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Department of Health and Human Services

2016 New Hampshire External Quality Review Technical Report

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

In 2011, the New Hampshire legislature passed Senate Bill 147 requiring a comprehensive statewide Medicaid managed care program for all Medicaid enrollees. On December 1, 2013, the New Hampshire Department of Health and Human Services (DHHS, or the Department) implemented the Medicaid Care Management (MCM) program. At the end of calendar year (CY) 2016, there were 135,548 New Hampshire Medicaid beneficiaries 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 2016 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 (PIPs), and validation of performance measures and encounter data. 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

In its evaluation, the EQRO documented strong performance results for both MCOs regarding their PIPs; each MCO designed scientifically sound projects supported by the use of key research principles. This year's contract compliance and performance measure validation (PMV) results revealed areas of strength as well as areas requiring improvement. Both MCOs scored 88.8 percent or higher on the contract compliance reviews and demonstrated opportunities for improvement in reporting specific measures found in the new Substance Use Disorder standard requirements. For each of the two years of PMV results included in this report, all measures except one were successfully approved for reporting for both MCOs. In 2015 **NHHF** was unable to report the *Community Demographic, Cultural, and Epidemiologic Profile: Preferred Spoken Language* measure correctly, and **Well Sense** was unable to report the *Member Requests for Assistance Accessing MCO Designated Primary Care Providers [PCPs]*

[1-1] The data source for all enrollment data is the December 1, 2016, extract from New Hampshire Medicaid Management Information System (MMIS).

per Average Members by Geographic Region for the New Hampshire Health Protection Program [NHHPP] Members measure correctly. In 2016, both plans failed to report the *Percentage of Medical Service, Equipment and Supply Service Authorization Determinations for Request Involving Urgent Care and Relating to the Extension of an Ongoing Course of Treatment Made Within 24 Hours After Receipt of Request for Requests Made During the Measure Data Period* measure successfully. By the end of SFY 2016, HSAG had generated two EDV reports, including encounters submitted by MCOs between December 1, 2013, and May 2, 2016. Based on the two reports, HSAG recommended that **NHHF** and **Well Sense** focus on data accuracy related to member identification numbers and servicing provider information.

Member Experience of Care Evaluation

New Hampshire uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] survey as the primary means of measuring each health plan's impact on members' experience of care. In CY 2015, results for both plans' adult populations were above the national average for most measures, including *Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service,* and *Shared Decision Making.* **Well Sense** was below the national average for the adult population in *Rating of Health Plan* and *Rating of All Health Care*, suggesting opportunities for improvement.

Results for both plans' child populations were above the national average for *Getting Care Quickly, How Well Doctors Communicate,* and *Shared Decision Making*. **NHHF** was below the national average for *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Customer Service.* **Well Sense** was below the national average for *Rating of All Health Care* and *Getting Needed Care.*

Health Outcome Evaluation

New Hampshire uses the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-3] as the primary method of measuring each health plan's impact on health outcomes. In CY 2015, the majority of prevention and behavioral healthcare measures for both plans met or exceeded the 50th percentile of national comparison rates. Both MCOs scored below the 25th percentile of national comparison rates in *Cervical Cancer Screening, Chlamydia Screening in Women—Total, Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease [COPD] Exacerbation—Bronchodilator,* and *Diabetes Monitoring for People with Diabetes and Schizophrenia,* representing opportunities for performance improvement.

[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

New Hampshire Medicaid Care Management Program Evaluation

Two focus groups were convened during SFY 2016, one in the fall and one in the spring. The targeted population for the fall focus groups included individuals currently enrolled in case management with the MCOs, and the majority of participants reported positive experiences with case management including support in managing medications, coordinating providers, and organizing ancillary needs such as transportation and housing. Participants expressed a desire for better communication and coordination between their health care providers and the managed care case/care managers.

The spring focus groups included individuals who previously opted out of the MCM program and who were now part of the mandatory population receiving benefits through an MCO. Overall, participants said their access to preventive care had remained the same since enrolling with an MCO. About half of participants indicated that accessing medications had become more difficult due to changed dosages, medications no longer being covered, and the requirement to switch medications.[1-4] The majority of participants said their providers worked well together. Parents of children with disabilities, however, were more likely to coordinate their children's care rather than relying on providers to do so.

In SFY 2016, the EQRO's activities revealed positive results as well as areas for improvement for the MCM program. Many of the same activities will be conducted in SFY 2017, which will allow further evaluation of targeted opportunities for improvement identified in this report.

[1-4] DHHS conducted a follow-up analysis of the larger population of children with severe disabilities. After examining a random sample of members, the majority (34 out of 38) saw no changes in maintenance medications in the first quarter of enrollment in Medicaid Managed Care compared to the last quarter they were enrolled in Medicaid fee-for-service.

2. Overview of the Medicaid Care Management (MCM) Program

Program Overview

In 2011, the New Hampshire legislature passed Senate Bill 147 requiring a comprehensive Medicaid managed care program for all Medicaid beneficiaries. The DHHS 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 over 30,000 beneficiaries were successfully transitioned to the remaining two plans. At the end of CY 2016, 135,548 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 C.

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 NHHPP in August of the same year. The NHHPP provided coverage to approximately 50,000 beneficiaries through the MCM program at the end of CY 2016. In addition to providing insurance to many beneficiaries not previously covered, the NHHPP offered a substance use disorder benefit including outpatient and residential services.[2-2] 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.[2-3] In this new program, the majority of beneficiaries 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 state plan amendment services through the program.[2-4] Step 2, Phase 2, and Phase 3 of the MCM program, which are not yet implemented, include beneficiaries receiving long-term services

[2-1] The data source for all enrollment data is the December 1, 2016, extract from New Hampshire MMIS.
[2-2] Substance use disorder benefits were later added for the non-NHHPP population on July 1, 2016.
[2-3] Approval from CMS Section 1115 Waiver for the Premium Assistance Program.
[2-4] Approval from CMS Section 1915b Waiver.

and supports (LTSS) waiver services through nursing facilities or the Choices for Independence Waiver, managed by the MCOs. Later phases of the MCM program include incorporating additional LTSS into the services, such as those waiver services received by individuals with developmental disabilities.

