personal Care Attendant, and Private Duty Nursing | 20 | 410 | 186 | 17 | 403 | 179 | 2 | 4 | 7 |
| Hospice | 16 | 39 | 8 | 15 | 37 | 8 | 1 | 2 | 0 |
| Inpatient Hospital (Exclude SUD, Maternity, Surgical, Mental Health) | 891 | 1,930 | 596 | 729 | 1,853 | 521 | 124 | 77 | 75 |
| Inpatient Hospital Maternity (Non-SUD) and NICU (including neonatal abstinence syndrome) | 61 | 897 | 249 | 58 | 756 | 246 | 2 | 140 | 3 |
| Inpatient Hospital Mental Health and SUD | 0 | 146 | 58 | 0 | 139 | 57 | 0 | 7 | 1 |
| Inpatient Hospital Surgical (Non-SUD) | 171 | 369 | 64 | 154 | 369 | 63 | 13 | 0 | 1 |
| LNA Services | 3 | 30 | 34 | 3 | 30 | 34 | 0 | 0 | 0 |
| Medical Supplies such as syringes, saline, gauze | 2 | 217 | 193 | 2 | 203 | 172 | 0 | 14 | 21 |
| Orthotics and prosthetics | 63 | 130 | 111 | 58 | 129 | 98 | 5 | 1 | 13 |
| Other | 376 | 947 | 112 | 352 | 890 | 108 | 24 | 55 | 3 |
| Other SUD Services (non-Methadone) | 6 | 1 | 750 | 1 | 1 | 750 | 0 | 0 | 0 |
| Outpatient Surgeries (all settings) | 139 | 236 | 91 | 119 | 198 | 82 | 19 | 38 | 9 |

| Service Category | Requested | | | Approved | | | Total Denied | | |
|---|---|---|---|---|---|---|---|---|---|
| | ACNH | NHHF | WS | ACNH | NHHF | WS | ACNH | NHHF | WS |
| Pain Management | 0 | 209 | 110 | 0 | 153 | 100 | 0 | 56 | 10 |
| Personal Care Attendant | 7 | 39 | 2 | 7 | 39 | 2 | 0 | 0 | 0 |
| Pharmacy: BH Drugs (Mental Health & SUD); includes office-based (including injections) | 650 | 782 | 1,122 | 356 | 505 | 761 | 294 | 277 | 361 |
| Pharmacy: Non-BH Drugs (including injections) | 1,407 | 3,670 | 2,589 | 757 | 2,176 | 1,378 | 650 | 1,494 | 1,211 |
| Physician/Medical services | 5,300 | 571 | 480 | 4,756 | 554 | 445 | 417 | 17 | 35 |
| Private Duty Nursing | 0 | 25 | 3 | 0 | 25 | 3 | 0 | 0 | 0 |
| Psychology including testing and neuropsychological testing | 0 | 74 | 26 | 0 | 49 | 25 | 0 | 25 | 1 |
| PT/OT/ST | 815 | 1,872 | 549 | 794 | 1,547 | 531 | 20 | 325 | 18 |
| Sleep Study | 1,298 | 147 | 50 | 1,251 | 145 | 48 | 47 | 2 | 2 |
| SUD Services—Intensive Outpatient | 1 | 0 | 271 | 1 | 0 | 271 | 0 | 0 | 0 |
| SUD Services—residential | 290 | 0 | 415 | 221 | 0 | 415 | 67 | 0 | 0 |
| **Statewide Totals** | **41,047** | | | **33,382** | | | **7,469** | | |

ABA=applied behavior analysis; EPSDT=Early and Periodic Screening, Diagnostic, and Treatment; LNA=licensed nursing assistant; NICU=neonatal intensive care unit; PT=physical therapy; OT=occupational therapy; ST= speech therapy

Statewide, there were 41,047 requests for service authorizations, and the overall denial rate for the State Plan population in Q3 2023 was 18.2 percent.

As HSAG began this study, HSAG's subcontractor, Horn Research, was concurrently conducting individual semi-structured interview sessions with 30 people who were adults or parents/guardians of children enrolled in the New Hampshire MCM Program. Horn Research conducted the interviews between December 27, 2023, and February 8, 2024. Interview participants submitted a service authorization request to their MCO between November 2022 and November 2023. Horn Research completed the interviews, and the study results indicated that the categories of services most frequently mentioned as areas of difficulty in obtaining approval for the requests included DME and medications.

Although the SERVICEAUTH.05 Report listed the number of authorizations separately for 1915b and State Plan members, DHHS restricted the study to State Plan members and four of the 32 service categories as shown below:

- DME
  - Adult excluding orthotics and prosthetics
  - Child (0–21 years) excluding orthotics and prosthetics

- Pharmacy
  - Behavioral health (BH) drugs (mental health and substance use disorder [SUD]) includes office-based (including injections)
  - Non-BH drugs (including injections)

After DHHS defined the four service categories to explore during the study, HSAG met with DHHS to determine the types of information needed to understand how each MCO categorized the denial information submitted in the SERVICEAUTH.05 Report. The remaining sections of this report focus on the investigation of those numbers and the comparison of denials across the three MCOs.

# 3. Findings

The study began with a meeting attended by DHHS, the MCOs, and HSAG. The purpose of the meeting was to discuss the information submitted by the MCOs in the quarterly SERVICEAUTH.05 Reports. During that meeting, HSAG learned that the three MCOs seemed to have interpreted the specifications provided by DHHS for the Total Denied column differently. As a result of the initial discussions concerning the report submissions, HSAG obtained information from the MCOs by creating two questionnaires and holding a virtual meeting with each MCO to obtain more specific information about the number of requested, approved, and denied service authorizations submitted in the SERVICEAUTH.05 Report.

On February 27, 2024, HSAG sent the first questionnaire to each MCO concerning the data submitted in the quarterly SERVICEAUTH.05 Reports. The information obtained from the MCOs offered clarity concerning many aspects of the submitted data. Appendix C includes a copy of the first questionnaire and each MCO's response. Once HSAG received the responses, a summary comparison prompted the need for further clarification and a second questionnaire. For example, HSAG noted that some of the MCOs' processes varied (e.g., following up for additional documentation, counting a request in the Pending category, and reporting data in the Total Denied column). Finally, to ensure a complete understanding of the written responses, HSAG held virtual meetings in July 2024 with each MCO to further clarify and confirm the MCO's responses. Appendix D includes the second questionnaire, each MCO's response, and information obtained during the virtual meeting.

## Completing the SERVICEAUTH.05 Report

The following information includes the questions sent to the MCOs and the responses received on the two questionnaires and during the virtual meeting.

**Question 1.a.—**Does your MCO consistently report numbers on the SERVICEAUTH.05 Report using header level or detail level information?

- Each MCO stipulated that the information on the SERVICEAUTH.05 Report included detail level (i.e., line-item) data.
- In follow-up, HSAG sent a second questionnaire and confirmed with each MCO that regardless of type of authorization (i.e., medical, DME, or pharmacy), the data reported remained at a detail level, including data received from any utilization management (UM) subcontractors.

**Question 1.b.—**How does your MCO determine the numbers included in the "Requested" column?

- Each MCO confirmed counting and reporting the total number of authorizations in the Requested column. The number included a summation of those received during the measurement period. In addition, **WS** indicated that it included those authorization requests received during the measurement period that had not been "canceled." **WS** confirmed that a canceled request is an authorization

determined to be retracted by the provider or identified as a duplicate (technical error in the electronic submission platform).

- In follow-up, HSAG sent a second questionnaire and engaged the MCOs in a virtual meeting. **ACNH**, **NHHF**, and **WS** confirmed using the detail-level items instead of header-level items.

**Question 1.b.i.**—How does your MCO manage partial denials on the SERVICEAUTH.05 Report?

- Each MCO reported counting partial denials as denied on the SERVICEAUTH.05 Report. **NHHF** noted that partial denials do not apply to the pharmacy benefit.
- A second questionnaire forwarded to the MCOs clarified and confirmed that each MCO included partial denials in the number of authorizations reported in the Total Denied column of the SERVICEAUTH.05 Report. To receive further clarity regarding the different types of authorizations, however, HSAG requested a virtual meeting with each MCO.
- During the virtual meetings, each MCO described a partial denial as an authorization request wherein one line item within the request is denied or reduced in the number of frequency or duration (e.g., number/frequency of home health visits or physical therapy sessions). If the MCO partially denied a line item within a request, the denial was counted and reported in the Total Denied column.

