State of New Hampshire

Department of Health and Human Services

New Hampshire External Quality Review Technical Report

SFY 2014–2015

March 2016

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Acknowledgments

In 2011, the New Hampshire legislature passed Senate Bill 147 requiring a comprehensive statewide Medicaid managed care program for all Medicaid enrollees. The New Hampshire Department of Health and Human Services (DHHS, or the Department) implemented the Medicaid Care Management (MCM) program on December 1, 2013. At the close of state fiscal year (SFY) 2015, 161,224 New Hampshire Medicaid beneficiaries were enrolled in the MCM program.[1-1] Beneficiaries enrolled in the program received services through one of two managed care organizations (MCOs): **New Hampshire Healthy Families** (**NHHF**) or **Well Sense Health Plan** (**Well Sense**). Each health plan is responsible for coordinating and managing their members' care through dedicated staff and a network of qualified providers.

The Department evaluates the MCM program through a comprehensive quality strategy which includes monitoring and public reporting of over 400 performance measures, requiring health plan accreditation from the National Committee for Quality Assurance (NCQA), requiring each health plan to implement a quality assurance and improvement program, and conducting a program evaluation by an external quality review organization (EQRO).

The 2015 technical report is a summative account of a wide variety of activities conducted by Health Services Advisory Group, Inc. (HSAG), the Department's EQRO. Activities conducted to evaluate individual MCOs included audits of each MCO's contract compliance, performance improvement projects, and validation of performance measures and encounter data.[1-2] Further analysis was conducted of each MCO's health outcome and beneficiary experience of care data compared to national performance measures. HSAG also conducted quality activities at the MCM program level, which include member and provider focused studies.

Health Plan Evaluation

The EQRO's evaluation documented very strong performance results for both MCOs' contract compliance, performance improvement projects, and performance measure validity. An opportunity for improvement identified during the compliance reviews for both MCOs was attaining the required frequency of Consumer Advisory Board meetings. No opportunities for improvement were identified for the performance improvement projects. The performance measure validation audit resulted in a recommendation that one MCO improve its monitoring of vendor data.

[1-1] The data source for all enrollment data is the July 2, 2015 extract from New Hampshire Medicaid Management Information System (MMIS).

[1-2] Encounter data validation began in SFY 2015; however, results will not be available until the following SFY.

Member Experience of Care Evaluation

New Hampshire uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS[1-3]) as the primary means of measuring each health plan's impact on members' experience of care. In calendar year (CY) 2014, member satisfaction results showed both health plans above the national average for getting needed care and getting needed care quickly. Members' overall ratings of both health plans were below the national average, suggesting opportunities for improvement.

Health Outcome Evaluation

New Hampshire uses the Healthcare Effectiveness Data and Information Set (HEDIS[1-4]) as the primary method of measuring each health plan's impact on health outcomes. **In CY 2014, the majority of preventive, acute/chronic care, and behavioral health care measures for both plans met or exceeded the 50th percentile of national comparison rates.**

Measures below the 25th percentile of national comparison rates identify opportunities for performance improvement activities, which include *Chlamydia Screening*, *Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation*, and *Diabetes Monitoring for People with Schizophrenia*.[1-5]

New Hampshire Medicaid Care Management Program Evaluation

To evaluate the MCM program, HSAG conducted member focus groups in the fall and the spring, and a provider focused study. During the fall focus groups, New Hampshire MCO members shared overall positive experiences with their MCO and their access to care. Clearer communication from the MCOs concerning benefits, coverage, and the grievance and appeals process were identified as the primary opportunities for improvement. The spring focused groups included individuals from the New Hampshire Health Protection Program. **New Hampshire Health Protection Program beneficiaries reported a significant improvement in their access to care since receiving Medicaid and enrolling in an MCO.**

During a provider focused study concerning service authorizations, providers furnished feedback indicating that MCOs' processes were inconsistent and cumbersome. Through a follow-up evaluation of each MCO's process, two opportunities for improvement were identified: a single method of requesting authorization and enhanced consistency of each MCO's individual determinations.

In 2015, the majority of the EQRO's activities show positive results for the first full SFY of the MCM program. Many of the same activities will be conducted in SFY 2016,

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[1-3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

[1-4] HEDIS® is a registered trademark of the National Committee on Quality Assurance.

[1-5] Noted results indicate measures where both health plans scored below the 25th percentile of national comparison rates.

which will allow further evaluation of targeted opportunities for improvement identified in this report.

Program Overview

In 2011, the New Hampshire legislature passed Senate Bill 147 requiring a comprehensive Medicaid managed care program for all Medicaid beneficiaries. The New Hampshire Department of Health and Human Services implemented Step 1 of the risk-based MCM program on December 1, 2013, with the majority of beneficiaries receiving their acute care services through one of three MCOs: **New Hampshire Healthy Families**, **Well Sense Health Plan**, or **Meridian Health Plan** (**Meridian**). Each health plan is responsible for coordinating and managing beneficiary care through dedicated staff and a network of qualified providers. In August 2014, **Meridian** exited New Hampshire, and 30,000 beneficiaries were successfully transitioned to the remaining two plans. At the end of SFY 2015, the first full fiscal year of the program, 161,224 New Hampshire Medicaid beneficiaries were enrolled in the MCM program.[2-1] The majority of beneficiaries were females and children and adolescents 0–18 years of age—all receiving Medicaid based on low income eligibility standards. Additional demographic data can be found in Appendix B.

With the onset of the MCM program, the Department implemented a comprehensive quality strategy approved by the Centers for Medicare & Medicaid Services (CMS) to evaluate the MCM program. The strategy included monitoring and public reporting of over 400 performance measures via medicaidquality.nh.gov, requiring health plan accreditation from the NCQA, requiring each health plan to implement a quality assurance and performance improvement program, and conducting a program evaluation by an EQRO.

In 2014, the New Hampshire legislature passed Senate Bill 413, resulting in the implementation of the New Hampshire Health Protection Plan (NHHPP) in August of the same year. The NHHPP provided coverage to 38,143 beneficiaries through the MCM program at the end of SFY 2015. In addition to providing insurance to many beneficiaries not previously covered, the NHHPP offered a substance use disorder benefit including outpatient and residential services. In 2015, the Department received approval from CMS to transition the majority of members eligible for the NHHPP through the MCM program to the Premium Assistance Program beginning on January 1, 2016.[2-2] In this new program, the majority of beneficiaries will receive their care through a selection of qualified health programs found on the federal Health Insurance Marketplace.

In 2015, CMS approved Step 2, Phase 1 of the MCM program. In this phase, populations who previously had the option of enrolling in the MCM program become mandatory for receiving the majority of their acute services through the program.[2-3] The Department conducted multiple stages of review and determined that the MCOs were ready to provide services to these additional populations on February 1, 2016.

[2-1] The data source for all enrollment data is the July 2, 2015, extract from New Hampshire MMIS.
[2-2] Approval from CMS Section 1115 Waiver for the Premium Assistance Program.
[2-3] Approval from CMS Section 1915b Waiver.

Step 2, Phase 2 and Phase 3 of the MCM program include beneficiaries receiving long-term services and supports (LTSS) through nursing facilities or the Choices for Independence Waiver who will now have these services managed by the MCOs. Later phases of the MCM program include incorporating long-term services and supports into the services managed by the MCOs.

Overview

The federal Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires state Medicaid agencies to "provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract."[3-1] HSAG is under contract with DHHS to perform the external quality review (EQR) activities for the State.

The SFY 2014–2015 New Hampshire EQR Technical Report for the New Hampshire MCM program complies with the Code of Federal Regulations (CFR) 42 §438.364 which requires the EQRO to produce "a detailed technical report that describes the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCOs."[3-2] The current report contains findings from the completed activities and a description of the status of the remaining activities as of June 30, 2015.

In addition, the report compares the rates of the two New Hampshire Medicaid health plans, **NHHF** and **Well Sense**, and offers nationally recognized comparisons, when appropriate. The report also offers recommendations for improving the quality and timeliness of, and access to, health care services provided by each health plan and provides an assessment of the follow-up to the SFY 2013–2014 recommendations for improvement.

External Quality Review Activities, Conclusions, and Recommendations

Managed Care Organization (MCO) Contractual Compliance

Each year HSAG conducts an on-site compliance review at the offices of **NHHF** and **Well Sense** to ensure compliance with federal and State requirements and the MCM Contract requirements. The SFY 2014–2015 review initiated a three-year cycle of reviewing one-third of all compliance elements contained in the compliance tool. This year's review also included a review of the elements from the SFY 2013–2014 corrective action plan.

Findings

Table 3-1 illustrates **NHHF**'s and **Well Sense**'s individual performance in each of the 14 standards and the overall score for the on-site review.

[3-1] U. S. Government Printing Office. (1997). *Public Law 105-33* (p. 249). Available at: http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf. Accessed on: October 21, 2015.

[3-2] U. S. Government Printing Office. (n.d.). *External quality review results.* Available at: http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec438-364.pdf. Accessed on: November 20, 2015.

Table 3-1—Summary of the SFY 2014–2015 Compliance Review Scores for the MCOs			
Standard	Standard Name	NHHF	Well Sense
I	Delegation and Subcontracting	100%	100%
II	Plans Required by the Contract	100%	100%
III	Emergency and Post-stabilization Care	100%	100%
IV	Care Management/Care Coordination	100%	100%
V	Wellness and Prevention	100%	100%
VI	Behavioral Health	100%	100%
VII	Member Enrollment and Disenrollment	100%	100%
VIII	Member Services	100%	100%
IX	Cultural Considerations	100%	100%
X	Grievances and Appeals	100%	100%
XI	Access	100%	100%
XII	Network Management	95.5%	95.5%
XIII	Utilization Management	100%	100%
XIV	Quality Management	100%	100%
Overall Rate		99.5%	99.5%

Of the 14 standards and 92 elements included in the SFY 2014–2015 compliance review, the two MCOs achieved 100 percent compliance for 13 standards. Both MCOs missed one element in the Network Management Standard. **NHHF** and **Well Sense** failed to convene a Consumer Advisory Board a minimum of four times during SFY 2014–2015.

The re-review of the SFY 2013–2014 corrective action plans included 34 items for **NHHF** and 38 items for **Well Sense**. Both MCOs met the requirements of all corrective action plan elements as verified through a review of policies and procedures and staff interviews during the current on-site review. Additional information concerning the compliance review activities for **NHHF** and **Well Sense** can be found in Section 4: Detailed Findings. Appendix B also contains a full description of the methodology HSAG uses to conduct compliance reviews.

Conclusions and Recommendations

NHHF and Well Sense

NHHF and **Well Sense** achieved very strong performance during the SFY 2014–2015 compliance review. Only one of the 92 elements was found to be noncompliant with the federal and State regulations.

Because only one item is outstanding from the compliance reviews, HSAG has one recommendation for **NHHF** and **Well Sense**:

◆ **NHHF** and **Well Sense** Consumer Advisory Board's must meet face-to-face a minimum of four times each agreement year as required by the MCM Contract.

Evaluation of Programs and Projects: Performance Improvement Projects (PIPs)

The purpose of a PIP, as defined by 42 CFR §438.240,[3-3] is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. In order for such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

Findings

During SFY 2014–2015, HSAG reviewed the design phase of the four PIP topics selected by **NHHF** and four PIP topics selected by **Well Sense** as shown in Table 3-2. One of the four PIP topics must be focused on behavioral health.

Table 3-2—Performance Improvement Project Topics Selected by NHHF and Well Sense Health Plan	
NHHF PIP Topics	**Well Sense PIP Topics**
Comprehensive Diabetes Screening—Vision Screening	Diabetes Care—HbA1c Testing
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	Reducing Hospital Readmissions
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Chlamydia Screening
Well-Child Visits for 3-to-6-Year-Olds	Well-Child Visits for 3-to-6-Year-Olds

For each MCO, Table 3-3 shows the aggregate number of applicable evaluation elements that were scored *Met* for each stage and the combined overall percentage of evaluation elements *Met* for the four PIPs.


[3-3] U. S. Government Printing Office. (n.d.). Quality assessment and performance improvement program. Available at: http://www.gpo.gov/fdsys/pkg/CFR-2009-title42-vol4/pdf/CFR-2009-title42-vol4-sec438-240.pdf. Accessed on: November 25, 2015.

Table 3-3—2014 PIP Validation Results Comparison by MCO for Topics Selected by NHHF and Well Sense			
		Percentage of Applicable Elements Scored *Met*	
Stage	**Activities**	**NHHF (Number [N]=4 PIPs)**	**Well Sense (N=4 PIPs)**
Design	Activities I–VI	100% (64/64)	100% (54/54)
Implementation	Activities VII–VIII	*To be assessed in 2015*	*To be assessed in 2015*
Outcomes	Activities IX–X	*To be assessed in 2016*	*To be assessed in 2016*
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**100%**	**100%**

Both MCOs progressed through Activity VI, the Design stage for each of the PIPs. The Design stage establishes the methodological framework for the PIP. The activities in this stage include development of the study topic, question, indicators, population, sampling, and data collection. To implement successful improvement strategies, a strong study design is necessary. Both MCOs met 100 percent of the requirements for all activities in the Design stage of each PIP and received a *Met* validation status for each PIP. Overall, the health plans designed scientifically sound PIPs supported by key research principles. The PIPs will be validated through the Implementation stage in 2015, when the MCOs progress to reporting baseline study indicator results and improvement strategies, and through the Outcomes stage in 2016, when the MCOs progress to reporting remeasurement results.

The contract between the MCOs and DHHS also required the MCOs to develop PIPs on four topics defined by DHHS. The four topics are displayed in Figure 3-1.

Figure 3-1—Four PIP Topics Selected by DHHS
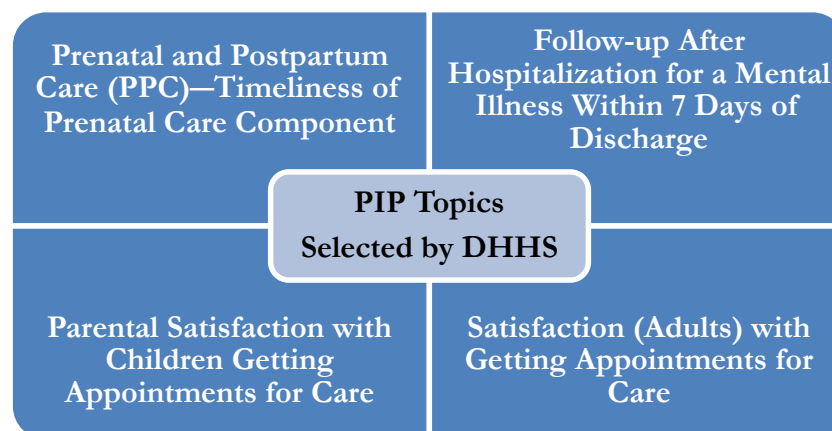
For each MCO, Table 3-4 shows the aggregate number of applicable evaluation elements that were scored *Met* for each stage and the combined overall percentage of evaluation elements *Met* for the four PIP topics chosen by DHHS.

Table 3-4—2014 PIP Validation Results Comparison by MCO for Topics Selected by DHHS			
Stage	**Activities**	**Percentage of Applicable Elements Scored *Met***	
		NHHF (N=4 PIPs)	**Well Sense (N=4 PIPs)**
Design	Activities I–VI	100% (63/63)	100% (58/58)
Implementation	Activities VII–VIII	*To be assessed in 2015*	*To be assessed in 2015*
Outcomes	Activities IX–X	*To be assessed in 2016*	*To be assessed in 2016*
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**100%**	**100%**

Both MCOs progressed through Activity VI, the Design stage for each of the PIPs. The Design stage establishes the methodological framework for the PIP. The activities in this stage include development of the study topic, question, indicators, population, sampling, and data collection. To implement successful improvement strategies, a strong study design is necessary. Both MCOs also met 100 percent of the requirements for all activities in the Design stage of each PIP and received a *Met* validation status for each PIP. Overall, the health plans designed scientifically sound PIPs supported by key research principles. The PIPs will be validated through the Implementation stage in 2015, when the MCOs progress to reporting baseline study indicator results and improvement strategies, and through the Outcomes stage in 2016, when the MCOs progress to reporting remeasurement results. Additional information concerning the PIPs for **NHHF** and **Well Sense** can be found in Section 4: Detailed Findings. Appendix B also contains a full description of the methodology HSAG uses to validate PIPs.

Conclusions and Recommendations

NHHF and Well Sense

Overall**, NHHF** and **Well Sense** designed scientifically sound projects supported by the use of key research principles. The technical design of each PIP was sufficient to measure and monitor outcomes.

Because **NHHF** and **Well Sense** met 100 percent of the requirements across the eight PIPs, HSAG has only one recommendation to share as a best practice that may strengthen future submissions:

◆ **NHHF** and **Well Sense** should review HSAG's feedback provided through *Points of Clarification* in the validation tools related to appropriate documentation for each PIP. By addressing all of the feedback and recommendations provided in the PIP validation tool, the MCO will ensure the PIP study design is accurately and completely documented and establish a sound methodological foundation for progression to the Implementation and Outcomes stages of the PIP.

For additional information concerning HSAG's methodology for validating PIPs, see Appendix B on page B-5 in the Methodologies for Conducting EQR Activities.

Validation of MCO Performance Measures

As required by 42 CFR §438.240,[3-4] HSAG completed the validation of MCO performance measures for SFY 2013–2014, and final reports were presented in December 2014. This section provides the findings, conclusions, and recommendations from the performance measure validation activities in SFY 2013–2014. Additional information concerning the performance measures activities for **NHHF** and **Well Sense** can be found in Section 4: Detailed Findings. Appendix B also contains a list of the measures reviewed in SFY 2013–2014 and a full description of the methodology HSAG uses to validate performance measures.

Findings

The table below provides an overview of the performance measure validation findings generated by the HSAG review team.

Table 3-5—Performance Measure Validation Findings		
Performance Measures	**NHHF**	**Well Sense**
Adequate documentation: Data integration, data control, and performance measure development	✓	✓
Claims systems and process adequacy: No non-standard forms used for claims	✓	✓
All primary and secondary coding schemes captured	✓	✓
Appropriate membership and enrollment file processing	✓	✓
Appropriate appeals data systems and accurate classification of appeal types and appeal reasons	✓	✓
Adequate call center systems and processes	✓	✓
Required measures received a "Reportable" designation	✓	✓

Conclusions and Recommendations

NHHF

NHHF had strong oversight on data received from providers, and adequate internal staff with business knowledge for performance reporting. **NHHF** staff members were able to reproduce the measures efficiently and accurately. The auditors did not make any recommendations for **NHHF**.

[3-4] U. S. Government Printing Office. (n.d.). Quality assessment and performance improvement program. Available at: http://www.gpo.gov/fdsys/pkg/CFR-2009-title42-vol4/pdf/CFR-2009-title42-vol4-sec438-240.pdf. Accessed on: November 25, 2015.

Well Sense

Well Sense had a team of staff who were dedicated and well versed in quality reporting. At the time of the audit, **Well Sense**'s quality department did not have a mechanism to track monthly claims volumes received from its external entities. HSAG recommends that **Well Sense** monitor each of its vendors monthly for encounter submissions. External claims volume reports can be helpful in identifying gaps when monitored monthly and would help the MCO identify missing data. In addition, it is recommended that trending reports for encounter submissions be added to the MCO's monthly monitoring process. This recommendation will be followed up as one of the activities included in the next annual validation.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting data. **NHHF** and **Well Sense** were responsible for obtaining a CAHPS vendor to administer the survey to adult members and parents or caretakers of child members. The two MCOs completed the surveys between January and May 2015.

Findings

The CAHPS 5.0H Surveys include a set of standardized items including four global ratings and five composite scores.[3-5] The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate).

For each of the four global ratings, the percentage of respondents who chose a positive satisfaction ratings on a scale of 0 to 10 was calculated. A positive or top-box response for the global ratings was defined as a value of 8, 9, or 10. For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes,"

[3-5] For purposes of this report, the 2015 Adult and Child Medicaid CAHPS results presented for **NHHF** and **Well Sense** are limited to the four CAHPS global ratings and five CAHPS composite measures evaluated through the CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys (i.e., CAHPS results are not presented for the two individual item measures or five Children with Chronic Conditions (CCC) composite scores/items).

"Usually," or "Always;" or (2) "No" or "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes."

Table 3-6 contains the results from the 2015 Adult Medicaid CAHPS Top-Box Rates calculated for **NHHF** and **Well Sense** and comparisons to the NCQA national averages.[3-6]

Table 3-6—NHHF and Well Sense Adult Medicaid CAHPS Results				
CAHPS Measure	**2015 Adult Medicaid Top-Box Rates**	**National Average Comparison**	**2015 Adult Medicaid Top-Box Rates**	**National Average Comparison**
Global Ratings	NHHF		Well Sense	
Rating of Health Plan	**67.7%**	↓	**72.9%**	↓
Rating of All Health Care	**70.6%**	↓	**77.2%**	↑
Rating of Personal Doctor	**80.4%**	↑	**76.8%**	↓
Rating of Specialist Seen Most Often	**82.7%**	↑	**80.9%**	↑
Composite Ratings	NHHF		Well Sense	
Getting Needed Care	**84.8%**	↑	**84.2%**	↑
Getting Care Quickly	**84.5%**	↑	**87.0%**	↑
How Well Doctors Communicate	**91.1%**	↑	**92.6%**	↑
Customer Service	**88.7%**	↑	**87.5%**	↑
Shared Decision Making	**77.8%**	NA	**80.5%**	NA

↑ Indicates the rate was above the 2014 NCQA Adult Medicaid national average

↔ Indicates the rate was at the 2014 NCQA Adult Medicaid national average

↓ Indicates the rate was below the 2014 NCQA Adult Medicaid national average

NA (not applicable) Indicates a comparison to the 2014 NCQA Adult Medicaid national average could not be performed

Table 3-7 contains the results from the 2015 General Child CAHPS Top-Box Rates calculated for **NHHF** and **Well Sense** and comparisons to NCQA national averages.[3-7] Additional information concerning the CAHPS activities for **NHHF** and **Well Sense** can be found in Section 4: Detailed Findings.

[3-6] The 2015 Adult Medicaid CAHPS Results presented in Table 3-6 for **NHHF** and **Well Sense** are based on the responses of adult Medicaid beneficiaries that returned a completed CAHPS survey. **NHHF** surveyed a total of 2,160 adult Medicaid members, of which 527 completed surveys were returned. **Well Sense** surveyed a total of 1,418 adult Medicaid members, of which 352 completed surveys were returned. In 2014, the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey was 28.6 percent, which was higher than the adult Medicaid **NHHF** and **Well Sense** response rates.

[3-7] The 2015 Child Medicaid CAHPS Results presented in Table 3-7 for **NHHF** and **Well Sense** are based on the responses of parents/caretakers of child Medicaid beneficiaries, selected as part of the general child sample only, that returned a completed CAHPS survey (i.e., based on the results of the general child population only). A total of 2,640 **NHHF** general child Medicaid members were selected for surveying, of which 648 completed surveys were returned. A total of 1,650 **Well Sense** general child Medicaid members were selected for surveying, of which 354 completed surveys were returned.

Table 3-7—NHHF and Well Sense Child Medicaid CAHPS Results				
CAHPS Measure	**2015 Child Medicaid Top-Box Rates**	**National Average Comparison**	**2015 Child Medicaid Top-Box Rates**	**National Average Comparison**
Global Ratings	**NHHF**		**Well Sense**	
Rating of Health Plan	**82.3%**	↓	**84.5%**	↔
Rating of All Health Care	**85.9%**	↑	**87.3%**	↑
Rating of Personal Doctor	**88.6%**	↑	**89.0%**	↑
Rating of Specialist Seen Most Often	**90.8%**	↑	**86.3%⁺**	↑
Composite Ratings	**NHHF**		**Well Sense**	
Getting Needed Care	**89.4%**	↑	**88.0%**	↑
Getting Care Quickly	**93.7%**	↑	**92.6%**	↑
How Well Doctors Communicate	**95.9%**	↑	**95.8%**	↑
Customer Service	**89.3%**	↑	**84.8%⁺**	↓
Shared Decision Making	**83.1%**	NA	**82.8%⁺**	NA

↑ Indicates the rate was above the 2014 NCQA Child Medicaid national average

↔ Indicates the rate was at the 2014 NCQA Child Medicaid national average

↓ Indicates the rate was below the 2014 NCQA Child Medicaid national average

+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response, caution should be exercised when interpreting results for those measures.

NA (not applicable) Indicates a comparison to the 2014 NCQA Child Medicaid national average could not be performed

Conclusions and Recommendations

NHHF

NHHF adult and child Medicaid *Rating of Health Plan* rates were below NCQA's 2014 Medicaid national average. HSAG recommends that **NHHF** focus quality improvement initiatives on enhancing members' experiences with *Rating of Health Plan*.

Well Sense

For **Well Sense**'s adult Medicaid population, *Rating of Health Plan* and *Rating of Personal Doctor* rates were below NCQA's 2014 Medicaid national averages. For **Well Sense**'s general child Medicaid population, the *Customer Service* rate was below NCQA's 2014 Medicaid national average. HSAG recommends that **Well Sense** focus quality improvement on enhancing members' experiences with *Rating of Health Plan*, *Rating of Personal Doctor*, and *Customer Service*.

For additional information concerning the CAHPS scores, see Section 4 on page 4-10 in the Detailed Findings.

Healthcare Effectiveness Data and Information Set (HEDIS)

DHHS requires MCOs to report NCQA HEDIS measures annually. To compile the information for the HEDIS section of this report, both MCOs provided their final audit reports, information system (IS) compliance tools, and the interactive data submission system

(IDSS) files approved by an NCQA-licensed organization (LO). The MCOs' NCQA HEDIS compliance auditors evaluated each MCO's IS and processes to determine the health plan's ability to report accurate and reliable HEDIS data. For HEDIS 2015, the auditors assessed seven IS standards. Both MCOs contracted with an external software vendor for HEDIS measure production and rate calculation, and the auditors found both MCOs to be fully compliant with all applicable IS assessment standards.

Findings

HSAG worked with DHHS to determine the 46 HEDIS performance measures included for reporting in this technical report. HSAG compared the rates achieved by the MCOs on the performance measures to the NCQA National Medicaid HEDIS 2014 percentiles (the most current rates available). HSAG displayed the results for each performance measure in figures that contain the rates achieved by **NHHF** and **Well Sense**, along with confidence intervals and the national benchmarks, when applicable. NCQA did not publish national benchmarks for two of the measures included in this report, and benchmarks for five of the utilization measures were not appropriate to display. **NHHF** and **Well Sense** each had two measures with populations too small to report (less than 30 members).

To evaluate the performance of **NHHF** and **Well Sense**, HSAG compiled the rates for the reported measures in the following categories that correspond with the national benchmarks: met or exceeded the 90th percentile, met the 75th percentile and below the 90th percentile, met the 50th percentile and below the 75th percentile, met the 25th percentile and below the 50th percentile, and under the 25th percentile.

Table 3-8 and Table 3-9 display the rates achieved by the MCOs according to the comparison of their rates to the national benchmarks.

Table 3-8—Summary of Scores for 2015 HEDIS Measures With National Comparative Rates for NHHF						
Measure Domain	**Met or Exceeded 90th Percentile**	**Met 75th Percentile and Below 90th Percentile**	**Met 50th Percentile and Below 75th Percentile**	**Met 25th Percentile and Below 50th Percentile**	**Under 25th Percentile**	**Total**
Prevention* (n=18)	2	7	5	3	1	**18**
Acute and Chronic Care (n=12)	1	4	4	1	2	**12**
Behavioral Health (n=7)	3	0	3	0	1	**7**
All Domains (n=37)	6	11	12	4	4	**37**
Percentage	16.2%	29.7%	32.4%	10.8%	10.8%	**100.0%**
Percentages may not equal 100 due to rounding. * Two additional measures were included in the Prevention domain, but **NHHF** had denominators less than 30 for both measures (a not applicable [NA] designation); therefore, rates for these measures were not compared to national percentiles.						

NHHF achieved ratings that met or exceeded the 90th percentile for six measures (16.2 percent). **NHHF** also met or exceeded the 50th percentile for 29 measures (78.4 percent). A total of eight measures (21.6 percent) were below the 50th percentile comparative rates.

Table 3-9—Summary of Scores for 2015 HEDIS Measures With National Comparative Rates for Well Sense						
Measure Domain	Met or Exceeded 90th Percentile	Met 75th Percentile and Below 90th Percentile	Met 50th Percentile and Below 75th Percentile	Met 25th Percentile and Below 50th Percentile	Under 25th Percentile	Total
Prevention* (n=18)	1	9	2	2	4	**18**
Acute and Chronic Care (n=12)	4	3	1	2	2	**12**
Behavioral Health (n=7)	3	1	1	0	2	**7**
All Domains (n=37)	8	13	4	4	8	**37**
Percentage	21.6%	35.1%	10.8%	10.8%	21.6%	**100.0%**

Percentages may not equal 100 due to rounding.

* Two additional measures were included in the Prevention domain, but **Well Sense** had denominators less than 30 for both measures (NA designation); therefore, rates for these measures were not compared to national percentiles.

Well Sense achieved ratings that met or exceeded the 90th percentile for 8 measures (21.6 percent). **Well Sense** also met or exceeded the 50th percentile for 25 measures (67.6 percent). A total of 12 measures (32.4 percent) were below the 50th percentile comparative rates. Additional information concerning the HEDIS measures for **NHHF** and **Well Sense** can be found in Section 4: Detailed Findings.

Conclusions and Recommendations

NHHF

Based on the rates the MCO achieved for the HEDIS measures, **NHHF** showed strong performance by scoring at or above the NCQA national Medicaid HEDIS 2014 90th percentile for the following measures:

- Two Prevention Measures

- One Acute and Chronic Care Measure

- Three Behavioral Health Measures

HSAG recommends that **NHHF** focus future quality improvement activities on the following performance measures that scored below the 25th percentile:

- One Prevention Measure

- Two Acute and Chronic Care Measures

◆ One Behavioral Health Measure

Well Sense

Based on the review of the final audit reports, IS compliance tools, and the IDSS files approved by a LO to conduct the NCQA HEDIS Compliance Audit, the following recommendations were identified:

◆ **Well Sense** may have dual eligible members in the New Hampshire Medicaid product. Based on this finding, HSAG recommended that dual eligible members be identified and excluded from the New Hampshire Medicaid HEDIS reporting.

◆ The accuracy level for a sample of clinician encounter forms was below 95 percent, and it was recommended that **Well Sense** increase standardization of data collection and increase rigor of quality assurance processes to improve accuracy to a minimum threshold of 95 percent.

Based on the rates the MCO achieved for the HEDIS measures, **Well Sense** showed strong performance by scoring at or above the NCQA national Medicaid HEDIS 2014 90th percentile for the following measures:

◆ One Prevention Measure

◆ Four Acute and Chronic Care Measures

◆ Three Behavioral Health Measures

HSAG recommends that **Well Sense** focus future quality improvement activities on the following performance measures that scored below the 25th percentile:

◆ Four Prevention Measures

◆ Two Acute and Chronic Care Measures

◆ Two Behavioral Health Measures

For additional information concerning the HEDIS measures, see Section 4 on page 4-25 in the Detailed Findings.

Summary of Other EQR Activities

Focus Groups

Horn Research, a subcontractor to HSAG, conducted two focus groups covering the same topic in fall 2014 and two focus groups covering the same topic in spring 2015. The fall focus groups were held in Keene, New Hampshire, and Rochester, New Hampshire, with 20 members either attending the meetings or responding to telephone interviews. The spring focus groups were held in Manchester, New Hampshire, and Nashua, New Hampshire, and 18 people participated in the study.

The fall focus groups included four key points of inquiry: Experience With Medicaid Care Management, Access to Care, Information Needs, and Improvements to MCO and Medicaid. Participants shared generally positive experiences regarding their MCO and revealed generally positive experiences with the preauthorization process. Participants most often mentioned wanting clear and concise information concerning their MCO's benefits and coverage, and updated provider listings. Participants suggested that MCOs providing access to alternative therapies and wellness opportunities would be a welcomed improvement.

The aim of the spring focus groups was to recruit individuals from the NHHPP, the Affordable Care Act's Medicaid expansion program in New Hampshire. The interviews included five key points of inquiry: Access to and Quality of Care Prior to Enrollment With MCO, Access to and Quality of Care Since Enrollment With MCO, Impact of Enrollment, Experience With MCO, and Improvements to MCO and Medicaid. The majority of participants reported a lack of insurance coverage prior to enrollment and very limited access to health care as a result. Participants generally agreed that their access to care improved significantly, which has resulted in more consistent care for their chronic illnesses and addressing of their health care needs. About half of the participants said their health had improved since joining the MCO. All participants described positive experiences with their MCOs and reported very few problems. Nearly half of the participants said they were satisfied with their MCO and Medicaid experiences and had no suggestions for improvement.

Encounter Data Validation (EDV)

For the contract year 2014–2015, DHHS contracted HSAG to develop an Encounter Data Quality Reporting System (EDQRS) for evaluating the quality encounter data files submitted by the MCOs. The EDQRS will be designed to import, store, and review incoming encounter data and generate automated, weekly validation reports for DHHS. At the end of SFY 2014–2015, HSAG had begun testing its implementation of an electronic data interchange (EDI) translator to calibrate the translation of New Hampshire's health plan encounter data. Once testing and implementation of the EDI translator is completed, HSAG will initiate programming of EDV-specific submission and quality edits along with development of the EDQRS reporting template.

Access Reporting: Secret Shopper Analysis

HSAG conducted a provider survey to monitor NHHPP and standard Medicaid members' access to health care services. Since the NHHPP fee schedule included a payment schedule for physician services which differed from the payment schedule for the standard MCM program, DHHS was interested in determining whether appointment accessibility differs based on the member's enrolled program. At the end of SFY 2014–2015, HSAG developed a

methodology for conducting a statewide secret shopper telephone survey of provider offices to evaluate the average length of time it takes for a Medicaid member to schedule an appointment with and be seen by a New Hampshire-licensed provider. The study will assist in determining whether appointment availability meets the performance standards established in the MCOs' Amendment #5, sections 19.3.4.2.3 and 19.3.4.2.4 of the MCM Agreement[3-8] between DHHS and the MCOs.[3-9]

Focused Study: Prior Authorizations

During SFY 2014–2015, DHHS requested assistance from HSAG to conduct a focused study to determine the current prior authorization process used by the two MCOs and the New Hampshire fee-for-service (FFS) system. Phase I of the study involved contacting Medicaid providers to request feedback concerning their experiences using the three prior authorization systems. Information obtained during the interviews defined the topics that HSAG investigated during the next phase of the study.

During Phase II, the areas of concern expressed during the interviews were grouped together to form four key elements of the prior authorization process: prior authorization requests, documentation requirements, determinations, and resolution. HSAG gathered information from policies, procedures, workflow documents, websites, and interviews to determine if the FFS system and the two MCOs were similar or if they differed in the handing of the four key elements of the prior authorization process. From that information, HSAG developed conclusions and worked with DHHS to create suggestions to improve and enhance the procedures for prior authorizations.

Overall Strengths and Opportunities for Improvement

New Hampshire Healthy Families

NHHF showed very strong performance in the overall results from the compliance review by scoring 99.5 percent. Of the 14 standards and 92 elements included in the SFY 2014–2015 compliance review, **NHHF** achieved 100 percent compliance with 13 standards. **NHHF** missed one element in the Network Management Standard. Improvement opportunities for **NHHF** from the compliance reviews include ensuring that the Consumer Advisory Board

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[3-8] State of New Hampshire Department of Health and Human Services. (2014). *Amendment #5 to the Medicaid Care Management Contract.* Available at: http://www.dhhs.nh.gov/ombp/caremgt/contracts.htm. Accessed on: September 21, 2015.

[3-9] The appointment availability standard for preventive visits is 30 days, while the standard for routine/episodic visits is 10 days.

meets face-to-face a minimum of four times each agreement year as required by the contract between DHHS and **NHHF**.

NHHF also showed very strong performance in the results from the PIP validations by scoring 100 percent on the validations for the eight PIPs. Although HSAG did not have any recommendations from the validations, **NHHF** should review the *Points of Clarification* in the validation tools related to appropriate documentation for each PIP to strengthen the next annual submission for validation.

There were no opportunities of improvement generated for **NHHF** from the SFY 2014–2015 performance measure validation. All required measures reviewed for **NHHF** received an *R (Report)* audit designation. This finding indicates that the measures were compliant with the State's specifications and that the rates could be reported.

The CAHPS results produced one measure that **NHHF** could strengthen: *Rating of Health Plan.* The rate for that measure, for both the adult and child Medicaid populations, was below NCQA's 2014 CAHPS national average. Furthermore, for the adult population, the measure's rate was at least 5 percentage points below NCQA's 2014 CAHPS adult Medicaid national average. Based on these comparisons, HSAG recommends that **NHHF** focus quality improvement initiatives on enhancing members' experiences with *Rating of Health Plan*.

The HEDIS measures offered the greatest area of opportunity for improvement for **NHHF**. Four measures scored below the 25th percentile: one *Chlamydia Screening in Women* measure, two *Pharmacotherapy Management of* Chronic Obstructive Pulmonary Disease *(COPD) Exacerbation* measures, and one *Diabetes Monitoring for People with Diabetes and Schizophrenia* measure. **NHHF** should place particular emphasis on improving those HEDIS scores.