3. Summary of Findings

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 2016 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, 2016.

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 2015 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. After completing a comprehensive contract review in SFY 2014, the SFY 2015 review initiated a three-year cycle of reviewing one-third of all the elements contained in the compliance tool. This year's review, SFY 2016, was the second year of the three-year cycle of evaluating one-third of the compliance requirements, and the compliance activities also included a review of the elements from the SFY 2015 corrective action plan (CAP).

[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: Dec 13, 2016.

[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: Dec 13, 2016.

Findings

Table 3-1 illustrates **NHHF**'s and **Well Sense**'s individual performance for each of the 13 standards included in the SFY 2016 compliance review and the overall score for the on-site review.

Table 3-1—Summary of the SFY 2016 Compliance Review Scores for the MCOs

Standard	Standard Name	NHHF	Well Sense
I	Delegation and Subcontracting	**100%**	**100%**
II	Plans Required by the Contract	**83.3%**	**100%**
III	Emergency and Post-stabilization Care	**100%**	**100%**
IV	Care Management/Care Coordination*	**NA**	**NA**
V	Wellness and Prevention*	**NA**	**NA**
VI	Behavioral Health	**92.9%**	**92.9%**
VII	Member Enrollment and Disenrollment	**85.7%**	**100%**
VIII	Member Services	**83.3%**	**50.0%**
IX	Cultural Considerations	**100%**	**100%**
X	Grievances and Appeals	**100%**	**92.3%**
XI	Access	**100%**	**100%**
XII	Network Management	**90.9%**	**95.5%**
XIII	Utilization Management	**95.0%**	**100%**
XIV	Quality Management	**100%**	**100%**
XV	Substance Use Disorder	**42.9%**	**14.3%**
Overall Rate		**92.7%**	**88.8%**

* Standards IV and V were not included in the SFY 2016 compliance review.

Of the 13 standards included in the SFY 2016 compliance review, **NHHF** achieved 100 percent compliance for six standards, 90–99 percent compliance for three standards, 80–89 percent compliance for three standards, and below 50 percent compliance for one standard. **Well Sense** achieved 100 percent compliance for eight standards, 90–99 percent compliance for three standards, and 50 percent compliance or below for two standards. Both MCOs scored the lowest on the new Substance Use Disorder Standard requirements added to the MCO contract with DHHS and evaluated for the first time during this compliance review.

The re-review of the SFY 2015 CAPs included one item for **NHHF** and one item for **Well Sense**. Both MCOs failed to convene a Consumer Advisory Board a minimum of four times during SFY 2015. **NHHF** and **Well Sense** corrected this element, and the Consumer Advisory Boards met the required number of times during SFY 2016 as verified through a review of the minutes of the meetings during the

SFY 2016 on-site audit. 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

NHHF achieved 92.7 percent on the SFY 2016 compliance reviews. A total of 117 **NHHF** elements were *Met*, seven elements were *Partially Met*, and six elements were *Not Met*. For additional information concerning the MCO contractual compliance activities, see Section 4 on page 4-1 in the Detailed Findings.

HSAG offers the following recommendations for **NHHF**:

- Retain documentation to substantiate DHHS' approval of the policies concerning coordination of care with PCPs and community mental health programs.
- Ensure that plan documents include the statement that the provider manual will be updated at least annually and that documentation is retained to substantiate DHHS' approval of the provider manual and provider training materials.
- Update the definition for "Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services" to include the appropriate age limits for the services.
- Create a transition plan within three calendar days following the effective date of a termination for all members affected by a provider termination.
- Include procedures for referral, tracking, and follow-up for annual dental examinations and visits upon receipt of dental claims information from DHHS in the EPSDT Plan.
- Ensure that disenrollment rights are sent to members at least 60 calendar days before the start of each reenrollment period.
- Arrange for video conferencing opportunities for the Member Advisory Board meetings.
- Implement the reporting requirements for substance use disorder services.

Well Sense

Well Sense achieved 88.8 percent on the SFY 2016 compliance reviews. A total of 113 **Well Sense** elements were *Met*, three elements were *Partially Met*, and 13 elements were *Not Met*. For additional information concerning HSAG's methodology for conducting an MCO contractual compliance review, see Appendix B on page B-1 in the Methodologies for Conducting EQR Activities.

HSAG offers the following recommendations for **Well Sense**:

- Retain documentation to substantiate DHHS' approval of the policies concerning coordination of care with PCPs and community mental health programs.

- Ensure that expedited appeals can be extended and that plan documents include the requirement that **Well Sense** is obligated to fully resolve all appeals and grievances until final resolution of any grievance or appeal upon termination of the agreement between **Well Sense** and DHHS.
- Retain documentation to substantiate DHHS' approval of the provider manual and provider training materials.
- Ensure that each member receives written notice of the changes affecting member rights; filing requirements; time frames for grievances, appeals, and State fair hearings; availability of assistance in submitting grievances and appeals; and the toll-free numbers of the MCO grievance system resources.
- Schedule in-person regional meetings for the Member Advisory Board at least twice each year and arrange for video conferencing opportunities for the Member Advisory Board meetings.
- Implement the reporting requirements for substance use disorder services.

HSAG is working with **NHHF** and **Well Sense** as they finalize their CAPs to ensure compliance with the items that were found to be *Partially Met* or *Not Met* during the 2016 compliance review. **NHHF** submitted CAPs for the following standards: Plans Required by the Contract, Behavioral Health, Member Enrollment and Disenrollment, Member Services, Network Management, Utilization Management, and Substance Use Disorder. **Well Sense** submitted CAPs for the following standards: Behavioral Health, Member Services, Grievances and Appeals, Network Management, and Substance Use Disorder.

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 2016, HSAG reviewed the Design and Implementation stages 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.

[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: Dec 13, 2016.

Table 3-2—Performance Improvement Project Topics Selected by NHHF and Well Sense

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 Readmissions to New Hampshire Hospital (New Hampshire's Inpatient Psychiatric facility)*
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.