**Question 1.b.ii.**—Does your MCO attempt to contact the provider for additional documents for submissions with incomplete documentation before counting them as a "Requested" service authorization?

- All MCOs reported counting the initial authorization request in the Requested column of the SERVICEAUTH.05 Report, even if documentation was not attached.

**Question 1.b.ii.1.**—If your MCO contacts a provider for additional documents, how many times do you make the attempt?

- The initial response from each MCO varied regarding the number of attempts made to contact the provider. **NHHF** contacted all providers once regardless of the service authorization category. **WS** contacted DME and pharmacy providers once. Excluding DME and pharmacy, **ACNH** and **WS** contacted all other providers twice.
- To further clarify MCOs' responses, specifically noting any variation between types of authorizations for DME and pharmacy, HSAG sent a second questionnaire and held a virtual meeting with each MCO.
- All MCOs confirmed making at least one attempt to contact a provider for additional documentation for both DME and pharmacy authorizations. **ACNH** made two attempts to obtain additional documentation for DME and pharmacy authorizations.
- All MCOs used multiple methods of communication, such as telephone and electronic outreach via a portal, including fax communication, in their attempts to reach the provider.

**Question 1.b.ii.2.**—Is there a time limit for making those attempts?

- Each MCO confirmed that completion of a prior authorization determination occurred within the required turnaround time for DME of 14 days in accordance with Title 42 of the Code of Federal Regulations (CFR) §438.210(d)(1): Standard authorizations. In addition, each MCO also confirmed that pharmacy authorization outreach and decisions occurred within 24 hours. Each MCO reported a timing process during which the MCO contacted the provider within 24–48 hours to clarify or request additional documentation.
- HSAG sent a follow-up questionnaire clarifying the outreach time limit specifically for DME and pharmacy authorizations. **ACNH** and **NHHF** reported a time range of 24–48 hours to attempt outreach depending on the type of authorization. **WS** reported a pre-service non-urgent and pre-service urgent process time range of 48 hours to seven days.
- HSAG then held a virtual meeting with each MCO to clarify the MCO's processes.
- **ACNH** completed outreach within 24 hours for a pharmacy request. **NHHF** completed outreach within 24 hours for both pharmacy and DME requests. **WS** worked with the subcontractor to complete processing of a pre-service non-urgent request within seven days. The MCO confirmed completion of a pre-service urgent request within 48 hours for DME authorizations. **WS** completed pharmacy authorizations within 24 hours.

**Question 1.b.iii.**—Does your MCO include expedited authorizations in the "Requested" column along with the non-urgent requests?

- All MCOs confirmed they included both non-urgent and expedited authorizations in the Requested column of the SERVICEAUTH.05 Report.

**Question 1.c.**—How does your MCO determine the numbers included in the "Approved" column?

- Each MCO stipulated that an authorization reported in the Approved column included all authorizations received in the reporting period with a line-item approval.
- In a follow-up virtual meeting with each MCO, HSAG validated that the authorizations reported in the Approved column included line-item approvals.

**Question 1.d.**—How does your MCO determine the numbers included in the "Denied" column?

- Each MCO stipulated that an authorization reported in the Total Denied column included all authorizations received in the reporting period with any line-item denial. **WS** reported, "The numbers/data reported in the "denied" column would be all line items…with a denied or partial denial status."
- HSAG sent a second questionnaire to each MCO requesting clarification on those denials with a partial or line-item denial.
- In a follow-up virtual meeting, HSAG validated with each MCO that the authorizations with a line-item denial were reported in the Total Denied column.

**Question 1.d.i.—**Does your MCO attempt to contact the provider for additional documents for submissions with incomplete documentation before counting them as a *Denied* service authorization?

- Each MCO confirmed that its process(es) included an attempt to reach the provider for additional documentation before counting the authorization as denied.

**Question 1.d.i.1.**—If your MCO contacts a provider for additional documents, how many times do you make the attempt?

- **ACNH** and **WS** reported contacting providers two times. **WS** contacted DME and pharmacy once and made two attempts for other services; however, **NHHF** and **WS** noted the attempts differed depending on the type of service authorization category.
- With the variation in attempts reported, HSAG sent each MCO a second questionnaire to clarify the number of attempts, specifically for pharmacy and DME. **ACNH** confirmed making two attempts for pharmacy and DME authorizations. **NHHF** and **WS** confirmed making one attempt for pharmacy and DME authorizations to secure the needed additional documentation.
- HSAG completed additional follow-up with each MCO, clarifying the method used to complete outreach. Each MCO confirmed that follow-up included multiple methods such as telephone and electronic portal communication, including faxes.

**Question 1.d.i.2.**—Is there a time limit for making those attempts?

- Each MCO confirmed that completion of a prior authorization determination occurred within the required turnaround time of 14 days for DME in accordance with 42 CFR §438.210(d)(1): Standard authorizations. In addition, each MCO confirmed that pharmacy authorization outreach and a decision occurred within 24 hours. Each MCO reported a process to reach the provider within 24–48 hours of receipt of the request.

**Question 1.d.ii.**—Does your MCO include expedited authorizations in the "Requested" column along with the non-urgent requests?

- All MCOs included non-urgent and expedited authorizations in the Requested column.

**Question 1.e.**—Explain how your MCO determines the numbers included in the "Pending" column on the SERVICEAUTH.05 Report.

- All MCOs initially reported pending an authorization request when the approval or denial decision had not been finalized. **NHHF** noted that "Pend" is not used for pharmacy requests.
- HSAG sent a second questionnaire to clarify the MCO's processes for reporting the authorizations counted as pending, specifically for pharmacy and DME.
- All MCOs reported that a pharmacy authorization request did not require a pended status and therefore was either approved or denied. Each MCO noted an outreach time frame of 24 hours and that methods of processing, such as electronic platforms, supported a same-day decision.

**Question 2.**—After your MCO denies a service authorization request, can you track whether the member or provider resubmitted the denial as an appeal?

- **ACNH** and **NHHF** responded that if a denial is resubmitted as an appeal, it can be tracked; however, **WS** reported that due to the limitations of a delegated vendor that manages the authorization process, the health plan could not match 100 percent of the denials to appeals.
- In the second questionnaire, HSAG confirmed with both **ACNH** and **NHHF** that their systems can track whether an authorization is resubmitted as an appeal, even if a subcontracted vendor manages the authorization process. **ACNH** confirmed that all appeals are loaded and matched with the original authorization within the health plan's information system. **NHHF** reported that the MCO does not subcontract authorization decisions for the service categories included in the study.

**Question 2.a.—**If your MCO can track denials resubmitted as an appeal, can your data system identify if the reviewer upheld or overturned the denial?

- **ACNH** and **NHHF** responded that if a denial is resubmitted as an appeal, it can be tracked, including if the appeal remained upheld or was overturned. **WS**, however, reported that not all appeals could be linked to denials due to the limitations of a delegated vendor.
- In a follow-up questionnaire, HSAG confirmed with both **ACNH** and **NHHF** that their systems can follow an authorization, even if a subcontracted vendor manages the authorization process. **ACNH** loaded and matched all appeals with the original authorization within the health plan's information system. **NHHF** reported that the MCO does not subcontract a request for authorization for the service categories included in the study.

## Summary of Service Authorization Denial Reasons

In addition to the qualitative responses from each MCO, HSAG reviewed the MCO-reported numbers of denied authorizations for the two focus categories: DME and pharmacy.