Well Sense

Well Sense showed very strong performance in the overall results from the compliance review by scoring 99.5 percent. Of the 14 standards and 92 elements included in the SFY 2014–2015 compliance review, **Well Sense** achieved 100 percent compliance with 13 standards. **Well Sense** missed one element in the Network Management Standard. Improvement opportunities for **Well Sense** from the compliance reviews include ensuring that the Consumer Advisory Board meets face-to-face a minimum of four times each agreement year as required by the contract between DHHS and **Well Sense**.

Well Sense also showed very strong performance in the results from the PIP validations by scoring 100 percent on the validations for the eight PIPs. Although HSAG did not have any recommendations from the validations, **Well Sense** should review the *Points of Clarification* in the validation tools related to appropriate documentation for each PIP to strengthen the next annual submission for validation.

The results from the performance measure validation activities provided one opportunity for improvement. HSAG recommends that **Well Sense** monitor each of its vendors monthly for encounter submissions. External claims volume reports can be helpful in identifying gaps

when monitored monthly and would help the MCO identify missing data. In addition, it is recommended that trending reports for encounter submissions be added to the MCO's monthly monitoring process.

The CAHPS results indicated three measures that **Well Sense** could strengthen. HSAG recommends that **Well Sense** focus quality improvement efforts on the adult Medicaid population's *Rating of Health Plan* and *Rating of Personal Doctor*, since the measures' rates were below NCQA's 2014 CAHPS adult Medicaid national averages. For **Well Sense**'s general child Medicaid population, HSAG recommends that efforts focus on improving *Customer Service*, since the measure's rate was below NCQA's 2014 CAHPS child Medicaid national average.

The HEDIS measures offered the greatest area of opportunity for improvement for **Well Sense**. Eight measures scored under the 25th percentile: two *Children and Adolescents' Access to Primary Care Practitioners* measures, one *Cervical Cancer Screening* measure, one *Chlamydia Screening in Women* measure, two *Pharmacotherapy Management of COPD Exacerbation* measures, one *Diabetes Monitoring for People with Diabetes and Schizophrenia* measure, and one *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication* measure. **Well Sense** should place particular emphasis on improving those HEDIS scores.

Health Plan Comparison by Activity and Health Plan-Specific Conclusions and Recommendations

MCO Contractual Compliance

The SFY 2013–2014 compliance activities consisted of reviewing all 14 standards containing 295 elements for each MCO. HSAG included the requirements found in 42 CFR §438 Subparts A–F of the BBA and the State contractual requirements in the New Hampshire MCM Contract[4-1] in the compliance tool. The current review of compliance conducted in SFY 2014–2015 began a three-year cycle of reviewing one-third of the elements contained in the compliance tool and included a total of 92 elements from the 14 standards. The corrective action plan elements from the SFY 2013–2014 review also were included in the SFY 2014–2015 on-site review to ensure that the policies and procedures submitted for the corrective action plan were operationalized correctly by the MCO. HSAG conducted a pre-on-site desk review of documents submitted by the MCOs and an on-site review that consisted of a review of additional documentation and staff interviews. The complete description of the methodology HSAG uses to conduct compliance reviews is included in Appendix B.

Results of the SFY 2014–2015 Compliance Review

Table 4-1 includes the findings from the SFY 2014–2015 compliance reviews for **NHHF** and **Well Sense**.

Table 4-1—Comparison of MCO Scores for the 2014–2015 Compliance Review			
Standard	**Standard Name**	**2014–2015 NHHF**	**2014–2015 Well Sense**
I	Delegation and Subcontracting	**100%**	**100%**
II	Plans Required by the Contract	**100%**	**100%**
III	Emergency and Post-stabilization Care	**100%**	**100%**
IV	Care Management/Care Coordination	**100%**	**100%**
V	Wellness and Prevention	**100%**	**100%**
VI	Behavioral Health	**100%**	**100%**
VII	Member Enrollment and Disenrollment	**100%**	**100%**
VIII	Member Services	**100%**	**100%**
IX	Cultural Considerations	**100%**	**100%**
X	Grievances and Appeals	**100%**	**100%**
XI	Access	**100%**	**100%**
XII	Network Management	**95.5%**	**95.5%**
XIII	Utilization Management	**100%**	**100%**

[4-1] New Hampshire Department of Health and Human Services. (2014). *Amendment #5 to the Medicaid Care Management Contract.* Available at: http://www.dhhs.nh.gov/ombp/caremgt/contracts.htm. Accessed on: November 25, 2015.

Table 4-1—Comparison of MCO Scores for the 2014–2015 Compliance Review			
Standard	Standard Name	2014–2015 NHHF	2014–2015 Well Sense
XIV	Quality Management	100%	100%
Overall Score		99.5%	99.5%

Both MCOs failed to meet the same requirement in the Network Management Standard. Neither MCO convened its Consumer Advisory Board a minimum of four times each agreement year as required by the MCM Contract with DHHS. A corrective action plan was submitted by **NHHF** and **Well Sense** to define the procedures that would be followed in the future to ensure that the Consumer Advisory Boards met face-to-face at least four times each agreement year. HSAG will conduct a follow-up review for this element during the SFY 2015–2016 on-site compliance review.

Trending

Figure 4-1 displays the compliance scores achieved by **NHHF** and **Well Sense** during the two years that HSAG conducted compliance reviews. In SFY 2013–2014, the number of elements reviewed was 294 for **NHHF** (one element was found to be NA) and 295 for **Well Sense**. The SFY 2014–2015 compliance review was the initial year for reviewing one-third of the elements in all the standards each year. In SFY 2014–2015, the number of elements reviewed was 92 for **NHHF** and 91 for **Well Sense** (one element was found to be NA)**.**

**Figure 4-1—Trending of Compliance Review Scores for NHHF and Well Sense
From SFY 2013–2014 and SFY 2014–2015**
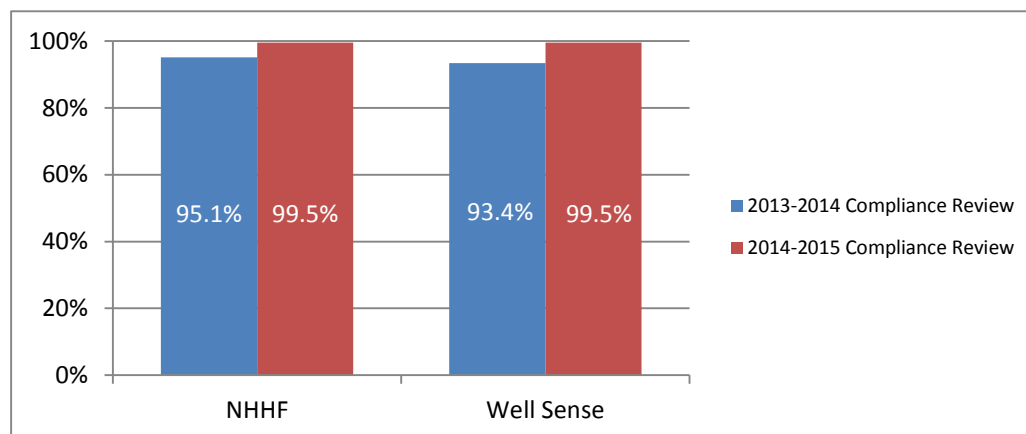
Both MCOs improved their compliance scores from the first compliance review (SFY 2013–2014) to the second compliance review (SFY 2014–2015). During the first compliance review, **NHHF** received a *Partially Met* score for 8.5 percent of the elements (n=25) and a *Not Met* score for 0.7 percent of the elements (n=2). **Well Sense** received a *Partially Met* score for 7.8 percent of the elements (n=23) and a *Not Met* score for 2.7 percent of the elements (n=8) during the first compliance review. Both MCOs missed one element in the second compliance review and scored a *Partially Met* score for 1.1 percent of the elements.

During the second compliance review, HSAG also evaluated the corrective action plans from the elements missed in the first compliance review. The number of corrective action plan items reviewed included 34 for **NHHF** and 38 for **Well Sense**. Both MCOs corrected every deficiency identified during the prior review.

NHHF Conclusions and Recommendations

NHHF demonstrated very strong performance during the SFY 2014–2015 compliance review. Only 1.1 percent of the elements (n=1) were found to be noncompliant with federal and State regulations. HSAG also validated through a review of policies, procedures, and staff interviews that the MCO corrected the 34 deficiencies found during the prior year's audit.

One item that was discussed with the staff at **NHHF** during the on-site review was the MCO policy that requires only an 80 percent compliance score for the interrater reliability testing of the utilization management staff. Although there is no benchmark established in the contract between DHHS and **NHHF** concerning the score that must be generated through the interrater reliability testing of the utilization management staff, HSAG requested that **NHHF** consider if it is appropriate to allow a 20 percent nonagreement rate between reviewers who are deciding if a service can be authorized or denied by the MCO.

Well Sense Conclusions and Recommendations

Well Sense demonstrated very strong performance during the SFY 2014–2015 compliance review. Only 1.1 percent of the elements (n=1) were found to be noncompliant with federal and State regulations. HSAG also validated through a review of policies, procedures, and staff interviews that the MCO corrected the 38 deficiencies found during the prior year's audit.

One item that was discussed with the staff at **Well Sense** during the on-site review was the MCO policy that requires only an 80 percent compliance score for the interrater reliability testing of the utilization management staff. Although there is no benchmark established in the contract between DHHS and **Well Sense** concerning the score that must be generated through the interrater reliability testing of the utilization management staff, HSAG requested that **Well Sense** consider if it is appropriate to allow a 20 percent nonagreement rate between reviewers who are deciding if a service can be authorized or denied by the MCO.

Assessment of Prior Year Recommendations for Compliance

During the first compliance review in SFY 2013–2014, **NHHF** received a *Partially Met* score for 8.5 percent of the elements (n=25) and a *Not Met* score for 0.7 percent of the elements (n=2). **Well Sense** received a *Partially Met* score for 7.8 percent of the elements (n=23) and a *Not Met* score for 2.7 percent of the elements (n=8) during the first compliance review. Table 4-2 lists the standards requiring corrective action for **NHHF**, and Table 4-3 lists the standards requiring corrective action for **Well Sense**. A total of 34 corrective action plan elements from the first compliance review were re-reviewed during the SFY 2014–2015 compliance review for **NHHF**, and 38 corrective action plan elements from the first compliance review were re-reviewed during the SFY 2014–2015 compliance review for **Well Sense**.

Table 4-2 provides details concerning scores of the re-review of the corrective action plan elements found to be noncompliant with a *Partially Met* or *Not Met* score during the SFY 2013–2014 compliance review. During the SFY 2014–2015 on-site review, staff interviews confirmed that the MCO initiated policies, procedures, and work processes to ensure that **NHHF** was compliant with the State and federal requirements.

Standard	Standard Name	Total Applicable Elements in the Corrective Action Plan	Number of Elements		
			Met	*Partially Met**	*Not Met**
I	Delegation and Subcontracting	4	4	0	0
II	Plans Required by the Contract	9	9	0	0
III	Emergency and Post-stabilization Care	1	1	0	0
IV	Care Management/Care Coordination	0	0	0	0
V	Wellness and Prevention	0	0	0	0
VI	Behavioral Health	0	0	0	0
VII	Member Enrollment and Disenrollment	0	0	0	0
VIII	Member Services	1	1	0	0
IX	Cultural Considerations	0	0	0	0
X	Grievances and Appeals	3	3	0	0
XI	Access Standards	0	0	0	0
XII	Network Management Standards	6	6	0	0
XIII	Utilization Management	3	3	0	0
XIV	Quality Management	0	0	0	0
	Appeals File Review	1	1	0	0
	Credentialing File Review	3	3	0	0
	Access Checklist	1	1	0	0
	Member Handbook Checklist	1	1	0	0
	Web Site Checklist	1	1	0	0
Standards Total		34	34	0	0
Percent *Met* (No Action Required)			100%		
Percent *Partially Met* (Action Required)			0.0%		
Percent *Not Met* (Action Required)			0.0%		

***Partially Met** and **Not Met** elements must be addressed in the corrective action plan.
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after nonapplicable elements are removed.

There were 34 elements in standards, checklists, and file reviews that were included in the corrective action plan generated from the findings of the SFY 2013–2014 **NHHF** compliance review. **NHHF** submitted documentation to correct the deficiencies noted, and interviews with staff during the current on-site review confirmed that the revised policies, procedures, and work processes met the requirements of the corrective action plan elements. No

deficiencies remain from the recommendations given to **NHHF** during the SFY 2013–2014 compliance review.

Table 4-3 provides details concerning scores of the re-review of the corrective action plan elements found to be noncompliant with a *Partially Met* or *Not Met* score during the SFY 2013–2014 compliance review for **Well Sense**. During the SFY 2014–2015 on-site review, staff interviews confirmed that the MCO initiated policies, procedures, and work processes to ensure that **Well Sense** was compliant with the State and federal requirements.

		Total Applicable Elements in the Corrective Action Plan	Number of Elements		
Standard	**Standard Name**		*Met*	*Partially Met**	*Not Met**
I	Delegation and Subcontracting	1	1	0	0
II	Plans Required by the Contract	5	5	0	0
III	Emergency and Post-stabilization Care	4	4	0	0
IV	Care Management/Care Coordination	3	3	0	0
V	Wellness and Prevention	0	0	0	0
VI	Behavioral Health	3	3	0	0
VII	Member Enrollment and Disenrollment	1	1	0	0
VIII	Member Services	1	1	0	0
IX	Cultural Considerations	0	0	0	0
X	Grievances and Appeals	8	8	0	0
XI	Access Standards	1	1	0	0
XII	Network Management Standards	3	3	0	0
XIII	Utilization Management	1	1	0	0
XIV	Quality Management	0	0	0	0
	Appeals File Review	1	1	0	0
	Access Checklist	1	1	0	0
	Provider Directory Checklist	2	2	0	0
	Member Identification Card Checklist	1	1	0	0
	Web Site Checklist	2	2	0	0
	Standards Total	**38**	**38**	**0**	**0**
	Percent *Met* (No Action Required)		**100%**		
	Percent *Partially Met* (Action Required)		**0.0%**		
	Percent *Not Met* (Action Required)		**0.0%**		

Table 4-3—Summary of Well Sense Scores for the Re-review of the SFY 2013–2014 Corrective Action Plan

****Partially Met** and **Not Met** elements must be addressed in the corrective action plan.*
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within the standard, after non-applicable elements are removed.

There were 38 elements in standards, checklists, and files reviews that were included in the corrective action plan generated from the findings of the SFY 2013–2014 **Well Sense** compliance review. **Well Sense** submitted documentation to correct the deficiencies noted,

and interviews with staff during the current on-site review confirmed that the revised policies, procedures, and work processes met the requirements of the corrective action plan elements. No deficiencies remain from the recommendations given to **Well Sense** during the SFY 2013–2014 compliance review.

Evaluation of MCO Programs and Projects: PIPs

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. The PIP process allows MCOs the opportunity to identify areas of concern affecting their membership and strategize ways to improve care. In order for such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner. A complete description of the methodology HSAG uses to validate PIPs is included in Appendix B.

During SFY 2014–2015, HSAG reviewed four PIP topics selected by **NHHF** and four PIP topics selected by **Well Sense** as shown in Table 4-4. The contract between DHHS and the MCOs requires that one of the four PIP topics be focused on behavioral health.

Table 4-4—Performance Improvement Project Topics Selected by NHHF and Well Sense Health Plan	
NHHF PIP Topics	**Well Sense PIP Topics**
Comprehensive Diabetes Screening—Vision Screening	Diabetes Care—HbA1c Testing
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	Reducing Hospital Readmissions
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Chlamydia Screening
Well-Child Visits for 3-to-6-Year-Olds	Well-Child Visits for 3-to-6-Year-Olds

Results

For each MCO, Table 4-5 shows the aggregate number of applicable evaluation elements that were scored *Met* for each stage and the combined overall percentage of evaluation elements *Met* for the four PIPs. This table illustrates **NHHF**'s and **Well Sense**'s overall application of the PIP process and the degree to which the MCOs achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 4-5 show the percentage of applicable evaluation elements that received a *Met* score for each study stage and an overall score across all three stages.

Table 4-5—2014 PIP Validation Results Comparison by MCO for Topics Selected by NHHF and Well Sense			
Stage	Activities	Percentage of Applicable Elements Scored *Met*	
		NHHF (N=4 PIPs)	Well Sense (N=4 PIPs)
Design	Activities I–VI	100% (64/64)	100% (54/54)
Implementation	Activities VII–VIII	*To be assessed in 2015*	*To be assessed in 2015*
Outcomes	Activities IX–X	*To be assessed in 2016*	*To be assessed in 2016*
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**100%**	**100%**

Both MCOs progressed through Activity VI, the Design stage for each of the PIPs. The Design stage establishes the methodological framework for the PIP. The activities in this stage include development of the study topic, question, indicators, population, sampling, and data collection. To implement successful improvement strategies, a strong study design is necessary. Both MCOs met 100 percent of the requirements for all activities in the Design stage of each PIP and received a *Met* validation status for each PIP. Overall, the health plans designed scientifically sound PIPs supported by key research principles. The technical design of each PIP was sufficient to measure and monitor PIP outcomes. The solid design of the PIPs will allow successful progression to the next stage of the PIP process. The MCOs will report baseline study indicator results for the next annual validation of each PIP. The PIPs will be validated through the Implementation stage in 2015, when the MCOs progress to reporting baseline study indicator results and improvement strategies, and through the Outcomes stage in 2016, when the MCOs progress to reporting remeasurement results.

Additional PIP Results

DHHS identified the four topics to be included in the New Hampshire PIPs. DHHS chose the PIP topics, and they are displayed in Figure 4-2.

Figure 4-2—Four PIP Topics Selected by DHHS
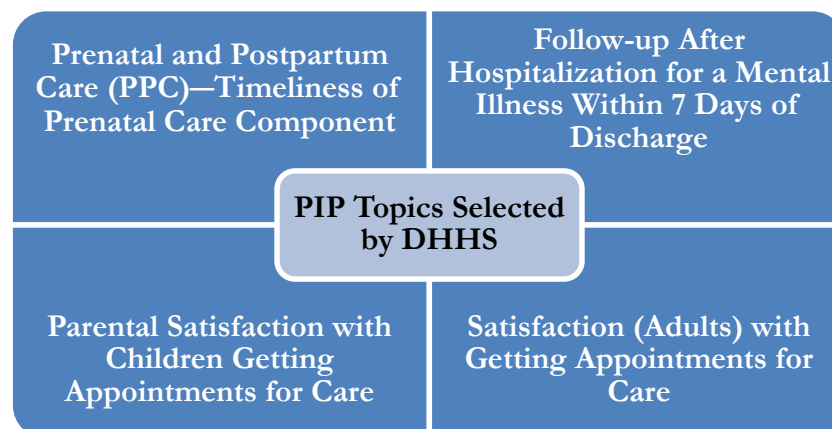
HSAG conducted a review of four PIPs chosen by DHHS for the two MCOs. For each MCO, Table 4-6 shows the aggregate number of applicable evaluation elements that were scored *Met* for each stage and the combined overall percentage of evaluation elements *Met* for the four PIPs.

Table 4-6—2014 PIP Validation Results Comparison by MCO for Topics Selected by DHHS			
		Percentage of Applicable Elements Scored *Met*	
Stage	Activities	NHHF (N=4 PIPs)	Well Sense (N=4 PIPs)
Design	Activities I–VI	100% (63/63)	100% (58/58)
Implementation	Activities VII–VIII	*To be assessed in 2015*	*To be assessed in 2015*
Outcomes	Activities IX–X	*To be assessed in 2016*	*To be assessed in 2016*
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**100%**	**100%**

Both MCOs progressed through Activity VI, the Design stage for each of the PIPs. The Design stage establishes the methodological framework for the PIP. The activities in this stage include development of the study topic, question, indicators, population, sampling, and data collection. To implement successful improvement strategies, a strong study design is necessary. Both MCOs also met 100 percent of the requirements for all activities in the Design stage of each PIP and received a *Met* validation status for each PIP. Overall, the health plans designed scientifically sound PIPs supported by key research principles. The technical design of each PIP was sufficient to measure and monitor PIP outcomes. The solid design of the PIPs will allow successful progression to the next stage of the PIP process. The MCOs will report baseline study indicator results for the next annual validation of each PIP. The PIPs will be validated through the Implementation stage in 2015, when the MCOs progress to reporting baseline study indicator results and improvement strategies, and through the Outcomes stage in 2016, when the MCOs progress to reporting remeasurement results.

Conclusions and Recommendations

NHHF

Overall**, NHHF** designed scientifically sound projects supported by the use of key research principles. The technical design of each PIP was sufficient to measure and monitor outcomes. **NHHF** did not progress to the Implementation and Outcomes stages of the PIPs. The MCO will report baseline PIP results for the next annual validation cycle.

Because 100 percent of the requirements were met across the eight PIPs, HSAG has only one recommendation to share as a best practice that may strengthen future submissions:

◆ **NHHF** should review HSAG's feedback provided through *Points of Clarification* in the validation tools related to appropriate documentation for each PIP. By addressing all of the feedback and recommendations provided in the PIP validation tool, the MCO will

ensure the PIP study design is accurately and completely documented and establish a sound methodological foundation for progression to the Implementation and Outcomes stages of the PIP.

Well Sense

Overall, **Well Sense** designed scientifically sound projects supported by the use of key research principles. The technical design of each PIP was sufficient to measure and monitor outcomes. **Well Sense** did not progress to the Implementation and Outcomes stages of the PIPs. The MCO will report baseline PIP results for the next annual validation cycle.

Because 100 percent of the requirements were met across the eight PIPs, HSAG has only one recommendation to share as a best practice that may strengthen future submissions:

◆ **NHHF** and **Well Sense** should review HSAG's feedback provided through *Points of Clarification* in the validation tools related to appropriate documentation for each PIP. By addressing all of the feedback and recommendations provided in the PIP validation tool, the MCO will ensure the PIP study design is accurately and completely documented and establish a sound methodological foundation for progression to the Implementation and Outcomes stages of the PIP.

Validation of MCO Performance Measures

This section of the report describes the results of HSAG's SFY 2013–2014 EQR activities specific to validation of performance measures. As of June 30, 2015, the performance measure validation activities for SFY 2014–2015 were ongoing, and the results from that review will be presented in the SFY 2015–2016 EQR Technical Report. This section provides conclusions as to the strengths and areas of opportunity related to the quality, timeliness, and access to care provided by the New Hampshire Medicaid MCOs. Each MCO submitted rates for thirty-four state specific measures that were validated during the performance measure validation. Additionally, recommendations are offered to each MCO to facilitate continued quality improvement in the Medicaid program. A list of the measures reviewed in SFY 2013–2014 and a complete description of the audit methodology used to conduct the review of performance measures is included in Appendix B.

Results

Table 4-7 provides an overview of the findings of the HSAG performance validation review.

Table 4-7—Performance Measure Validation Findings		
Performance Measures	**NHHF**	**Well Sense**
Data Integration, Data Control, and Performance Measure Documentation	Acceptable	Acceptable
Claims and Encounter Data System and Process Findings	Acceptable	Acceptable
Membership and Enrollment Data System and Process Findings	Acceptable	Acceptable
Provider Data System and Process Findings	Acceptable	Acceptable

Table 4-7—Performance Measure Validation Findings		
Performance Measures	NHHF	Well Sense
Appeals Data System and Process Findings	Acceptable	Acceptable
Prior Authorization Data System and Process Findings	Acceptable	Acceptable
Call Center Data System and Process Findings	Acceptable	Acceptable
Performance Measure Production and Reporting Findings	Acceptable	Acceptable

Conclusions and Recommendations for Improvement

NHHF

NHHF had a strong oversight on data received from providers and adequate internal staff with business knowledge for performance reporting. **NHHF** staff was able to reproduce the measures efficiently and accurately. The auditors did not make any recommendations for **NHHF**.

Well Sense

Well Sense had a team of staff members who were dedicated and well versed in quality reporting.

At the time of the audit, **Well Sense**'s quality department did not have a mechanism to track monthly claims volumes received from its external entities. HSAG recommended that **Well Sense** monitor each of its vendors monthly for encounter submissions. External claims volume reports can be helpful in identifying gaps when monitored monthly and would help the MCO identify if data were missing. In addition, it was recommended that trending reports for encounter submissions be added to the MCO's monthly monitoring process. This recommendation will be followed up as one of the tasks included in the next annual validation activities.

CAHPS

Introduction and Description of the Activity

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. The surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The CAHPS survey is recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting data. **NHHF** and **Well Sense** were responsible for obtaining a CAHPS vendor to conduct CAHPS surveys of its adult and child Medicaid populations. Symphony Performance Health (SPH) Analytics, an NCQA-certified HEDIS/CAHPS vendor, administered the 2015 CAHPS surveys for **NHHF** and **Well Sense**.

Technical Methods of Data Collection

For both **NHHF** and **Well Sense**, the technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid Health Plan Survey (with Children with Chronic Conditions [CCC] measurement set) to the child Medicaid population. **NHHF** used a standard Internet mixed-mode methodology for data collection (i.e., mailed surveys with the option to complete the survey via Internet) for the adult Medicaid population, and a mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of nonrespondents to the mailed surveys) for the child Medicaid population.[4-2] **Well Sense** used a mixed-mode methodology for data collection for both the adult and child Medicaid populations.[4-3] Following NCQA protocol, adult members and parents or caretakers of child members completed the surveys between the time period of January to May 2015.

The CAHPS 5.0H Surveys include a set of standardized items (58 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey and 83 items for the CAHPS 5.0H Child Medicaid Health Plan Survey with CCC measurement set) that assess patient perspectives on care. The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores.[4-4] The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 8, 9, or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response). For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always;" or (2) "No" or "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores. The top-box rates presented in this report for **NHHF** and **Well Sense** are based on the CAHPS survey results calculated by their CAHPS survey vendor. Each MCO provided HSAG with the requested CAHPS survey data for purposes of calculating confidence intervals for each of the global ratings and composite measures presented in this report.[4-5]

[4-2] For the child Medicaid population, **NHHF** used an enhanced mixed-mode survey methodology pre-approved by NCQA.

[4-3] For the adult and child Medicaid populations, **Well Sense** used an enhanced mixed-mode survey methodology pre-approved by NCQA.

[4-4] For purposes of this report, the 2015 Child Medicaid CAHPS results presented for **NHHF** and **Well Sense** are based on the CAHPS survey results of the general child population only (i.e., results for children selected as part of the general child CAHPS sample). Therefore, results for the CAHPS survey measures evaluated through the CCC measurement set of questions (i.e., five CCC composite scores and items) and CCC population are not presented in this report.

[4-5] The CAHPS survey results presented throughout this report are based on the CAHPS survey data and results each MCO provided to HSAG for reporting purposes.

For purposes of this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was *Not Met*. Caution should be exercised when interpreting results for those measures with less than 100 respondents. CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Additionally, for purposes of this report, the adult and general child Medicaid populations' survey findings were compared to 2014 NCQA CAHPS Adult and General Child Medicaid national averages, where applicable.[4-6] For each MCO, a measure was noted when the measure's rate was at least 5 percentage points higher or lower than the NCQA national average.

It is important to note that with the release of the 2015 CAHPS 5.0H Medicaid Health Plan Surveys, changes were made to the survey question language and response options for the *Shared Decision Making* composite measure. As a result of these changes, comparisons to the 2014 NCQA CAHPS national averages could not be performed for this composite measure for 2015.

Results

NHHF

In 2015, a total of 2,160 **NHHF** adult Medicaid members were surveyed, of which 527 completed surveys were returned. After ineligible members were excluded, the response rate was 26.3 percent. In 2014, the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey was 28.6 percent, which was higher than the **NHHF** adult Medicaid response rate. Figure 4-3 and Figure 4-4 show the 2015 top-box rates, and lower and upper confidence intervals for the CAHPS global ratings and composite measures, respectively, for **NHHF**'s adult Medicaid population.[4-7]

[4-6] National data were obtained from the 2014 Quality Compass. Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[4-7] As previously noted, due to changes to the *Shared Decision Making* composite measure, 2014 NCQA national average data were not available for this measure, and comparisons could not be performed.

Figure 4-3—NHHF Adult Medicaid CAHPS Results: Global Ratings
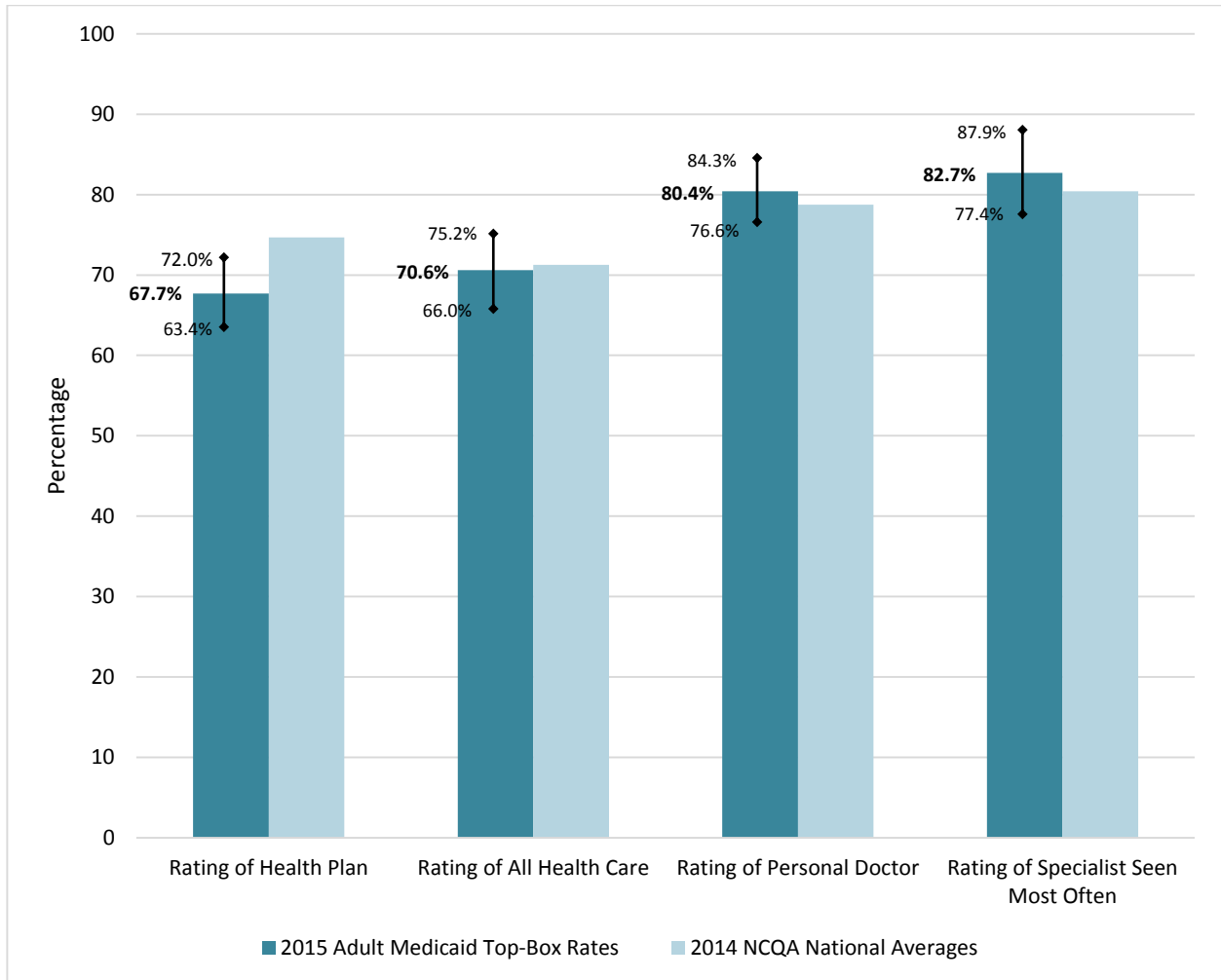
Figure 4-4—NHHF Adult Medicaid CAHPS Results: Composite Measures
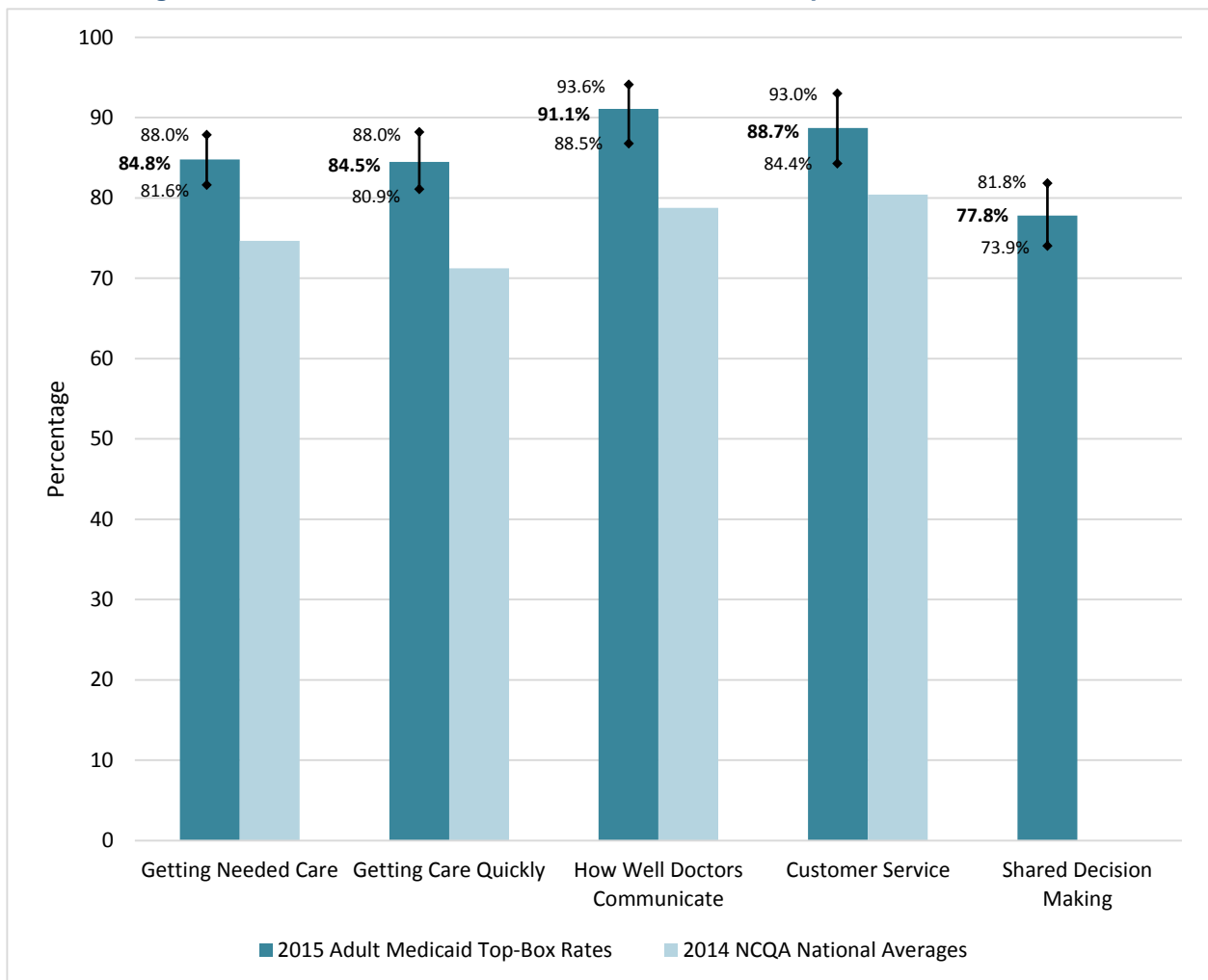
Legend: ■ 2015 Adult Medicaid Top-Box Rates ■ 2014 NCQA National Averages

For **NHHF**'s adult Medicaid population, the 2015 top-box rate for one of the eight comparable measures, *Rating of Health Plan*, was lower than the 2014 NCQA adult Medicaid national average by at least 5 percentage points. However, the 2015 top-box rates were higher than the 2014 NCQA adult Medicaid national averages for six measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. For one measure, *Rating of All Health Care*, the 2015 top-box rate was lower than the 2014 NCQA national average.