Table 3-3—2015 PIP Validation Results Comparison by MCO for Topics Selected by NHHF and Well Sense

Stage	Activities	Percentage of Applicable Elements Scored *Met*	
		NHHF (Number [N]=4 PIPs)	Well Sense (N=4 PIPs)
Design	Activities I–VI	100% (70/70)	100% (57/57)
Implementation	Activities VII–VIII	100% (32/32)	100% (30/30)
Outcomes	Activities IX–X	*Assessed in 2016; results to be included in 2017 technical report*	*Assessed in 2016; results to be included in 2017 technical report*
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**100%**	**100%**

Both MCOs progressed through Activity VIII, the Design and Implementation stages, for each of the PIPs. The Design stage establishes the methodological framework for the PIP. The Implementation stage includes data analysis and interpretation, as well as development and implementation of improvement strategies. In 2015, the MCOs reported the baseline study indicator results for each PIP and described quality improvement activities that occurred during the baseline measurement period. Both MCOs met 100 percent of the requirements for all activities in the Design and Implementation stages of each PIP and received a *Met* validation status for each PIP. Overall, the health plans designed and implemented scientifically sound PIPs supported by key research principles and quality improvement methods. The

PIPs will be validated through the Outcomes stage in 2016, when the MCOs progress to reporting re-measurement results. Those results will be reported in the *2017 New Hampshire EQR Technical Report*.

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. The MCOs used methodologically sound approaches to data analysis and quality improvement activities in the Implementation stage.

For additional information concerning the PIP activities, see Section 4 on page 4-6 in the Detailed Findings.

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

HSAG offers the following recommendations for **NHHF**, identified as *Points of Clarification* in the PIP validation tools, which may strengthen future submissions:

- Establish and document specific, measureable goals for the first re-measurement of the study indicators, based on the baseline PIP results in each PIP.
- Ensure that next year's annual PIP submission identifies the priority level, or priority ranking, of identified barriers and clearly documents the process used to prioritize barriers. Additionally, high-priority barriers should have a direct impact on the PIP study indicators.
- Ensure that each intervention implemented during the first re-measurement period is accompanied by an intervention-specific evaluation of effectiveness. Next year's annual PIP submission will require documentation of the results of each intervention's evaluation. The MCO will need to document each intervention's effectiveness based on evaluation data that determine the specific impact of the intervention on the study indicators.

HSAG offered the following recommendation for the **Well Sense** *Diabetes Care—HbA1c Testing* PIP:

- Because the high baseline study indicator rate does not support the selection of HbA1c testing as an area for performance improvement, **Well Sense** should work with DHHS and HSAG to pursue selection of a replacement PIP topic for the next validation cycle.[3-4]

[3-4] **Well Sense** selected *Comprehensive Diabetes Care—Medical Attention for Nephropathy* as the PIP topic to replace the *Diabetes Care-HbAlc Testing* PIP.

Validation of MCO Performance Measures

As required by 42 CFR §438.240,[3-5] HSAG completed the validation of MCO performance measures for SFY 2015 and SFY 2016, and this section provides a summary of the findings, conclusions, and recommendations from the PMV activities in SFY 2015 and SFY 2016.

Findings

The table below provides an overview of the findings generated by the HSAG review team for the 32 state-specific measures validated in the SFY 2015 PMV audit and the 11 state-specific measures validated during the SFY 2016 PMV audit. The two MCOs received the same score both years, and all measures except one in each year, described below, were found to be valid for reporting.

Table 3-4—SFY 2015 and SFY 2016 PMV Findings

Performance Measures	SFY 2015		SFY 2016	
	NHHF	Well Sense	NHHF	Well Sense
Adequate documentation: Data integration, data control, and performance measure development	Acceptable	Acceptable	Acceptable	Acceptable
Claims systems and process adequacy: No non-standard forms used for claims	Acceptable	Acceptable	Acceptable	Acceptable
All primary and secondary coding schemes captured	Acceptable	Acceptable	Acceptable	Acceptable
Appropriate membership and enrollment file processing	Acceptable	Acceptable	Acceptable	Acceptable
Appropriate appeals data systems and accurate classification of appeal types and appeal reasons	Acceptable	Acceptable	Acceptable	Acceptable
Adequate call center systems and processes	Acceptable	Acceptable	Acceptable	Acceptable
Required measures received a "Reportable" designation	One Measure Not Acceptable	One Measure Not Acceptable	One Measure Not Acceptable	One Measure Not Acceptable

[3-5] 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: Dec 13, 2016.

Conclusions and Recommendations

NHHF

NHHF staff members were dedicated to quality reporting. In SFY 2015, HSAG found that the information technology staff members were experienced data miners and proficient in SQL and Informatica software packages, and the business staff provided critical documentation and presentations for the completion of the audit. In SFY 2016, staff members reported measures to DHHS and HSAG in a timely manner throughout the year, and **NHHF** staff members were able to appropriately capture the reporting periods for each reviewed measure. **NHHF** staff also utilized systemic practices when possible to reduce manual processing of data to ensure data integrity.

The auditors provided the following recommendations to **NHHF**:

- **NHHF** should provide source code for review prior to HSAG's on-site audit.
- In SFY 2015, **NHHF** was unable to report the DEMOGPROF.01 (i.e., *Community Demographic, Cultural, and Epidemiologic Profile: Preferred Spoken Language*) measure correctly. While data were captured in the health risk assessment as required for this measure, they were not uploaded to the Care Management system. Therefore, these data were not available for measure calculation and reporting. The health plan should revise its processes for data capture in order to report this rate in the future.
- In SFY 2016, all measures except SERVICEAUTH.02 (i.e., *Percentage of Medical Service, Equipment and Supply Service Authorization Determinations for Request Involving Urgent Care and Relating to the Extension of an Ongoing Course of Treatment Made Within 24 Hours After Receipt of Request for Requests Made During the Measure Data Period*) were successfully approved for reporting. HSAG considered the calculation of the measure to be materially biased and *Not Reportable* due to concerns with the authorization processes of **NHHF** and its behavioral health vendor. The auditors recommended that **NHHF** continue to consult with DHHS to ensure timely and accurate reporting of the measures to DHHS throughout the year and to HSAG for final review.