**Table 7—Number and Percentage of Denied Service Authorizations: Q2 and Q3 2023**

| Service Category | Q2 2023 | | | Q3 2023 | | |
|---|---|---|---|---|---|---|
| | ACNH | NHHF | WS | ACNH | NHHF | WS |
| Total Denied: DME adult excluding orthotics and prosthetics | 49 | 9 | 10 | 17 | 5 | 7 |
| Total Requested: DME adult excluding orthotics and prosthetics | 558 | 493 | 74 | 186 | 476 | 135 |
| Percentage of Requested Denied | 8.8% | 1.8% | 13.5% | 9.1% | 1.1% | 5.2% |
| Total Denied: DME child (0–21 years) excluding orthotics and prosthetics | 3 | 7 | 15 | 6 | 11 | 1 |
| Total Requested: DME child (0–21 years) excluding orthotics and prosthetics | 83 | 192 | 67 | 61 | 173 | 24 |

| Service Category | Q2 2023 | | | Q3 2023 | | |
|---|---|---|---|---|---|---|
| | ACNH | NHHF | WS | ACNH | NHHF | WS |
| Percentage of Requested Denied | 3.6% | 3.6% | 22.4% | 9.8% | 6.4% | 4.2% |
| **MCO Total DME Denied** | 52 | 16 | 25 | 23 | 16 | 8 |
| **MCO Total DME Requested** | 641 | 685 | 141 | 247 | 649 | 159 |
| **MCO Percentage of Requested DME Denied** | 8.1% | 2.3% | 17.7% | 9.3% | 2.5% | 5.0% |
| **DME Statewide Total Denied** | 93 | | | 47 | | |
| **DME Statewide Total Requested** | 1,467 | | | 1,055 | | |
| **Statewide Percentage of Requested DME Denied** | 6.3% | | | 4.5% | | |
| Total Denied: Pharmacy: Behavioral health (BH) drugs (mental health and substance use disorder [SUD]); includes office-based (including injections) | 380 | 444 | 356 | 294 | 277 | 361 |
| Total Requested: Pharmacy: Behavioral health (BH) drugs (mental health and substance use disorder [SUD]); includes office-based (including injections) | 804 | 1,142 | 1,180 | 650 | 782 | 1,122 |
| Percentage of Requested Denied | 47.3% | 38.9% | 30.2% | 45.2% | 35.4% | 32.2% |
| Total Denied: Pharmacy: Non-BH drugs (including injections) | 879 | 1,931 | 1,149 | 650 | 1,494 | 1,211 |
| Total Requested: Pharmacy: Non-BH drugs (including injections) | 2,014 | 4,558 | 2,513 | 1,407 | 3,670 | 2,589 |
| Percentage of Requested Denied | 43.6% | 42.4% | 45.7% | 46.2% | 40.7% | 46.8% |
| **MCO Total Pharmacy Denied** | 1,259 | 2,375 | 1,505 | 944 | 1,771 | 1,572 |
| **MCO Total Pharmacy Requested** | 2,818 | 5,700 | 3,693 | 2,057 | 4,452 | 3,711 |
| **MCO Percentage of Requested Pharmacy Denied** | 44.7% | 41.7% | 40.8% | 45.9% | 39.8% | 42.4% |
| **Pharmacy Statewide Total Denied** | 5,139 | | | 4,287 | | |
| **Pharmacy Statewide Total Requested** | 12,211 | | | 10,220 | | |
| **Statewide Percentage of Requested Pharmacy Denied** | 42.1% | | | 41.9% | | |

Overall, the statewide percentages of DME requests denied during Q2 and Q3 2023 were 6.3 percent and 4.5 percent, respectively. The statewide percentages of pharmacy requests denied during Q2 and Q3 2023 were 42.1 percent and 41.2 percent, respectively. **NHHF** denied the lowest percentage of its requests for DME (2.3 percent in Q2 and 2.5 percent in Q3), while **WS** denied the highest percentage of its requests for DME in Q2 (17.7 percent); **ACNH** denied the highest percentage of its requests for DME

during Q3 (9.3 percent). **WS** denied the lowest percentage of its requests for pharmacy during Q2 (40.8 percent), while **NHHF** denied the lowest percentage of its requests for pharmacy during Q3 (39.8 percent). **ACNH** denied the highest percentage of its requests for pharmacy during both Q2 and Q3 (44.7 percent and 45.9 percent, respectively).

As a final step in the study, HSAG requested detailed reasons for the Q2 and Q3 2023 DME and pharmacy authorizations that the MCOs submitted as denied in the SERVICEAUTH.05 Report. In addition to the qualitative responses from each MCO, HSAG reviewed the MCO-reported quantitative information concerning the numbers of denied authorizations for the focused service categories of DME and pharmacy and the reasons for the denials. Table 8 displays the total number of requested authorizations, total number of denied authorizations, and the percentage of the requested authorizations that the MCO denied for Q2 and Q3 2023. The table also classifies the denied authorizations into five descriptive denial reasons and includes the denial percentages in those categories. The cells shaded red denote the denial reason with the highest percentage for that MCO per quarter. HSAG noted that the number of denials reported in August 2024 may be inconsistent with the numbers reported in the original Q2 and Q3 SERVICEAUTH.05 Reports for 2023 due to the "point in time" nature of the reports (e.g., some authorizations may have been in pending status when the reports were originally submitted and have since been either approved, cancelled, or denied).

**Table 8—Q2 and Q3 2023 SERVICEAUTH.05 MCO State Plan Denials With Descriptive Denial Reasons**

| Service Category MCO | | Total Requested | Total Denied* | | Reason for Denial | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Incomplete/ Incorrect Paperwork | | Not a Covered Service | | Request Determined Not Medically Necessary | | Out-of-Network Denials | | Other | |
| MCO | QTR | # | # | % | # | % | # | % | # | % | # | % | # | % |
| **DME adult excluding orthotics and prosthetics** | | | | | | | | | | | | | | |
| ACNH | 2 | 558 | 54 | 9.7% | 0 | 0.0% | 4 | 7.4% | 45 | 83.3% | 0 | 0.0% | 5 | 9.3% |
| NHHF | 2 | 493 | 9 | 1.8% | 0 | 0.0% | 0 | 0.0% | 9 | 100% | 0 | 0.0% | 0 | 0.0% |
| WS | 2 | 74 | 12 | 16.2% | 0 | 0.0% | 4 | 33.3% | 7 | 58.3% | 1 | 8.3% | 0 | 0.0% |
| **Statewide** | **2** | **1,125** | **75** | **6.7%** | **0** | **0.0%** | **8** | **10.7%** | **61** | **81.3%** | **1** | **1.3%** | **5** | **6.7%** |
| ACNH | 3 | 186 | 30 | 16.1% | 0 | 0.0% | 3 | 10.0% | 27 | 90.0% | 0 | 0.0% | 0 | 0.0% |
| NHHF | 3 | 476 | 7 | 1.5% | 0 | 0.0% | 0 | 0.0% | 7 | 100% | 0 | 0.0% | 0 | 0.0% |
| WS | 3 | 135 | 7 | 5.2% | 3 | 42.9% | 1 | 14.3% | 2 | 28.6% | 1 | 14.3% | 0 | 0.0% |
| **Statewide** | **3** | **797** | **44** | **5.5%** | **3** | **6.8%** | **4** | **9.1%** | **36** | **81.8%** | **1** | **2.3%** | **0** | **0.0%** |