In 2015, a total of 2,640 **NHHF** general child Medicaid members were surveyed, of which 648 completed surveys were returned on behalf of the child member. After ineligible members were excluded, the response rate for the general child population was 25.1 percent.[4-8] In 2014, the average NCQA response rate for the CAHPS 5.0H Child Medicaid Health Plan Survey without CCC measurement set was 27.7 percent, which was higher than the **NHHF** general child Medicaid response rate. Figure 4-5 and Figure 4-6 show the 2015 general child top-box

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[4-8] The survey disposition and response rate results are based on the responses of parents/caretakers of child Medicaid beneficiaries in the general child sample only (i.e., do not include survey responses from the CCC supplemental sample).

rates, and lower and upper confidence intervals for the CAHPS global ratings and composite measures, respectively, for **NHHF**'s child Medicaid population.[4-9,4-10]

Figure 4-5—NHHF Child Medicaid CAHPS Results: Global Ratings
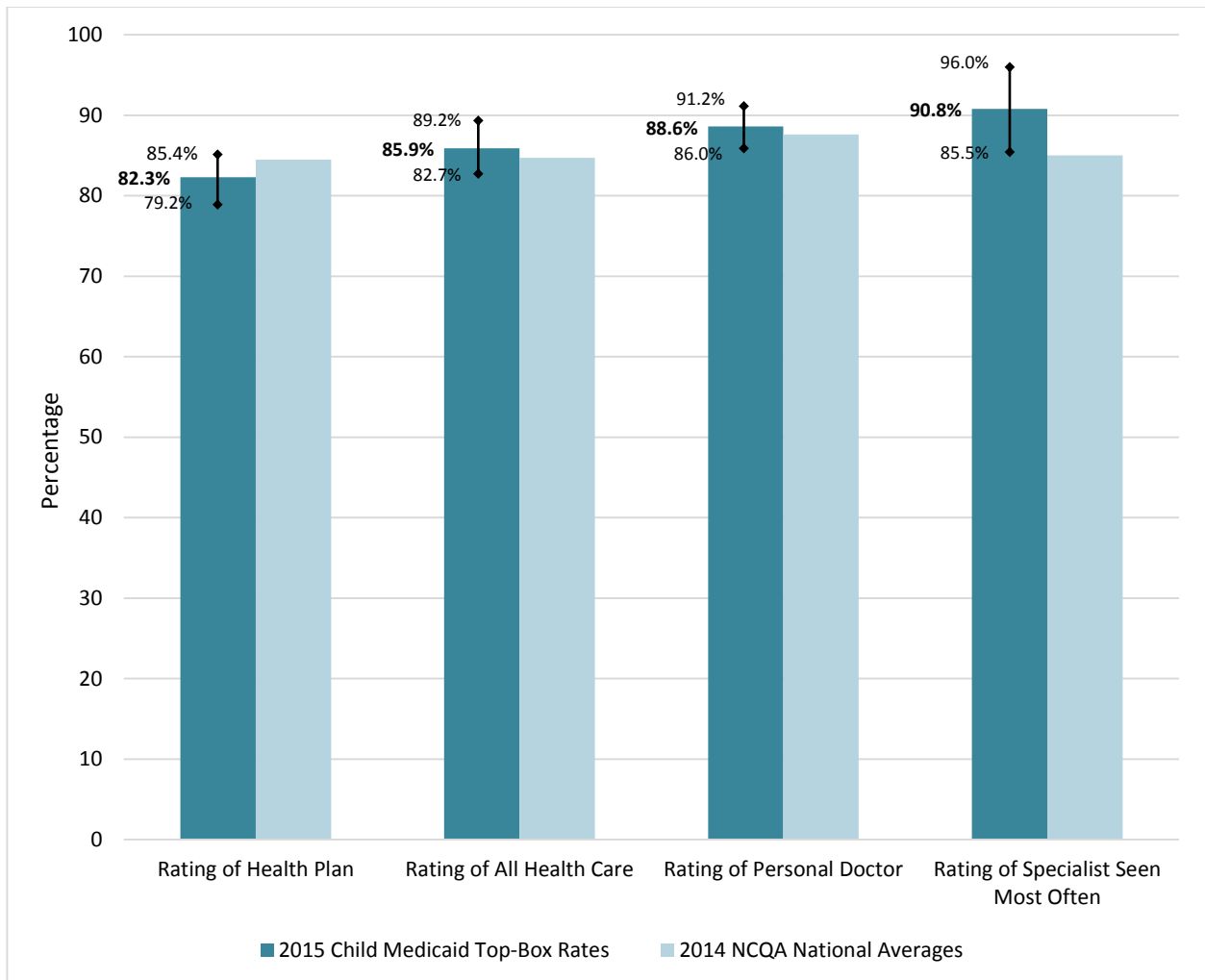
4-9 The 2015 child Medicaid CAHPS results presented in Figure 4-5 for **NHHF** are based on results of the general child population only.

4-10 As previously noted, due to changes to the *Shared Decision Making* composite measure, 2014 NCQA national average data were not available for this measure, and comparisons could not be performed.

Figure 4-6—NHHF Child Medicaid CAHPS Results: Composite Measures

Legend: ■ 2015 Child Medicaid Top-Box Rates ■ 2014 NCQA National Averages
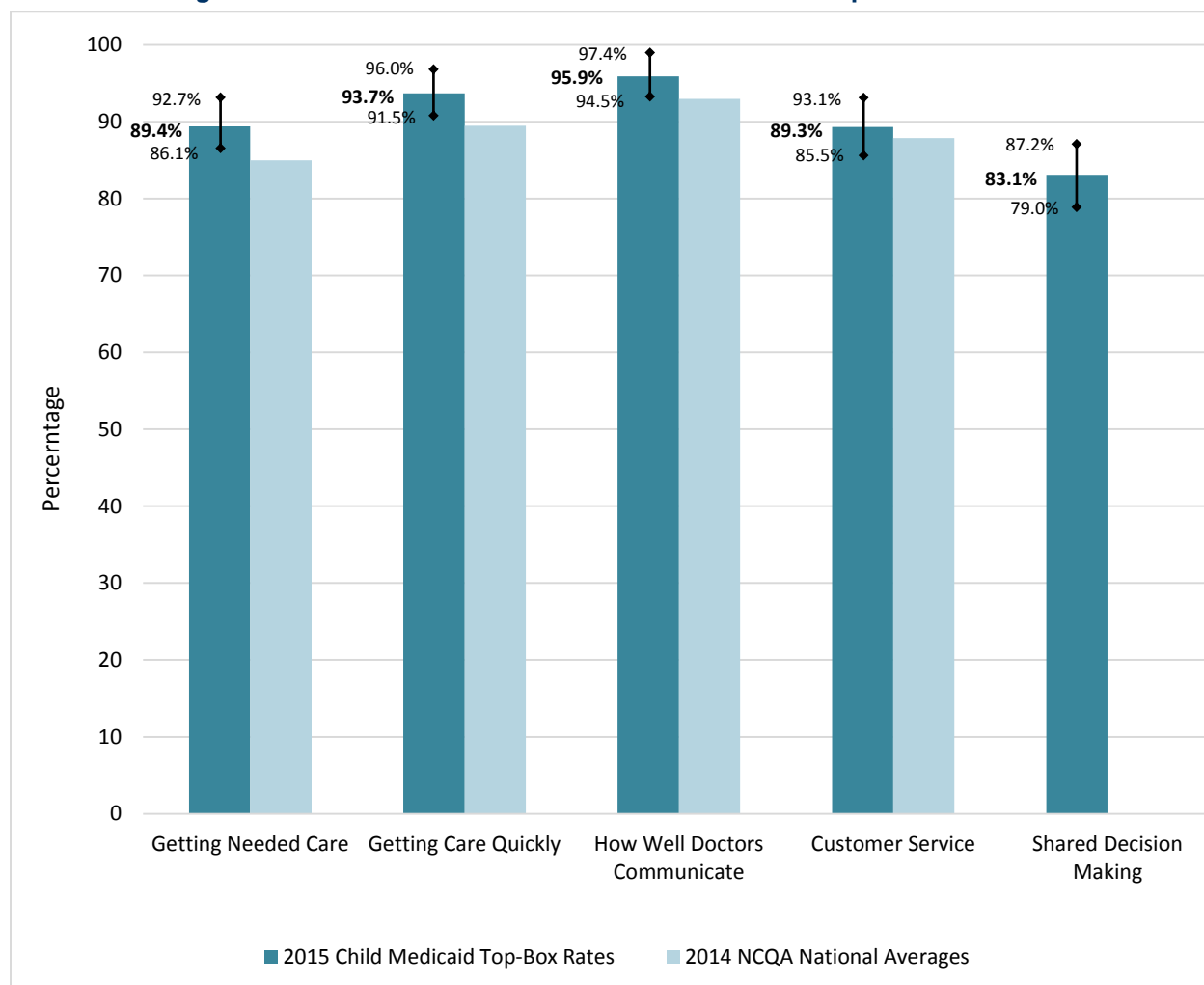
For **NHHF**'s general child Medicaid population, the 2015 top-box rate for one of the eight comparable measures (*Rating of Health Plan*) was lower than the 2014 NCQA child Medicaid national average. However, for the remaining seven comparable measures, the 2015 top-box rates for the general child population were higher than the 2014 NCQA child Medicaid national average; of these, the rate for *Rating of Specialist Seen Most Often* was higher than the 2014 NCQA child Medicaid national average by at least 5 percentage points.

Well Sense

In 2015, a total of 1,418 **Well Sense** adult Medicaid members were surveyed, of which 352 completed surveys were returned. After ineligible members were excluded, the response rate was 27.7 percent. In 2014, the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey was 28.6 percent, which was higher than the adult Medicaid **Well Sense** response rate. Figure 4-7 and Figure 4-8 show the 2015 top-box rates, and lower and upper confidence intervals for the CAHPS global ratings and composite measures, respectively, for **Well Sense**'s adult Medicaid population.

Figure 4-7—Well Sense Adult Medicaid CAHPS Results: Global Ratings
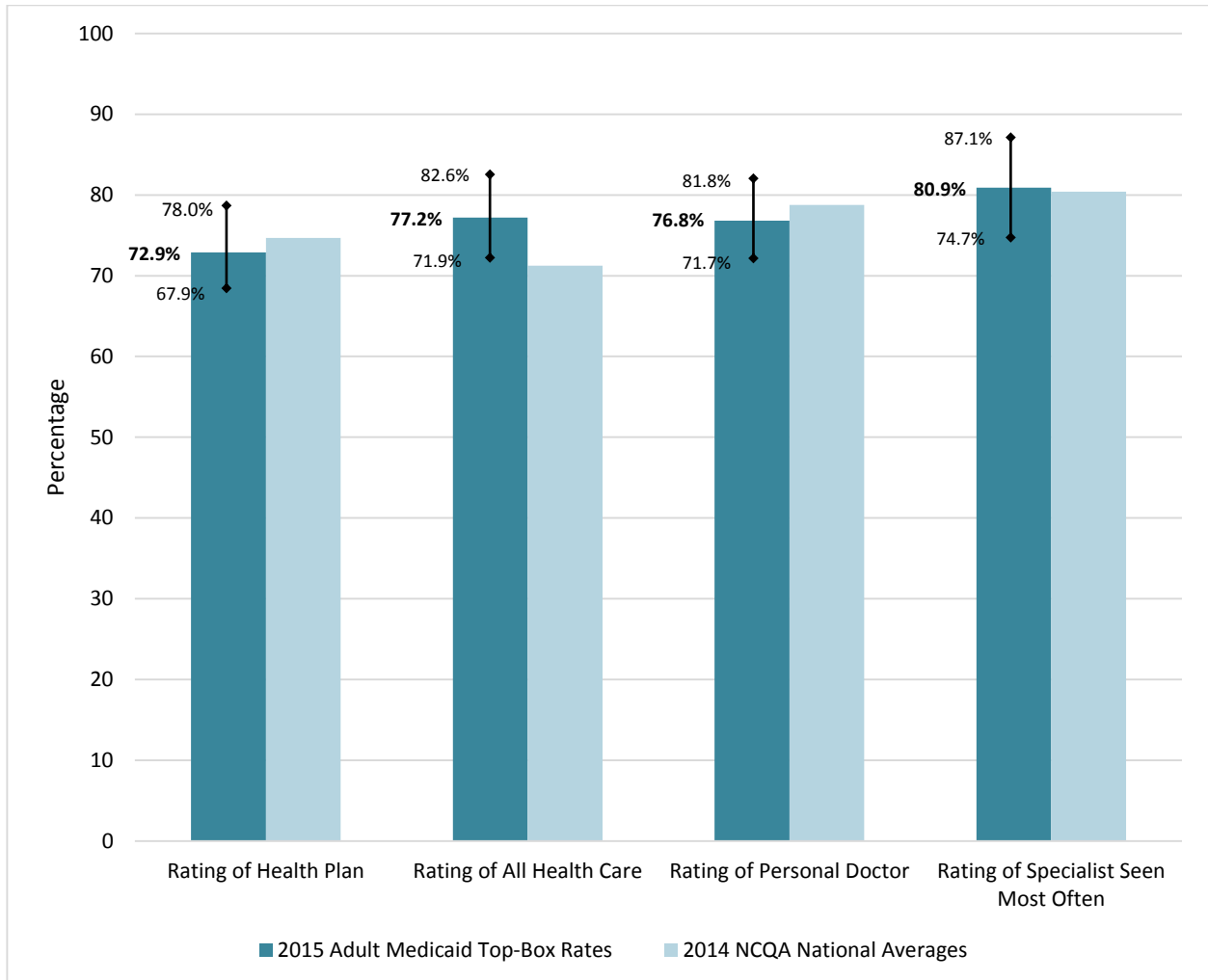
Figure 4-8—Well Sense Adult Medicaid CAHPS Results: Composite Measures
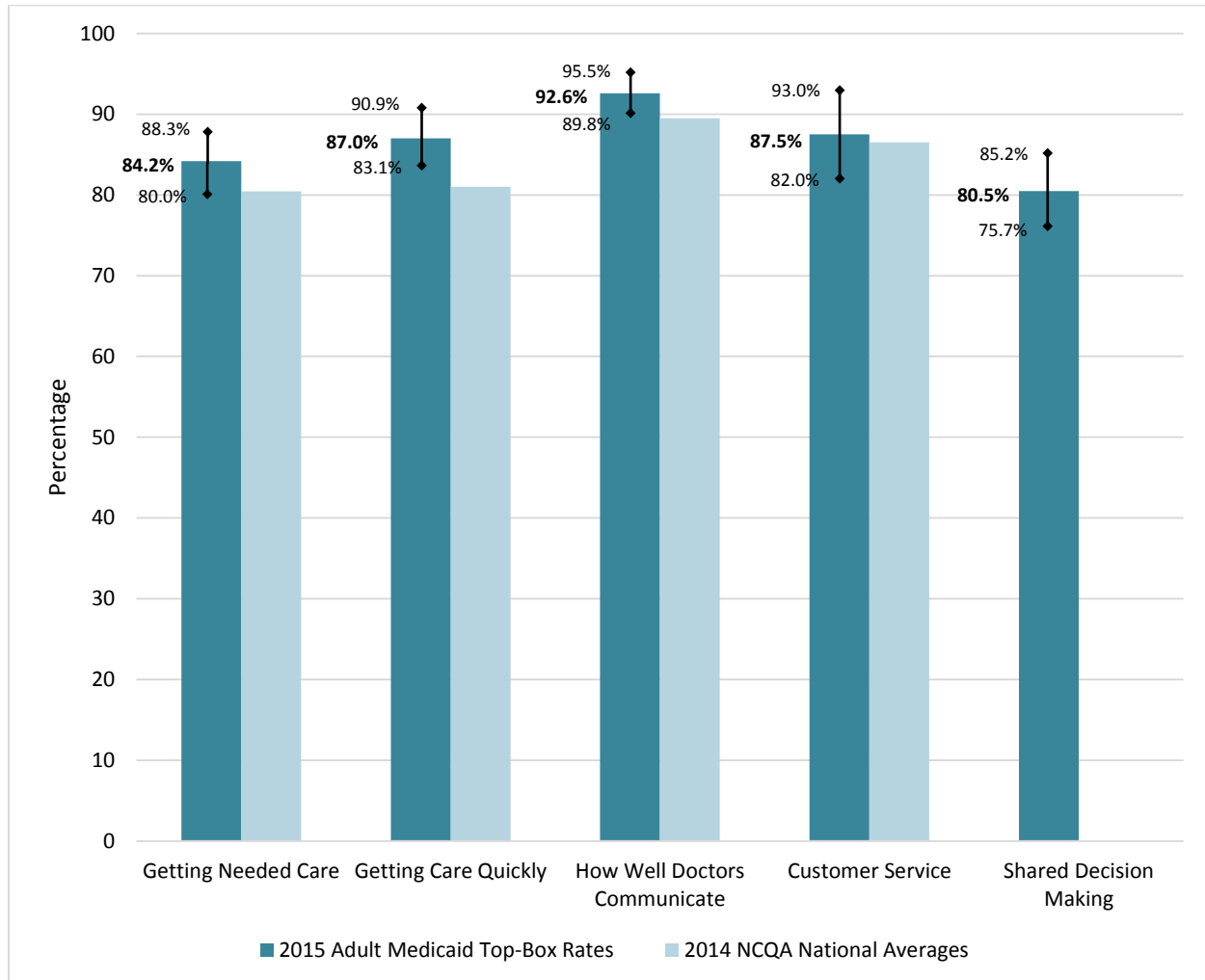
For **Well Sense**'s adult Medicaid population, the 2015 top-box rates for two of the eight comparable measures were lower than the 2014 NCQA adult Medicaid national averages: *Rating of Health Plan* and *Rating of Personal Doctor*. However, for the remaining six comparable measures, the 2015 top-box rates for the adult Medicaid population were higher than the 2014 NCQA national averages. Moreover, the 2015 top-box rates for *Rating of All Health Care* and *Getting Care Quickly* were higher than the 2014 NCQA adult Medicaid national average by at least 5 percentage points.

In 2015, a total of 1,650 **Well Sense** general child Medicaid members were surveyed, of which 354 completed surveys were returned on behalf of the child member. After ineligible members were excluded, the response rate for the general child population was 23.0 percent.[4-11] In 2014, the average NCQA response rate for the CAHPS 5.0 Child Medicaid Health Plan Survey without CCC measurement set was 27.7 percent, which was lower than the **Well Sense** child Medicaid response rate. Figure 4-9 and Figure 4-10 show the 2015 general child top-box rates,

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[4-11] The survey disposition and response rate results are based on the responses of parents/caretakers of child Medicaid beneficiaries in the general child sample only (i.e., do not include survey responses from the CCC supplemental sample).

and lower and upper confidence intervals for the CAHPS global ratings and composite measures, respectively, for **Well Sense**'s general child Medicaid population.[4-12, 4-13]

Figure 4-9—Well Sense Child Medicaid CAHPS Results: Global Ratings
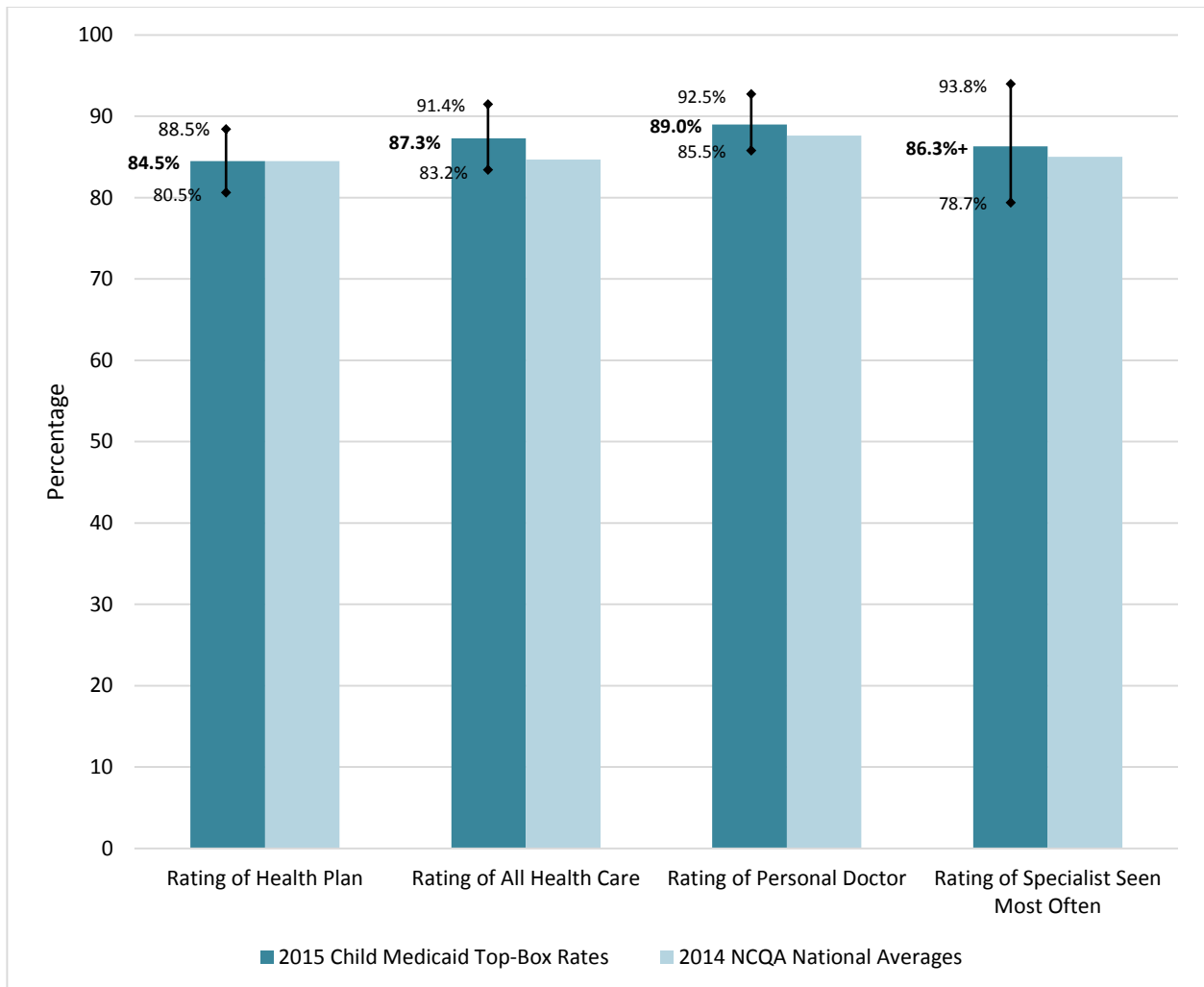
+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting results for those measures with less than 100 respondents.

[4-12] The 2015 child Medicaid CAHPS results presented in Figure 4-9 and Figure 4-10 for **Well Sense** are based on results of the general child population only.

[4-13] As previously noted, due to changes to the *Shared Decision Making* composite measure, 2014 NCQA national average data were not available for this measure, and comparisons could not be performed.

Figure 4-10—Well Sense Child Medicaid CAHPS Results: Composite Measures
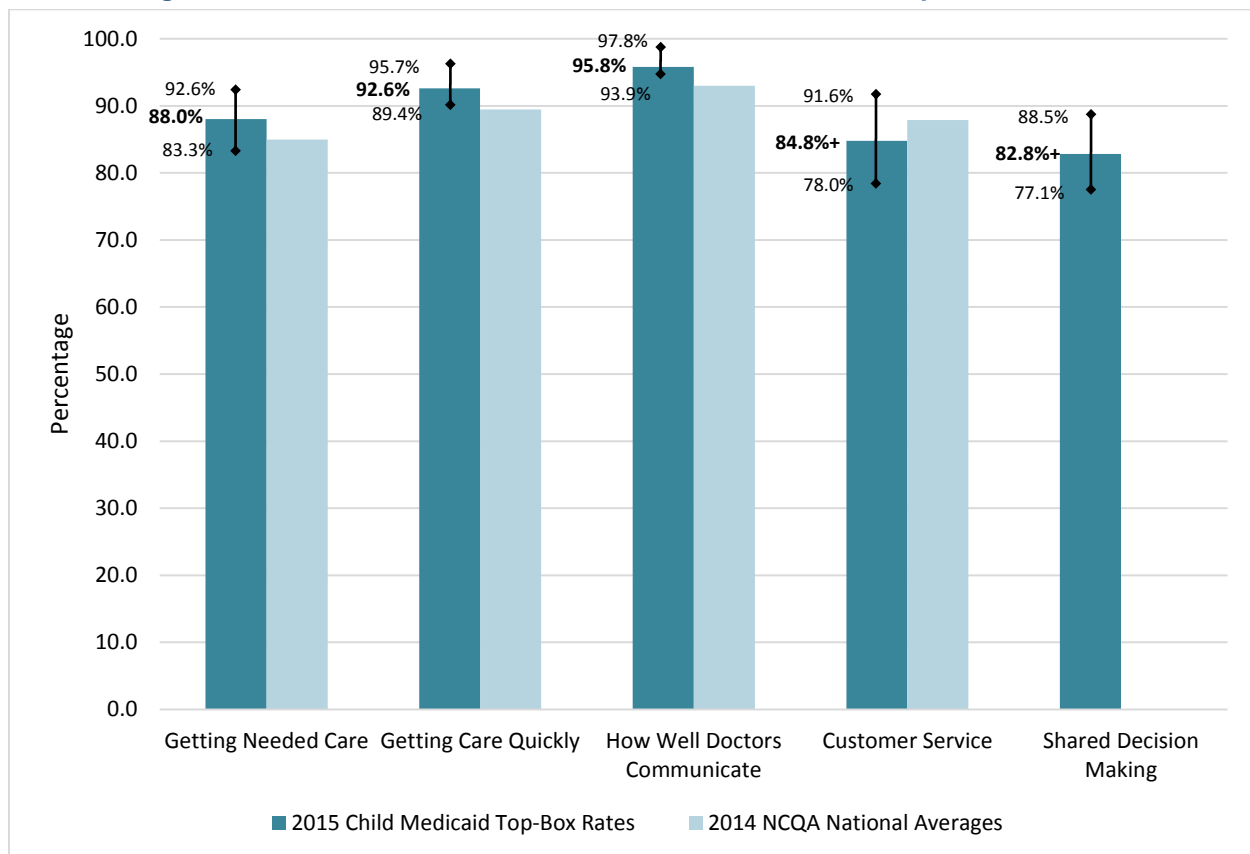
+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting results for those measures with less than 100 respondents.

For **Well Sense**'s general child Medicaid population, the 2015 top-box rate for one of the eight comparable measures, *Customer Service*, was lower than the 2014 NCQA child Medicaid national average. For the remaining seven comparable measures, the 2015 top-box rates for the general child population were higher than or equal to the 2014 NCQA child Medicaid national average.[4-14]

New Hampshire Healthy Families

Conclusions and Recommendations for Improvement

HSAG performed a comparison of **NHHF**'s adult and child Medicaid populations' 2015 CAHPS survey results to the 2014 NCQA CAHPS Adult and Child Medicaid national averages to determine potential areas for improvement. HSAG recommends that **NHHF** focus quality improvement efforts on *Rating of Health Plan,* since the rate for this measure for both the adult and child Medicaid populations was below NCQA's 2014 CAHPS national average. Furthermore, for the adult population, the measure's rate was at least 5 percentage points below NCQA's 2014 CAHPS adult Medicaid national average.

[4-14] The 2015 top-box rate for one measure, *Rating of Health Plan*, was equal to the 2014 NCQA national average.

Based on these comparisons, HSAG recommends that **NHHF** focus quality improvement initiatives on enhancing members' experiences with *Rating of Health Plan*. The following are recommendations of best practices and other proven strategies that can be used or adapted by the MCO to target improvement in this area.

Rating of Health Plan

Alternatives to One-on-One Visits—Health plans should engage in efforts that assist providers in examining and improving their systems' abilities to manage patient demand. As an example, the health plan could test alternatives to traditional one-on-one visits, such as telephone consultations or telemedicine, for certain types of health care services and appointments. Alternatives to traditional in-office visits can assist in improving physician availability and ensuring patients receive immediate medical care and services.

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

Promote Quality Improvement Initiatives— Implementation of organization-wide quality improvement (QI) initiatives is most successful when health plan staff members at every level are involved. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan, establishing health plan-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, progress of QI initiatives should be monitored and reported internally to assess the effectiveness of these efforts. Specific QI initiatives aimed at engaging employees can include quarterly employee forums, an annual all-staff assembly, topic-specific improvement teams, leadership development courses, and employee awards. As an example, improvement teams can be implemented to focus on specific topics such as service quality; rewards and recognition; and patient, physician, and employee satisfaction.

Well Sense

Conclusions and Recommendations for Improvement

HSAG performed a comparison of **Well Sense**'s adult and child Medicaid populations' 2015 CAHPS survey results to the 2014 NCQA CAHPS Adult and Child Medicaid national averages to determine potential areas for improvement. For **Well Sense**'s adult Medicaid population, HSAG recommends that **Well Sense** focus quality improvement efforts on *Rating of Health Plan* and *Rating of Personal Doctor,* since the measures' rates were below NCQA's 2014 CAHPS adult Medicaid national averages. For **Well Sense**'s general child Medicaid population, HSAG recommends that efforts focus on improving *Customer Service*, since the measure's rate was below NCQA's 2014 CAHPS child Medicaid national average.

Based on these comparisons, HSAG recommends that **Well Sense** focus quality improvement on enhancing members' experiences with *Rating of Health Plan*, *Rating of Personal Doctor*, and *Customer Service*. The following are recommendations of best practices and other proven strategies that can be used or adapted by the MCO to target improvement in each of these areas.

Rating of Health Plan

Alternatives to One-on-One Visits—Health plans should engage in efforts that assist providers in examining and improving their systems' abilities to manage patient demand. As an example, the health plan could test alternatives to traditional one-on-one visits, such as telephone consultations or telemedicine, for certain types of health care services and appointments. Alternatives to traditional in-office visits can assist in improving physician availability and ensuring patients receive immediate medical care and services.

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

Promote Quality Improvement Initiatives—Implementation of organization-wide QI initiatives is most successful when health plan staff members at every level are involved. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan, establishing health plan-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, progress of QI initiatives should be monitored and reported internally to assess the effectiveness of these efforts. Specific QI initiatives aimed at engaging employees can include quarterly employee forums, an annual all-staff assembly, topic-specific improvement teams, leadership development courses, and employee awards. As an example, improvement teams can be implemented to focus on specific topics such as service quality; rewards and recognition; and patient, physician, and employee satisfaction.

Rating of Personal Doctor

Maintain Truth in Scheduling—Health plans can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit and provide assistance or instructions to those physicians unfamiliar with this type of assessment. One method for evaluating appropriate scheduling of various appointment types is to measure the amount of time it takes to complete the scheduled visit. This type of monitoring will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times.

Additionally, by measuring the amount of time it takes to provide care, both health plans and physician offices can identify where streamlining opportunities exist.

Direct-Patient Feedback—Health plans can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Health plans can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or email. Asking patients to describe what they liked most about the care received during their recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative). Comment card questions may also prompt feedback regarding other topics, such as providers' listening skills, wait time to obtaining an appointment, customer service, and other items of interest.

Physician-Patient Communication—Health plans should encourage physician-patient communication to improve patient satisfaction and outcomes. Indicators of good physician-patient communication include providing clear explanations, listening carefully, and being understanding of patients' perspectives. Health plans can also create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication. Training sessions can include topics such as improving listening techniques, patient-centered interviewing skills, collaborative communication which involves allowing the patient to discuss and share in the decision-making process, as well as effectively communicating expectations and goals of health care treatment. In addition, workshops can include training on the use of tools that improve physician-patient communication.

Improving Shared Decision Making—Health plans should encourage skills training in shared decision making for all physicians. Implementing an environment of shared decision making and physician-patient collaboration requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, one key to a successful shared decision making model is ensuring that physicians are properly trained. Training should focus on providing physicians with the skills necessary to facilitate the shared decision making process; ensuring that physicians understand the importance of taking each patient's values into consideration; and understanding patients' preferences and needs. Effective and efficient training methods include seminars and workshops.

Care Manager Training for Physicians—A patient's negative perception of his or her health can have detrimental impact. For example, as the patient's and family's stress increases, the likelihood of treatment compliance decreases. In order to relieve family tension and improve the health care of members, health plans should contemplate training their personal doctors to consider the medical and emotional needs of both the patient and the family. Doctors should be evaluated on several core competencies, such as caring and compassion, communication and listening, job skills and functional knowledge, customer service, leadership, outcome orientation, team orientation, and talent assessment and development.

Customer Service

Call Centers—An evaluation of current call center hours and practices can be conducted to determine if the hours and resources meet members' needs. If it is determined that the member services department call center is not meeting these needs, the MCO may consider expanding the hours to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call can assist in determining if they are receiving the help they need and identify potential areas for customer service improvement.

Creating an Effective Customer Service Training Program—Health plans should consider enhancing their customer service training program to meet the needs of their unique work environment. Recommendations from employees, managers, and business administrators could serve as guidance when constructing the training program. The customer service training program could be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and service recovery to ensure staff members feel competent in their ability to deal with difficult patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to consider implementing a support structure when they are back on the job.

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

HEDIS

This section reports results of the 2015 NCQA HEDIS Compliance Audits for the health plans. Also presented in this section are the actual HEDIS performance measure rates attained by each health plan on the required performance measures, with comparisons to the NCQA national Medicaid HEDIS 2014 percentiles, where applicable.

NCQA's IS standards are the guidelines used by certified NCQA HEDIS compliance auditors to assess a health plan's ability to report HEDIS data accurately and reliably. Compliance with the guidelines also helps an auditor to understand a health plan's HEDIS reporting capabilities. For HEDIS 2015, health plans were assessed on seven IS standards. To assess an MCO's adherence to the IS standards, HSAG reviewed several documents for the New Hampshire MCOs. These included the MCOs' final audit reports, IS compliance tools, and the IDSS files approved by an NCQA-LO.

Both MCOs contracted with an external software vendor for HEDIS measure production and rate calculation. HSAG reviewed the MCOs' final audit reports (FARs) and ensured that these software vendors participated and passed the NCQA's Measure Certification process. MCOs either purchase the software with certified measures and generate HEDIS measure results internally or provide all data to the software vendor who generates HEDIS measures for them.

IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry

This standard assesses whether:

◆ Industry standard codes are used and all characters are captured.

◆ Principal codes are identified and secondary codes are captured.

◆ Nonstandard coding schemes are fully documented and mapped back to industry standard codes.

◆ Standard submission forms are used and capture all fields relevant to measure reporting; all proprietary forms capture equivalent data; and electronic transmission procedures conform to industry standards.

◆ Data entry processes are timely and accurate, and include sufficient edit checks to ensure the accurate entry of submitted data in transaction files for measure reporting.

◆ The organization continually assesses data completeness and takes steps to improve performance.

◆ The organization regularly monitors vendor performance against expected performance standards.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

This standard assesses whether:

◆ The organization has procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of membership data have necessary procedures to ensure accuracy.

◆ Data entry processes are timely and accurate, and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.

◆ The organization continually assesses data completeness and takes steps to improve performance.

◆ The organization regularly monitors vendor performance against expected performance standards.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

This standard assesses whether:

◆ Provider specialties are fully documented and mapped to HEDIS provider specialties necessary for measure reporting.

◆ The organization has effective procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of practitioner data are checked to ensure accuracy.

◆ Data entry processes are timely and accurate, and include edit checks to ensure accurate entry of submitted data in transaction files.

◆ The organization continually assesses data completeness and takes steps to improve performance.

◆ The organization regularly monitors vendor performance against expected performance standards.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

This standard assesses whether:

◆ Forms capture all fields relevant to measure reporting, and whether electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off).

◆ Retrieval and abstraction of data from medical records are reliably and accurately performed.

◆ Data entry processes are timely and accurate, and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.

◆ The organization continually assesses data completeness and takes steps to improve performance.

◆ The organization regularly monitors vendor performance against expected performance standards.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

This standard assesses whether:

◆ Nonstandard coding schemes are fully documented and mapped to industry standard codes.

◆ The organization has effective procedures for submitting measure-relevant information for data entry, and whether electronic transmissions of data have checking procedures to ensure accuracy.

◆ Data entry processes are timely and accurate, and include edit checks to ensure accurate entry of submitted data in transaction files.

◆ The organization continually assesses data completeness and takes steps to improve performance.

◆ The organization regularly monitors vendor performance against expected performance standards.

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

This standard assesses whether member call center data are reliably and accurately captured.

Note: IS 6.0, Member Call Center Data—Capture, Transfer, and Entry was not applicable to the measures required to be reported by the MCOs. The call center measures were not part of the required DHHS Medicaid HEDIS set of performance measures.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

This standard assesses whether:

◆ Nonstandard coding schemes are fully documented and mapped to industry standard codes.

◆ Data transfers to repository from transaction files are accurate.

◆ File consolidations, extracts, and derivations are accurate.

◆ Repository structure and formatting are suitable for measures and enable required programming efforts.

◆ Report production is managed effectively and operators perform appropriately.

◆ Measure reporting software is managed properly with regard to development, methodology, documentation, revision control, and testing.

- ◆ Physical control procedures ensure measure data in areas related to physical security, data access authorization, disaster recovery facilities, and fire protection.
- ◆ The organization regularly monitors vendor performance against expected performance standards.

IS Review Results

NHHF was found to be fully compliant with all applicable IS assessment standards. (Note: The call center standards [IS 6.0] were not applicable to the measures required to be reported by the MCO.) **NHHF** demonstrated that it had the automated systems, information management practices, processing environment, and control procedures in place to access, capture, translate, analyze, and report the selected HEDIS measures accurately.

NHHF elected to use one nonstandard and three standard supplemental data sources for its performance measure reporting. The auditor confirmed that the data sources used to supplement the transactional data met the appropriate specifications.