Well Sense

Well Sense staff members were well versed in quality reporting. In 2015, HSAG noted that **Well Sense** staff members were dedicated to accurate reporting and demonstrated this through regular internal meetings and quality review sessions. **Well Sense** reviewed the measure specifications and asked questions when it was unsure of measure specification requirements or interpretation. **Well Sense** worked closely with HSAG and DHHS to pose questions and ideas on reporting efficiencies and appropriateness. **Well Sense** maintained close relationships with its external vendors as was demonstrated in the pre-on-site vendor reviews, and also monitored its vendors closely to ensure all data submissions were timely and complete. In 2016, HSAG noted that **Well Sense** continued to accurately capture the reporting periods for each measure.

The auditors provided the following recommendations to **Well Sense**:

- In SFY 2015, **Well Sense** was unable to report the HPP_ACCESSREQ.01 (i.e., *Member Requests for Assistance Accessing MCO Designated PCPs per Average Members by Geographic Region for the*

NHHPP Members) measure correctly. After discussions with the HSAG auditor, **Well Sense** identified an issue with the configuration of this measure and confirmed that the MCO was not accurately reporting the measure.

- In SFY 2015, HSAG recommended that **Well Sense** should begin an internal vendor monitoring system to track monthly claims volumes received from its external entities. This will allow **Well Sense** to have an additional check and balance for each external vendor, identify gaps, and trend claims over time.
- In SFY 2016, HSAG considered the calculation of the SERVICEAUTH.02 (i.e., *Percentage of Medical Service, Equipment and Supply Service Authorization Determinations for Request Involving Urgent Care and Relating to the Extension of an Ongoing Course of Treatment Made Within 24 Hours After Receipt of Request for Requests Made During the Measure Data Period*) measure to be materially biased and *Not Reportable* due to the way **Well Sense** created and extended existing authorizations. **Well Sense** should continue to work with DHHS and HSAG to understand the details of each measure. **Well Sense** still has several manual steps in the measure production process. This primarily affects measures that rely heavily on external vendor data. **Well Sense** should continue to automate data flow processes and integrate automation steps to systematically produce the measures.

For additional information concerning the validation of the MCO performance measures, see Section 4 on page 4-12 in the Detailed Findings.

For additional information concerning HSAG's methodology for validating MCO performance measures, see Appendix B on page B-7 in the Methodologies for Conducting EQR Activities.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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 administer the survey to adult members and parents or caretakers of child members. Adult members and parents or caretakers of child members completed the surveys in 2016, following NCQA's data collection protocol.

Findings

The CAHPS 5.0H Surveys include a set of standardized items including four global ratings and five composite scores.[3-6] The global ratings reflected patients' overall satisfaction with their personal doctor,

[3-6] For purposes of this report, the 2016 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).

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 rating on a scale of 0 to 10 was calculated. A positive 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," "Usually," or "Always;" or (2) "No" or "Yes." A positive response for the composites was defined as a response of "Usually/Always" or "Yes."

Table 3-5 contains the results from the 2015 Adult Medicaid CAHPS positive rates calculated for **NHHF** and **Well Sense** and comparisons to the NCQA national averages.[3-7]

Table 3-5—NHHF and Well Sense Adult Medicaid CAHPS Results

CAHPS Measure	2015 Adult Medicaid Positive Rates	2015 National Average Comparison	2015 Adult Medicaid Positive Rates	2015 National Average Comparison
Global Ratings	**NHHF**		**Well Sense**	
Rating of Health Plan	**75.9%**	↑	**73.7%**	↓
Rating of All Health Care	**75.3%**	↑	**70.6%**	↓
Rating of Personal Doctor	**83.9%**	↑	**81.3%**	↑
Rating of Specialist Seen Most Often	**82.8%**	↑	**82.1%**	↑
Composite Ratings	**NHHF**		**Well Sense**	
Getting Needed Care	**85.3%**	↑	**85.8%**	↑
Getting Care Quickly	**84.0%**	↑	**86.1%**	↑
How Well Doctors Communicate	**90.9%**	↑	**92.8%**	↑
Customer Service	**90.6%**	↑	**91.2%**+	↑
Shared Decision Making	**81.5%**	↑	**81.4%**	↑

↑ Indicates the rate was above the 2015 NCQA Adult Medicaid national average
↓ Indicates the rate was below the 2015 NCQA Adult 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.

[3-7] The 2015 Adult Medicaid CAHPS Results presented in Table 3-5 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 2,228 adult Medicaid members, of which 485 completed surveys were returned. **Well Sense** surveyed a total of 1,418 adult Medicaid members, of which 316 completed surveys were returned. In 2015, the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey was 27.2 percent, which was higher than the adult Medicaid **NHHF** and **Well Sense** response rates.

Table 3-6 contains the results from the 2015 General Child CAHPS positive rates calculated for **NHHF** and **Well Sense** and comparisons to NCQA national averages.[3-8] Additional information concerning the CAHPS activities for **NHHF** and **Well Sense** can be found in Section 4: Detailed Findings.

Table 3-6—NHHF and Well Sense Child Medicaid CAHPS Results

CAHPS Measure	2015 Child Medicaid Positive Rates	2015 National Average Comparison	2015 Child Medicaid Positive Rates	2015 National Average Comparison
Global Ratings	**NHHF**		**Well Sense**	
Rating of Health Plan	**78.2%**	↓	**86.6%**	↑
Rating of All Health Care	**83.4%**	↓	**84.6%**	↓
Rating of Personal Doctor	**87.5%**	↓	**89.4%**	↑
Rating of Specialist Seen Most Often	**82.5%**	↓	**92.2%+**	↑
Composite Ratings	**NHHF**		**Well Sense**	
Getting Needed Care	**86.0%**	↑	**82.8%**	↓
Getting Care Quickly	**92.1%**	↑	**92.2%**	↑
How Well Doctors Communicate	**95.7%**	↑	**95.2%**	↑
Customer Service	**87.4%+**	↓	**93.4%+**	↑
Shared Decision Making	**79.7%**	↑	**81.7%+**	↑

↑ Indicates the rate was above the 2015 NCQA Adult Medicaid national average
↓ Indicates the rate was below the 2015 NCQA Adult 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.