| Service Category MCO | | Total Requested | Total Denied* | | Reason for Denial | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Incomplete/ Incorrect Paperwork | | Not a Covered Service | | Request Determined Not Medically Necessary | | Out-of-Network Denials | | Other | |
| MCO | QTR | # | # | % | # | % | # | % | # | % | # | % | # | % |
| **DME child (0–21 years) excluding orthotics and prosthetics** | | | | | | | | | | | | | | |
| ACNH | 2 | 83 | 3 | 3.6% | 0 | 0.0% | 0 | 0.0% | 2 | 66.7% | 0 | 0.0% | 1 | 33.3% |
| NHHF | 2 | 192 | 10 | 5.2% | 0 | 0.0% | 0 | 0.0% | 10 | 100% | 0 | 0.0% | 0 | 0.0% |
| WS | 2 | 67 | 17 | 25.4% | 5 | 29.4% | 0 | 0.0% | 9 | 52.9% | 3 | 17.6% | 0 | 0.0% |
| **Statewide** | **2** | **344** | **30** | **8.7%** | **5** | **16.7%** | **0** | **0.0%** | **21** | **70.0%** | **3** | **10.0%** | **1** | **3.3%** |
| ACNH | 3 | 61 | 12 | 19.7% | 0 | 0.0% | 0 | 0.0% | 11 | 91.7% | 1 | 8.3% | 0 | 0.0% |
| NHHF | 3 | 173 | 24 | 13.9% | 0 | 0.0% | 0 | 0.0% | 24 | 100% | 0 | 0.0% | 0 | 0.0% |
| WS | 3 | 24 | 3 | 12.5% | 1 | 33.3% | 0 | 0.0% | 2 | 66.7% | 0 | 0.0% | 0 | 0.0% |
| **Statewide** | **3** | **258** | **39** | **15.1%** | **1** | **2.6%** | **0** | **0.0%** | **37** | **94.9%** | **1** | **2.6%** | **0** | **0.0%** |
| **Pharmacy: BH drugs (mental health and SUD); includes office-based (including injections)** | | | | | | | | | | | | | | |
| ACNH | 2 | **804** | 380 | 47.3% | 0 | 0.0% | 1 | 0.3% | 379 | 99.7% | 0 | 0.0% | 0 | 0.0% |
| NHHF | 2 | **1,142** | 444 | 38.9% | 25 | 5.6% | 0 | 0.0% | 390 | 87.8% | 0 | 0.0% | 29 | 6.5% |
| WS | 2 | **1,180** | 359 | 30.4% | 0 | 0.0% | 0 | 0.0% | 359 | 100% | 0 | 0.0% | 0 | 0.0% |
| **Statewide** | **2** | **3,126** | **1,183** | **37.8%** | **25** | **2.1%** | **1** | **0.1%** | **1,128** | **95.4%** | **0** | **0.0%** | **29** | **2.5%** |
| ACNH | 3 | 650 | 294 | 45.2% | 0 | 0.0% | 1 | 0.3% | 293 | 99.7% | 0 | 0.0% | 0 | 0.0% |
| NHHF | 3 | 782 | 277 | 35.4% | 7 | 2.5% | 0 | 0.0% | 251 | 90.6% | 0 | 0.0 % | 19 | 6.9% |
| WS | 3 | 1,122 | 329 | 29.3% | 0 | 0.0% | 0 | 0.0% | 329 | 100% | 0 | 0.0% | 0 | 0.0% |
| **Statewide** | **3** | **2,554** | **900** | **35.2%** | **7** | **0.8%** | **1** | **0.1%** | **873** | **97.0%** | **0** | **0.0%** | **19** | **2.1%** |
| **Pharmacy: Non-BH drugs (including injections)** | | | | | | | | | | | | | | |
| ACNH | 2 | 2,014 | 879 | 43.6% | 0 | 0.0% | 70 | 8.0% | 809 | 92.0% | 0 | 0.0% | 0 | 0.0% |
| NHHF | 2 | 4,558 | 1,927 | 42.3% | 218 | 11.3% | 83 | 4.3% | 1,497 | 77.7% | 1 | 0.1% | 128 | 6.6% |
| WS | 2 | 2,513 | 1,142 | 45.4% | 0 | 0.0% | 0 | 0.0% | 1,142 | 100% | 0 | 0.0% | 0 | 0.0% |
| **Statewide** | **2** | **7,285** | **3,948** | **54.2%** | **218** | **5.5%** | **153** | **3.9%** | **3,448** | **87.3%** | **1** | **0.0%** | **128** | **3.2%** |

| Service Category MCO | | Total Requested | Total Denied* | | Reason for Denial | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Incomplete/ Incorrect Paperwork | | Not a Covered Service | | Request Determined Not Medically Necessary | | Out-of-Network Denials | | Other | |
| MCO | QTR | # | # | % | # | % | # | % | # | % | # | % | # | % |
| ACNH | 3 | 1,407 | 650 | 46.2% | 0 | 0.0% | 60 | 9.2% | 590 | 90.8% | 0 | 0.0% | 0 | 0.0% |
| NHHF | 3 | 3,670 | 1,497 | 40.8% | 52 | 3.5% | 67 | 4.5% | 1,235 | 82.5% | 0 | 0.0% | 143 | 9.6% |
| WS | 3 | 2,589 | 924 | 35.7% | 0 | 0.0% | 0 | 0.0% | 924 | 100% | 0 | 0.0% | 0 | 0.0% |
| **Statewide** | **3** | **7,666** | **3,071** | **40.1%** | **52** | **1.7%** | **127** | **4.1%** | **2,749** | **89.5%** | **0** | **0.0%** | **143** | **4.7%** |

* HSAG used the number of denied authorizations in this table from information submitted by the MCOs to explain the reasons for the denials. The number of denied authorizations do not consistently match the numbers submitted in the SERVICEAUTH.05 Reports.

With one exception, the most prevalent denial reason across all MCOs for all four categories of services was that the request was not medically necessary. The exception, **WS**'s Q3 rate for the adult DME excluding orthotics and prosthetics service type, had seven total denials for the quarter, three of which were due to incomplete/incorrect paperwork. The service authorization requests determined to be not medically necessary for DME in the two quarters ranged from 28.6 percent to 100 percent. In both pharmacy services studied, from 77.7 percent to 100 percent of the cases denied in both quarters were denied for not meeting the medical necessity requirement.

# 4. Conclusions, Limitations, and Recommendations

The New Hampshire DHHS asked HSAG to conduct a quality study to determine how each MCO defined the denied service authorizations included in the quarterly SERVICEAUTH.05 Reports. After meeting with each MCO and clarifying their processes through questionnaires and virtual follow-up, HSAG noted the following conclusions, limitations, and recommendations:

## Conclusions

There were many similarities in the way that the MCOs submit information in the SERVICEAUTH.05 Reports.

- Each MCO reported requested authorizations using the line-item level information for the SERVICEAUTH.05 Report and counted an authorization as requested even if the file was awaiting additional documentation from the provider.
- The MCOs included non-urgent and expedited requests for authorization in the Requested column.
- The MCOs confirmed that a service authorization is counted as a request, even if additional information is pending.
- All three MCOs contacted a provider at least once for missing information.
- The MCOs reported varying processes and lengths of time to obtain the additional documentation needed to process an authorization. All three MCOs, however, completed the request for additional DME information within 14 calendar days of receipt as required in CFR §438.210(d)(1).
- All MCOs used multiple methods of communication, such as telephone and electronic outreach via a portal, including fax communication, in their attempts to reach a provider to request additional information.

The MCOs differed in how they handled contacting providers for additional information.

- **ACNH** completed outreach within 24 hours for a pharmacy request, and the health plan made two attempts to obtain information for the pharmacy and DME authorizations.
- **NHHF** completed outreach within 24 hours for both pharmacy and DME requests.
- **WS** completed a pre-service, non-urgent request within seven days and within 48 hours for pharmacy and DME authorizations.
- Each MCO reported using the Pending category differently.

## Limitations

HSAG noted that the SERVICEAUTH.05 Report is a snapshot in time. The data reported included the dates of reference; however, within that date range, authorization requests could be mid-decision. In

addition, when reviewing the data submitted by the MCOs, HSAG noted that the values reported did not reconcile with the numbers found on the SERVICEAUTH.05 Report. The MCOs reported varying reasons, which included that the report is a snapshot in time; involves a dynamic process; and that authorizations are often mid-processing and cannot be categorized as approved, denied, or pended.

In addition, the study found some limitations in understanding the MCO's process for a canceled request. **WS** reported that a request could be canceled or nullified related to duplication or retraction of the request. Those requests which the MCO canceled were not included in the Requested category, nor was it clear if all MCOs removed the canceled requests prior to counting them as approved or denied.

HSAG could not determine the case mix of the members assigned to each MCO to evaluate if a higher number of service authorizations was appropriate for an MCO due to having members with more chronic conditions.

## Recommendations

DHHS needs to develop more detailed specifications for each MCO to follow when submitting information on the SERVICEAUTH.05 Report. The findings of this study could assist in developing those specifications, and standardizing the submission of information from the MCOs would assist in being able to better compare the numbers submitted in the quarterly reports.

HSAG was unable to determine the number of authorization requests that may have been canceled prior to being counted in the Requested column. DHHS could consider including a Canceled column in the SERVICEAUTH.05 Report to assist the MCOs in submitting this information in the report. Further studies could be conducted to investigate a category for canceled service authorizations.