Well Sense was found to be fully compliant with all applicable IS assessment standards. (Note: The call center standards [IS 6.0] were not applicable to the measures required to be reported by the MCO.) **Well Sense** demonstrated that it had the automated systems, information management practices, processing environment, and control procedures in place to access, capture, translate, analyze, and report the selected HEDIS measures accurately.

Well Sense elected to use one standard and two nonstandard supplemental data sources for its performance measure reporting. HSAG recommended that **Well Sense** collaborate with its software vendor to develop and implement unique, alphanumeric data source identification (ID) that can be assigned to each data source to facilitate consolidation of databases such as laboratory results or medical record abstraction databases.

HEDIS Measures Results

HSAG organized, aggregated, and analyzed the validated performance measure data to draw conclusions about **NHHF**'s and **Well Sense**'s performance in providing quality, accessible, and timely care and services to its members. The following performance measure results reflect all three domains of care—quality, access, and timeliness. Each figure contains performance measure rates for **NHHF** and **Well Sense**, along with confidence intervals and national benchmarks, when applicable. Although performance measure rates were derived using the entire eligible population, confidence intervals are displayed to provide an indication of the variability in the data, which should be taken into consideration when inferences about these results are made regarding the comparison of the MCO rates and expected future performance.

Prevention

Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total

AAP—Total measures the percentage of members 20 years and older who had an ambulatory or preventive care visit during 2014. **NHHF**'s and **Well Sense**'s *AAP—Total* measure results are shown in Figure 4-11.

Figure 4-11—2014 AAP—*Total* Measure Results
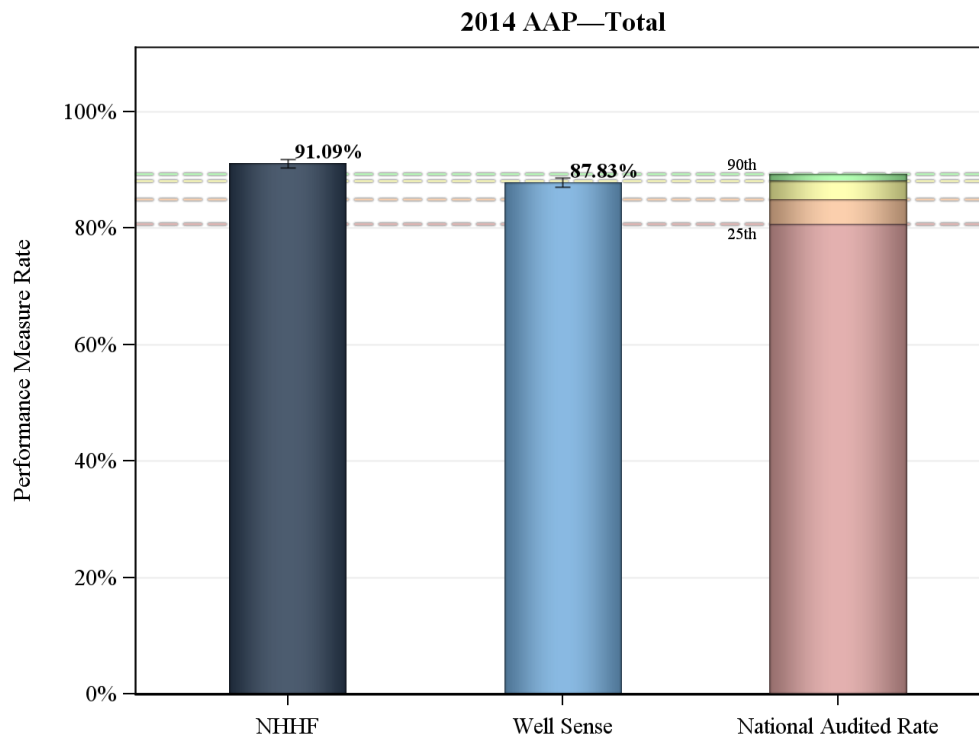
NHHF's reported rate was above the 90th percentile, and **Well Sense**'s reported rate was between the 50th and 75th percentiles.

Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months

CAP—12–24 Months measures the percentage of members ages 12–24 months who had a visit with a primary care physician (PCP) during 2014. **NHHF**'s and **Well Sense**'s *CAP—12–24 Months* measure results are shown in Figure 4-12.

Figure 4-12—2014 *CAP—Ages 12–24 Months* Measure Results
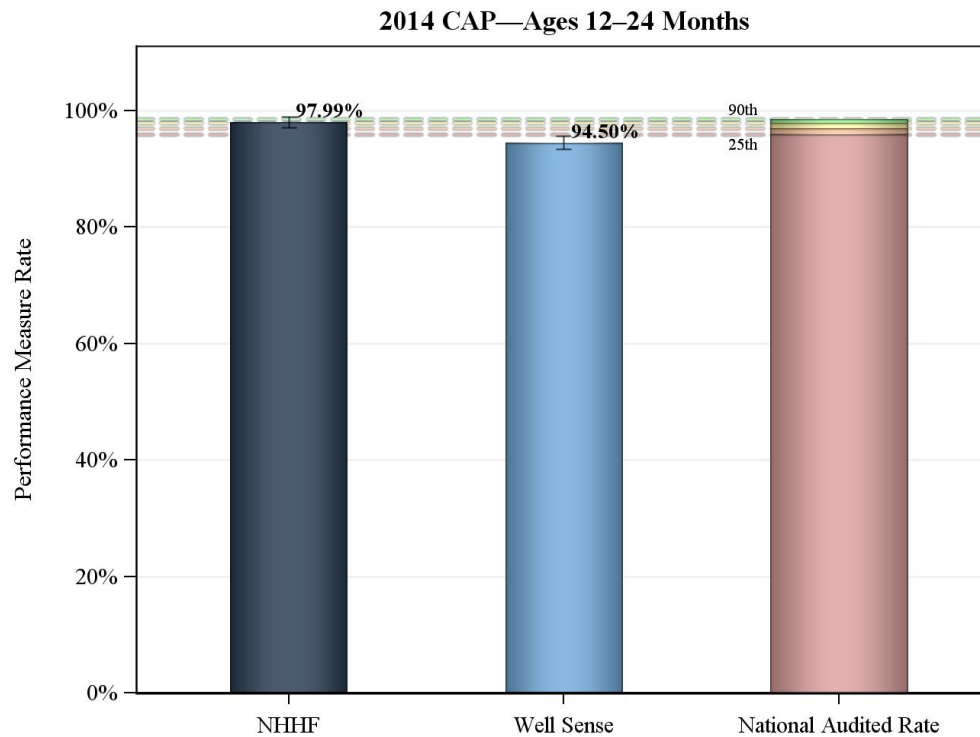
NHHF's reported rate was between the 75th and 90th percentiles, and **Well Sense**'s reported rate was below the 25th percentile.

Children and Adolescents' Access to Primary Care Practitioners (CAP)—25 Months–6 Years

CAP—25 Months–6 Years measures the percentage of members ages 25 months to 6 years who had a visit with a PCP during 2014. **NHHF**'s and **Well Sense**'s *CAP—25 Months–6 Years* measure results are shown in Figure 4-13.

Figure 4-13—2014 *CAP—Ages 25 Months–6 Years* Measure Results

2014 CAP—Ages 25 Months–6 Years

NHHF's reported rate was between the 50th and 75th percentiles, and **Well Sense**'s reported rate was below the 25th percentile.

Children and Adolescents' Access to Primary Care Practitioners (CAP)—7–11 Years

CAP—7–11 Years measures the percentage of members ages 7–11 years who had a visit with a PCP during 2014. Rates for this measure were *NA* for **NHHF** and **Well Sense** because the denominator was too small (<30) to report a valid rate.

Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–19 Years

CAP—12–19 Years measures the percentage of members ages 12–19 years who had a visit with a PCP during 2014. Rates for this measure were *NA* for **NHHF** and **Well Sense** because the denominator was too small (<30) to report a valid rate.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

W34 measures the percentage of members 3–6 years of age who had one or more well-child visits with a PCP during 2014. **NHHF**'s and **Well Sense**'s *W34* measure results are shown in Figure 4-14.

Figure 4-14—2014 *W34* Measure Results
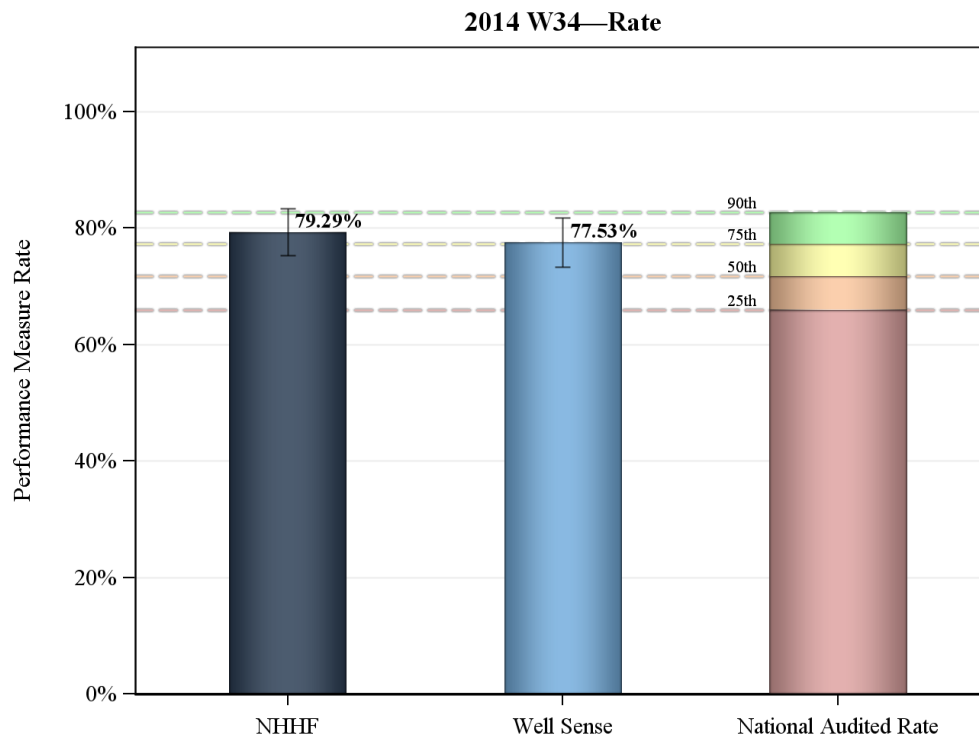
Both plans' reported rates were between the 75th and 90th percentiles.

Adolescent Well-Care Visits (AWC)

AWC measures the percentage of members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrician/gynecologist (OB/GYN) practitioner during 2014. **NHHF**'s and **Well Sense**'s AWC measure results are shown in Figure 4-15.

Figure 4-15—2014 *AWC—Rate* Measure Results
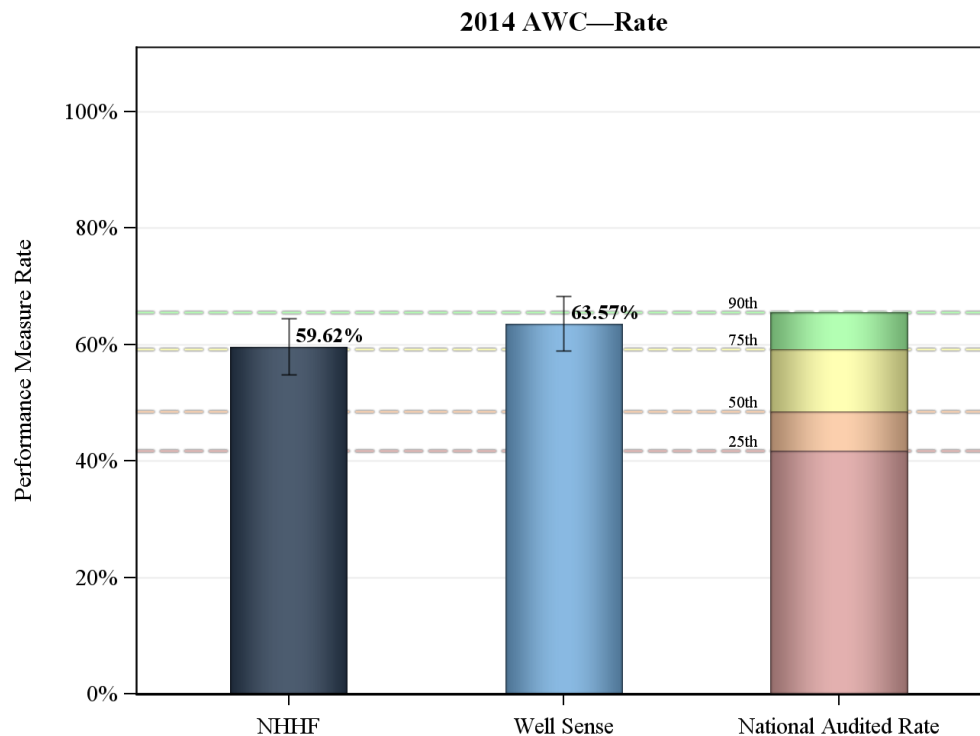
Both plans' reported rates were between the 75th and 90th percentiles.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Body Mass Index (BMI) Percentile

WCC—BMI Percentile measures the percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had documentation of BMI percentile during 2014. **NHHF**'s and **Well Sense**'s *WCC—BMI Percentile* measure results are shown in Figure 4-16.

Figure 4-16—2014 *WCC—BMI Percentile* Measure Results
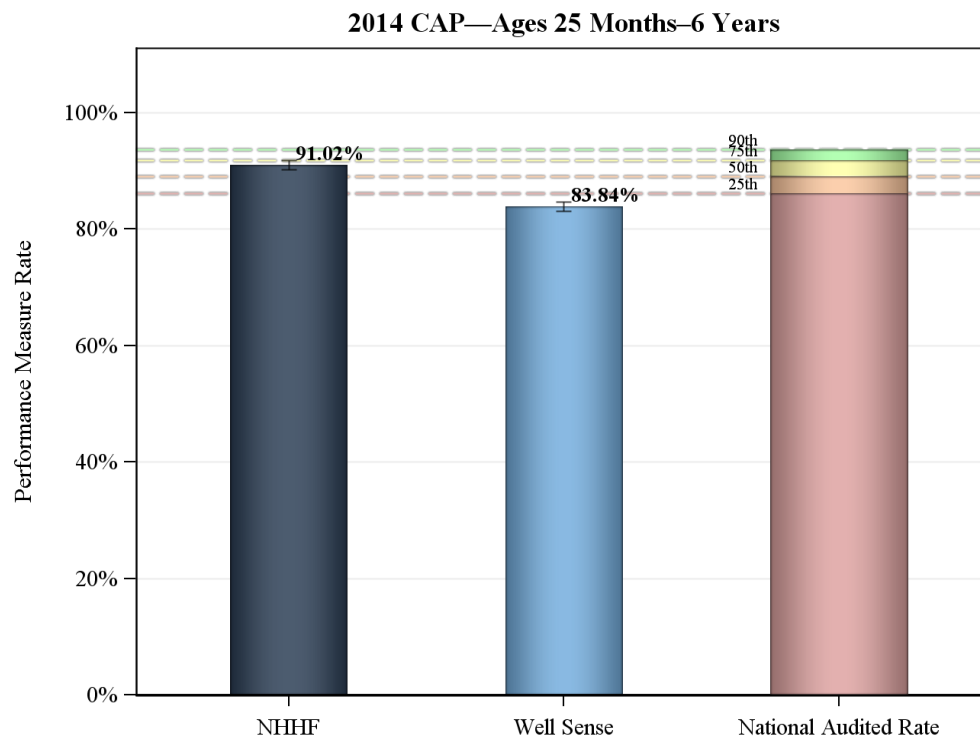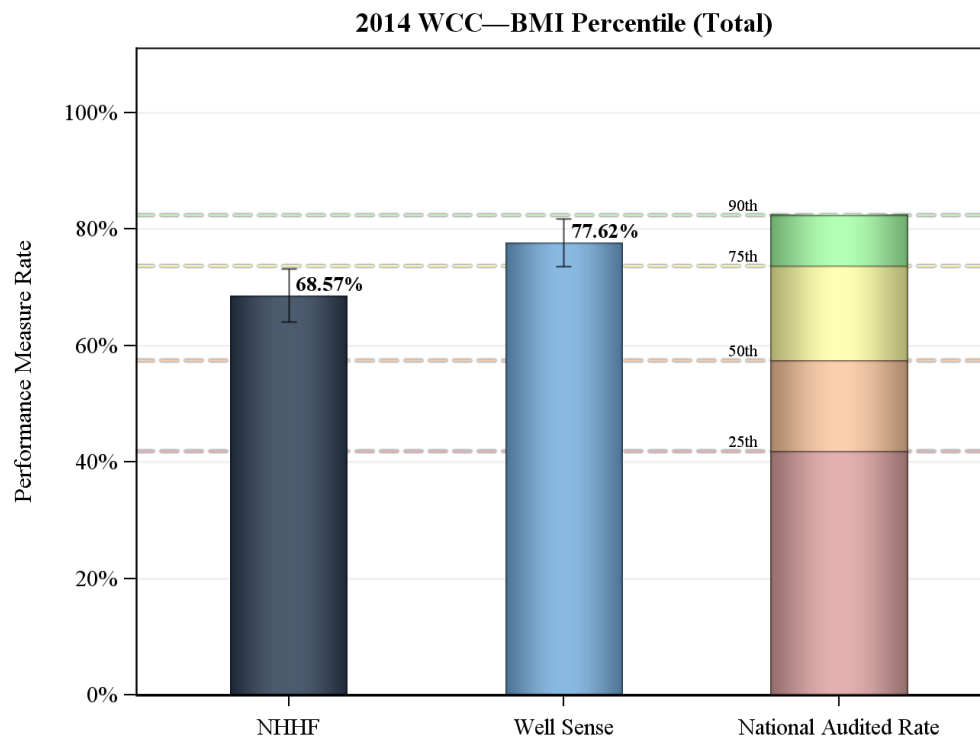

2014 WCC—BMI Percentile (Total)

NHHF's reported rate was between the 50th and 75th percentiles, and **Well Sense**'s reported rate was between the 75th and 90th percentiles.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition

WCC—Counseling for Nutrition measures the percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had documentation of counseling for nutrition during 2014. **NHHF**'s and **Well Sense**'s *WCC—Counseling for Nutrition* measure results are shown in Figure 4-17.

Figure 4-17—2014 *WCC—Counseling for Nutrition* Measure Results
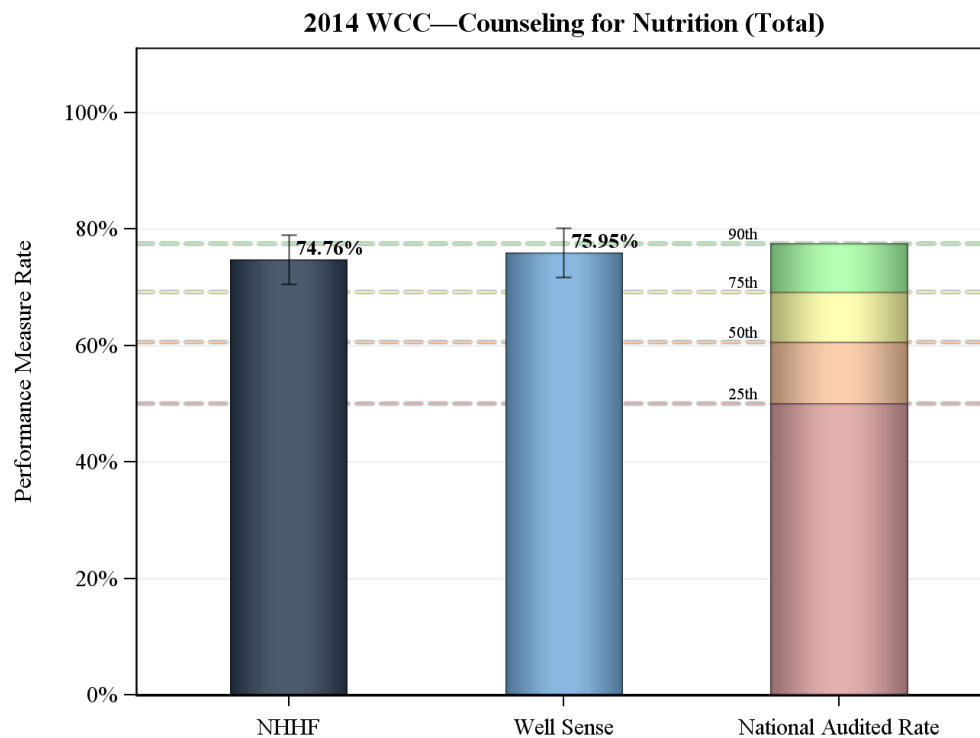
Both plans' reported rates were between the 75th and 90th percentiles.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity

WCC—Counseling for Physical Activity measures the percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had documentation of counseling for physical activity during 2014. **NHHF**'s and **Well Sense**'s *WCC—Counseling for Physical Activity* measure results are shown in Figure 4-18.

Figure 4-18—2014 *WCC—Counseling for Physical Activity* Measure Results
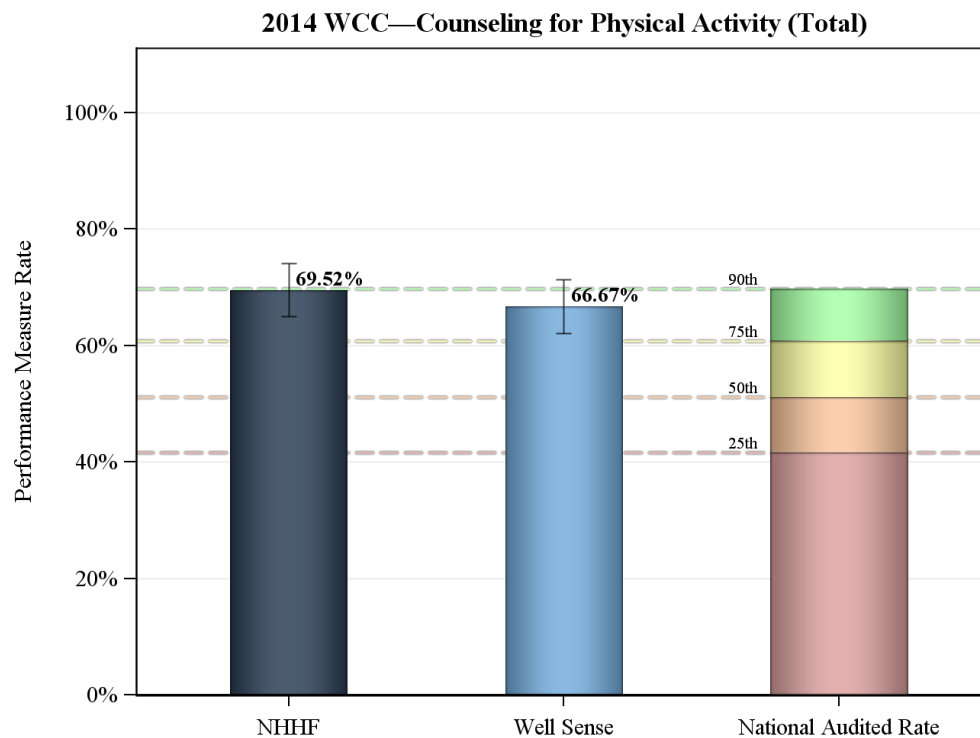
2014 WCC—Counseling for Physical Activity (Total)

Both plans' reported rates were between the 75th and 90th percentiles.

Childhood Immunization Status (CIS)—Combination 2

CIS—Combination 2 measures the percentage of children 2 years of age during 2014 who were given the required immunizations listed in Combination 2 by their second birthday. This measure proscribes appropriate vaccinations for diphtheria, tetanus and pertussis (DTaP), polio (IPV), measles, mumps and rubella (MMR), Haemophilus influenza type B (HiB), hepatitis B (HepB), and chicken pox (VZV). **NHHF**'s and **Well Sense**'s *CIS—Combination 2* measure results are shown in Figure 4-19.

Figure 4-19—2014 *CIS—Combination 2* Measure Results
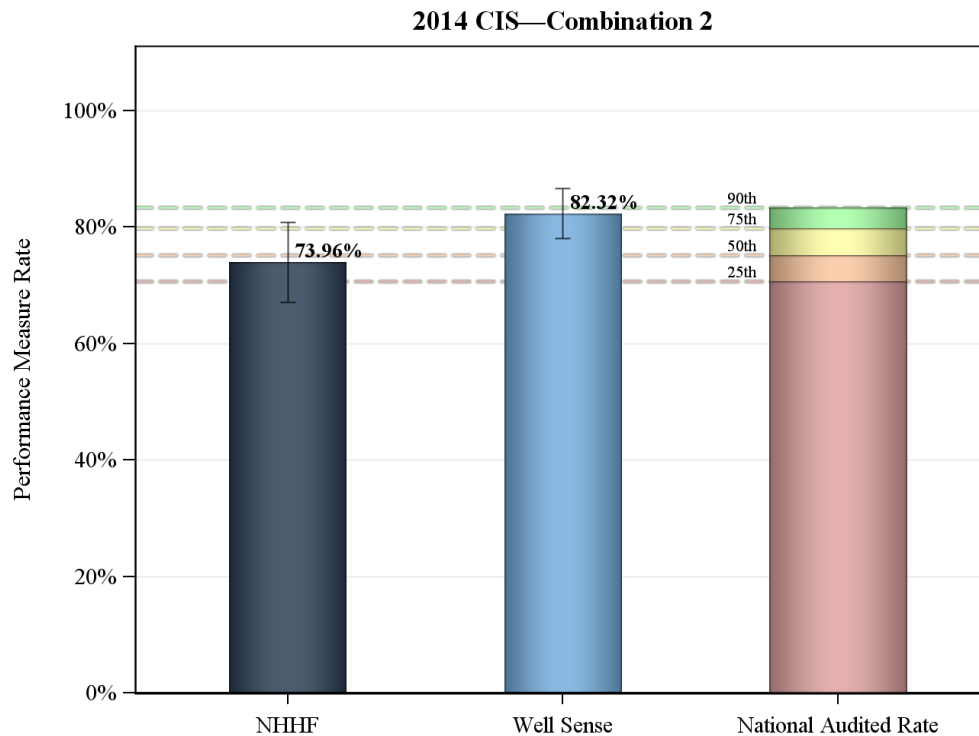
2014 CIS—Combination 2

NHHF's reported rate was between the 25th and 50th percentiles, and **Well Sense**'s reported rate was between the 75th and 90th percentiles.

Childhood Immunization Status (CIS)—Combination 10

CIS—Combination 10 measures the percentage of children 2 years of age during 2014 who were given the immunizations listed in Combination 10 by their second birthday. This measure proscribes all of the vaccinations from Combination 2, plus pneumococcal conjugate (PCV), hepatitis A (HepA), rotavirus (RV) and influenza. **NHHF**'s and **Well Sense**'s *CIS—Combination 10* measure results are shown in Figure 4-20.

Figure 4-20—2014 *CIS—Combination 10* Measure Results
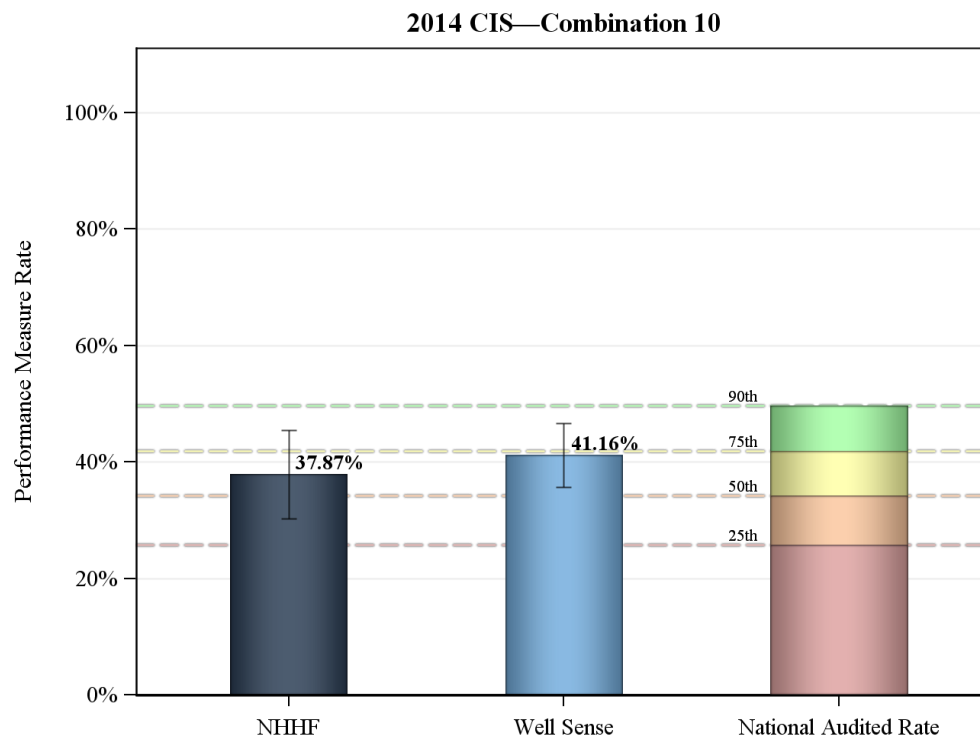
Both plans' reported rates were between the 50th and 75th percentiles.

Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap/Td)

IMA—Combination 1 (Meningococcal, Tdap/Td) measures the percentage of adolescents 13 years of age during 2014 who had appropriate vaccinations by their 13th birthday. Combination 1 prescribes one dose of meningococcal vaccine, and one tetanus, diphtheria and pertussis (Tdap) or one tetanus diphtheria toxoids vaccine (Td) by a child's 13th birthday. **NHHF**'s and **Well Sense**'s *IMA—Combination 1 (Meningococcal, Tdap/Td)* measure results are shown in Figure 4-21.

Figure 4-21—2014 *IMA—Combination 1 (Meningococcal, Tdap/Td)* Measure Results
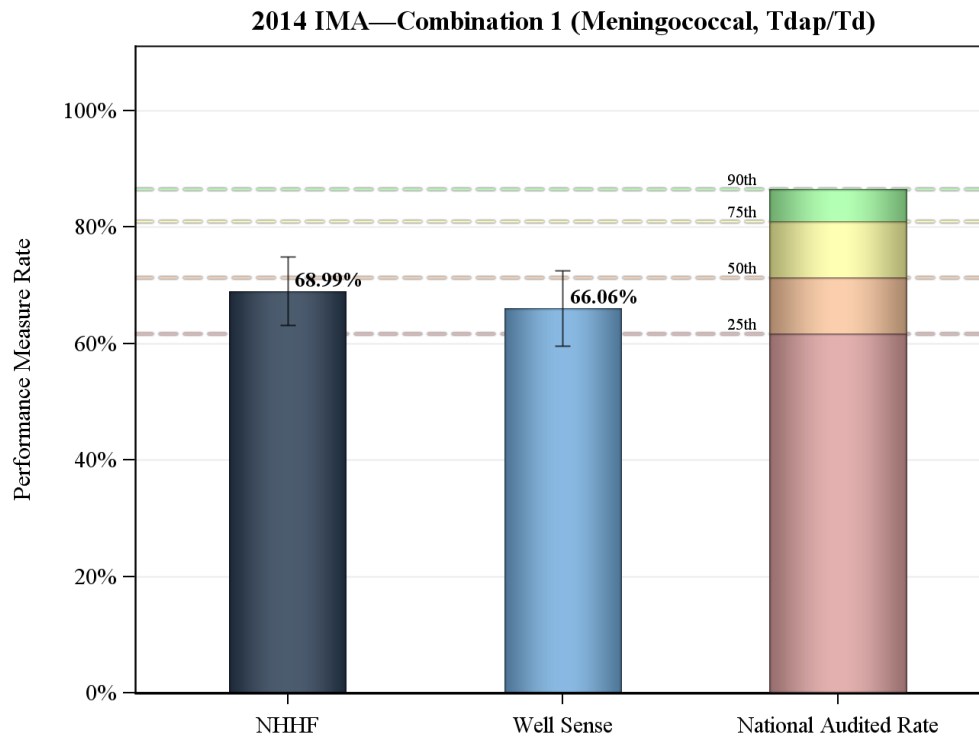
Both plans' reported rates were between the 25th and 50th percentiles.

Human Papillomavirus Vaccine for Female Adolescents (HPV)

HPV measures the percentage of female adolescents 13 years of age who had three doses of the human papillomavirus vaccine by their 13th birthday during 2014. **NHHF**'s and **Well Sense**'s *HPV* measure results are shown in Figure 4-22.

Figure 4-22—2014 *HPV* Measure Results
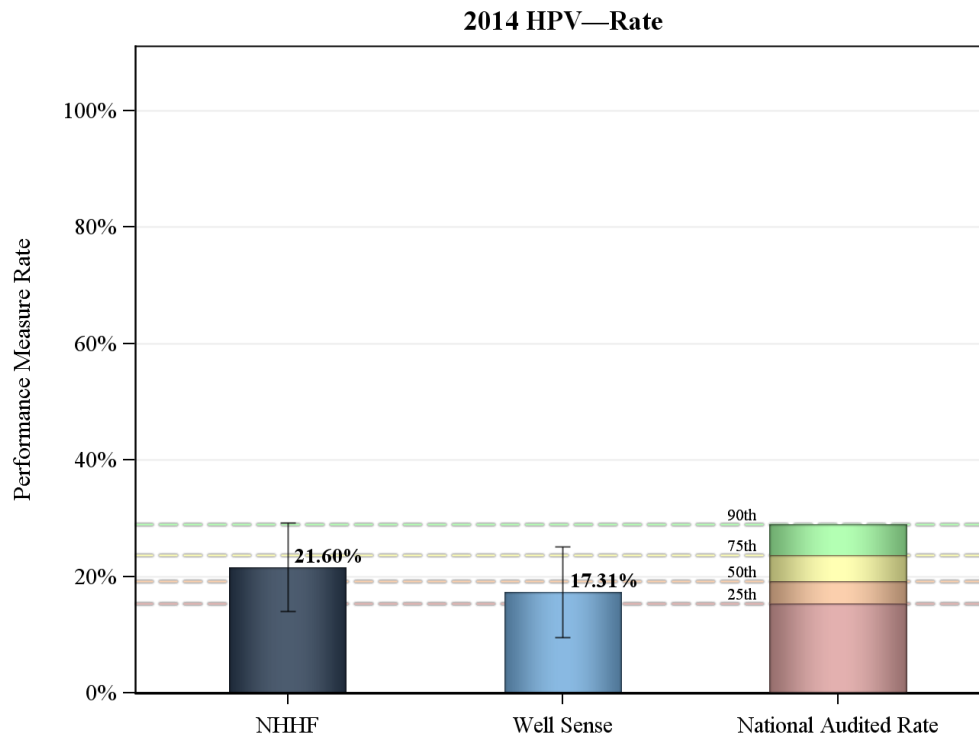
2014 HPV—Rate

NHHF: 21.60%
Well Sense: 17.31%

NHHF's reported rate was between the 50th and 75th percentiles, and **Well Sense**'s reported rate was between the 25th and 50th percentiles.

Cervical Cancer Screening (CCS)

CCS measures the percentage of women 21–64 years of age who met the criteria for appropriate screening for cervical cancer during 2014. **NHHF**'s and **Well Sense**'s *CCS* measure results are shown in Figure 4-23.

Figure 4-23—2014 *CCS* Measure Results
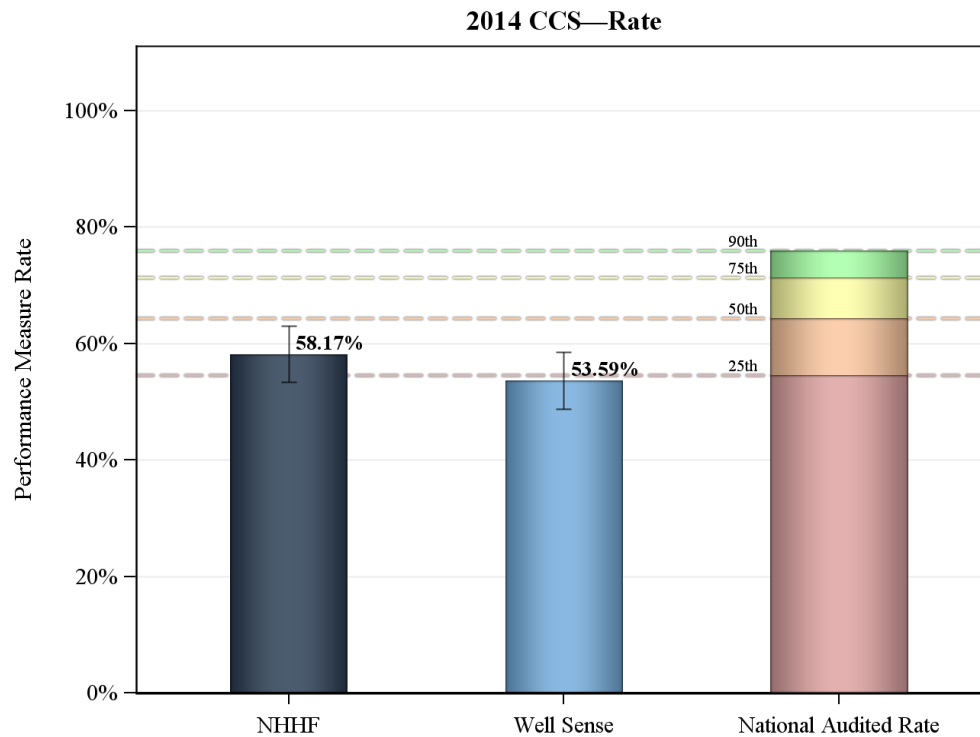
2014 CCS—Rate

NHHF's reported rate was between the 25th and 50th percentiles, and **Well Sense**'s reported rate was below the 25th percentile.