Conclusions and Recommendations

NHHF

For **NHHF**'s adult Medicaid population, all rates were above the NCQA's 2015 Medicaid national average. For **NHHF**'s general child Medicaid population, the *Rating of Health Plan*, *Rating of All*

[3-8] The 2015 Child Medicaid CAHPS Results presented in Table 3-6 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 2,723 **NHHF** general child Medicaid members were selected for surveying, of which 513 completed surveys were returned. A total of 1,650 **Well Sense** general child Medicaid members were selected for surveying, of which 338 completed surveys were returned. In 2015, the average NCQA response rate for the CAHPS 5.0H Child Medicaid Health Plan Survey was 26.8 percent, which was higher than the child Medicaid **NHHF** and **Well Sense** response rates.

Health Care, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Customer Service* rates were below NCQA's 2015 Medicaid national average.

HSAG recommends the following for **NHHF**:

- The plan should focus quality improvement on enhancing child members' experiences with *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Customer Service*.

Well Sense

For **Well Sense**'s adult Medicaid population, *Rating of Health Plan* and *Rating of All Health Care* rates were below NCQA's 2015 Medicaid national averages. For **Well Sense**'s general child Medicaid population, the *Rating of All Health Care* and *Getting Needed Care* rates were below NCQA's 2015 Medicaid national averages. HSAG recommends the following for **Well Sense**:

- The plan should focus quality improvement on enhancing members' experiences with *Rating of Health Plan* for the adult population, *Rating of All Health Care* for the adult and child populations, and *Getting Needed Care* for the child population.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a standardized set of nationally recognized indicators that are used in measuring performance of managed care plans. According to NCQA, HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. **NHHF** and **Well Sense** were responsible for generating HEDIS rates for the indicators prescribed by DHHS and contracting with independent certified HEDIS compliance auditors (CHCAs) to validate and confirm the rates generated by the respective MCO. 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 compliance tools, and the interactive data submission system files approved by an NCQA-licensed organization.

Findings

The auditors found both MCOs to be fully compliant with all applicable information system assessment standards. HSAG compared the rates achieved by the MCOs on 48 performance measures to NCQA's HEDIS Audit Means and Percentiles National Medicaid HMO Percentiles for HEDIS 2015 (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.

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:

- At or above the national Medicaid 90th percentile
- At or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile
- At or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile
- At or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile
- Below the national Medicaid 25th percentile

Table 3-7 and Table 3-8 display the rates achieved by the MCOs according to the comparison of their rates to the national benchmarks.

Table 3-7—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 the 90th Percentile	Met 50th Percentile and Below the 75th Percentile	Met 25th Percentile and Below 50th Percentile	Under 25th Percentile	Total
Prevention	1	5	7	5	3	**21**
Acute and Chronic Care	0	3	3	4	4	**14**
Behavioral Health	3	4	3	2	1	**13**
All Domains	**4**	**12**	**13**	**11**	**8**	**48**
Percentage	**8.33%**	**25.00%**	**27.08%**	**22.92%**	**16.67%**	**100%**

NHHF's rates ranked at or above the national Medicaid 50th percentile for 29 measures (60.42 percent), with four of these measures ranking at or above the national Medicaid 90th percentile (8.33 percent). Rates for eight measures (16.67 percent) fell below the national Medicaid 25th percentile.

Table 3-8—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 the 90th Percentile	Met 50th Percentile and Below the 75th Percentile	Met 25th Percentile and Below 50th Percentile	Under 25th Percentile	Total
Prevention	2	8	8	1	2	**21**
Acute and Chronic Care	2	3	6	2	1	**14**
Behavioral Health	0	7	3	2	1	**13**
All Domains	**4**	**18**	**17**	**5**	**4**	**48**
Percentage	**8.33%**	**37.50%**	**35.42%**	**10.42%**	**8.33%**	**100%**

Well Sense's rates ranked at or above the national Medicaid 50th percentile for 39 measures (81.25 percent), with four of these measures ranking at or above the national Medicaid 90th percentile (8.33 percent). Rates for four measures (8.33 percent) fell below the national Medicaid 25th percentile. 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 national Medicaid 90th percentile for the following:

- One Prevention measure: *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- Three Behavioral Health measures: *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*, *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*, and *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*

HSAG recommends that **NHHF** focus future quality improvement activities on the following, which scored below the national Medicaid 25th percentile:

- Three Prevention measures: *Cervical Cancer Screening*, *Chlamydia Screening in Women—Total*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- Four Acute and Chronic Care measures: *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid*, *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*, *Annual Monitoring for Patients on Persistent Medications—Total*, and *Use of Imaging Studies for Low Back Pain*
- One Behavioral Health measure: *Diabetes Monitoring for People with Diabetes and Schizophrenia*

Well Sense

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

- Two Prevention measures: *W15—Well-Child Visits in the First 15 Months of Life—Six or More Visits* and *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- Two Acute and Chronic Care measures: *Appropriate Treatment for Children with Upper Respiratory Infection* and *Controlling High Blood Pressure*

HSAG recommends that **Well Sense** focus future quality improvement activities on the following, which scored below the national Medicaid 25th percentile:

- Two Prevention measures: *Cervical Cancer Screening* and *Chlamydia Screening in Women—Total*
- One Acute and Chronic Care measure: *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*
- One Behavioral Health measure: *Diabetes Monitoring for People with Diabetes and Schizophrenia*

For additional information concerning the HEDIS measures, see Section 4 on page 4-28 in the Detailed Findings.

Summary of Other EQR Activities

Focus Groups

Horn Research, a subcontractor to HSAG, conducted two focus groups covering in fall 2015 and two focus groups in spring 2016.