HSAG confirmed that the MCOs could break down the Total Denied column into additional subcategories. Further refinement may be needed to identify specific reasons the MCOs consider a service request not medically necessary (medication not on the formulary, medication has a generic equivalent, DME requested with features not needed for that member, etc.).

The Code of Federal Regulations (CFR) 438.210(f)(4) requires MCOs to report denied prior authorization requests that were approved after an appeal. WS must work with vendors to ensure that all denied prior authorizations can be linked to any appeals concerning those denied authorizations.

Further study could investigate the reasons that the MCOs find the overwhelming majority of DME requests to be denied due to not meeting medical necessity. DME requests could involve equipment that is necessary, such as a wheelchair; however, the request could involve a motorized wheelchair which the MCO determines to be not medically necessary for that member. It is unclear if the MCOs would categorize those denials as Not a Covered Service or Request Determined Not Medically Necessary.

The high rate of pharmacy denials could be due to generic medications being available for requested brand-name medications. If a medication is not on the formulary, it is unclear if the MCOs categorize those denials as Not a Covered Service or Request Determined Not Medically Necessary. Further

studies could assist in determining how the MCOs categorize requests for brand-name medications being denied due to a generic equivalent being available on the formulary.

DHHS could consider exploring the denials included in the Not a Covered Service category to determine if the same services are being requested by members enrolled in different MCOs. Although some services would not be considered as payable with Medicaid funds, some requests may be appropriate to consider as additional Medicaid services.

A future study could involve researching the denial decisions that were appealed by the member or provider to determine if the appeal overturned the original decision to deny.

# Appendix A. Process to Conduct the Service Authorization Study

Appendix A lists the 11 steps HSAG used to conduct the Service Authorization Study.

**Table A-1—Process to Conduct the Service Authorization Study**

| | |
|---|---|
| **Step 1:** | **Meet with DHHS to define study parameters** |
| | HSAG will meet with DHHS to determine the information that will need to be generated from the study to determine how each MCO decides the number of service authorization denials to include on the quarterly SERVICEAUTH.05 Report. |
| **Step 2:** | **Receive SERVICEAUTH.05 Reports from DHHS** |
| | HSAG will request two quarters of SERVICEAUTH.05 Reports from DHHS to review the information submitted in the report. |
| **Step 3:** | **Send a questionnaire to the MCOs** |
| | HSAG will work with DHHS to develop a questionnaire concerning how the MCOs determine the number of denials submitted in the SERVICEAUTH.05 Reports provided to DHHS. |
| **Step 4:** | **Receive and review questionnaires from the MCOs** |
| | Once the MCOs return the questionnaire, HSAG will review the documents to ensure that the MCOs answer all the questions on the form. |
| **Step 5:** | **Compile the MCO responses** |
| | HSAG will evaluate the responses and determine if the MCOs submitted complete answers concerning how they determine the number of DME and pharmacy denials. HSAG will create a document with answers from each MCO to facilitate the comparison of the information across the three MCOs. |
| **Step 6:** | **Meet with DHHS to review responses from the questionnaire** |
| | HSAG will meet with DHHS to review the information submitted by the MCOs on the questionnaire and determine if additional clarification will be needed concerning the responses. |
| **Step 7:** | **Determine if a second questionnaire or meeting is needed** |
| | If additional information is needed from the MCOs, HSAG, and DHHS will determine if the MCOs should send written responses or if a meeting with each MCO would be necessary to obtain the information for the study. |
| **Step 8:** | **Continue gathering information until complete information is obtained from the MCOs** |
| | HSAG will continue to work with DHHS and the MCOs until complete information is obtained from the MCOs concerning the number of denials submitted in the SERVICEAUTH.05 Report. |
| **Step 9:** | **Prepare a final document with all responses by each MCO** |
| | After receiving the final responses from each MCO, HSAG will prepare a document showing all responses received from the MCO. The report will include information concerning how the MCO determines the cases to be included in the Total Denied column on the SERVICEAUTH.05 Report. |

| Step 10: | Write the report |
|---|---|
| | HSAG will prepare a report providing details of the information obtained during the study. |
| **Step 11:** | **Receive DHHS approval of the draft report** |
| | HSAG will send a draft report to DHHS for approval. After approval of the information contained in the draft report, HSAG will send a finalized version of the report to DHHS. |

# Appendix B. HSAG Quality Study Review Team

HSAG assembled a Quality Study Review Team based on the full complement of skills required for the New Hampshire Service Authorization Quality Study activity. Table B-1 lists the Quality Study Review Team members, their roles, and relevant skills and expertise.

**Table B-1—Quality Study Review Team**

| Name/Role | Skills and Expertise |
|---|---|
| Debra Chotkevys, DHA, MBA<br>*Executive Director, State & Corporate Services (S&CS)* | Dr. Chotkevys has more than 40 years of healthcare experience in compliance activities, hospital administration, physician services, marketing, credentialing, office site reviews, Healthcare Effectiveness Data and Information Set (HEDIS®)[1] audits, medical record abstraction, and accreditation standards. Dr. Chotkevys has been employed by HSAG for 21 years and has been the director of EQR services in New Hampshire since 2013. |
| Natalie Honeycutt, MHA/Ed., BHSA, RN<br>*Director, State & Corporate Services* | Ms. Honeycutt has over 35 years of healthcare industry experience including clinical nursing, EQR, regulatory compliance, performance improvement, HEDIS data collection, utilization management, case management, medical record protocols, data abstraction, and healthcare education. Ms. Honeycutt has been employed by HSAG for 10 years and has been involved in EQR services in New Hampshire since 2016. |
| Sara Landes, MHA, CPHQ<br>*Director, State & Corporate Services* | Ms. Landes has over 13 years of experience as a project leader in healthcare quality improvement, and she is proficient in federal, National Committee for Quality Assurance (NCQA), and other regulatory compliance guidelines as well as in data analysis, evaluation, and research/resolution capabilities. Ms. Landes joined HSAG in 2021. |
| Christina Cebriak, MSN-CCM, RN<br>*Project Manager II*<br>*State & Corporate Services* | Ms. Cebriak has over 30 years of healthcare industry experience, including clinical nursing, regulatory compliance, performance improvement, case management, and utilization review. Ms. Cebriak joined HSAG in early 2024. |

[1] HEDIS® is a registered trademark of the NCQA.

# Appendix C. First MCO Questionnaire and Responses

This appendix contains the answers to study questions as submitted by the MCOs. HSAG did not edit these responses.

| Question 1.a. | Does your MCO consistently report numbers on the SERVICEAUTH.05 Report using header level or detail level information? |
|---|---|
| ACNH | AmeriHealth Caritas New Hampshire (ACNH) reports the data using detail level information. If an authorization has multiple service lines, then each request is reported separately. |
| NHHF | Detail level (line-item). |
| WS | Numbers/data reported is consistently done at the Detail level information – i.e. the item (HCPCS) level. |
| HSAG's Comparison of Answers | All three MCOs report information on the SERVICEAUTH.05 Report using detail (i.e., line-item) responses. |
| **Question 1.b.** | **How does your MCO determine the numbers included in the "Requested" column?** |
| ACNH | ACNH determines the number to include by including all authorizations with a Requested Date in the measurement period. This number equals the sum of approved, denied, and pending authorizations. |
| NHHF | Total number of authorization requests received during the report measurement period. |
| WS | The numbers/data reported in the 'Requested' column would be all line items/HCPCS requested (whether electronic, phone, fax) that fall within the reporting period timeframe and are not canceled. |
| HSAG's Comparison of Answers | All three MCOs include the total number of authorizations requested during the measurement period on the report. WS stipulated that the plan does not count canceled requests. |
| **Question 1.b.i.** | **How does your MCO manage partial denials on the SERVICEAUTH.05 Report?** |
| ACNH | Partial denials count towards approved and denied. Request lines with a final decision of approved are counted as approved. Request lines with a final decision of denied are counted as denied. |
| NHHF | Determinations are reported by the line-item determination status, but generally a partial denial is considered a denial. Note – partial denials do not apply to pharmacy benefit. |
| WS | Partial denials are included in Total Denied counts. |
| HSAG's Comparison of Answers | Each MCO reported counting partial denials as *Denied* on the SERVICEAUTH.05 Report. NHHF noted that partial denials do not apply to the pharmacy benefit, prompting all MCOs to clarify any exclusions or caveats for those authorizations reported as *Denied*. |