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)

NCS measures the percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer during 2014. **NHHF**'s and **Well Sense**'s *NCS* measure results are shown in Figure 4-24. Note that for this measure, a lower rate indicates better performance.

Figure 4-24—2014 *NCS* Measure Results

NOTE: A lower rate indicates a better performance for this measure.

Both plans' reported rates were better than the 90th percentile.

Chlamydia Screening in Women (CHL)—Total

CHL—Total measures the percentage of women 16–24 years of age identified as sexually active who had at least one test for chlamydia during 2014. **NHHF**'s and **Well Sense**'s *CHL—Total* measure results are shown in Figure 4-25.

Figure 4-25—2014 *CHL—Total* Measure Results
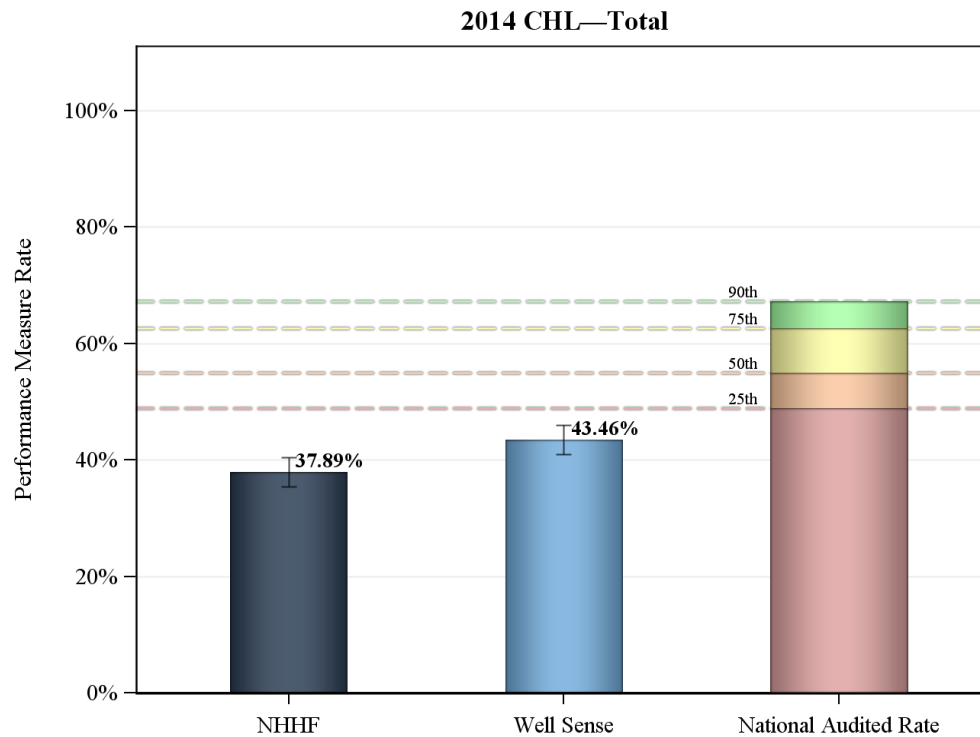
Both plans' reported rates were below the 25th percentile.

Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care

PPC—Timeliness of Prenatal Care measures the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization during 2014. **NHHF**'s and **Well Sense**'s *PPC—Timeliness of Prenatal Care* measure results are shown in Figure 4-26.

Figure 4-26—2014 *PPC—Timeliness of Prenatal Care* Measure Results

2014 PPC—Timeliness of Prenatal Care
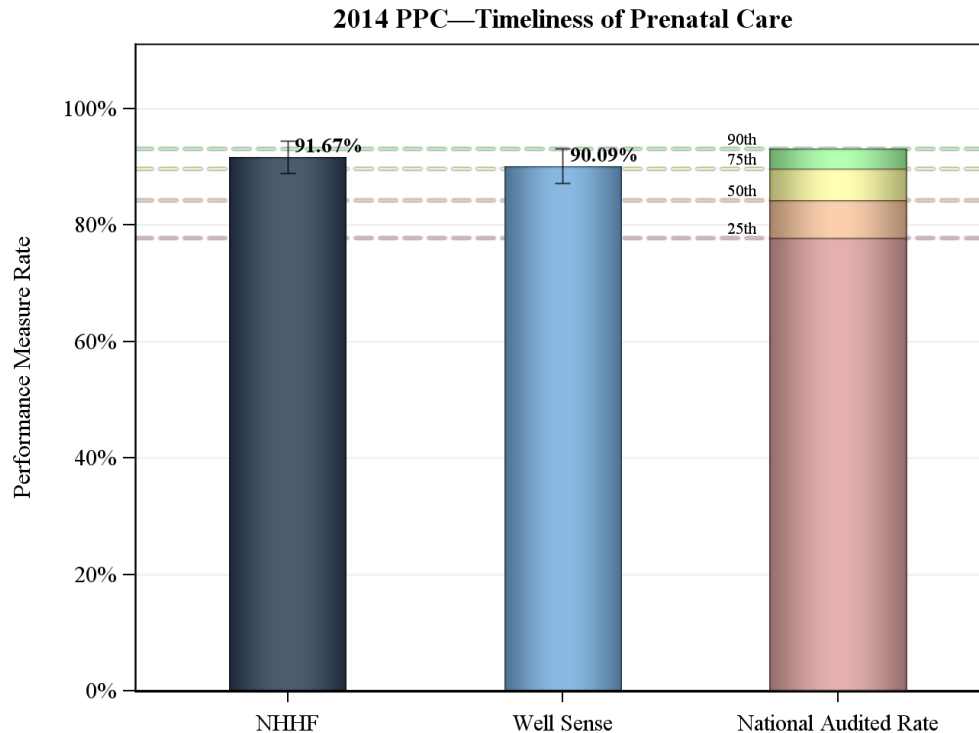
Both plans' reported rates were between the 75th and 90th percentiles.

Prenatal and Postpartum Care (PPC)—Postpartum Care

PPC—Postpartum Care measures the percentage of deliveries that received a postpartum visit on or between 21 and 56 days after delivery during 2014. **NHHF**'s and **Well Sense**'s *PPC—Postpartum Care* measure results are shown in Figure 4-27.

Figure 4-27—2014 *PPC—Postpartum Care* Measure Results
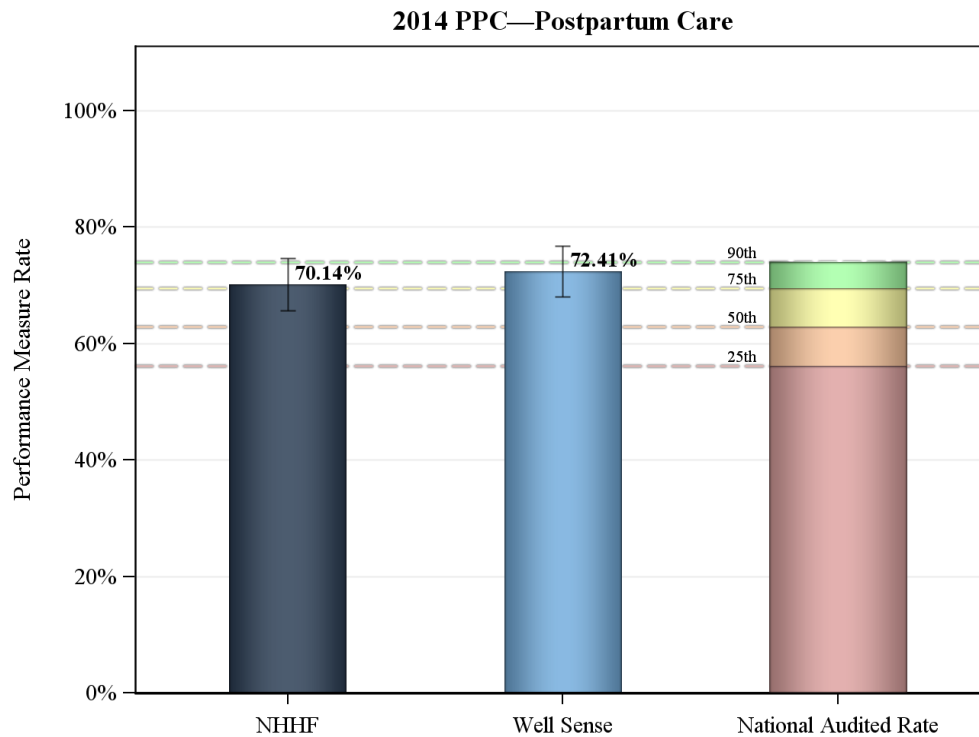
Both plans' reported rates were between the 75th and 90th percentiles.

Frequency of Ongoing Prenatal Care (FPC)—≥ 81 Percent of Expected Visits

FPC—≥ 81 Percent of Expected Visits measures the percentage of Medicaid deliveries in which the mother had at least 81 percent of the expected number of prenatal visits during 2014. **NHHF**'s and **Well Sense**'s *FPC—≥ 81 Percent of Expected Visits* measure results are shown in Figure 4-28.

Figure 4-28—2014 *FPC—≥ 81 Percent of Expected Visits* Measure Results
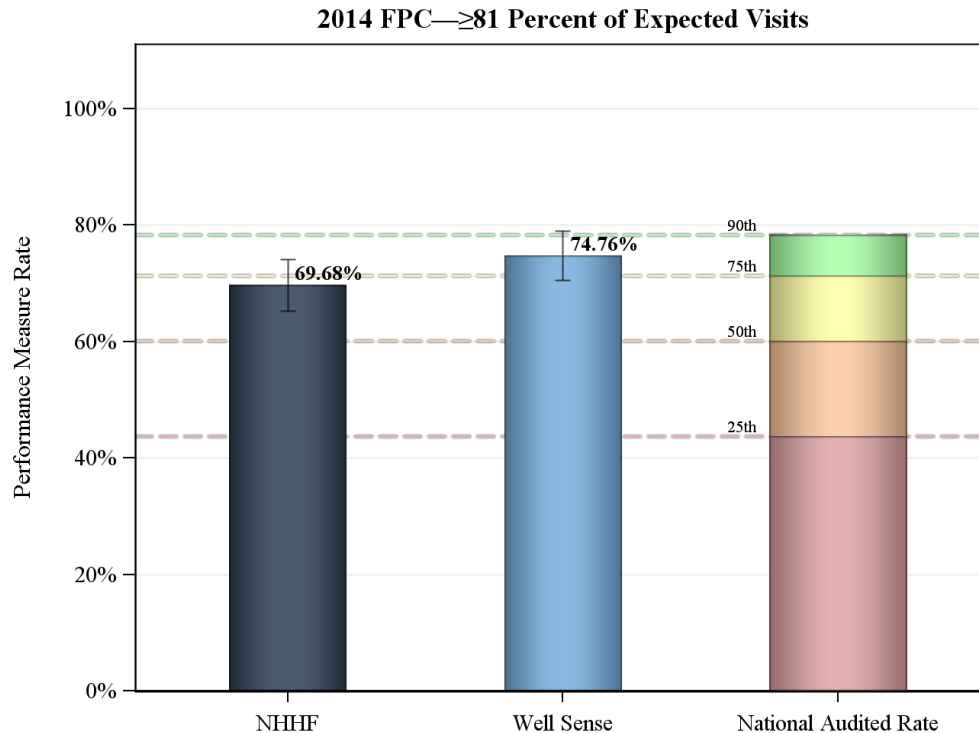
NHHF's reported rate was between the 50th and 75th percentiles, and **Well Sense**'s reported rate was between the 75th and 90th percentiles.

Acute and Chronic Care

Appropriate Testing for Children with Pharyngitis (CWP)

CWP measures the percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode during 2014. (A higher rate represents better performance; i.e. appropriate testing.) **NHHF**'s and **Well Sense**'s *CWP* measure results are shown in Figure 4-29.

Figure 4-29—2014 *CWP* Measure Results
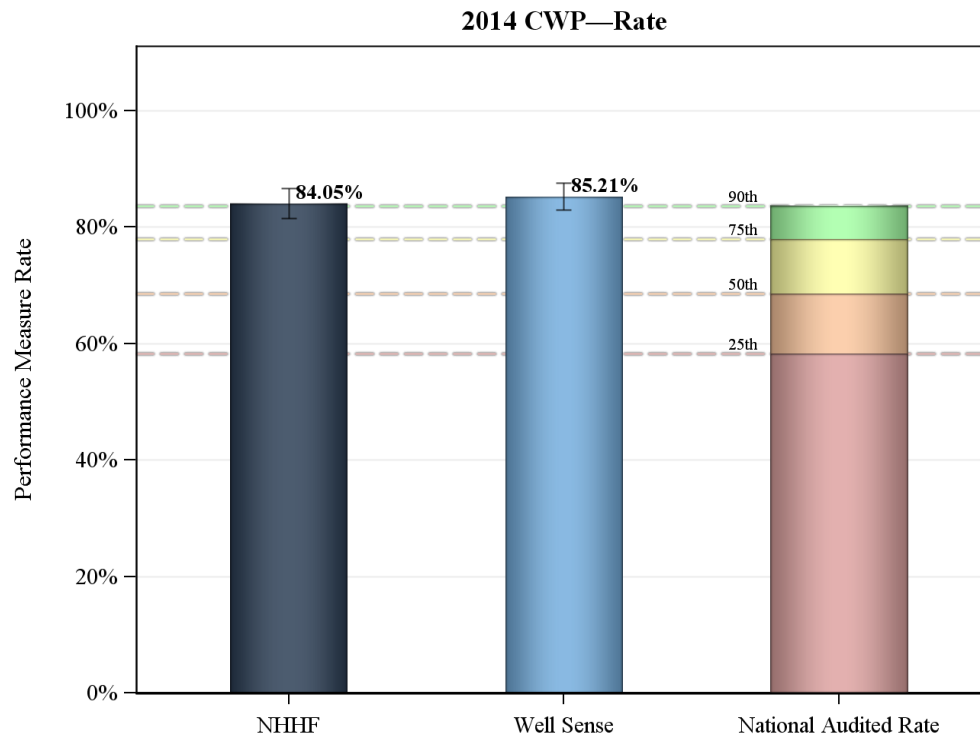
Both plans' reported rates were above the 90th percentile.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

URI measures the percentage of children 3 months to 18 years of age who were given a diagnosis of upper respiratory infection and who were not dispensed an antibiotic prescription during 2014. **NHHF**'s and **Well Sense**'s *URI* measure results are shown in Figure 4-30

Figure 4-30—2014 *URI* Measure Results
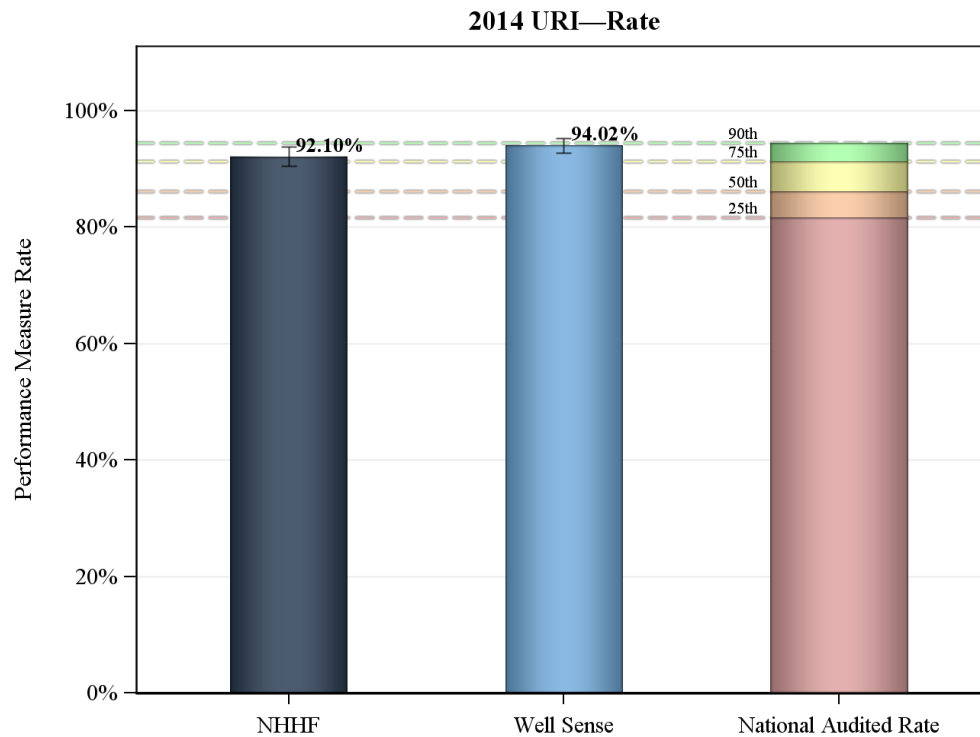
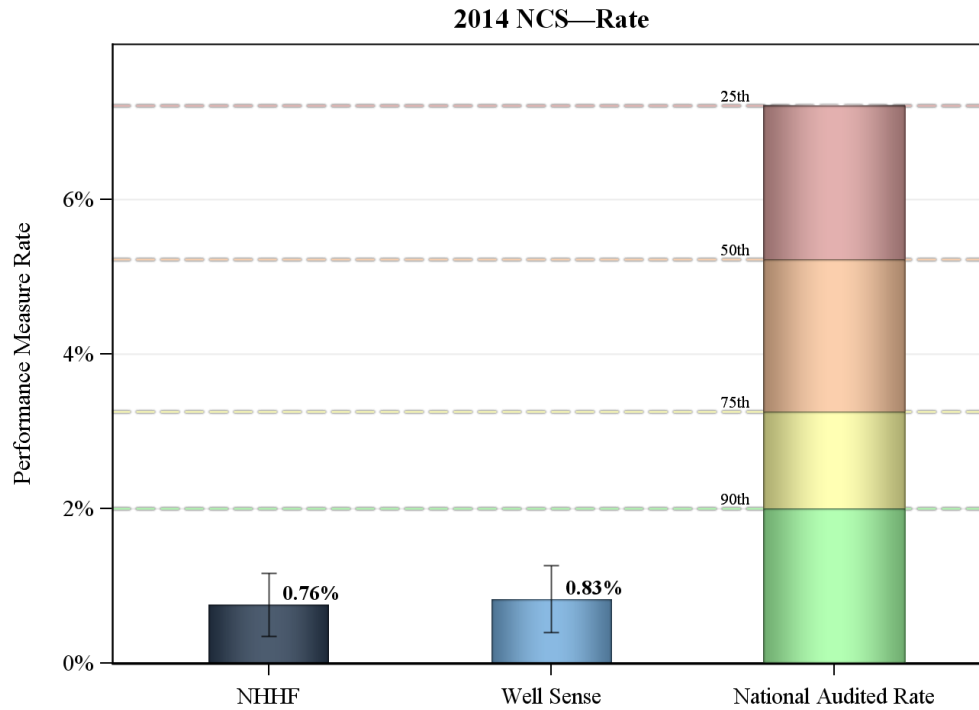Both plans' reported rates were between the 75th and 90th percentiles.

Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid

PCE—Systemic Corticosteroid measures the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or emergency department (ED) visit and who were dispensed a systemic corticosteroid within 14 days of the event during 2014. **NHHF**'s and **Well Sense**'s *PCE—Systemic Corticosteroid* measure results are shown in Figure 4-31.

Figure 4-31—2014 *PCE—Systemic Corticosteroid* Measure Results
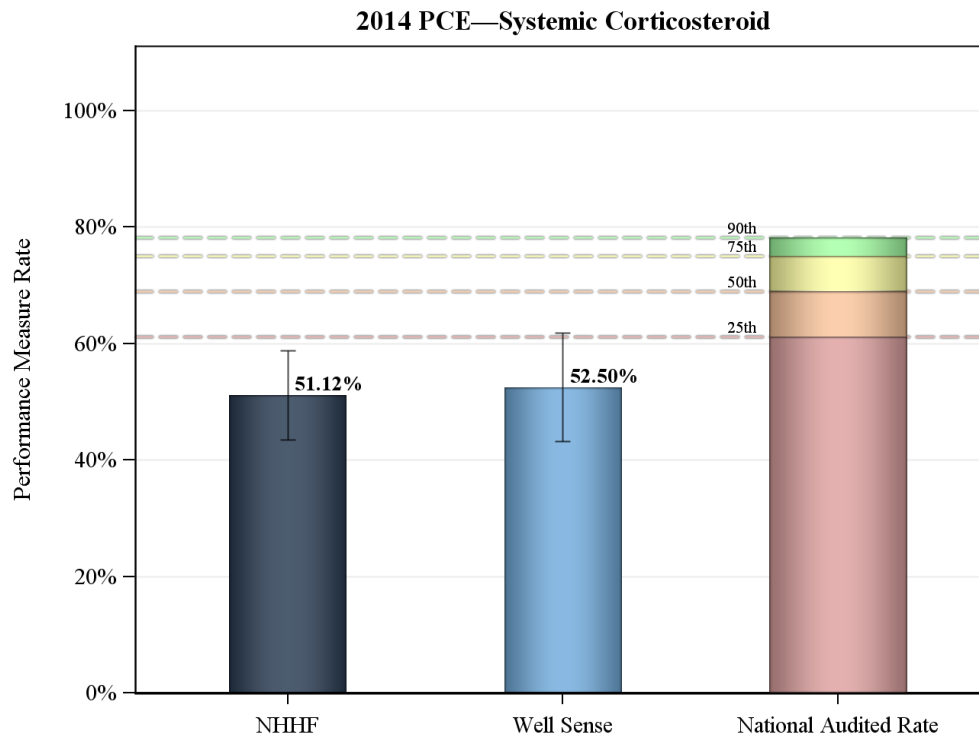
Both plans' reported rates were below the 25th percentile.

Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator

PCE—Bronchodilator measures the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit and who were dispensed a bronchodilator within 30 days of the event during 2014. **NHHF**'s and **Well Sense**'s *PCE—Bronchodilator* measure results are shown in Figure 4-32.

Figure 4-32—2014 *PCE—Bronchodilator* Measure Results
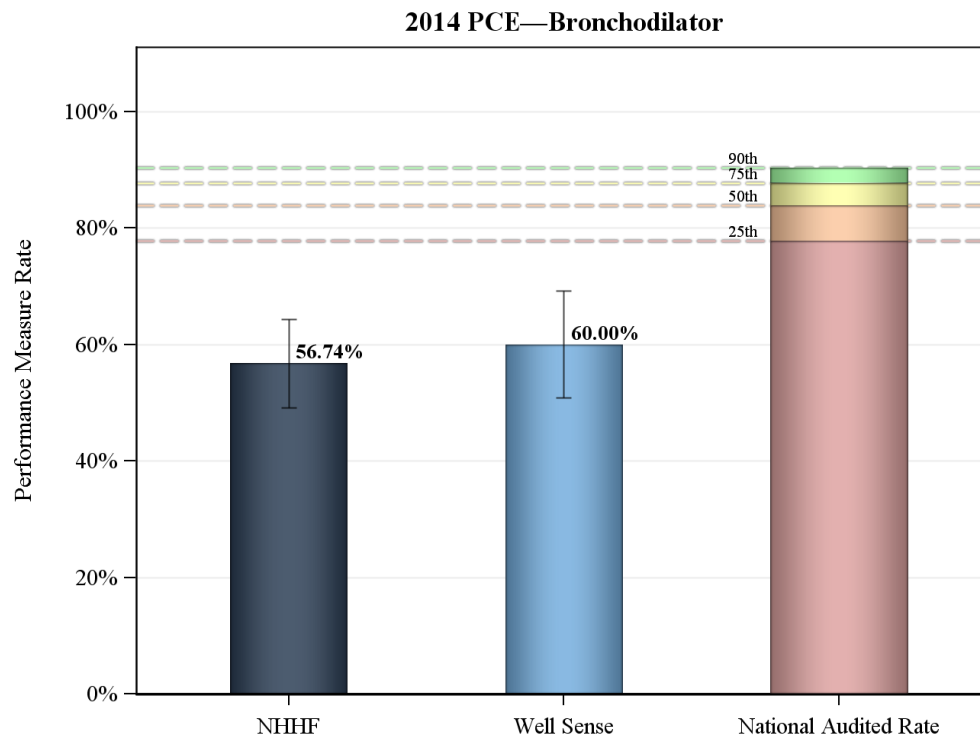
Both plans' reported rates were below the 25th percentile.

Annual Monitoring for Patients on Persistent Medications (MPM)—Total

MPM—Total is a composite of the percentages of members 18 years of age and older who received 180 days of treatment with angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blocker (ARB), digoxin, or diuretics and who received at least one therapeutic monitoring event for each appropriate medication during 2014. **NHHF**'s and **Well Sense**'s *MPM—Total* measure results are shown in Figure 4-33.

Figure 4-33—2014 *MPM* Measure Results
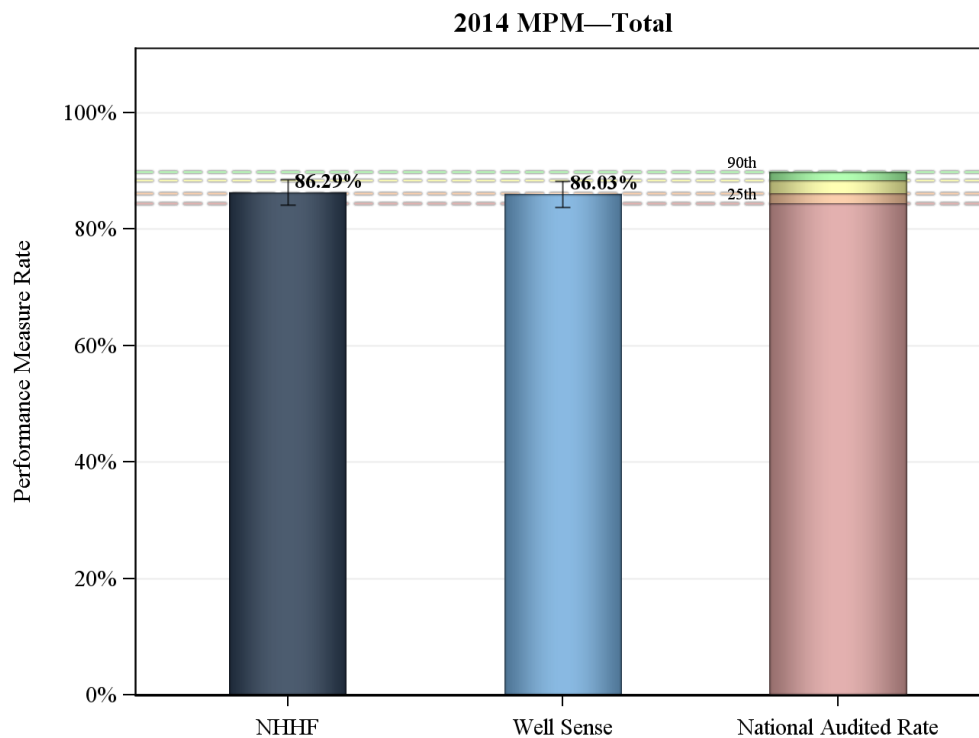
2014 MPM—Total

NHHF: 86.29% Well Sense: 86.03%

NHHF's reported rate was between the 50th and 75th percentiles, and **Well Sense**'s reported rate was between the 25th and 50th percentiles.

Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing

CDC—HbA1c Testing measures the percentage of members 18–75 years of age with diabetes (both type 1 and type 2) who had HbA1c testing during 2014. **NHHF**'s and **Well Sense**'s *CDC—HbA1c Testing* measure results are shown in Figure 4-34.

Figure 4-34—2014 *CDC—Hemoglobin A1c (HbA1c) Testing* Measure Results
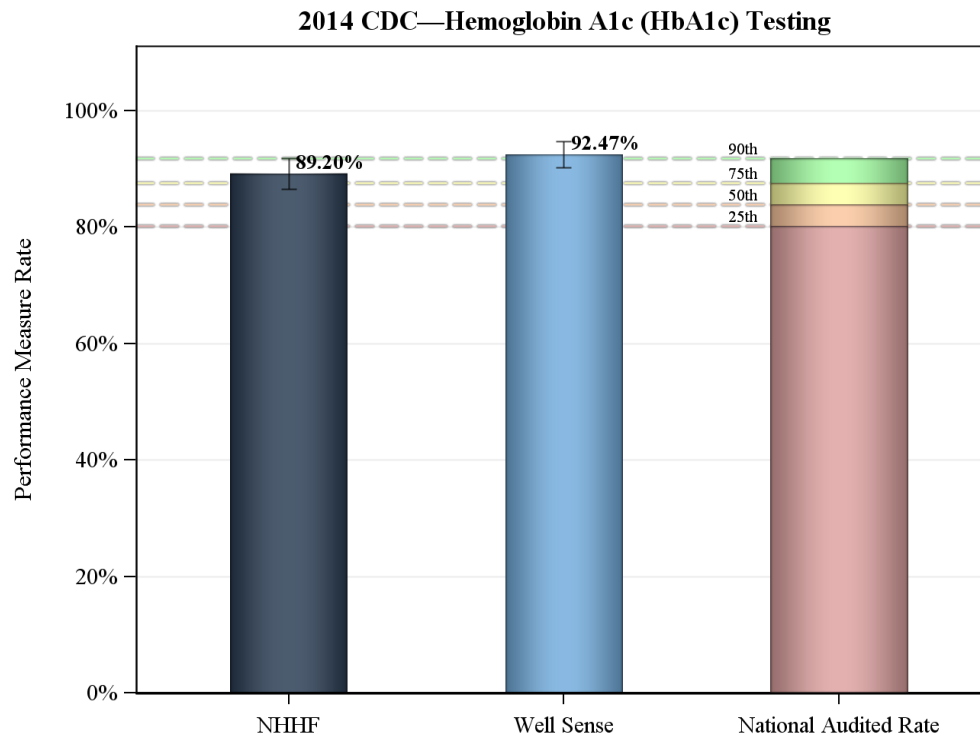
2014 CDC—Hemoglobin A1c (HbA1c) Testing

NHHF's reported rate was between the 75th and 90th percentiles, and **Well Sense**'s reported rate was above the 90th percentile.

Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)

CDC—HbA1c Poor Control (>9.0%) measures the percentage of members 18–75 years of age with diabetes (both type 1 and type 2) whose HbA1c testing showed poor control, with levels greater than 9.0 percent during 2014. **NHHF**'s and **Well Sense**'s *CDC—HbA1c Poor Control (>9.0%)* measure results are shown in Figure 4-35. Note that for this measure, a lower rate indicates better performance.

Figure 4-35—2014 *CDC—HbA1c Poor Control* (>9.0%) Measure Results
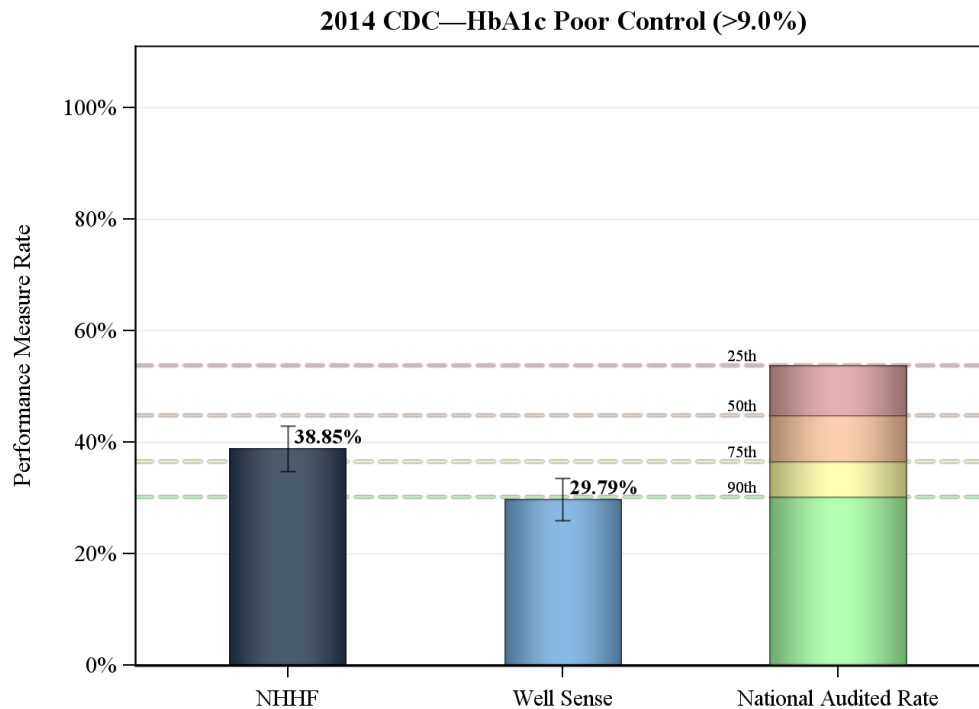
2014 CDC—HbA1c Poor Control (>9.0%)

NOTE: A lower rate indicates a better performance for this measure.

NHHF's reported rate was between the 50th and 75th percentiles, and **Well Sense**'s reported rate was better than the 90th percentile.

Comprehensive Diabetes Care (CDC)—HbA1c Control (<8.0%)

CDC—HbA1c Control (<8.0%) measures the percentage of members 18–75 years of age with diabetes (both type 1 and type 2) whose HbA1c testing revealed levels less than 8.0 percent during 2014. **NHHF**'s and **Well Sense**'s *CDC—HbA1c Control (<8.0%)* measure results are shown in Figure 4-36.

Figure 4-36—2014 *CDC—HbA1c Control (<8.0%)* Measure Results
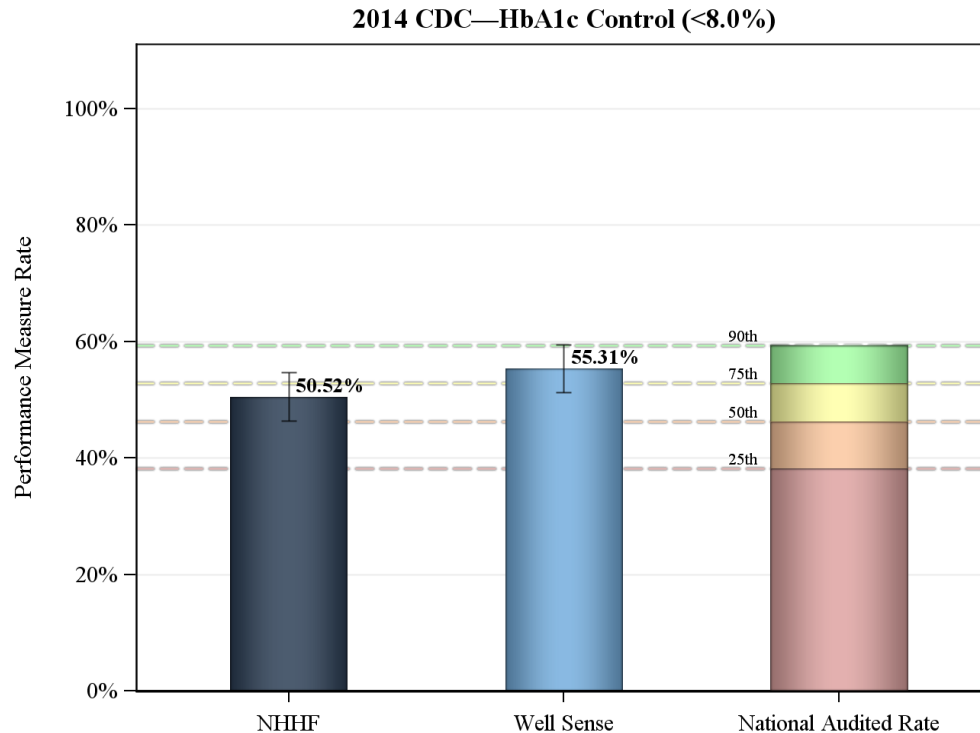
NHHF's reported rate was between the 50th and 75th percentiles, and **Well Sense**'s reported rate was between the 75th and 90th percentiles.

Controlling High Blood Pressure (CBP)

CBP measures the percentage of members 18–85 years of age and diagnosed with hypertension whose blood pressure was adequately controlled during 2014. **NHHF**'s and **Well Sense**'s *CBP* measure results are shown in Figure 4-37.