The fall focus groups were held in Manchester, New Hampshire with 21 members either attending the meetings or responding to telephone interviews. The targeted population for the fall focus groups included individuals currently enrolled in case management with the MCOs for at least 30 days and members discharged from case management within the last three months and currently enrolled with the MCO. Four key points of inquiry were explored with the focus groups: *Access to Case Management, Experience with Health Care Management, Barriers to Receiving Care, and Suggested Improvements*. The majority of participants reported positive experiences with case management. Key challenges connected with case management for participants included difficulties with continuity between case managers, a lack of consistency in quality between case managers, and communication on behalf of family members. The most commonly mentioned suggestion was to improve and enhance communication from their MCO and between their MCO and healthcare providers.

The spring focus groups were held in Concord, New Hampshire, and Derry, New Hampshire, and 21 people participated in the study. For the spring focus groups, the targeted population included individuals who previously opted out of the MCM program and who were now part of the mandatory population receiving benefits through an MCO as of February 1, 2016. Four key points of inquiry were explored during this period's data collection efforts: *Experience with Medicaid Care Management*, *Access to Care*, *Quality of Care and Care Management*, and *Suggested Improvements.* The majority of participants said they either understood their plan or could find the answers they needed. Parents of children with severe disabilities reported more negative experiences with their MCO than other populations in the study. Overall, participants said their access to preventive care had remained the same since enrolling with an MCO. About half of the participants indicated that accessing medications had become more difficult due to changed dosages, medications no longer being covered, and the requirement to switch medications. While the majority of participants said their access to specialists had remained the same, parents of children with disabilities said their access to specialists had dramatically decreased since enrolling with an MCO. Participants nearly universally had positive experiences with their PCPs, most of which were the same physicians they had prior to enrolling with an MCO. The majority of participants said their providers worked well together, but parents of children with disabilities were more likely to say they coordinated their children's care rather than relying on providers to do so. Participants suggested that they would like to receive details on their benefits and coverage, healthcare options, nutrition and healthy eating advice, and cost and quality information.

For additional information concerning the focus group activities, see Section 4 on page 4-89 in the Detailed Findings.

Encounter Data Validation (EDV)

For contract year 2015–2016, DHHS contracted HSAG to develop and implement an Encounter Data Quality Reporting System (EDQRS) for evaluating the quality of encounter data files submitted by **NHHF** and **Well Sense**. The EDQRS was designed to import, store, and review incoming encounter data and generate automated, weekly reports for DHHS. Participating MCOs prepare and submit 837 Professional (P)/Institutional (I) and National Council for Prescription Drug Program (NCPDP) pharmacy files to HSAG daily or weekly. HSAG then processes the files and evaluates the encounter data in four areas: (1) encounter submission accuracy and completeness; (2) encounter data completeness; (3) encounter data accuracy; and (4) encounter data timeliness.

Findings

By the end of SFY 2016, HSAG had generated two EDV reports, including encounters submitted by MCOs between December 1, 2013, and May 2, 2016. Based on the two reports, this section presents the aggregate rates for three standards within Exhibit A—Amendment #7 of the MCM Contract. These standards include:

- Passing X12 EDI compliance edits (Standard 25.2.24.2.1)
- Accuracy and validity of member identification numbers (Standard 25.2.24.2.3)
- Accuracy and validity of servicing provider information (Standard 25.2.24.2.4)

Table 3-9 displays aggregate compliance rates for each MCO in relation to the standards. Values in green font indicate rates meeting the corresponding standards.

Table 3-9—Aggregate Rates for Encounter Data Submission and Quality Standards

Evaluation Area	Standard	837 P Encounters		837 I Encounters		NCPDP Encounters	
		NHHF	Well Sense	NHHF	Well Sense	NHHF	Well Sense
X12 EDI Compliance Edits	98.0%	100.0%	100.0%	100.0%	100.0%	NA	NA
Validity of Member Identification Number							
Percent Present	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Percent Valid*		99.9%	99.7%	99.9%	99.7%	99.1%	99.4%
Validity of Servicing Provider Information*							
Percent Present	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Percent Valid*		98.0%	97.1%	96.0%	95.1%	97.9%	97.8%

* Refer to Table 4-17 and Table 4-18 for more detail regarding these items.

The list below shows the findings for each standard:

- **X12 EDI Compliance Edits**: **NHHF** and **Well Sense** met submission standards regarding X12 EDI compliance edits, with 100 percent of all submitted 837 P/I records successfully translated by HSAG. This metric was not applicable to NCPDP encounters.

- **Member Identification Number**: **NHHF** and **Well Sense** populated all submitted encounters with member identification numbers for all three encounter types. However, when these values were assessed, both MCOs fell below the percent accurate standard of 100 percent.
- **Servicing Provider Information**: **NHHF** and **Well Sense** populated all submitted encounters with servicing provider information for all three encounter types. **NHHF** met the percent accurate standard for its 837 P encounters, and nearly met the standard for NCPDP encounters as well. **Well Sense**'s submitted encounters did not meet the percent accurate standard for any of the three encounter types assessed.

Conclusions and Recommendations

NHHF

Based on aggregate compliance rates for the three contract standards assessed, **NHHF**'s submitted encounters met the following standard:

- X12 EDI compliance edits

HSAG recommends that **NHHF** focus on data accuracy related to member identification numbers and servicing provider information.

Well Sense

Based on aggregate compliance rates for the three contract standards assessed, **Well Sense**'s submitted encounters met the following standard:

- X12 EDI compliance edits

HSAG recommends that **Well Sense** focus on data accuracy related to member identification numbers and servicing provider information.

For additional information concerning EDV, see Section 4 on page 4-93 in the Detailed Findings.

Provider Secret Shopper Survey

HSAG conducted a provider telephone 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 at a higher rate than the standard MCM program, the study was conducted to determine whether appointment accessibility differed based on the member's enrolled program. The study also assisted in determining whether appointment availability met the performance standards established in the contract[3-9] between DHHS and the MCOs.[3-10] The results of the study suggested no bias in the

[3-9] 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: Dec 13, 2016.