| Question 1.b.ii. | Does your MCO attempt to contact the provider for additional documents for submissions with incomplete documentation before counting them as a "Requested" service authorization? |
|---|---|
| ACNH | The ACNH utilization management (UM) team does contact the provider if additional clinical documentation is needed to complete the review. The first request, even if missing documentation is counted as the request received date. |
| NHHF | Yes, if the request is completely missing information (e.g. service being requested), the request for information is made at the time the auth request is received. If missing certain elements, the request is made during the review process. For the pharmacy **benefit no outreach** is performed prior to counting this as a "requested" service authorization as all requests would be counted under the column "requested" regardless of completeness of request. |
| WS | All requests for authorization by item/HCPCS are counted as a request regardless if documentation is not attached. |
| HSAG's Comparison of Answers | All MCOs count as a request, even if documentation is not attached. |
| **Question 1.b.ii.1.** | **If your MCO contacts a provider for additional documents, how many times do you make the attempt?** |
| ACNH | ACNH contacts the provider twice to request additional information. |
| NHHF | Yes, at least one documented attempt. This does not apply to pharmacy benefit. |
| WS | One attempt by DME and Pharmacy vendors, and 2 attempts for everybody else. |
| HSAG's Comparison of Answers | NHHF contacts providers at least once. WS contacts DME and pharmacy vendors once. ACNH and WS, for all other providers except DME and pharmacy, contacts providers twice. |
| **Question 1.b.ii.2** | **Is there a time limit for making those attempts?** |
| ACNH | Within 14 days. |
| NHHF | If a determination cannot be made due to lack of necessary clinical information, at least one (1) documented attempt to obtain the additional information within the original 2 calendar days (for diagnostic radiology) or 14 calendar days (for non-diagnostic radiology requests). If the additional information needed is not received the health plan can pend the request for 14 calendar days from the date of the receipt of the original request. This does not apply to pharmacy benefit. |
| WS | The time limit applied for making outreach attempts and receiving the documentation is based on required turnaround time. |
| HSAG's Comparison of Answers | Required turnaround time (42 CFR §438.210(c)(1)): Standard authorizations: 14 calendar days.<br>All MCOs complete requests for additional information within 14 calendar days. |

| Question 1.b.iii. | Does your MCO include expedited authorizations in the "Requested" column along with the non-urgent requests? |
|---|---|
| ACNH | Yes, expedited authorizations are included in the Requested column. |
| NHHF | Yes |
| WS | Yes. |
| HSAG's Comparison of Answers | All MCOs include non-urgent and expedited authorizations in the "Requested" column. |
| **Question 1.c.** | **How does your MCO determine the numbers included in the "Approved" column?** |
| ACNH | The number of service lines with a decision of "approved." |
| NHHF | Number of authorization requests received during the report measurement period with line item status determination = approved |
| WS | The numbers/data reported in the 'Approved' column would be all line items/HCPCS with an Active/Approved status. |
| HSAG's Comparison of Answers | All MCOs count all approved line-item requests in the "Approved" column. |
| **Question 1.d.** | **How does your MCO determine the numbers included in the "Denied" column?** |
| ACNH | The number of service lines with a decision of "denied." |
| NHHF | Number of authorization requests received during the report measurement period with line item status determination = denied |
| WS | The numbers/data reported in the 'Denied' column would be all line items/HCPCS with a Denied or Partial Denial status. |
| HSAG's Comparison of Answers | All MCOs count all denied line-item requests in the "Denied" column. |
| **Question 1.d.i.** | **Does your MCO attempt to contact the provider for additional documents for submissions with incomplete documentation before counting them as a "Denied" service authorization?** |
| ACNH | UM does contact the provider if additional clinical documentation is needed before determination is made. |
| NHHF | Yes, see above answer for additional information on the non-pharmacy benefit process. |
| WS | Yes. |
| HSAG's Comparison of Answers | All MCOs contact the provider for additional documentation before counting them as "Denied." |

| Question 1.d.i.1. | If your MCO contacts a provider for additional documents, how many times do you make the attempt? |
|---|---|
| ACNH | The MCO attempts to contact the provider once. |
| NHHF | Yes, at least one documented attempt. |
| WS | One attempt by DME and Pharmacy vendor, and 2 attempts for everything else. |
| HSAG's Comparison of Answers | ACNH and NHHF contact providers once. WS contacts DME and pharmacy once and makes two attempts for other services. |
| **Question 1.d.i.2.** | **Is there a time limit for making those attempts?** |
| ACNH | 24-hour period. |
| NHHF | If a determination cannot be made due to lack of necessary clinical information, at least one (1) documented attempt to obtain the additional information within 24 hours (for pharmacy benefit), 2 calendar days (for diagnostic radiology) or 14 calendar days (for non-diagnostic radiology requests). If the additional information needed is not received the health plan can pend the request for 14 calendar days from the date of the receipt of the original request – this does not apply to pharmacy benefit. |
| WS | All decisions and notifications need to occur within the required UM turnaround timeframes allotted based on authorization request type. |
| HSAG's Comparison of Answers | Each MCO confirmed that completion of a prior authorization determination occurred within the required turnaround time of 14 days per CFR §438.210(c)(1): Standard authorizations.<br>ACNH and NHHF noted specific time frames for turnaround. WS reported within the required UM turnaround time. |
| **Question 1.d.ii.** | **Does your MCO include expedited authorizations in the "Requested" column along with the non-urgent requests?** |
| ACNH | Yes, expedited authorizations are included in the Requested column. |
| NHHF | Yes |
| WS | Yes. |
| HSAG's Comparison of Answers | All MCOs include non-urgent and expedited authorization in the "Requested" column. |
| **Question 1.e.** | **Explain how your MCO determines the numbers included in the "Pending" column on the SERVICEAUTH.05 Report.** |
| ACNH | The number of services lines with a decision of "pending." These are awaiting review, require further information, etc. |
| NHHF | Number of authorization requests received during the report measurement period with line item status determination = pend. This does not apply to the pharmacy benefit. |
| WS | Any pending in this column would be authorizations not completed and in a pending status at the time of report run. (N/A for the pharmacy subcontractor as everything is either approved or denied) |

| | |
|---|---|
| HSAG's Comparison of Answers | All MCOs pend a decision when the approval or denial decision has not been finalized. **NHHF** noted that pend is not used for pharmacy benefits. |
| **Question 2.** | **After your MCO denies a service authorization request, can you track whether the member or provider resubmitted the denial as an appeal?** |
| **ACNH** | Yes, the **ACNH** appeals department can track whether the member or provider resubmitted the denial as an appeal. |
| **NHHF** | Yes |
| **WS** | Not 100%, since system of record is different for **WellSense** vs delegated vendor entities, creating a link for an authorization between initial determination and an appeal, will not end up with 100% match systematically. |
| HSAG's Comparison of Answers | **ACNH** and **NHHF** can identify if a denial was upheld or overturned.<br>**WS** cannot identify if all vendor denials were upheld or overturned. |
| **Question 2.a.** | **If your MCO can track denials resubmitted as an appeal, can your data system identify if the reviewer upheld or overturned the denial?** |
| **ACNH** | Yes, the **ACNH** medical informatics system can identify if the denial was upheld or overturned. |
| **NHHF** | Yes |
| **WS** | Same as above (2). |
| HSAG's Comparison of Answers | **ACNH** and **NHHF** can identify if a denial was upheld or overturned.<br>**WS** cannot identify if all vendor denials were upheld or overturned. |

# Appendix D. Second MCO Questionnaire and Virtual Meeting Responses

This appendix contains the answers to study questions as submitted by the MCOs. HSAG did not edit these responses.