Figure 4-37—2014 *CBP* Measure Results
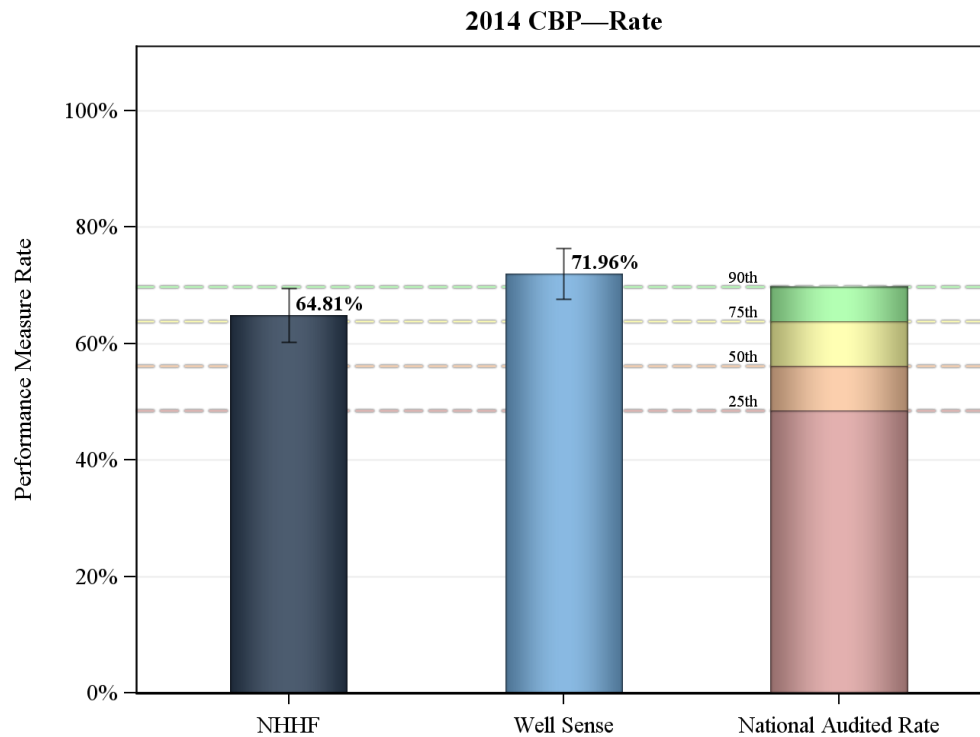
2014 CBP—Rate

NHHF's reported rate was between the 75th and 90th percentiles, and **Well Sense**'s reported rate was above the 90th percentile.

Use of Imaging Studies for Low Back Pain (LBP)

LBP measures the percentage of members with a primary diagnosis of low back pain who received appropriate treatment for back pain, (i.e., they did not have an imaging study within 28 days of the diagnosis) during 2014. **NHHF**'s and **Well Sense**'s *LBP* measure results are shown in Figure 4-38.

Figure 4-38—2014 *LBP* Measure Results

2014 LBP—Rate
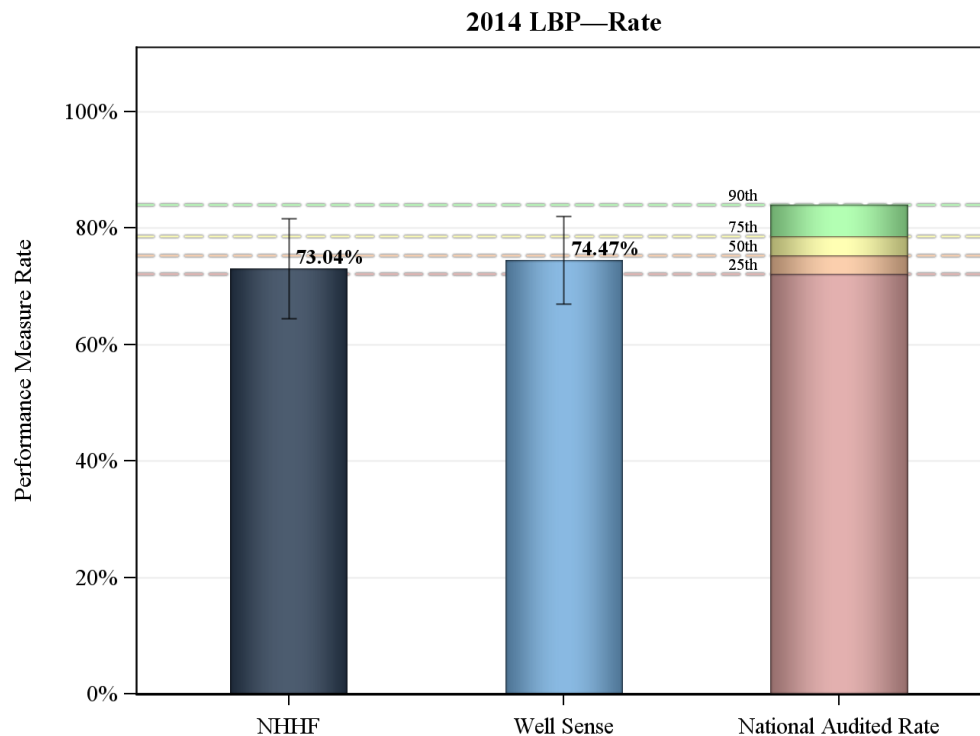
Both plans' reported rates were between the 25th and 50th percentiles.

Ambulatory Care (AMBA)—ED Visits

AMBA—ED Visits measures the utilization of ED visits among the member population during 2014. **NHHF**'s and **Well Sense**'s *AMBA—ED Visits* measure results are shown in Figure 4-39.[4-15] Note that for this measure, a lower rate indicates better performance.

Figure 4-39—2014 *AMBA—ED Visits* Measure Results
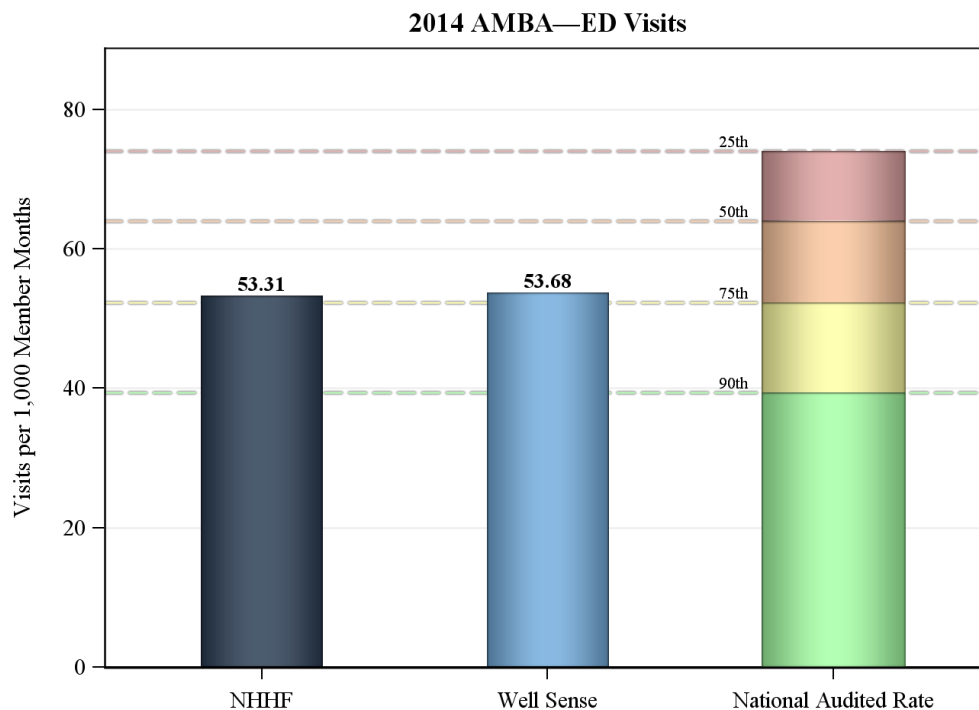
2014 AMBA—ED Visits

NOTE: A lower rate indicates a better performance for this measure.

Both plans' reported rates were between the 50th and 75th percentiles.

[4-15] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Inpatient Utilization (IPUA)—General Hospital/Acute Care—Total Inpatient Discharges

IPUA—General Hospital/Acute Care—Total Inpatient Discharges measures the rate of acute inpatient stays with a discharge date during 2014, per 1,000 member months during 2014. **NHHF**'s and **Well Sense**'s *IPUA—General Hospital/Acute Care—Total* Inpatient Discharges measure results are shown in Figure 4-40.[4-16]

Figure 4-40—2014 *IPUA General Hospital/Acute Care—Total Inpatient Discharges* Measure Results
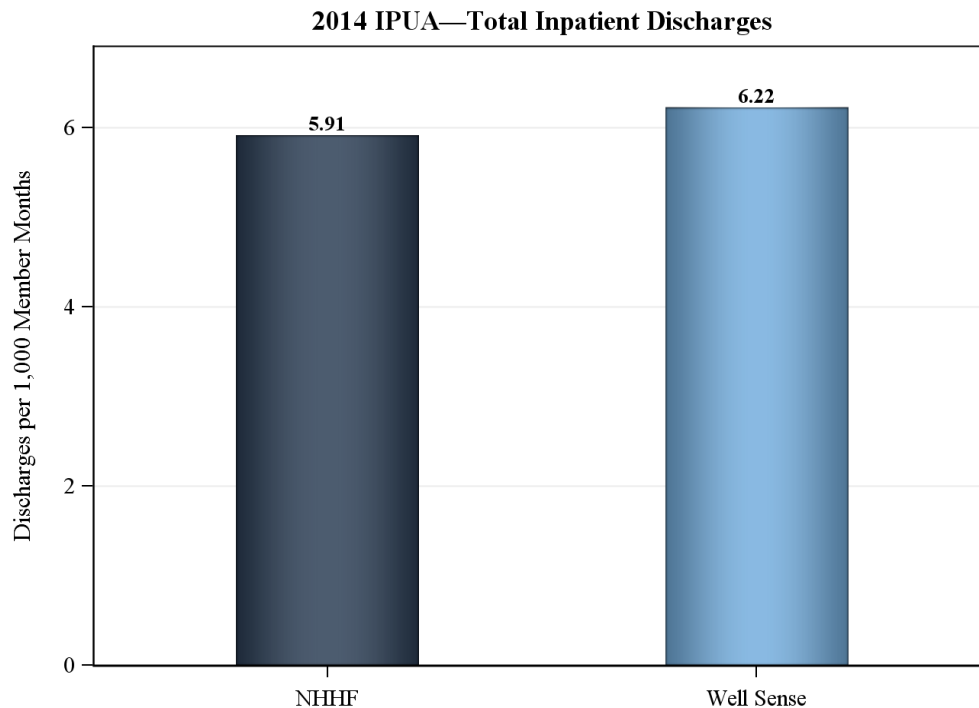
2014 IPUA—Total Inpatient Discharges

NHHF: 5.91
Well Sense: 6.22

Y-axis: Discharges per 1,000 Member Months

NOTE: These rates are presented for information purposes only. Therefore, HEDIS benchmarks are not included.

Rates for this measure were similar between **NHHF** and **Well Sense**.

[4-16] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Inpatient Utilization (IPUA)—General Hospital/Acute Care—Total Inpatient Days

IPUA—General Hospital/Acute Care—Total Inpatient Days measures the days associated with the in-patient utilization (IPU)—General Hospital/Acute Care—Total Inpatient Discharges during 2014, reported as a rate per 1,000 member months during 2014. **NHHF**'s and **Well Sense**'s *IPUA—General Hospital/Acute Care—Total Inpatient Days* measure results are shown in Figure 4-41.[4-17]

Figure 4-41—2014 *IPUA General Hospital/Acute Care—Total Inpatient Days* Measure Results
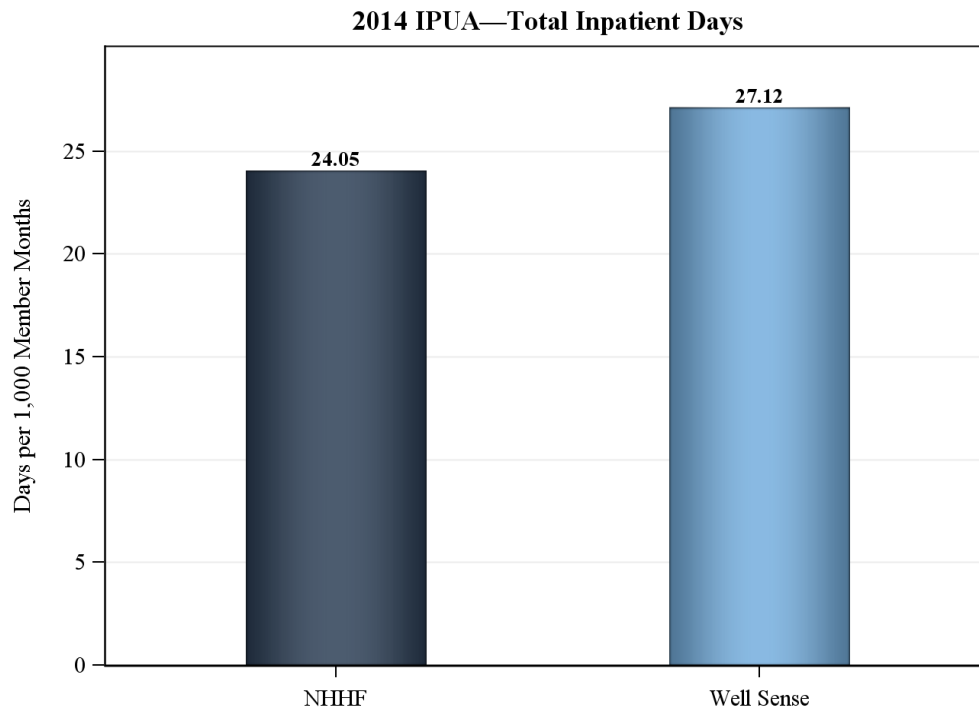
2014 IPUA—Total Inpatient Days

NOTE: These rates are presented for information purposes only. Therefore, HEDIS benchmarks are not included.

Rates for this measure were similar between **NHHF** and **Well Sense**.

[4-17] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Inpatient Utilization (IPUA)—General Hospital/Acute Care—Total Inpatient—Average Length of Stay

IPUA—General Hospital/Acute Care—Total Inpatient—Average Length of Stay measures the average length of stay for all acute inpatient stays with a discharge during 2014. **NHHF**'s and **Well Sense**'s *IPUA—General Hospital/Acute Care—Total Inpatient—Average Length of Stay* measure results are shown in Figure 4-42.[4-18]

Figure 4-42—2014 *IPUA—General Hospital/Acute Care—Total Inpatient—Average Length of Stay* Measure Results

2014 IPUA—Total Inpatient Average Length of Stay
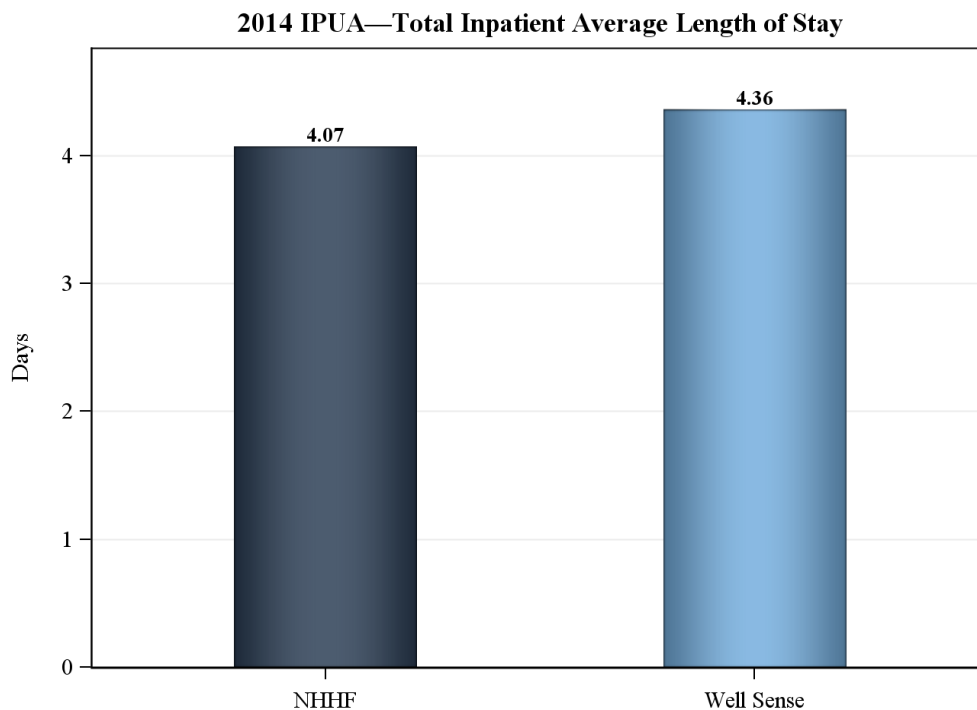
NOTE: These rates are presented for information purposes only. Therefore, HEDIS benchmarks are not included.

The total inpatient average length of stay was similar between **NHHF** and **Well Sense**.

[4-18] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Antibiotic Utilization (ABXA)—Percentage of Antibiotics of Concern for All Antibiotics Prescriptions

ABXA—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions measures the percentage of prescriptions for antibiotics of concern compared to the total prescriptions for antibiotics during 2014. **NHHF**'s and **Well Sense**'s *ABXA—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions* measure results are shown in Figure 4-43.[4-19] Note that for this measure, a lower rate indicates better performance.

Figure 4-43—2014 *ABXA—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions* Measure Results

2014 ABXA—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions

NOTE: A lower rate indicates a better performance for this measure.
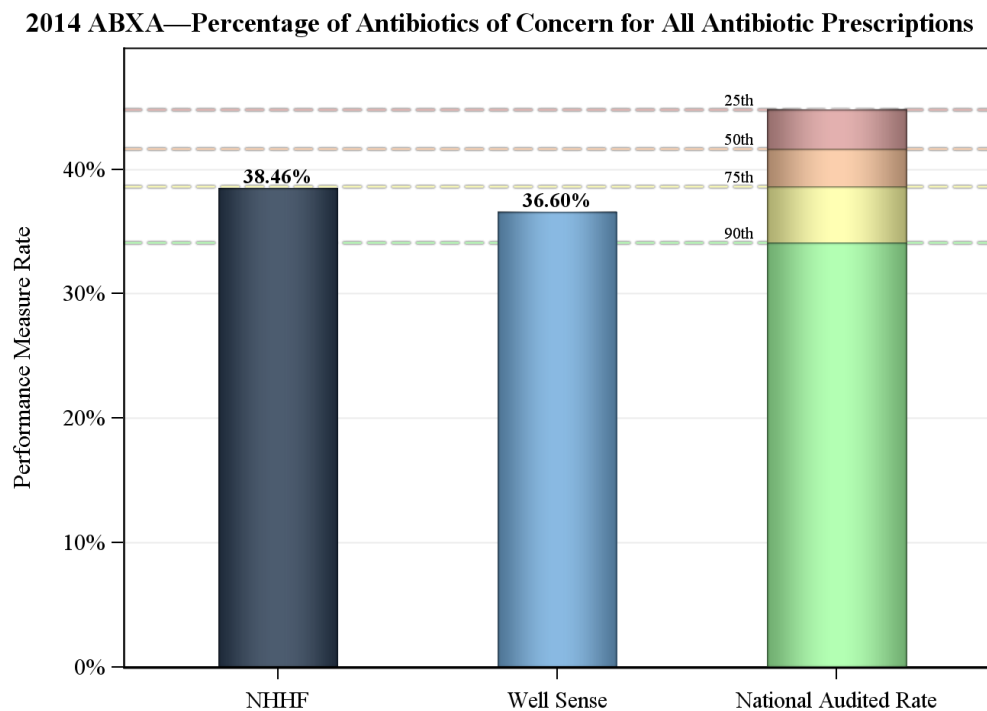
Both plans' reported rates were between the 75th and 90th percentiles.

[4-19] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Behavioral Health

Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up

FUH—7-Day Follow-Up measures the percentage of members 6 years of age and older who were hospitalized for treatment of mental illness, and who had an appropriate follow-up visit within 7 days of discharge during 2014. **NHHF**'s and **Well Sense**'s *FUH—7-Day Follow-Up* measure results are shown in Figure 4-44.

Figure 4-44—2014 *FUH—7-Day Follow-Up* Measure Results
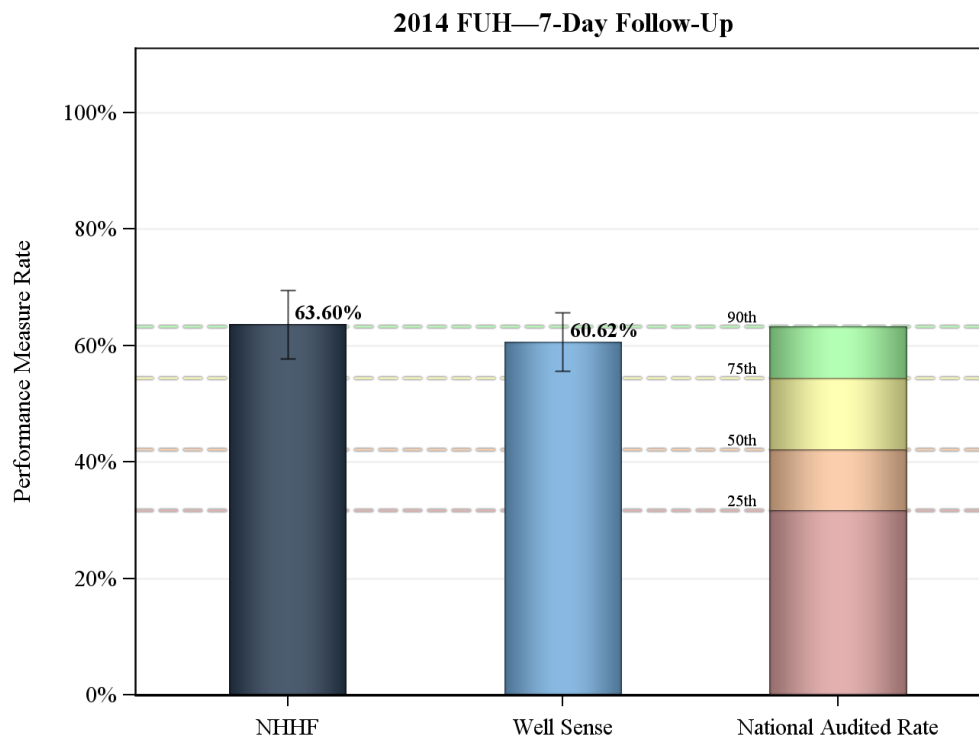
NHHF's reported rate was above the 90th percentile, and **Well Sense**'s reported rate was between the 75th and 90th percentiles.

Follow-Up After Hospitalization for Mental Illness (FUH)—30-Day Follow-Up

FUH—30-Day Follow-Up measures the percentage of members 6 years of age and older who were hospitalized for treatment of mental illness, and who had an appropriate follow-up visit within 30 days of discharge during 2014. **NHHF**'s and **Well Sense**'s *FUH—30-Day Follow-Up* measure results are shown in Figure 4-45.

Figure 4-45—2014 *FUH—30-Day Follow-Up* Measure Results
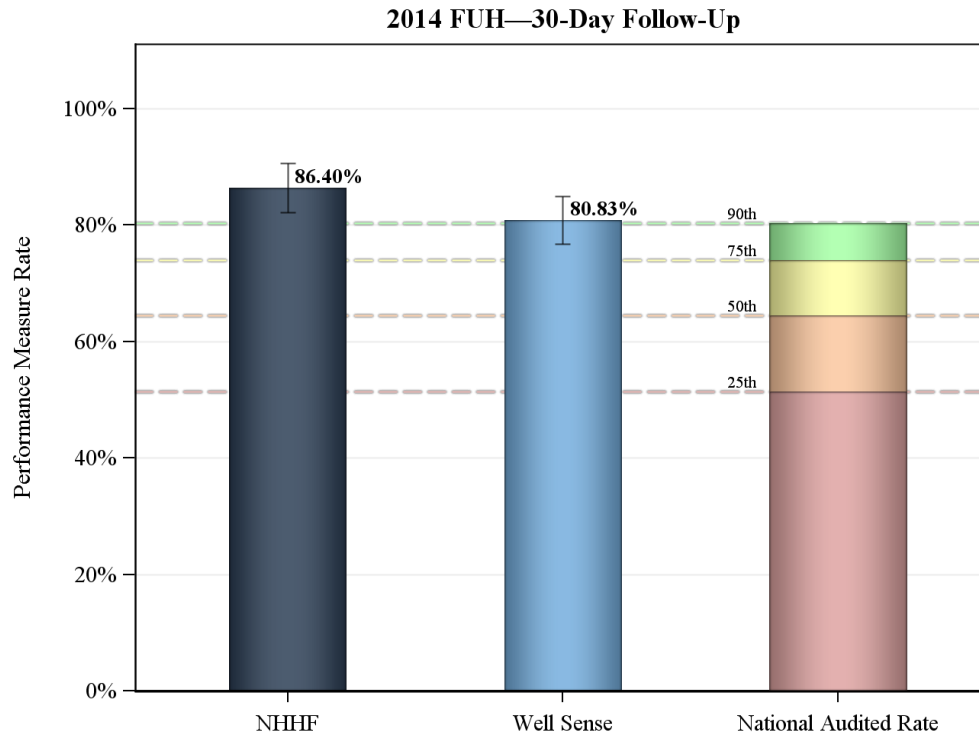
Both plans' reported rates were above the 90th percentile.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)

SSD measures the percentage of members 18–64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during 2014. **NHHF**'s and **Well Sense**'s *SSD* measure results are shown in Figure 4-46.

Figure 4-46—2014 *SSD* Measure Results
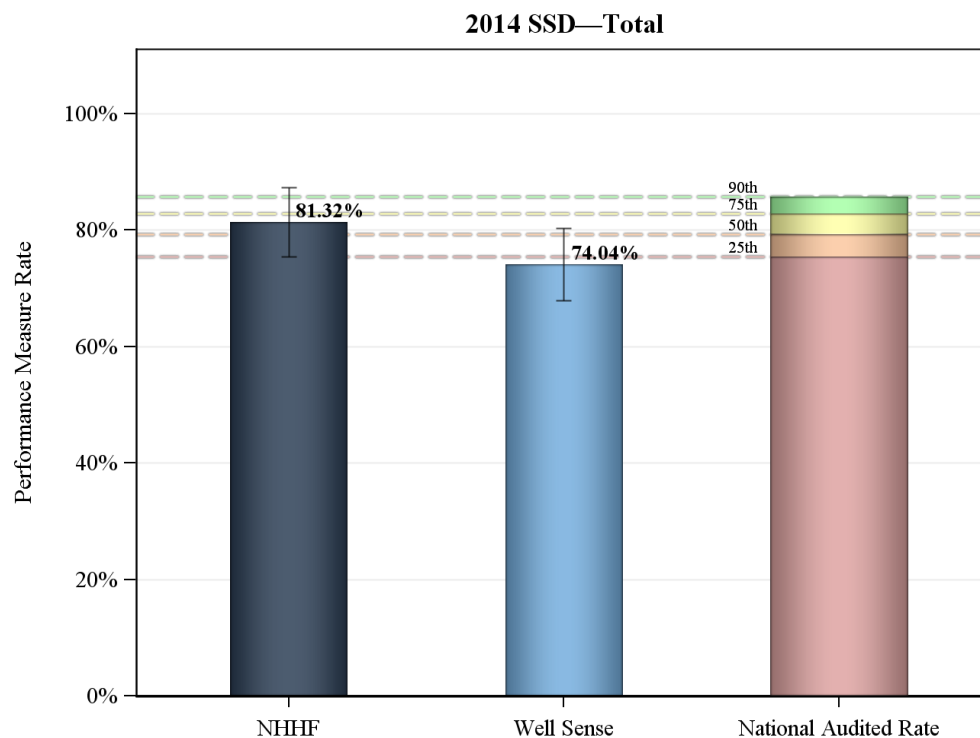
NHHF's reported rate was between the 50th and 75th percentiles, and **Well Sense**'s reported rate was below the 25th percentile.

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

SMD measures the percentage of members 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during 2014. **NHHF**'s and **Well Sense**'s *SMD* measure results are shown in Figure 4-47.

Figure 4-47—2014 *SMD* Measure Results

2014 SMD—Total
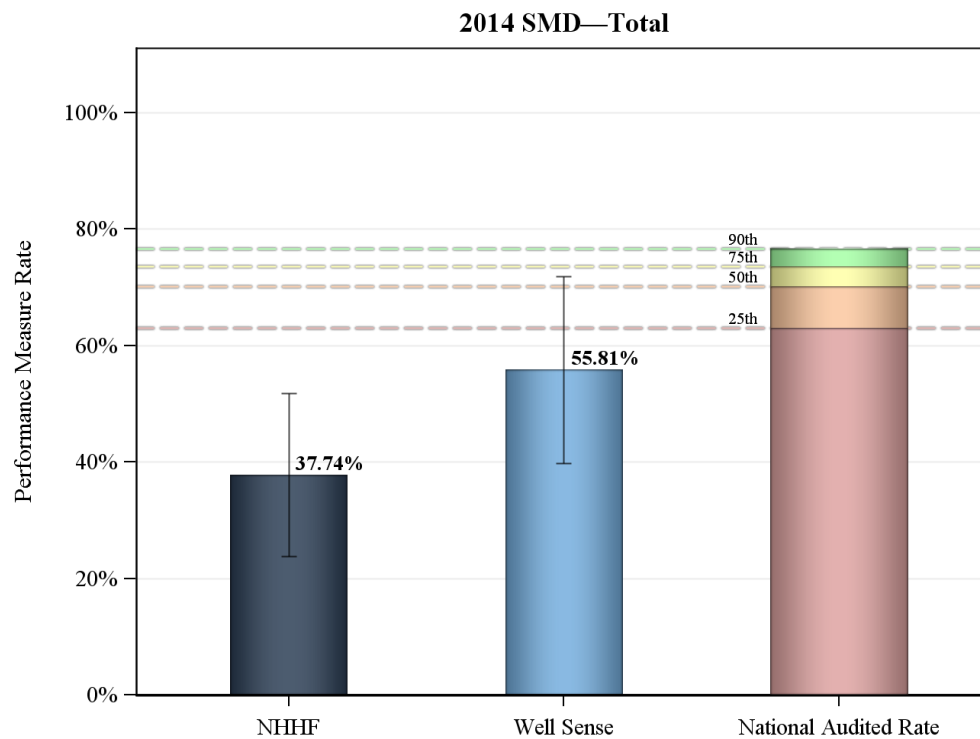
Well Sense scored approximately 18 percentage points higher on this measure than **NHHF**; however, both plans' reported rates were below the 25th percentile.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

SAA measures the percentage of members 19–64 years of age with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period during 2014. **NHHF**'s and **Well Sense**'s *SAA* measure results are shown in Figure 4-48.

Figure 4-48—2014 *SAA* Measure Results
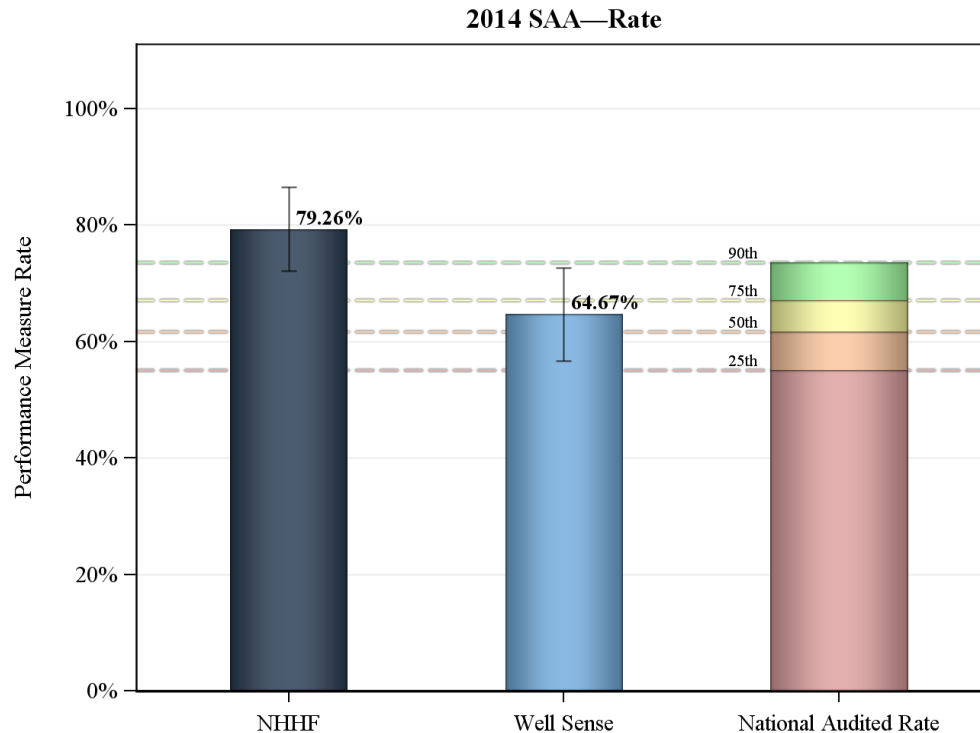
NHHF scored approximately 14 percentage points higher on this measure than **Well Sense**. **NHHF**'s reported rate was above the 90th percentile, and **Well Sense**'s reported rate was between the 50th and 75th percentiles.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Total

APM—Total measures the percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing during 2014. **NHHF**'s and **Well Sense**'s *APM—Total* measure results are shown in Figure 4-49. Note: 2014 represents the first time this measure was collected; therefore, no benchmarks are available.

Figure 4-49—2014 *APM* Measure Results

2014 APM—Total

NOTE: HEDIS Benchmarks are not available for this measure.
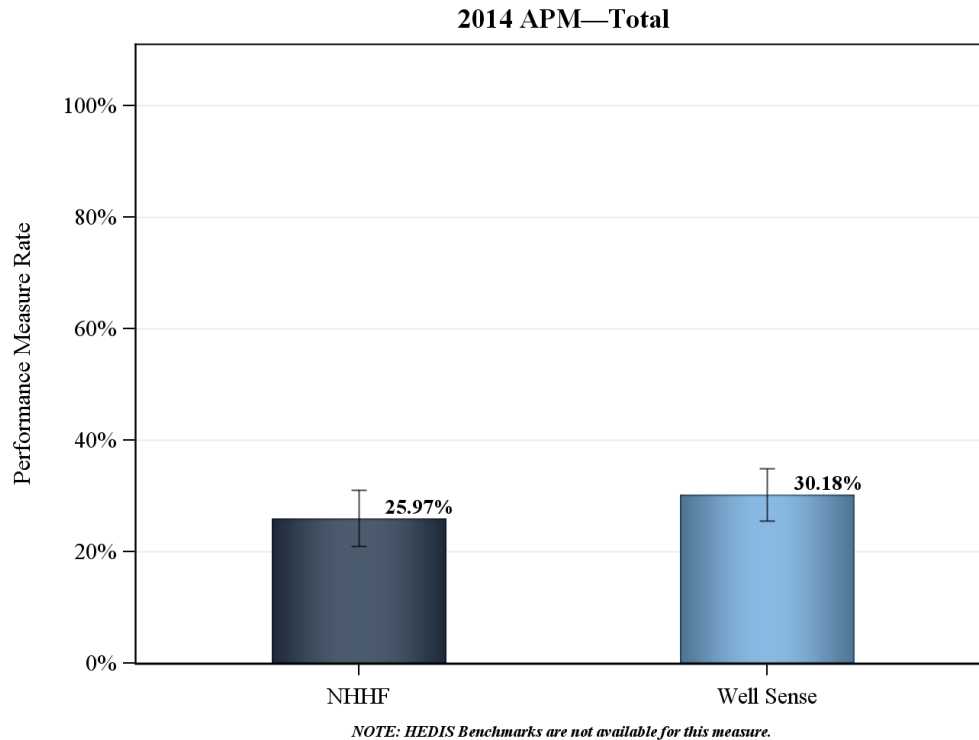
Rates for this measure were similar between **NHHF** and **Well Sense**.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total

APP—Total measures the percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment during 2014. **NHHF**'s and **Well Sense**'s *APP—Total* measure results are shown in Figure 4-50. Note: 2014 represents the first time this measure was collected; therefore, no benchmarks are available.

Figure 4-50—2014 *APP—Total* Measure Results

2014 APP—Total

NOTE: HEDIS Benchmarks are not available for this measure.
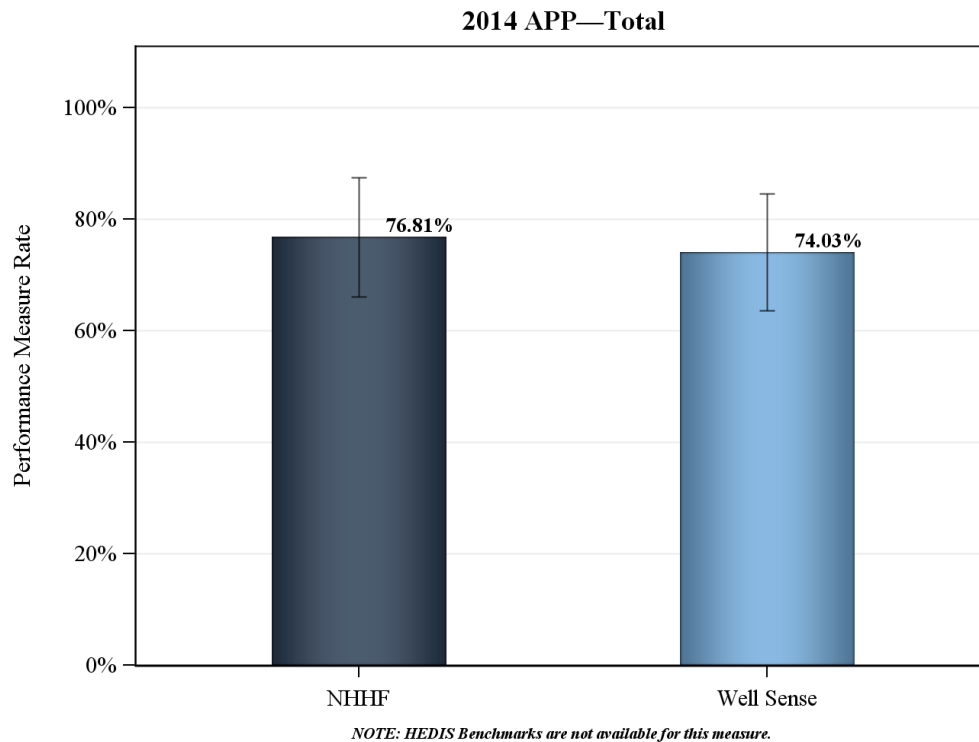
Rates for this measure were similar between **NHHF** and **Well Sense**.

Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment (IET)—Initiation of AOD Treatment

IET—Initiation of AOD Treatment measures the percentage of adolescent and adult members with a new episode of alcohol or other drug dependence who received initiation of appropriate AOD treatment during 2014. **NHHF**'s and **Well Sense**'s *IET—Initiation of AOD Treatment* measure results are shown in Figure 4-51.

Figure 4-51—2014 *IET—Initiation of AOD Treatment* Measure Results
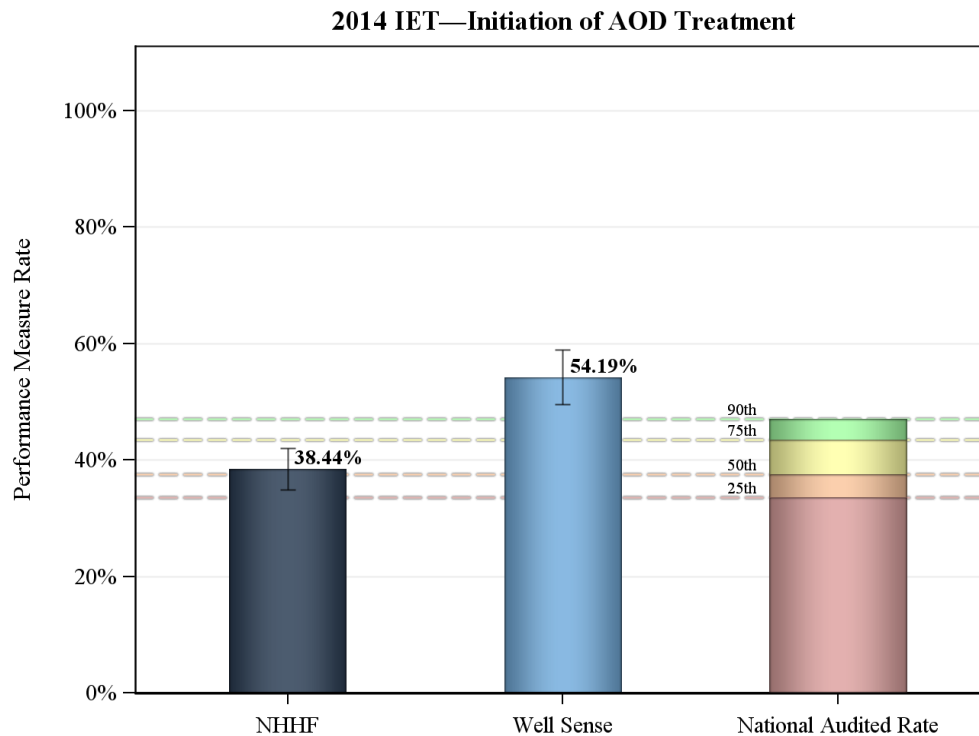
2014 IET—Initiation of AOD Treatment

Well Sense scored almost 16 percentage points higher on this measure than **NHHF**. Of note, **NHHF**'s reported rate was between the 50th and 75th percentiles, and **Well Sense**'s reported rate was above the 90th percentile.

Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment (IET)—Engagement of AOD Treatment

IET—Engagement of AOD Treatment measures the percentage of adolescent and adult members with a new episode of alcohol or other drug dependence who initiated dependency treatment and who had two or more additional services related to the diagnosis within 30 days during 2014. **NHHF**'s and **Well Sense**'s *IET—Engagement of AOD Treatment* measure results are shown in Figure 4-52.

Figure 4-52—2014 *IET—Engagement of AOD Treatment* Measure Results
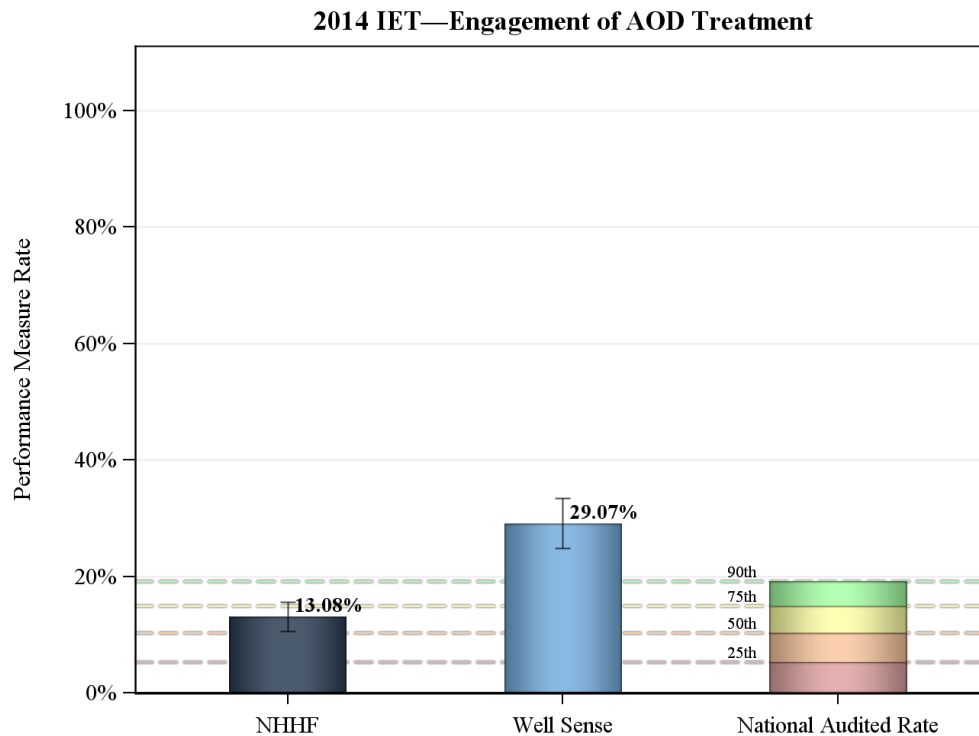
As with the previous measure, **Well Sense** scored almost 16 percentage points higher on this measure than **NHHF**. Of note, **NHHF**'s reported rate was between the 50th and 75th percentiles, and **Well Sense**'s reported rate was above the 90th percentile.

Identification of Alcohol and Other Drug Services (IADA)—Any Service

IADA—Any Service measures the percentage of members with an alcohol or other drug claim who received any chemical dependency services during 2014. **NHHF**'s and **Well Sense**'s *IADA—Any Service* measure results are shown in Figure 4-53.[4-20]

Figure 4-53—2014 *IADA—Any Service* Measure Results
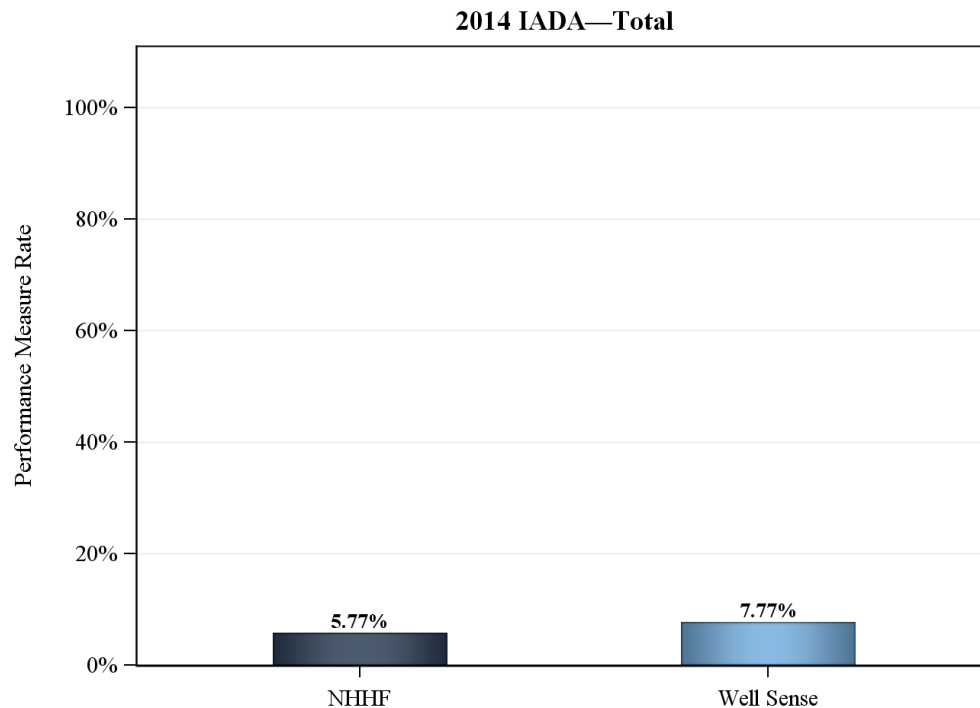
2014 IADA—Total

NOTE: *These rates are presented for information purposes only. Therefore, HEDIS benchmarks are not included.*

Rates for this measure were similar between **NHHF** and **Well Sense**.

[4-20] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Mental Health Utilization (MPTA)—Any Service

MPTA—Any Service measures the number and percentage of members receiving any mental health services during 2014. **NHHF**'s and **Well Sense**'s *MPTA—Any Service* measure results are shown in Figure 4-54.[4-21]

Figure 4-54—2014 *MPTA—Any Service* Measure Results
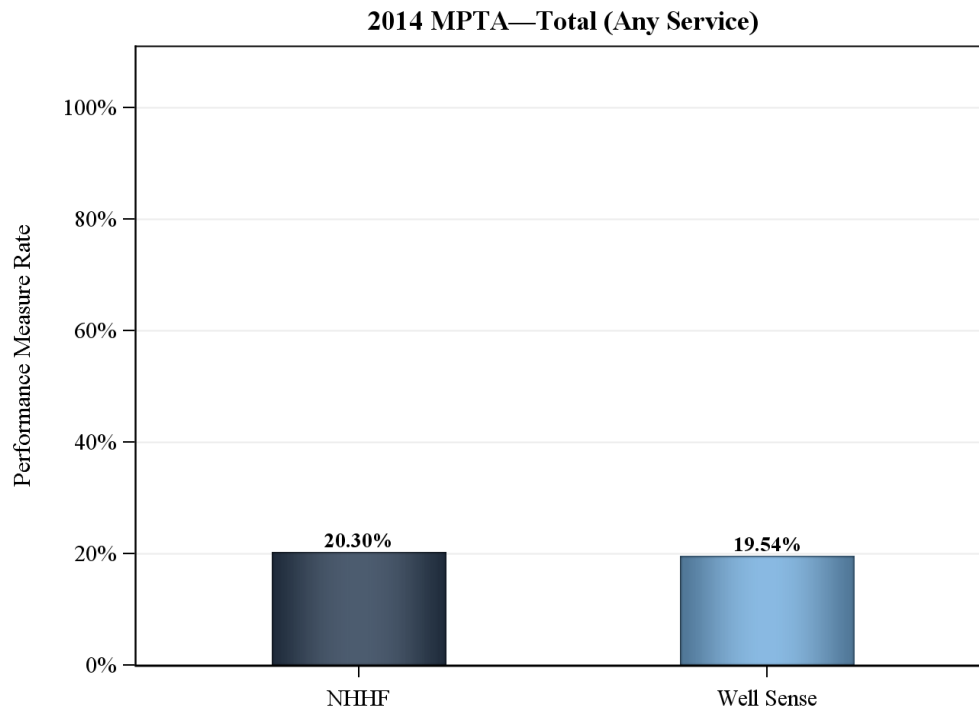
2014 MPTA—Total (Any Service)

NOTE: These rates are presented for information purposes only. Therefore, HEDIS benchmarks are not included.

Rates for this measure were similar between **NHHF** and **Well Sense**.

[4-21] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Conclusions and Recommendations

NHHF

Based on the review of the final audit reports, IS compliance tools, and the IDSS files approved by an NCQA-LO, the following recommendations were identified:

◆ Due to occasional challenges with version control for measures not generated via certified source code, it was recommended that **NHHF** adopt a review process ensuring that all manually entered rates are correct and use most recent and updated versions of code.

◆ A concern was noted with regard to duplicate IDs and delays in process regarding identification for hybrid numerator hits for the final medical record review validation. **NHHF** was recommended to reassess the process with the objective of assigning unique chart IDs which are clearly linked to the provided documentation.

◆ The *Controlling High Blood Pressure (CBP)* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* measures failed the first round of the medical record review validation process, and a second sample was required. It was recommended that **NHHF** improve its vendor oversight and over-read processes for HEDIS 2016.

Based on the MCO's performance measure results, **NHHF** scored at or above the NCQA national Medicaid HEDIS 2014 75th percentile for the following measures. An asterisk (*) indicates measures that met or exceeded the 90th percentile of performance.

Prevention

◆ *AAP—Adults' Access to Preventive/Ambulatory Health Services—Total**

◆ *CAP—Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*

◆ *W34—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

◆ *AWC—Adolescent Well-Care Visits*

◆ *WCC—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition*

◆ *WCC—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity*

◆ *NCS—Non-recommended Cervical Cancer Screening in Adolescent Females**

◆ *PPC—Prenatal and Postpartum Care—Timeliness of Prenatal Care*

◆ *PPC—Prenatal and Postpartum Care—Postpartum Care*

Acute and Chronic Care

◆ *CWP—Appropriate Testing for Children with Pharyngitis**

◆ *URI—Appropriate Treatment for Children with Upper Respiratory Infection*

- *CDC—Comprehensive Diabetes Care—HbA1c Testing*
- *CBP—Controlling High Blood Pressure*
- *ABXA—Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotics Prescriptions*

Behavioral Health

- *FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up**
- *FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up**
- *SAA—Adherence to Antipsychotic Medications for Individuals with Schizophrenia**

NHHF scored below the 25th percentile for the following measures and should focus future quality improvement activities in these areas:

Prevention

- *CHL—Chlamydia Screening in Women—Total*

Acute and Chronic Care

- *PCE—Pharmacotherapy Management of COPD Exacerbation—Dispensed a Systemic Corticosteroid*
- *PCE—Pharmacotherapy Management of COPD Exacerbation—Dispensed a Bronchodilator*

Behavioral Health

- *SMD—Diabetes Monitoring for People with Diabetes and Schizophrenia*

Well Sense

Based on the review of the final audit reports, IS compliance tools, and the IDSS files approved by an NCQA-LO the following recommendations were identified:

- **Well Sense** may have dual eligible members in the New Hampshire Medicaid product. Based on this finding, it was recommended that dual eligible members be identified and excluded from the New Hampshire Medicaid HEDIS reporting.
- The accuracy level for a sample of clinician encounter forms was below 95 percent, and it was recommended that **Well Sense** increase standardization of data collection and increase rigor of quality assurance processes to improve accuracy to a minimum threshold of 95 percent.

Based on the MCO's performance measure results, **Well Sense** scored at or above the NCQA national Medicaid HEDIS 2014 75th percentile for the following measures. An asterisk (*) indicates measures that met or exceeded the 90th percentile of performance.

Prevention

◆ *W34—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

◆ *AWC—Adolescent Well-Care Visits*

◆ *WCC—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile*

◆ *WCC—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition*

◆ *WCC—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity*

◆ *CIS—Childhood Immunization Status—Combination 2*

◆ *NCS—Non-recommended Cervical Cancer Screening in Adolescent Females**

◆ *PPC—Prenatal and Postpartum Care—Timeliness of Prenatal Care*

◆ *PPC—Prenatal and Postpartum Care—Postpartum Care*

◆ *FPC—Frequency of Ongoing Prenatal Care—≥ 81 Percent of Expected Visits*

Acute and Chronic Care

◆ *CWP—Appropriate Testing for Children with Pharyngitis**

◆ *URI—Appropriate Treatment for Children with Upper Respiratory Infection*

◆ *CDC—Comprehensive Diabetes Care—HbA1c Testing**

◆ *CDC—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**

◆ *CDC—Comprehensive Diabetes Care—HbA1c Control (<8.0%)*

◆ *CBP—Controlling High Blood Pressure**

◆ *ABXA—Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotics Prescriptions*

Behavioral Health

◆ *FUH—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*

◆ *FUH—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up **

◆ *IET—Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment—Initiation of AOD Treatment**

◆ *IET—Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment—Engagement in AOD Treatment**

Well Sense scored below the 25th percentile for the following measures and should focus future quality improvement activities in these areas:

Prevention

◆ *CAP—Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*

◆ *CAP—Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*

◆ *CCS—Cervical Cancer Screening*

◆ *CHL—Chlamydia Screening in Women*

Acute and Chronic Care

◆ *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid*

◆ *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*

Behavioral Health

◆ *SSD—Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*

◆ *SMD—Diabetes Monitoring for People with Diabetes and Schizophrenia*

Other EQR Activities

Focus Groups

During SFY 2014–2015, Horn Research conducted two focus groups covering the same topic in the fall of 2014 and two focus groups covering the same topic in the spring of 2015. DHHS chose the topics for the focus groups and assisted Horn Research in developing the questions for the sessions with the MCO members.

Fall Focus Groups

The fall focus groups included four key points of inquiry: Experience With Medicaid Care Management, Access to Care, Information Needs, and Improvements to MCO and Medicaid. Horn Research conducted the fall stakeholder interviews in Keene, New Hampshire, and Rochester, New Hampshire. The sampled population participated in the study by attending focus groups or responding to telephone interviews. A total of 20 people participated in the study: eight from Keene and 12 from Rochester.

The results of the fall focus groups are shown below:

Experience With Medicaid Care Management
Participants shared generally positive experiences about their MCO. They expressed appreciation for the coverage and reported that it was easy to use. The main challenges faced

by participants included confusion over what is and is not covered by their MCO and a desire for expanded benefits. While a number of participants noted they had trouble understanding their MCO and benefits, nearly all said they knew where to find the information they needed. Participants also said they had limited, but generally positive experiences with member services. Experience with the grievance and appeals procedure was almost nonexistent.

Access to Care
Overall, participants' responses revealed generally positive experiences with the pre-authorization process. Participants who noted challenges with pre-authorization remarked exclusively on the time span required to receive approval for medications and services, not on denial of authorization. Participants were satisfied with the process for referrals for ancillary services such as laboratory and imaging services. The vast majority of participants did not report problems in accessing medications, but some suggested that having to use specialty pharmacies rather than their regular pharmacy was challenging. Participants said they rarely used emergency room services and only did so when it was medically necessary.

Information Needs
Participants most often mentioned wanting clear and concise information concerning their MCO's benefits and coverage, and updated provider listings. In addition, participants noted an interest in alternative therapies and wellness education including any special promotions that might be available to improve their health.

Improvements to MCO and Medicaid
Participants suggested that providing access to alternative therapies and wellness opportunities would be a welcomed improvement from their MCO. Others suggested quicker turnaround on pre-authorization. Participants also reiterated wanting clear and concise information on their benefits and coverage. Participants wanted Medicaid to improve dental coverage and provide more information for the public about the availability and stability of the program since one MCO exited the market.

Opportunities for Improvement and Recommendations

Horn Research provided the following recommendations from the information gathered during the fall focus groups:

- While there was a marked improvement in participants' understanding of their benefits and ability to access support from member services, participants continue to request a clear and concise overview of MCO benefits provided in easy-to-understand language.

- Participants expressed confusion and concern over several aspects of the MCM program including whether pre-authorization is required for emergency room care, the use of specialty pharmacies, and the stability of the program after the withdrawal of one of the MCOs. Proactive communication from the MCOs and Medicaid explaining these and any future changes may improve participants' understanding and reduce anxieties.

- Half of the focus group participants indicated that they had not heard of the grievance and appeals process available through their MCO. Improved communication to ensure

that participants are aware of the process and how to use it may improve their overall health care experience.

◆ While far fewer participants reported problems with the pre-authorization process than in Year 1, a notable number expressed challenges with the turnaround time to receive approval for their medications. Continued efforts to improve this process will ensure that participants are receiving needed medications in a timely manner.

◆ Participants reported a desire to receive more support and information to improve their health through opportunities to eat healthier, exercise, and explore non-pharmaceutical alternative therapies. These options follow current trends in maintaining health and wellbeing.

◆ Participants continued to advocate for expanding preventive health benefits to include preventive dental care for adults to reduce long-term health costs.

Spring Focus Groups

The spring focus groups focused on recruiting individuals from the NHHPP, the Affordable Care Act's Medicaid expansion program in New Hampshire. The interviews included five key points of inquiry: Access to and Quality of Care Prior to Enrollment With MCO, Access to and Quality of Care Since Enrollment With MCO, Impact of Enrollment, Experience With MCO, and Improvements to MCO and Medicaid. Horn Research conducted the spring stakeholder interviews in Manchester, New Hampshire, and Nashua, New Hampshire. The sampled population participated in the study by attending focus groups or responding to telephone interviews. A total of 18 people participated in the study: nine from Manchester and nine from Nashua.

The results of the spring focus groups are shown below:

Access to and Quality of Care Prior to Enrollment With MCO
The majority of participants reported a lack of insurance coverage prior to enrollment and very limited access to health care as a result. Most participants chose to refrain from accessing health care and utilizing emergency rooms and charitable care. Several participants said they had acquired debt due to the lack of insurance coverage.

Access to and Quality of Care Since Enrolling in MCO
Participants generally agreed that there was a significant improvement in their access to care which has resulted in more consistent care for their chronic illnesses and health care needs. Participants also shared that they were able, for the most part, to keep their primary care physicians and were satisfied with the quality of care they were receiving.

Impact of Enrollment
About half of the participants said their health had improved since joining the MCO. In particular, participants noted that having access to needed medications and monitoring for chronic health conditions such as high blood pressure and asthma was improving their health. Several participants noted that their quality of life had improved simply by having the peace of mind insurance coverage brought them. Some participants said they had not used the coverage yet but felt more comfortable knowing it was there in case of emergency.

Experience With MCO

All participants described positive experiences with their MCOs and reported very few problems. Participants said the customer service at their MCO was helpful and readily available, and that the provider network was diverse. Overall, participants said they had not experienced any difficulties with their MCO other than minor challenges with the initial enrollment paperwork and getting their MCOs to cover doctors' visits. These issues, however, have been resolved. Participants also shared that they wished their MCO had expanded coverage for dental and vision care.

Improvements to MCO and Medicaid

Generally, participants said they did not want to receive any additional information from their MCO. A few participants said they would like more information on their benefits and coverage, providers, and alternative resources for health care. About half of the participants said they were satisfied with their experience with their MCO and Medicaid and did not have any suggestions for improvements.

Opportunities for Improvement and Recommendations

Horn Research provided the following recommendations from the information gathered during the spring focus groups:

◆ The most frequently suggested improvement was the expansion of benefits available through the participants' MCO. Participants advocated for increased access to dental care, prescriptions, vision care, and chiropractic care as well as increasing the number of mental health providers in the MCO network.

◆ Participants noted concerns about not knowing whether their enrollment will continue and the specifics of the eligibility guidelines. They were concerned that they would lose coverage and were unsure how they would pay for the federally mandated coverage. Participants would like more information on how to continue to receive coverage while also maintaining employment.

◆ While many participants reported a seamless experience with enrollment, some participants suggested that an improvement would be streamlining the process to eliminate some of the paperwork and providing more information concerning benefits prior to enrollment. One participant suggested improving the communication between providers and MCOs/Medicaid to ensure prior authorization is promptly received for needed services.

◆ Two participants in this round of focus groups noted a difference in how providers responded to their MCO versus their previous insurance companies. They suggested continued outreach and communication with providers by the MCO to reduce the feeling of stigma experienced by participants.

EDV

Overview

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, DHHS requires its contracted MCOs to submit high-quality encounter data. For the contract year 2014–2015, DHHS contracted HSAG to develop an Encounter Data Quality Reporting System (EDQRS) for evaluating the quality encounter data files submitted by the MCOs. The EDQRS will be designed to import, store, and review incoming encounter data and generate automated, weekly validation reports for DHHS.

Methodology

HSAG will use the same files and general process as DHHS's fiscal agent, Xerox, the EDV activity will focus on providing the State with an assessment of the overall quality of encounter data being submitted by its contracted MCOs. Once in production, each participating MCO, on a daily or weekly basis, will prepare and translate claims and encounter data into 837 Professional (P)/Institutional (I) and National Council for Prescription Drug Program (NCPDP) pharmacy files. Once ready, the files will be simultaneously transmitted via secure file transfer protocol (FTP) to DHHS (and Xerox) and HSAG where the files will be downloaded and processed. During the initial processing, the MCOs' 837 P/I files will be processed through an Electronic Data Interchange (EDI) translator by both vendors; however, the application and function of compliance edits implemented by Xerox and HSAG will be slightly different. HSAG's process will include a subset of edits designed to capture (1) an MCO's overall compliance with submission requirements (e.g., filename conventions) and (2) key encounter data quality elements (e.g., data field compliance and completeness). Additionally, while failure to pass certain edits during Xerox's processing may lead to rejection and resubmission of files/records by the MCOs, HSAG's edit processing will be used for reporting purposes only.

Once the 837 professional and institutional (P/I) files are successfully translated by HSAG, the files will be loaded into HSAG's data warehouse. Each respective system will then run a secondary set of edits. These edits will be used for reporting purposes only and are designed to identify potential issues related to encounter data quality. All HSAG edits will be customized to address DHHS's overall project goals. Additionally, the MCOs' NCPDP files will be processed simultaneously through a comparable process; however, the NCPDP files will not undergo EDI translation. Instead, the NCPDP files will be processed directly into HSAG's data warehouse.

In order to monitor and evaluate the overall quality (i.e., completeness, accuracy, and timeliness) of New Hampshire's Medicaid managed care encounter data, HSAG will develop and implement an EDQRS designed to evaluate both the completeness and accuracy of the MCOs' encounter data submissions as well as the general quality of professional, institutional, and pharmacy encounters. This system includes the automated processing of weekly encounter data submissions (i.e., 837 P/I and NCPDP file formats), the application of EDI process and encounter data system quality edits, and the reporting of key indicators.

At the end of SFY 2014–2015, HSAG had begun testing its implementation of an EDI translator to calibrate the translation of New Hampshire's health plan encounter data. Once testing and implementation of the EDI translator is completed, HSAG will initiate programming of EDV-specific submission and quality edits along with development of the EDQRS reporting template. The results from the SFY 2015–2016 encounter data validation activities will be included in the New Hampshire EQR Technical Report for SFY 2015–2016. In order to successfully complete this project, HSAG will collaborate with key DHHS staff and vendors to address the reporting of encounter data quality.

Access Reporting: Secret Shopper Analysis

Overview

HSAG conducted a provider survey to monitor NHHPP and standard Medicaid members' access to health care services. Since the NHHPP fee schedule included a different payment schedule for physician services from the payment schedule for the standard MCM program, DHHS was interested in determining whether appointment accessibility is different based on the member's enrolled program. In order to evaluate whether differences in appointment availability exist, HSAG designed and conducted a secret shopper provider survey to compare the average length of time to the first available appointment for new members enrolled in the NHHPP and MCM program.

Methodology

At the end of SFY 2014–2015, HSAG developed a methodology for conducting a secret shopper telephone survey of provider offices statewide to evaluate the average length of time it takes for a Medicaid member to schedule and be seen by a New Hampshire-licensed provider. A secret shopper is a person employed to pose as a client or patient in order to evaluate the quality of customer service or the validity of information (e.g., accurate prices or location information). The secret shopper telephone survey allows for objective data collection from health care providers without potential bias introduced by knowing the identity of the surveyor. HSAG prepared New Hampshire's Medicaid provider file and conducted a preliminary file review. Next, HSAG selected a sample of providers and loaded the sample into a data collection tool to prepare for the survey.

Eligible Population

The eligible population will include PCPs who were actively enrolled in the New Hampshire Medicaid program as of May 28, 2015. PCPs will be defined as physicians whose primary specialty is as follows: family practice, general practice, internal medicine, or advanced registered nurse practitioners.[4-22]

[4-22] Specific criteria used to identify PCPs are as follows: PROVSPEC in ("001", "008", "011", "080") and PRVDR_LISTED_AS_PCP_IN_DIR_IND = "Y" and PRVDR_CLOSED_BY_MCO_DT = "12/31/9999" and PROVTYPE in ("020", "021", "022", "023", "033", "034"). In addition, PCP-type physicians and advanced registered nurse practitioners who practice in nonoffice settings (e.g., hospital-based providers, school-based providers, urgent care) will be excluded, as well as pediatricians since the NHHPP is primarily a program for adults.

Data Collection

As of the end of SFY 2014–2015, HSAG had obtained Medicaid provider information (including practice location and specialty) from DHHS for all providers enrolled as of May 28, 2015, in one of the two MCOs.[4-23] Upon receipt of the data, HSAG defined a subgroup of active, office-based PCPs based on provider specialty, status as a PCP, and provider type. HSAG began to clean, process, and standardize physician addresses using Quest Analytics software, and was in the process of performing an initial review of the provider distributions to determine the percentage of providers that overlap across the two MCOs and ensure the reasonableness of the approved sampling methodology. Any modifications required to the sampling protocol will be discussed with DHHS prior to implementation of the study in SFY 2015–2016.

Appointment Availability Analysis

PCPs with phone numbers and who are associated with both MCOs and programs (i.e., NHHPP and MCM program) will be included in the secret shopper telephone survey. HSAG will use a two-stage random sampling approach to generate the list of sampled provider locations. The sampled providers will be surveyed by telephone, and the information collected will be used to evaluate the availability of appointments and determine whether appointment availability varies based on Medicaid program and type of appointments:

- Preventive (e.g., annual check-up)
- Routine/Episodic (e.g., sore throat with congested nose)

Specifically, HSAG will determine whether appointment availability meets the performance standards established in the MCOs' Amendment #5, Sections 19.3.4.2.3 and 19.3.4.2.4 of the MCM Agreement[4-24] between DHHS and the MCOs.[4-25]

Based on the eligible population, HSAG will generate a random sample of PCPs. For each sampled provider associated with two or more locations, HSAG will randomly select one subsequent location. HSAG will select 412 unique providers/ provider locations and randomly assign 50 percent of them to each appointment type to ensure a maximum margin of error of +/- 7.1 percent and 95 percent confidence level at the appointment type level. An additional 25 percent oversample (or 104 cases) will be sampled to account for invalid or incomplete provider contact information for a final sample size of 516 cases. Callers will contact each provider/provider location twice: once as a member of the MCM program and once as a member of the NHHPP.

[4-23] HSAG assumes that the provider network is identical for the NHHPP and MCM program. If different provider networks are maintained, HSAG will collect, clean, and sample providers based on the specific program provider files.

[4-24] State of New Hampshire Department of Health and Human Services. (2014). *Amendment #5 to the Medicaid Care Management Contract.* Available at: http://www.dhhs.nh.gov/ombp/caremgt/contracts.htm. Accessed on: September 21, 2015.

[4-25] The appointment availability standard for preventive visits is 30 days while the standard for routine/episodic visits is 10 days.

Based on the findings from the analysis, HSAG will prepare an aggregate report that includes, at a minimum, a study overview, methodology, findings, and conclusions/recommendations section. Additional charts and graphs may be used to display results pertinent to the analysis. The results from the SFY 2015–2016 encounter data validation activities will be included in the New Hampshire EQR Technical Report for SFY 2015–2016.

Focus Study: Prior Authorizations

During SFY 2014–2015, DHHS requested assistance from HSAG to conduct a focused study to determine the current prior authorization process used by the two MCOs and the New Hampshire FFS system. DHHS and HSAG met to discuss the study and to determine the methodology that would be used to elicit the information needed to assess the prior authorization processes. DHHS and HSAG decided to structure the study with two distinct phases.

Phase I of the study involved contacting Medicaid providers to request feedback concerning their experiences using the three prior authorization systems (i.e., **NHHF**, **Well Sense**, and FFS). Telephone interviews were conducted with 40 providers' offices that served members in both MCOs. Information obtained during the interviews defined the topics that HSAG investigated during the next phase of the study. During Phase II, the areas of concern expressed during the interviews were grouped together to form four key elements of the prior authorization process: prior authorization requests, documentation requirements, determinations, and resolution. HSAG gathered information from policies, procedures, workflow documents, websites, and interviews to determine if the FFS system and the two MCOs were similar or if they differed in the handing of the four key elements of the prior authorization process. From that information, HSAG developed conclusions and worked with DHHS to create suggestions to improve and enhance the procedures for prior authorizations.

Conclusions and Areas for Consideration

After reviewing the information provided for the study, HSAG identified several key areas that DHHS, the MCOs, and FFS vendors should consider as they work to make improvements to the Medicaid prior authorization processes. Those areas for consideration are organized by the key elements of the prior authorization process—request and access, documentation requirements, determinations, and appeals and resolution.

Request and Access

DHHS and the MCOs should consider:

- Determining if additional opportunities to streamline the current prior authorization process exist. One way to streamline would be to offer providers a single location for submitting prior authorizations online in a web-enabled form that allows providers to verify eligibility and track progress of requests.

- Making websites easy to navigate so that providers are able to get to needed information and/or prior authorization forms within "3 clicks."

Documentation Requirements

DHHS and the MCOs should consider:

◆ Gathering provider input into the development and rollout of the standardized template currently being evaluated by DHHS and the MCOs. While a standard prior authorization form template cannot address the clinical detail needed for each medical or pharmacy services request, it could help to gather demographic information consistently and improve the prior authorization process.

◆ Developing a centralized location that includes links to all three payers' prior authorization request submission guidelines, medical policies, clinical criteria, and the standardized prior authorization request form.

Determinations

MCOs should consider:

◆ Reviewing the high proportion of denials to determine if there is a pattern in the type of service denied. Consider using process mapping to illustrate the sequence of actions that comprise the prior authorization process.

◆ Using provider focus groups to obtain insight into what changes should be included in the prior authorization process and the most effective way to communicate those changes to providers.

◆ Determining the level of consistency of medical determinations made by MCO, FFS, and delegated vendor staff. An increase in the interrater reliability threshold from 80 percent to 90 percent may ensure greater consistency among those making prior authorization decisions within the same entity.

◆ Expanding the use of "auto-PA" wherein web-based prior authorization requests are able to query data (typically administrative data) to determine, for example, if a trial of step therapy medication or a required diagnosis is present.

◆ Using a single set of clinical prior authorization criteria and a single prior authorization process across the MCOs and FFS.

Appeals and Resolution

The MCOs should consider:

◆ Allowing prescribers quick and clear access to physicians who are the same specialty as the physician requesting the appeal for peer-to-peer discussions regarding prior authorization decisions.

◆ Determining if a pattern exists in the types of reversed appeals. If there is a pattern, determine if the reversal could be eliminated by clarifying the first-level decision criteria in order to decrease the time and effort expended on the prior authorization process.

◆ Conducting focus groups or interviews with members and providers to determine the reasons for the high numbers of both pharmacy denials (45.0 percent for **NHHF** and 30.9 percent for **Well Sense**) and abandoned appeals (20.5 percent for **NHHF** and 37.8 percent for **Well Sense**) and determine if the number of appeals can be reduced overall.