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

scheduling of appointments due to program enrollment (i.e., MCM versus NHHPP). Regardless of the appointment type (i.e., preventive or routine/episodic), differences in the ability to schedule appointments was negligible and not statistically significant. While of the 80 appointments that could have been scheduled, less than half of the appointments were within the required time frame (i.e., 45 percent), this was true regardless of appointment type or program (i.e., 42.6 percent for MCM and 48.0 percent for NHHPP). As such, there is no evidence that appointment time varied based on program, and subsequently, differential payment structures.

For additional information concerning the provider secret shopper survey, see Section 4 on page 4-97 in the Detailed Findings.

Focused Study

In March 2016, at the request of DHHS, HSAG conducted a focused review of the MCOs, **NHHF** and **Well Sense**, to examine the processes and methods employed by each health plan to identify and assess members for care management and care coordination. HSAG reviewed 10 member records during the on-site care management review.

Both MCOs used nationally recognized care management information systems, and employees in both care management departments included registered nurses, behavioral health specialists, social workers, and clerical staff. A member remained in care management in both MCOs until goals were achieved, the member was no longer eligible for benefits with the MCO, the member decided to no longer participate in care management, or the MCO could no longer reach the member. Nine of the initially identified 20 cases were closed at the time of the audit.

Recommendations included:

- Ensuring that the care management systems used by the MCOs are continuously enhanced to include protocols and algorithms to evaluate and accommodate the needs of new populations served or additional services provided by the MCOs.
- Maintaining the current caseload ratios, which appear consistent with current industry standards.
- Continuing to assess members upon enrollment and also employ methods to trigger an assessment for case management if there was a change in a member's health status after enrollment.
- Displaying prominently the names of the PCPs and specialists involved in the member's care. All the case management files included the name of the PCPs, and HSAG recommended that the names of specialists involved in the member's care be more prominently displayed in the files.
- Providing copies of care plan goals and objectives to the members and the PCPs.

For additional information concerning the prior authorization study, see Section 4 on page 4-99 in the Detailed Findings.

Overall Strengths and Opportunities for Improvement

New Hampshire Healthy Families

Compliance

NHHF obtained an overall score of 92.7 percent in the SFY 2016 compliance review. Of the 13 standard areas reviewed, **NHHF** achieved *100 percent compliance* on six standards (Delegation and Subcontracting, Emergency and Post-stabilization Care, Cultural Considerations, Grievances and Appeals, Access, and Quality Management), demonstrating strength and adherence to all requirements in these standards.

Standards representing opportunities for improvement for **NHHF** include the following:

- Behavioral Health
- Network Management
- Utilization Management
- Plans Required by the Contract
- Member Enrollment and Disenrollment
- Member Services
- Substance Use Disorder

PIPs

NHHF demonstrated very strong performance in the results from the PIP validations by scoring 100 percent in the 70 elements evaluate in the Design stage of the four PIPs and 100 percent in the 32 elements evaluated in the Implementation stage of the four PIPs. Overall, **NHHF** designed and implemented scientifically sound PIPs supported by key research principles and used methodologically sound approaches to data analysis and quality improvement strategies.

PMV

For SFY 2015, all measures except one were successfully approved for reporting for **NHHF**. **NHHF** was unable to report the DEMOGPROF.01 (i.e., *Community Demographic, Cultural, and Epidemiologic Profile: Preferred Spoken Language*) measure. The auditors recommended that **NHHF** revise its processes for capturing the data required for the unsuccessful measure to ensure that the rate can be reported in the future.

For SFY 2016, all measures except one were successfully approved for reporting for **NHHF**. HSAG considered the calculation of the SERVICEAUTH.02 (i.e., *Percentage of Medical Service, Equipment and Supply Service Authorization Determinations for Request Involving Urgent Care and Relating to the Extension of an Ongoing Course of Treatment Made Within 24 Hours After Receipt of Request for Requests Made During the Measure Data Period*) measure to be materially biased and *Not Reportable.*

The auditors recommended that **NHHF** continue to consult with DHHS to ensure timely and accurate reporting of the measures to DHHS throughout the year.

CAHPS

For **NHHF**'s adult Medicaid population, all nine 2015 positive rates exceeded the 2015 NCQA adult Medicaid national average. For **NHHF**'s general child Medicaid population, four 2015 positive rates exceeded the 2015 NCQA child Medicaid national averages. The 2015 positive rates for five general child measures fell below the 2015 NCQA child Medicaid national averages: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Customer Service*.

HEDIS

Based on the rates the MCO achieved for the HEDIS measures, **NHHF** showed strong performance by scoring at or above the national Medicaid 90th percentile for one Prevention measure and three Behavioral Health measures. HSAG recommends that **NHHF** focus future quality improvement activities on the following, which scored below the national Medicaid 25th percentile: three Prevention measures, four Acute and Chronic Care measures, and one Behavioral Health measure.

Encounter Data Validation

While **NHHF** met the standard for X12 EDI compliance edits, **NHHF** should continue improving data accuracy for the member identification number and servicing provider information so that **NHHF** can exceed the standard.

Well Sense Health Plan

Compliance

Well Sense obtained an overall score of 88.8 percent in the SFY 2016 compliance review. Of the 13 standard areas reviewed, **Well Sense** achieved *100 percent compliance* on eight standards (Delegation and Subcontracting, Plans Required by the Contract, Emergency and Post-stabilization Care, Member Enrollment and Disenrollment, Cultural Considerations, Access, Utilization Management, and Quality Management), demonstrating strength and adherence to all requirements in these standards.

Standards representing opportunities for improvement for **Well Sense** include the following:

- Behavioral Health
- Grievances and Appeals
- Network Management
- Member Services
- Substance Use Disorder

PIPs

Well Sense demonstrated very strong performance in the results from the SFY 2016 PIP validations by scoring 100 percent in the 57 elements evaluated in the Design stage of the four PIPs and 100 percent in the 30 elements evaluated in the Implementation stage of the four PIPs. Overall, **Well Sense** designed and implemented scientifically sound PIPs supported by key research principles and used methodologically sound approach to data analysis and quality improvement strategies.