| Question 1.a. | Does your MCO consistently report numbers on the SERVICEAUTH.05 Report using header level or detail level information? |
|---|---|
| Additional Questions sent to the MCOs | **ACNH**, **NHHF**, and **WS**: Does your MCO handle DME prior authorizations the same way as a medical service request for prior authorization? If not, please clarify the differences. |
| **ACNH** | DME is handled the same way as a medical service request for prior authorization. |
| **NHHF** | DME requests are handled the same as medical request for PA. |
| **WS** | The **WS** managed care subcontractor is NCQA accredited in Utilization Management and has standard procedures for handling requests for authorizations that follow established guidelines and specific regulatory requirements. Requests for authorization may be received via **WS**'s managed care subcontractor provider portal, fax or phone from a DME provider. If the request and related equipment/service meet scripted criteria an approved authorization is given and faxed to the requesting DME provider. Requests that cannot be approved are sent to **WS**'s managed care subcontractor Case Review department. If additional information is needed to review the request, **WS**'s managed care subcontractor Case Review department will request additional information by sending a letter to the prescriber with a copy to the member. If additional information is received, and the member meets the scripted criteria, the authorization request is approved and the parties notified. If the additional information needed to approve the request for authorization is not received and/or the request for authorization does not meet the scripted medical criteria, the case is sent to **WellSense** for their review and decision. If **WellSense** determines that the request can be authorized, **WellSense** notifies the subcontractor of the approval and the subcontractor notifies the parties. If the subcontractor determines that the request for authorization does not meet criteria, the subcontractor will issue a denial and notify the parties. |
| HSAG's Comparison of Answers | All MCOs handle DME authorizations the same way as medical authorizations. |
| Virtual Meeting Follow-up | HSAG to **WS**: Does **WS** handle a DME request for authorization with the same process as a medical authorization? |
| MCO Response | **WS** confirmed the subcontracted entity handles the DME authorization requests if received from a DME supplier. **WS** handles DME requests that are received from a provider office, etc. If the subcontracted entity is unable to approve the authorization, it is reviewed by **WS** prior to being denied. |

| Question 1.b. | How does your MCO determine the numbers included in the "Requested" column? |
|---|---|
| Additional Questions to Send to the MCOs | **ACNH**, **NHHF**, and **WS**: Are the numbers included in the "Requested" column counted by totaling header-level items or by totaling detail-level items? |
| **ACNH** | They are counted by totaling detail-level items. |
| **NHHF** | Detail-level items |
| **WS** | The numbers/data reported in the 'Requested' column would be all line items/HCPCS requested (whether electronic, phone, fax) that fall within the reporting period timeframe and are not canceled. |
| HSAG's Comparison of Answers | All MCOs count authorizations by totaling detail-level items. |
| Virtual Meeting Follow-up | HSAG to **WS:** Clarify the statement – "…and are not canceled." |
| MCO Response | **WS** confirmed a canceled authorization is a voided authorization. An example is duplicate or a rescinded request. **WS** also confirmed, if needed, the provider is contacted to confirm the request could/should be canceled. |
| **Question 1.b.i.** | **How does your MCO manage partial denials on the SERVICEAUTH.05 Report?** |
| Virtual Meeting Follow-up | HSAG to **NHHF:** What is an example of a partial denial? |
| MCO Response | **NHHF**: A line- item denial or partial denial is counted as a denial. |
| **Question 1.b.ii.1.** | **If your MCO contacts a provider for additional documents, how many times do you make the attempt?** |
| Additional Questions to Send to the MCOs | **ACNH** and **NHHF**: For pharmacy providers, does your MCO make any attempts to contact providers for additional documents? If so, how many?<br>**ACNH** and **NHHF**: For DME providers, does your MCO make any attempts to contact the provider for additional documents? If so, how many? |
| **ACNH** | **Pharmacy and DME:** Two attempts |
| **NHHF** | **Pharmacy:** Our original answer to 1bii is referring to no additional outreach on pharmacy benefit is necessary to count a pharmacy request in the serviceauth.05 "requested" field.<br>If there is insufficient information to render a determination, pharmacy will perform one documented outreach attempt prior to a denial designation.<br>**DME:** One attempt |
| **WS** | N/A |
| HSAG's Comparison of Answers | All MCOs make at least one attempt to secure additional documents. **ACNH** makes two attempts. |
| Virtual Meeting Follow-up | HSAG to **ACNH**: For a pharmacy authorization, what is the process to complete two attempts in 24 hours? |

| | |
|---|---|
| MCO Response | **ACNH** confirmed two attempts are made for pharmacy prior authorization requests.<br>Attempt number one is via phone and attempt number two is via fax.<br>Prior authorization requests are completed within 24 hours. |
| **Question 1.b.ii.2.** | **Is there a time limit for making those attempts?** |
| Additional Questions to Send to the MCOs | **ACNH**, **NHHF**, and **WS**: For pharmacy providers, what is the specific time limit for attempts to contact providers?<br>**ACNH**, **NHHF**, and **WS**: For DME providers, what is the specific time limit for attempts to contact providers? |
| **ACNH** | **Pharmacy:** 24 hours<br>**DME:** 48 hours |
| **NHHF** | **Pharmacy:** Federal regulation requires pharmacy benefit requests be reviewed and determined within 24 hours. Pharmacy reviewers will perform at least one documented outreach to providers within this timeframe to attempt to obtain additional documentation if necessary.<br>**DME**: We contact as soon as the lack of information is identified and allow at least 24 hours for response. |
| **WS** | **Pharmacy:**<br>Pre-service non-urgent: Not Applicable<br>Pre-service Urgent: A good faith effort is made to obtain the information (via fax phone or epa). The time to respond is based on the turnaround time requirements for the plan, meaning the provider would have 24 hour, or less, to respond.<br>**DME:**<br>For a pre-service, non-urgent request requiring additional information, the prescriber has 7 days from the date of request (the date that the request was sent to The **WS** managed care subcontractor) to respond to our request for information.<br>For a pre-service urgent request requiring additional information, the prescriber has 48 hours from the date of request (the date that the request was sent to The **WS** managed care subcontractor) to respond to our request for information.<br>For a post-service request requiring additional information, the prescriber has 15 days from the date of request (the date that the request was sent to The **WS** managed care subcontractor) to respond to our request for information. |
| HSAG's Comparison of Answers | All MCOs complete outreach within 24 hours for pharmacy. **ACNH** and **WS** outreach for 48 hours; however, **WS** also divides authorizations into categories of urgent and non-urgent. |
| Virtual Meeting Follow-up | HSAG to **WS:** What is the standard you are using for the "required turnaround time?"<br>What is the different between pre-service and pre-service urgent? |
| MCO Response | **WS:**<br>Pharmacy authorizations are considered urgent. DME authorizations are considered pre-service.<br>The definition of EPA = electronic prior authorization |

| | |
|---|---|
| | **WS** utilizes the pre-service non-urgent/urgent and post-service timeframes. A post-service request is completed within 30 days (15 days by the **WS** managed care subcontractor to allow for communication between the **WS** managed care subcontractor and **WS**). Each request for information is given about half the time limit for decisions in order to receive the information and review it in the required timeframes. |
| **Question 1.d.i.** | **Does your MCO attempt to contact the provider for additional documents for submissions with incomplete documentation before counting them as a "Denied" service authorization?** |
| Additional Questions to Send to the MCOs | **ACNH** and **NHHF**: Does your MCO contact pharmacy providers for additional information for an incomplete submission prior to counting as denied?<br>**ACNH** and **NHHF**: Does your MCO contact DME providers for additional information for an incomplete submission prior to counting as denied? |
| **ACNH** | **Pharmacy:** Yes, the prior authorization technician will make a telephonic outreach to obtain the missing information and document the call in the PA request notes. If the technician is unable to reach the provider's office or the additional information is not provided, a fax will be sent to the provider. This fax will inform the provider that the request is unable to be processed because of missing information and will list what information is missing. The fax will ask the provider to resubmit the original request with this information. The prior authorization request is not denied, but rather closed.<br>**DME:** Yes |
| **NHHF** | **Pharmacy:** If there is insufficient information to render a determination, pharmacy will perform one documented outreach attempt prior to a denial determination.<br>**DME:** Yes, by policy we cannot review without attempting to get the information needed. |
| **WS** | N/A |
| HSAG's Comparison of Answers | All MCOs outreach for additional documentation prior to counting as denied. |
| Virtual Meeting Follow-up | **HSAG to ACNH:** Clarify the final statement, "The prior authorization request is not denied, but rather closed." |
| MCO Response | **ACNH:**<br>A prior authorization request is closed when the request is presented with missing information such as demographics, member name, medication name or specifics, etc.<br>**ACNH** confirmed the prior authorization request is not removed from their system. If the provider provides the basic information, it will be processed as a new request according to guidelines.<br>**ACNH** does not close a prior authorization request if the information provided can be processed to an approved or denied status. |