Commonly Used Abbreviations and Acronyms

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

◆ **AAP**─Adults' Access to Preventive/Ambulatory Health Services

◆ **ABXA**─Antibiotic Utilization

◆ **ACE**─angiotensin converting enzyme

◆ **AHRQ**─Agency for Healthcare Research and Quality

◆ **AMBA**─Ambulatory Care Utilization

◆ **AOD**─Alcohol and Other Drug Dependence

◆ **APM**─Metabolic Monitoring for Children and Adolescents on Antipsychotics

◆ **APRN**—advanced practice registered nurse

◆ **APP**─Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics

◆ **ARB**─angiotensin receptor blocker

◆ **AWC**─Adolescent Well-care Visits

◆ **BBA**─federal Balanced Budget Act of 1997

◆ **BCCP**─Breast and Cervical Cancer Program

◆ **BMI**─Body Mass Index

◆ **CAHPS®**─Consumer Assessment of Healthcare Providers and Systems

◆ **CAP**─Children and Adolescents' Access to Primary Care Practitioners

◆ **CBP**─Controlling High Blood Pressure

◆ **CCC**─Children with Chronic Conditions

◆ **CCS**─Cervical Cancer Screening

◆ **CDC**─Comprehensive Diabetes Care

◆ **CFR**─Code of Federal Regulations

◆ **CHL**–Chlamydia Screening in Women

◆ **CIS**─Childhood Immunization Status

◆ **CMS**─Centers for Medicare & Medicaid Services

◆ **COPD**─Chronic Obstructive Pulmonary Disease

◆ **CY**—calendar year

◆ **CWP**─Appropriate Testing for Children with Pharyngitis

- **DHHS**—State of New Hampshire, Department of Health and Human Services
- **DTaP**—diphtheria, tetanus, and pertussis vaccine
- **ED**—emergency department
- **EDI**—electronic data interchange
- **EDQRS**—Encounter Data Quality Reporting System
- **EDV**—encounter data validation
- **EQR**—external quality review
- **EQRO**—external quality review organization
- **FAR**—final audit report
- **FFS**—fee-for-service
- **FPC**—Frequency of Ongoing Prenatal Care
- **FTP**—file transfer protocol
- **FUH**—Follow-up After Hospitalization for Mental Illness
- **HbA1c**—hemoglobin
- **HEDIS®**—Healthcare Effectiveness Data and Information Set
- **HepA**—hepatitis A vaccine
- **HepB**—hepatitis B vaccine
- **HiB**—Haemophilus influenza type B
- **HPV**—Human Papillomavirus Vaccine for Female Adolescents
- **HSAG**—Health Services Advisory Group, Inc.
- **I**—Institutional
- **IADA**—Identification of Alcohol and Other Drug Services
- **ID**—identification
- **IDSS**—Interactive Data Submission System
- **IET**—Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment
- **IMA**—Immunizations for Adolescents
- **IPU**–In-patient Utilization
- **IPUA**—Inpatient Utilization Measure
- **IPV**—polio vaccine
- **IS**—information system
- **ISCAT**—Information System Capability Assessment Tool
- **LBP**—Use of Imaging Studies for Low Back Pain

- **LO**—National Committee for Quality Assurance-Licensed Organization
- **LTSS-** Long-term care Supports and Services
- **MCM**—Medicaid Care Management
- **MCO**—managed care organization
- **MMIS**—New Hampshire Medicaid Management Information System
- **MMR**—measles, mumps, and rubella vaccine
- **MPM**—Annual Monitoring for Patients on Persistent Medications
- **MPTA**—Mental Health Utilization
- **N**—number
- **NA**—not applicable
- **NB**—no benefit
- **NCPDP**—National Council for Prescription Drug Program
- **NCQA**—National Committee for Quality Assurance
- **NCS**—Non-recommended Cervical Cancer Screening in Adolescent Females
- **n.d.**—no date
- **NHHF**—New Hampshire Healthy Families
- **NHHPP**—New Hampshire Health Protection Program
- **NR**—not reported
- **OB/GYN**—obstetrician/gynecologist
- **OMBP**—Office of Medicaid Business and Policy
- **P**—professional
- **PCE**—Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation
- **PCP**—primary care physician
- **PCV**—pneumococcal conjugate vaccine
- **PIHP**—prepaid inpatient health plans
- **PIP**—performance improvement project
- **PMPY**—per-member-per-year
- **PPC**—Prenatal and Postpartum Care
- **QI**—quality improvement
- **R**—report
- **RFP**—request for proposal
- **RV**—rotavirus

- **SAA**─Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- **SFY**─state fiscal year
- **SMD**─Diabetes Monitoring for People with Diabetes and Schizophrenia
- **SPH**─Symphony Performance Health
- **SSD**─Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication
- **Td**─tetanus diphtheria toxoids vaccine
- **Tdap**─tetanus, diphtheria, and pertussis vaccine
- **URI**─Appropriate Treatment for Children with Upper Respiratory Infection
- **VZV**─varicella (chicken pox) vaccine
- **W34**–Well-Child Visits in the Third, Fourth, firth, and Sixth Years of Life
- **WCC**─Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

MCO Contractual Compliance

According to 42 CFR §438.358, a review to determine an MCO's or a prepaid inpatient health plan's (PIHP's) compliance with state standards must be conducted within a three-year period by a state Medicaid agency, its agent, or an EQRO.[B-1] Based on 42 CFR §438.204(g), the standards evaluated during the compliance reviews must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438—Managed Care, which address requirements related to access to care, structure and operations, and quality measurement and improvement.[B-2] To meet these requirements, DHHS:

- Continued to ensure that its agreement with the MCOs included the applicable CMS Medicaid managed care requirements and that they were at least as stringent as the CMS requirements.

- Contracted with HSAG as its EQRO to conduct reviews to assess the MCOs' performance in complying with the federal Medicaid managed care regulations and DHHS's agreement with **NHHF** and **Well Sense**.

- Maintained its focus on encouraging and supporting the MCOs in targeting areas for continually improving its performance in providing quality, timely, and accessible care to members.

The primary objective of HSAG's compliance review is to provide meaningful information to DHHS and the MCOs that can be used to:

- Evaluate the quality and timeliness of, and access to, care and services the MCOs furnished to members.

- Identify, implement, and monitor interventions to continue to drive performance improvement for these aspects of care and services for the New Hampshire MCM program.

To conduct a compliance review, HSAG assembles a review team to:

- Collaborate with DHHS to determine the scope of the review as well as the scoring methodology; data collection methods; desk review, on-site review activities, and timelines; and on-site review agenda.

[B-1] U. S. Government Printing Office. (n.d.). *External quality review results.* Available at: http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec438-364.pdf. Accessed on: November 20, 2015.
[B-2] U. S. Government Printing Office. (n.d.). Elements of State Quality Strategies. Available at: http://www.ecfr.gov/cgi-bin/text-idx?SID=3cfc63d354dbe8a3474c4a7850b9cf04&mc=true&node=se42.4.438_1204&rgn=div8. Accessed on: November 17, 2015.

◆ Collect data and documents from the MCOs and review the information before and during the on-site review.

◆ Conduct the on-site review.

◆ Aggregate and analyze the data and information collected.

◆ Prepare the report of its findings and any recommendations or suggestions for improvement.

Table B-1 contains the 10-step process HSAG uses to conduct a compliance review.

Table B-1—The Compliance Review Methodology	
Step 1:	**Establish the review schedule.**
	Before the review, HSAG works with DHHS and the MCOs to establish the on-site review schedule and assign HSAG reviewers to the review team.
Step 2:	**Prepare the data collection tool and submit it to DHHS for review and comment.**
	To ensure that all applicable information is collected, HSAG develops a compliance review tool consistent with CMS protocols. HSAG uses the requirements in the Agreement between DHHS and the MCOs to develop the standards (groups of requirements related to broad content areas) to be reviewed. HSAG also uses the federal Medicaid managed care regulations described at 42 CFR §438 version 2 effective September 1, 2012. Additional criteria that are critical in developing the monitoring tool include applicable State and federal requirements. Prior to finalizing the tool, HSAG submits the draft to DHHS for its review and comments.
Step 3:	**Prepare and submit the Desk Review Form to the MCOs.**
	HSAG prepares and forwards a desk review form to the MCOs and requests that they submit information and documents to HSAG within a specified number of days of the request. The desk review form includes instructions for organizing and preparing the documents related to the review of the standards, submitting documentation for HSAG's desk review, and having additional documents available for HSAG's on-site review.
Step 4:	**Forward a Documentation Request and Evaluation Form to the MCOs.**
	HSAG forwards to the MCOs, as an accompaniment to the desk review form, a documentation request and evaluation form containing the same standards and contract requirements as the tool HSAG used to assess the MCOs' compliance with each of the requirements within the standards. The desk review form includes detailed instructions for completing the "Evidence/Documentation as Submitted by the MCO" portion of this form. This step provides the opportunity for the MCOs to identify for each requirement the specific documents or other information that furnish evidence of its compliance with the requirement, and streamlines the HSAG reviewers' ability to identify all applicable documentation for the review.
Step 5:	**Develop an on-site review agenda and submit the agenda to DHHS and the MCOs.**
	HSAG develops the agendas to assist the MCO staff members in planning to participate in HSAG's on-site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective on-site review and minimizing disruption to the organization's day-to-day operations. An agenda sets the tone and expectations for the on-site review so that all participants understand the process and time frames allotted for the reviews.

Table B-1—The Compliance Review Methodology	
Step 6:	**Provide technical assistance.**
	As requested by the MCOs, and in collaboration with DHHS, HSAG staff members respond to any MCO questions concerning the requirements HSAG uses to evaluate MCO performance during the compliance reviews.
Step 7:	**Receive MCOs' documents for HSAG's desk review and evaluate the information before conducting the on-site review.**
	HSAG reviewers review the documentation received from the MCOs to gain insight into the organization's structure, services, operations, resources, information systems, quality program, and delegated functions; and to begin compiling the information and preliminary findings before the on-site portion of the review. During the desk review process, reviewers: ◆ Document findings from the review of the materials submitted as evidence of MCOs' compliance with the requirements. ◆ Identify areas and issues requiring further clarification or follow-up during the on-site interviews. ◆ Identify information not found in the desk review documentation to be requested during the on-site review.
Step 8:	**Conduct the on-site portion of the review.**
	During the on-site review, staff members from the MCO answer questions to assist the HSAG review team in locating specific documents or other sources of information. HSAG's activities completed during the on-site review included the following: ◆ Conduct an opening conference that included introductions, HSAG's overview of the on-site review process and schedule, MCO's overview of its structure and processes, and a discussion about any changes needed to the agenda and general logistical issues. ◆ Conduct interviews with the MCO's staff. HSAG uses the interviews to obtain a complete picture of the MCO's compliance with the federal Medicaid managed care regulations and associated State contract requirements, explore any issues not fully addressed in the documents that HSAG reviewed, and increase HSAG reviewers' overall understanding of MCO's performance. ◆ Review additional documentation. The HSAG on-site team reviews additional documentation and uses the review tool to identify relevant information sources. Documents reviewed on-site included, but were not limited to, written policies and procedures, minutes of key committee or other group meetings, and data and reports across a broad range of areas. While on-site, MCO staff members also discuss the organization's information system data collection process and reporting capabilities related to the standards HSAG reviewed. ◆ Summarize findings at the completion of the on-site portion of the review. As a final step, HSAG conducts a closing conference to provide the MCO's staff members and DHHS with a high-level summary of HSAG's preliminary findings. For each of the standards, a brief overview is given that includes HSAG's assessment of the MCO's strengths; if applicable, any area requiring corrective action; and HSAG's suggestions for further strengthening the MCO's processes, performance results, and/or documentation.

Table B-1—The Compliance Review Methodology	
Step 9:	**Calculate the individual scores and determine the overall compliance score for performance.**
	HSAG evaluates and analyzes the MCOs' performance in complying with the requirements in each of the standards contained in the review tool. HSAG used *Met*, *Partially Met*, and *Not Met* scores to document the degree to which each MCO complies with each of the requirements. A designation of *NA* is used if an individual requirement does not apply to the MCO during the period covered by the review. For each of the standards, HSAG calculates a percentage of compliance rate and then an overall percentage of compliance score across all standards.
Step 10:	**Prepare a report of findings.**
	After completing the documentation of findings and scoring for each of the standards, HSAG prepares a draft report that describes HSAG's compliance review findings; the scores assigned for each requirement within each standard; and HSAG's assessment of each MCO's strengths, any areas requiring corrective action, and HSAG's suggestions for further enhancing the MCO's performance results, processes, and/or documentation. HSAG forwards the report to DHHS for review and comment. Following DHHS's review of the draft, HSAG sends the draft report to the MCOs. After the MCO review, HSAG issues the final report.

Determining Conclusions

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the MCOs' performance complied with the requirements. HSAG used a designation of *NA* when a requirement was not applicable to the MCO during the period covered by HSAG's review. This scoring methodology is defined as follows:

Met indicates full compliance, defined as both of the following:

◆ All documentation listed under a regulatory provision, or component thereof, is present.

◆ Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as either of the following:

◆ There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.

◆ Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as either of the following:

◆ No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.

◆ For a provision with multiple components, key components of the provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall finding of noncompliance for the provision, regardless of the findings noted for the remaining components.

From the rates assigned for each of the requirements, HSAG calculates a total percentage-of-compliance rate for the standards and an overall percentage-of-compliance score across the standards. HSAG calculates the total score for each standard by adding the weighted value of the scores for each requirement in the standard—i.e., *Met* (value: 1 point), *Partially Met* (value: 0.50 points), *Not Met* (value: 0.00 points), and *Not Applicable* (value: 0.00 points)— and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determines the overall percentage-of-compliance score across the standards by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the results by the total number of applicable requirements). If requested by DHHS, HSAG also can assist in reviewing the corrective action plans from the MCOs to determine if their proposed corrections will meet the intent of the standards that were scored *Partially Met* or *Not Met*.

Evaluation of Programs and Projects: PIPs

HSAG's PIP validation process includes two key components of the quality improvement process:

1. Evaluation of the technical structure of the PIP to ensure that the MCO designed, conducted, and reported the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's evaluation determines whether the PIP design (e.g., study question, population, indicator(s), sampling techniques, and data collection methodology) is based on sound methodological principles and can reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and indicators used have the capability to achieve statistically significant and sustained improvement.

2. Evaluation of the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCO improves its rates by implementing effective processes (i.e., barrier analyses, intervention, and evaluation of results). HSAG conducts a critical analysis of the MCO's processes for identifying barriers and evaluating the effectiveness of interventions. HSAG presents detailed feedback based on the findings of this critical analysis. This type of feedback provides the MCO with guidance on how to refine its approach in identifying specific barriers that impede improvement, as well as identifying more appropriate interventions that can overcome these barriers and result in meaningful improvement in the targeted areas. This process also helps to ensure that the PIP is not simply an exercise in documentation, but

that the process is fully implemented in a way that can positively affect health care delivery and/or outcomes of care.

HSAG uses an outcome-focused scoring methodology to rate a PIP's compliance with each of the 10 activities listed in the CMS protocols. HSAG's outcome-focused validation methodology places greater emphasis on actual study indicator(s) outcomes. Each evaluation element within a given activity will be given a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed* based on the PIP documentation and study indicator outcomes. *Not Applicable* is used for those situations in which the evaluation element does not apply to the PIP For example, in Activity V, if the MCO did not use sampling techniques, HSAG would score the evaluation elements in Activity V as *Not Applicable*. HSAG uses the *Not Assessed* scoring designation when the PIP has not progressed to a particular activity.

In Activity IX (real improvement achieved), statistically significant improvement over the baseline must be achieved across all study indicators to receive a *Met* score. For Activity X (sustained improvement achieved), HSAG will assess for sustained improvement once each study indicator has achieved statistically significant improvement and a subsequent measurement period of data has been reported.

The goal of HSAG's PIP validation will be to ensure that DHHS and other key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP. HSAG's methodology for assessing and documenting PIP findings provides a consistent, structured process and a mechanism for providing the MCOs with specific feedback and recommendations for the PIP. Using its PIP Validation Tool and standardized scoring, HSAG will report the overall validity and reliability of the findings as one of the following:

◆ *Met* = high confidence/confidence in the reported findings.

◆ *Partially Met* = low confidence in the reported findings.

◆ *Not Met* = reported findings are not credible.

HSAG has designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all of the critical elements must receive a *Met* score. Given the importance of critical elements to the scoring methodology, any critical evaluation element that receives a score of *Not Met* will result in an overall PIP validation rating of *Not Met*. A PIP that accurately documents CMS protocol requirements has high validity and reliability. Validity is the extent to which the data collected for a PIP measure its intent. Reliability is the extent to which an individual can reproduce the study results. For each completed PIP, HSAG assesses threats to the validity and reliability of PIP findings and determines when a PIP is no longer credible.

HSAG assigns each PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Me*t by the sum of the critical elements scored as *Met, Partially*

Met, and *Not Met*. The outcome of these calculations determines the validation status of *Met*, *Partially Met*, or *Not Met*.

Validation of MCO Performance Measures

As set forth in 42 CFR §438.358,[B-3] validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected.

- Determine the extent to which the specific performance measures calculated by the health plans followed the specifications established for calculation of the performance measures.

- Identify overall strengths and areas for improvement in the performance measure process.

The following table presents the State-selected performance measures for the SFY 2013–2014 validation activities. HSAG completed the reports for this activity in December 2014.

Table B-2—Performance Measures Audited by HSAG for SFY 2013–2014
Ambulatory Care: Physician/Advanced Practice Registered Nurse (APRN)/Clinic Visits ◆ *by Age Group* ◆ *by Eligibility Group* ◆ *by Geographic Region*
Ambulatory Care: Emergency Department Visits ◆ *by Age Group* ◆ *by Eligibility Group* ◆ *by Geographic Region*
Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care ◆ *by Age Group* ◆ *by Eligibility Group* ◆ *by Geographic Region*
Resolution of Appeals
Appeals by Reason Type
Timely Professional and Facility Medical Claim Processing within 30 Calendar Days of Receipt
Claims Quality Assurance: Claims Payment Accuracy
Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members (Quarterly Rate)

[B-3] U. S. Government Printing Office. (n.d.). *External quality review results.* Available at: http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec438-364.pdf. Accessed on: November 20, 2015.

Table B-2—Performance Measures Audited by HSAG for SFY 2013–2014
Member Communications: Reasons for Telephone Inquiries
Pharmacy Payments PMPY [per-member-per-year] ♦ *Mean Payments by Age Group* ♦ *Median Payments by Age Group*
Polypharmacy Monitoring for All Medications by Age Group
Polypharmacy Monitoring for Behavioral Health Medications ♦ *All Children* ♦ *Children Receiving Foster Care Services*
Pharmacy Utilization Management: Adherence to State Preferred Drug List
Provider Communications: Reasons for Telephone Inquiries
Member to Provider Ratio by Geographic Region ♦ *MCO Designated Primary Care Providers* ♦ *Pediatricians* ♦ *Maternity Providers*
Medical Services, Equipment and Supply Service Authorization Timely Determination Rate: New Routine Requests

Technical Methods of Data Collection and Analysis

HSAG conducted the validation activities as outlined in the CMS' publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.[B-4]

The same process was followed for each performance measure validation conducted by HSAG and included: (1) pre-review activities such as development of measure-specific work sheets and a review of completed MCO responses to the Information System Capability Assessment Tool (ISCAT); and (2) on-site activities such as interviews with staff members, primary source verification, programming logic review and inspection of dated job logs, and computer database and file structure review.

HSAG validated the MCOs' information system capabilities for accurate reporting. The review team focused specifically on aspects of the MCOs' systems that could affect the selected measures. Items reviewed included coding and data capture, transfer, and entry processes for medical data; membership data; provider data; and data integration and measure calculation. If an area of noncompliance was noted with any validation component listed in the CMS protocol, the audit team determined if the issue resulted in significant, minimal, or no impact to the final reported rate.

[B-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

Each measure verified by the HSAG review team received an audit result consistent with one of the three designation categories listed in the following table.

Table B-3—Designation Categories for Performance Measures Audited by HSAG	
Report (R)	Measure was compliant with the State's specifications and the rate can be reported.
Not Reported (NR)	This designation is assigned to measures for which: (1) the MCO rate was materially biased or (2) the MCO was not required to report.
No Benefit (NB)	Measure was not reported because the MCO did not offer the benefit required by the measure.

Description of Data Obtained

HSAG used a number of different methods and sources of information to conduct the validation. These included:

◆ Completed responses to the ISCAT by each MCO.

◆ Source code, computer programming, and query language (if applicable) used by the MCOs to calculate the selected measures.

◆ Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.

◆ Final performance measure rates.

Information was also obtained through interaction, discussion, and formal interviews with key staff members, as well as through system demonstrations and data processing observations.

After completing the validation process, HSAG prepared a final report detailing the performance measure validation findings and any associated recommendations for each MCO. These reports were provided to DHHS and to each MCO.

Demographics of the New Hampshire MCM Program

The demographic information displayed in this section of the report was provided by DHHS. Figure C-1 displays information concerning the age groups of the Medicaid members in **NHHF** and **Well Sense** as of December 1, 2014.

Figure C-1—Point-in-Time Age Groups by MCO as of December 1, 2014
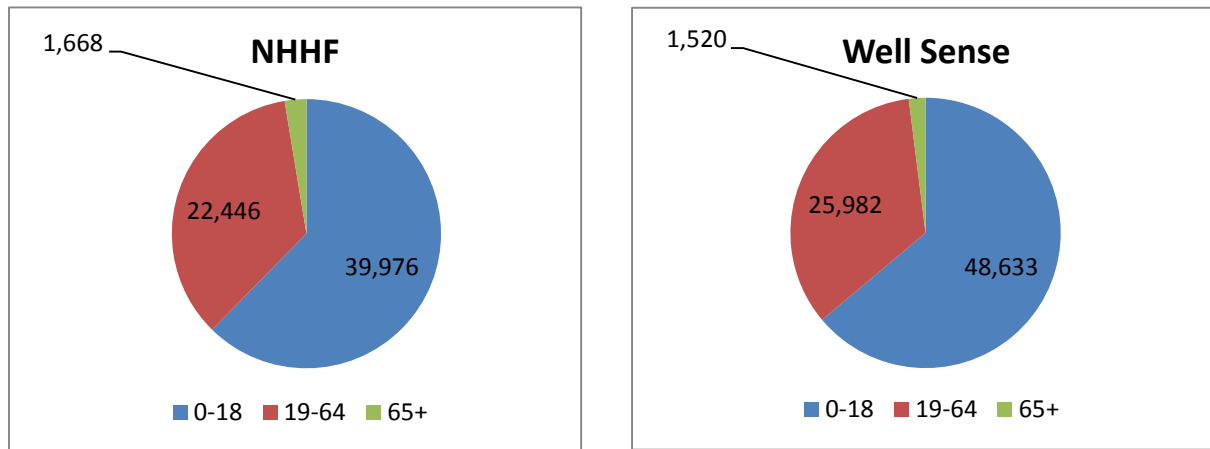
The age distribution in the two MCOs was very similar. A total of 62.4 percent of the **NHHF** population was 0–18 years old as was 63.9 percent of the **Well Sense** population. A total of 35.0 percent of the **NHHF** population was 19–64 years old as was 34.1 percent of the **Well Sense** population. The **NHHF** population over 65 years of age totaled 2.6 percent, and the **Well Sense** population over 65 years of age totaled 2.0 percent.

Figure C-2 presents the gender distribution of the MCO members as of December 1, 2014.

Figure C-2—Point-in-Time Gender by MCO as of December 1, 2014
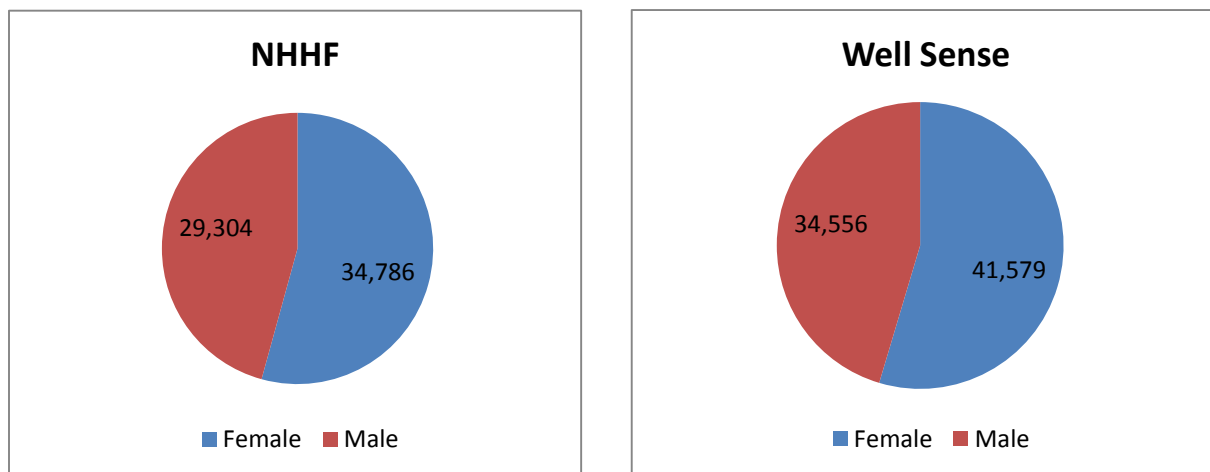
The gender distribution in both plans was almost identical. Female members comprised 54.3 percent of the membership in **NHHF** and 54.6 percent of the membership in **Well Sense**. Male members comprised 45.7 percent of the membership in **NHHF** and 45.4 percent of the membership in **Well Sense**.

Figure C-3 displays the eligibility categories of the MCO members as of December 1, 2014.

**Figure C-3—Point-in-Time Eligibility Category by MCO as of December 1, 2014**
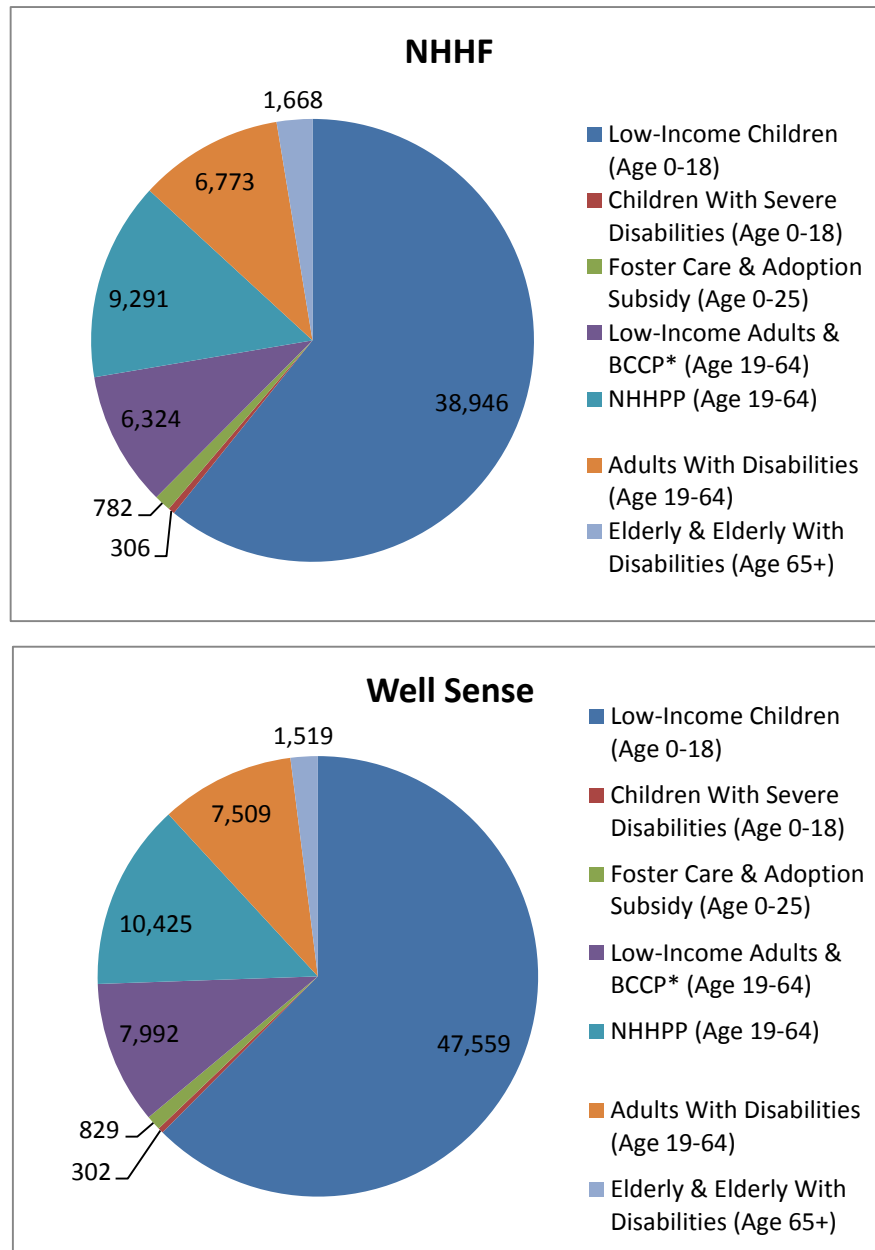
* BCCP = Breast and Cervical Cancer program

The low-income children category represented over 60 percent of members in both MCOs (60.8 percent for **NHHF** and 62.5 percent for **Well Sense**). Total membership on December 1, 2014, in the seven eligibility categories was 64,090 for **NHHF** and 76,135 for **Well Sense**.

Figure C-4 shows the distribution of membership in the two MCOs for the 10 counties in New Hampshire as of December 1, 2014.

Figure C-4—Point-in-Time County Breakout by MCO as of December 1, 2014
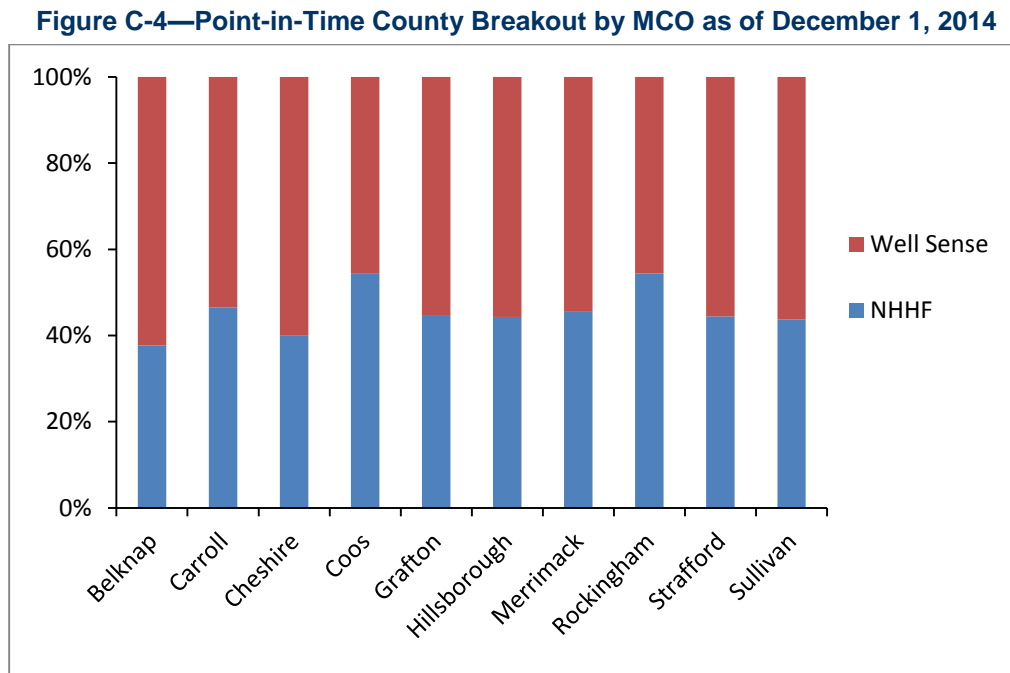
The percentage of membership in the counties varied for **NHHF** between 37.7 percent in Belknap County to 54.4 percent in Rockingham County. The **Well Sense** membership in the counties varied between 45.6 percent in Rockingham County to 62.3 percent in Belknap County.

Table C-1 through Table C-6 provide information concerning the average quarterly MCO enrollment in six eligibility categories during the four quarters of 2014. The six eligibility categories include: low-income children, children with severe disabilities, children in foster care and children with adoption subsidies, low-income adults and adults in the breast and cervical cancer program, adults with disabilities, and the elderly and the elderly with disabilities. The figures only include enrollment information for **Meridian** for two quarters because the New Hampshire MCM Contract with **Meridian** terminated on July 31, 2014.

Table C-1 shows the average quarterly enrollment for low-income children by MCO during 2014.

Table C-1—Average Quarterly Enrollment for Low-Income Children (Age 0–18) by MCO During 2014				
MCO	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Meridian	19,180	20,649	NA	NA
NHHF	26,704	28,354	36,388	39,051
Well Sense	34,379	35,736	44,707	47,636
Total	**80,263**	**84,739**	**81,095**	**86,687**

There was an increase in the average quarterly enrollment of low-income children in the MCOs during 2014 with 80,263 children in the first quarter of 2014 and 86,687 children in the fourth quarter of 2014.

Table C-2 displays the average quarterly enrollment for children with severe disabilities by MCO during 2014.

Table C-2—Average Quarterly Enrollment for Children With Severe Disabilities by MCO During 2014				
MCO	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Meridian	223	236	NA	NA
NHHF	229	232	304	311
Well Sense	228	229	299	306
Total	**680**	**697**	**603**	**617**

Table C-2 shows a slight decrease in the overall number of children with severe disabilities in the MCOs during 2014, with an average of 680 children in the MCOs during the first quarter of 2014, and an average of 617 children in the MCOs during the fourth quarter of 2014.

Table C-3 shows the average quarterly enrollment for foster care children and children with adoption subsidies by MCO during 2014.

Table C-3—Average Quarterly Enrollment for Foster Care and Adoption Subsidy Children (Age 0–25) by MCO During 2014				
MCO	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Meridian	363	383	NA	NA
NHHF	528	553	691	771
Well Sense	570	593	737	810
Total	**1,461**	**1,529**	**1,428**	**1,581**

The overall participation in the MCM program by children in foster care and with adoption subsidies increased during the year as shown in Table C-3. The average quarterly MCM program enrollment for that eligibility category included 1,461 children in the first quarter of 2014 and 1,581 children in the fourth quarter of 2014.

Table C-4 displays the average quarterly enrollment for low-income adults and members in the breast and cervical cancer program by MCO during 2014.

Table C-4—Average Quarterly Enrollment for Low Income Adults (Age 19–64) and Breast and Cervical Cancer Program (BCCP) by MCO During 2014				
MCO	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Meridian	2,848	3,541	NA	NA
NHHF	3,861	4,684	6,291	6,384
Well Sense	5,090	5,934	7,951	8,081
Total	11,799	14,159	14,242	14,465

During 2014, the average quarterly number of low-income adults and adults in the BCCP enrolled in the MCOs increased from 11,799 in the first quarter of 2014 to 14,465 in the fourth quarter of 2014.

Table C-5 shows the average quarterly enrollment for adults with disabilities by MCO during 2014.

Table C-5—Average Quarterly Enrollment for Adults With Disabilities by MCO During 2014				
MCO	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Meridian	3,972	4,261	NA	NA
NHHF	4,807	4,784	6,471	6,810
Well Sense	5,276	5,224	7,081	7,558
Total	14,055	14,269	13,552	14,368

The average quarterly enrollment of adults with disabilities in the New Hampshire MCM program increased during 2014 with an average quarterly enrollment of 14,055 in the first quarter of 2014 and an average quarterly enrollment of 14,368 in the fourth quarter of 2014.

Table C-6 shows the average quarterly enrollment for the elderly and the elderly with disabilities by MCO during 2014.

Table C-6—Average Quarterly Enrollment for Elderly and Elderly With Disabilities (Age 65+) by MCO During 2014				
MCO	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Meridian	798	825	NA	NA
NHHF	1,038	1,057	1,480	1,665
Well Sense	1,088	1,088	1,401	1,511
Total	2,924	2,970	2,881	3,176

The average quarterly enrollment for the final category of eligibility, the elderly and elderly with disabilities, increased from an average quarterly enrollment of 2,924 in the first quarter of 2014 to an average quarterly enrollment of 3,176 in the fourth quarter of 2014.

In 2014, Senate Bill 413 created the New Hampshire Health Protection Program (NHHPP), which included the Medicaid expansion population resulting from New Hampshire's implementation of the Affordable Care Act.[C-1] Enrollment began in the fall of 2014. Figure C-5 shows the average enrollment by MCO for the fourth quarter of 2014.

Figure C-5—Average Enrollment for NHHPP by MCO for the Fourth Quarter of 2014
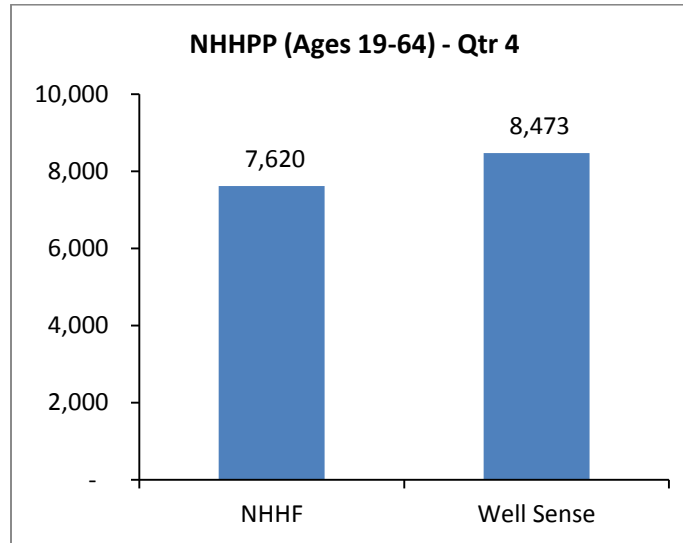
NHHF had 47.3 percent of the enrollment in the NHHPP in the fourth quarter of 2014, and **Well Sense** had 52.7 percent of the enrollment.

[C-1] New Hampshire Department of Health and Human Services. (2014). *Quality Strategy for the New Hampshire Medicaid Care Management Program*. Available at: http://www.dhhs.nh.gov/ombp/quality/documents/quality-strategy.pdf. Accessed on December 11, 2015.