| Question 1.d.i.1. | If your MCO contacts a provider for additional documents, how many times do you make the attempt? |
|---|---|
| Additional Questions to Send to the MCOs | **ACNH** and **NHHF**: How many times does your MCO attempt to contact a pharmacy provider for additional documents?<br>**ACNH** and **NHHF**: How many times does your MCO attempt to contact a DME provider for additional documents? |
| **ACNH** | **Pharmacy and DME:** Two times |
| **NHHF** | **Pharmacy and DME:** One time |
| **WS** | N/A |
| HSAG's Comparison of Answers | All MCOs attempt to contact the provider: **NHHF** and **WS** attempt one time. **ACNH** attempts twice. |
| Virtual Meeting Follow-up | HSAG to **ACNH**: For a pharmacy authorization, what is the process to complete two attempts in 24 hours? |
| MCO Response | **ACNH** confirmed two attempts are made for pharmacy prior authorization requests.<br>Attempt number one is via phone and attempt number two is via fax.<br>Prior authorization requests are completed within 24 hours. |
| **Question 1.d.i.2.** | **Is there a time limit for making those attempts?** |
| Additional Questions to Send to the MCOs | **ACNH** and **WS**: What is the specific time limit for attempts to contact a pharmacy provider for additional documents?<br>**ACNH** and **WS**: What is the specific time limit for attempts to contact a DME provider for additional documents? |
| **ACNH** | **Pharmacy:** 24 hours<br>**DME:** 48 hours |
| **NHHF** | N/A |
| **WS** | **Pharmacy:**<br>Pre-service non-urgent: Not Applicable<br>Pre-service Urgent: A good faith effort is made to obtain the information (via fax phone or epa). The time to respond is based on the turnaround time requirements for the plan, meaning the provider would have 24 hour, or less, to respond.<br>**DME:**<br>For a pre-service, non-urgent request requiring additional information, the prescriber has 7 days from the date of request (the date that the request was sent to The **WS** managed care subcontractor) to respond to our request for information.<br>For a pre-service urgent request requiring additional information, the prescriber has 48 hours from the date of request (the date that the request was sent to The **WS** managed care subcontractor) to respond to our request for information.<br>For a post-service request requiring additional information, the prescriber has 15 days from the date of request (the date that the request was sent to The **WS** managed care subcontractor) to respond to our request for information. |

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| HSAG's Comparison of Answers | All MCOs complete outreach within 24 hours for pharmacy. **ACNH** and **WS** outreach for 48 hours; however, **WS** also divides authorizations into categories of urgent and non-urgent. |
| Virtual Meeting Follow-up | HSAG to **NHHF**: What is meant by, "If the additional information needed is not received the health plan can pend the request for 13 calendar days…" |
| MCO Response | **NHHF:**<br>If a determination cannot be made due to lack of necessary clinical information, at least one (1) documented attempt to obtain the additional information within 24 hours (for pharmacy benefit), 2 calendar days (for diagnostic radiology) or 14 calendar days (for non-diagnostic radiology requests). If the additional information needed is not received the health plan can pend the request for 14 calendar days from the date of the receipt of the original request – this does not apply to pharmacy benefit.<br>**NHHF** noted authorizations are approved or denied (resolved) prior to the report. Authorizations are not placed in the "pending" column for the report.<br>**NHHF** is only reporting completed authorizations on the report. |
| **Question 1.e.** | **Explain how your MCO determines the numbers included in the "Pending" column on the SERVICEAUTH.05 Report.** |
| Additional Questions to Send to the MCOs | **ACNH**, **NHHF**, and **WS**: Does your MCO pend pharmacy requests?<br>**ACNH**, **NHHF**, and **WS**: Does your MCO pend DME requests? |
| **ACNH** | **Pharmacy:** Yes<br>**DME:** Yes |
| **NHHF** | **Pharmacy:** No<br>**DME:** There is a "pend" option for claims purposes, - it is for payment integrity. All DME requests are decisioned. |
| **WS** | **Pharmacy:** The pharmacy subcontractor either approves or denies PA request.<br>**DME:** The **WS** managed care subcontractor (DME Vendor) can pend an authorization due to a new request that hasn't been processed yet or when waiting for additional clinical. |
| HSAG's Comparison of Answers | Each MCO utilizes the "pend" column with a different definition. **ACNH** stipulated it does pend pharmacy and DME requests. **NHHF** confirmed it did not pend authorization requests. **WS** reported pharmacy authorizations are not pended and The **WS** managed care subcontractor, can pend while waiting for additional clinical. |
| Virtual Follow-up | HSAG to **ACNH:** Explain how your MCO determines the numbers included in the "Pending" column on the SERVICEAUTH.05 Report?<br>HSAG to **WS:** Explain how your MCO determines the numbers included in the "Pending" column on the SERVICEAUTH.05 Report? |
| MCO Responses | **ACNH:**<br>• Pharmacy requests are not included in the SERVICEAUTH.05 report in the pend field.<br>• A pend status is defined as a claim which has not been processed to the point of approved or denied. |

| | |
|---|---|
| | **WS**: A pending authorization is defined as not completed or not able to make a decision. The MCO pharmacy subcontractor does not pend authorization requests. |
| **Question 2.** | **After your MCO denies a service authorization request, can you track whether the member or provider resubmitted the denial as an appeal?** |
| Additional Questions to Send to the MCOs | **ACNH** and **NHHF**: If a subcontracted vendor denied the authorization request, can your MCO track whether the member or provider submitted an appeal? |
| **ACNH** | Yes, all appeals received for an authorization denial by a subcontractor, are loaded, and tracked in Jiva, **ACNH**'s Medical Management System. This appeal information is also tracked on a daily inventory Tableau Dashboard report. |
| **NHHF** | Yes – but **NHHF** does not subcontract prior authorization for the service categories included in this study |
| **WS** | N/A |
| HSAG's Comparison of Answers | **ACNH** and **NHHF** confirmed the ability to track an authorization if the provider submitted and appeal. **WS** reported a lack of ability to connect the original authorization and appeal 100% of the time when working with their vendor. |
| **Question 2.a.** | **If your MCO can track denials resubmitted as an appeal, can your data system identify if the reviewer upheld or overturned the denial?** |
| Additional Questions to Send to the MCOs | **ACNH** and **NHHF**: If a subcontracted vendor denied the authorization request, can your MCO track whether the appeal was upheld or overturned? |
| **ACNH** | Yes, all appeal decisions of an authorization denial by a subcontractor are tracked in Jiva. Whether the appeal was upheld or overturned is also captured on reporting and dashboards. |
| **NHHF** | Yes – but **NHHF** does not subcontract prior authorization for the service categories included in this study. |
| **WS** | N/A |
| HSAG's Comparison of Answers | **ACNH** and **NHHF** agreed if a subcontracted vendor denied the authorization, they could track an appeal decision. **WS** reported a lack of ability to connect the original authorization and appeal 100% of the time when working with their vendor. |

# Appendix E. Recommendations for the EQRO.01 Report

Appendix E contains specific recommendations generated by the study for each MCO to include in the EQRO.01 Report.

There are no findings/recommendations for improvement generated by the study for **ACNH** or **NHHF** that need to be included in the EQRO.01 report. **WS** had one finding/recommendation listed below in Table E-1.

**Table E-1—Recommendation for WS**

| Number | Recommendation |
|---|---|
| WS-2024-EQRO.01-QS-SrvAuth-01 | The Code of Federal Regulations (CFR) 438.210(f)(4) requires MCOs to report denied prior authorization requests that were approved after an appeal. **WS** must work with vendors to ensure that all denied prior authorizations can be linked to all appeals concerning those denied authorizations. |