PMV

For SFY 2015, **Well Sense** was unable to report on one measure. After discussions with the HSAG auditor, **Well Sense** identified an issue with the configuration of this measure and confirmed that the MCO was not accurately reporting the measure. HSAG also recommended that **Well Sense** create an internal vendor monitoring system to track claims monthly. This will allow **Well Sense** to have an additional check and balance for each external vendor, identify gaps, and trend claims over time.

For SFY 2016, HSAG determined that **Well Sense** did not capture information that met the intent of the SERVICEAUTH.02 (i.e., *Percentage of Medical Service, Equipment and Supply Service Authorization Determinations for Request Involving Urgent Care and Relating to the Extension of an Ongoing Course of Treatment Made Within 24 Hours After Receipt of Request for Requests Made During the Measure Data Period*) measure. As a result, HSAG considers the calculation of the SERVICEAUTH.02 measure to be materially biased and *Not Reportable*. **Well Sense** still has several manual steps in the measure production process primarily affecting measures that rely heavily on external vendor data (e.g., SERVICEAUTH.02 and CLAIM.11). **Well Sense** should continue to automate data flow processes and integrate automation steps to systematically produce the measures.

CAHPS

For **Well Sense**'s adult Medicaid population, seven 2015 positive rates for the adult Medicaid population exceeded the 2015 NCQA national averages. The 2015 positive rates for two of the adult measures fell below the 2015 NCQA adult Medicaid national averages: *Rating of Health Plan* and *Rating of All Health Care*. For **Well Sense**'s general child Medicaid population, seven 2015 positive rates exceeded the 2015 NCQA child Medicaid national average. The 2015 positive rates for two general child measures, *Rating of All Health Care* and *Getting Needed Care*, fell below the 2015 NCQA child Medicaid national averages.

HEDIS

Based on the rates the MCO achieved for the HEDIS measures, **Well Sense** showed strong performance by scoring at or above the national Medicaid 90th percentile for two Prevention measures and two Acute and Chronic Care measures. HSAG recommends that **Well Sense** focus future quality improvement activities on the one Acute and Chronic Care, one Behavioral Health, and two Prevention performance measures that scored below the national Medicaid 25th percentile.

Encounter Data Validation

While **Well Sense** met the standard for X12 EDI compliance edits, **Well Sense** should continue improving data accuracy for the member identification number and servicing provider information so that **Well Sense** can exceed the standard.

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

MCO Contractual Compliance

The SFY 2014 compliance activities consisted of reviewing all 14 standards containing 294 applicable elements for **NHHF** and 295 applicable elements for **Well Sense**. 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 review of compliance conducted in SFY 2015 began a three-year cycle of reviewing one-third of the elements contained in the compliance tool. The review for SFY 2015 included a total of 92 applicable elements for **NHHF** and 91 applicable elements for **Well Sense** from the 14 standards. The current review of compliance conducted in SFY 2016 continued the three-year cycle of reviewing one-third of the elements, which included 130 applicable elements for **NHHF** and 129 applicable elements for **Well Sense** from 13 standards.

The CAP elements from the SFY 2015 review also were included in the SFY 2016 on-site review to ensure that the information submitted for the CAP was 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 2016 Compliance Review

Table 4-1 includes the findings from the SFY 2016 compliance reviews for **NHHF** and **Well Sense**.

Table 4-1—Comparison of MCO Scores for the SFY 2016 Compliance Review

Standard	Standard Name	2015–2016 NHHF	2015–2016 Well Sense
I	Delegation and Subcontracting	**100%**	**100%**
II	Plans Required by the Contract	**83.3%**	**100%**
III	Emergency and Post-stabilization Care	**100%**	**100%**
IV	Care Management/Care Coordination*	**NA**	**NA**
V	Wellness and Prevention*	**NA**	**NA**
VI	Behavioral Health	**92.9%**	**92.9%**

[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: Dec 13, 2016.

Standard	Standard Name	2015–2016 NHHF	2015–2016 Well Sense
VII	Member Enrollment and Disenrollment	**85.7%**	**100%**
VIII	Member Services	**83.3%**	**50.0%**
IX	Cultural Considerations	**100%**	**100%**
X	Grievances and Appeals	**100%**	**92.3%**
XI	Access	**100%**	**100%**
XII	Network Management	**90.9%**	**95.5%**
XIII	Utilization Management	**95.0%**	**100%**
XIV	Quality Management	**100%**	**100%**
XV	Substance Use Disorder	**42.9%**	**14.3%**
Overall Rate		**92.7%**	**88.8%**

* Standards IV and V were not included in the 2015–2016 compliance review.

Of the 13 standards included in the SFY 2016 compliance review, **NHHF** achieved 100 percent compliance for six standards, 90–99 percent compliance for three standards, 80–89 percent compliance for three standards, and below 80 percent compliance for one standard. **Well Sense** achieved 100 percent compliance for eight standards, 90–99 percent compliance for three standards, and below 90 percent compliance for two standards. Both MCOs scored the lowest on the new Substance Use Disorder Standard requirements added to the MCO contract with DHHS and evaluated for the first time during this compliance review.

The SFY 2016 compliance review also included a review of grievance, appeal, and denial files. **NHHF**'s file reviews included a total of 102 elements, and **Well Sense**'s file reviews included a total of 100 elements. HSAG reviewed 10 files for each review, and the findings are listed below.

Table 4-2—Comparison of MCO Scores for the SFY 2016 File Reviews

File Review	NHHF	Well Sense
Grievances	93.3%	96.8%
Appeals	100%	97.5%
Denials of Services	93.3%	100%
File Review Totals	**96.1%**	**98.0%**

NHHF achieved 100 percent compliance on all elements contained in the appeals file review. **NHHF** scored 93.3 percent on both grievance and denial file reviews. Two acknowledgement letters were sent later than required by the MCO's policies in the grievance files, and two acknowledgement letters were sent later than required by the MCO's policies in the denial files.

Well Sense achieved 100 percent compliance on the denial file review. **Well Sense** scored 97.5 percent on the appeals review and 96.8 percent on the grievances review. In the appeals files, one

acknowledgement letter was sent later than required by the MCO's policies. Similarly, in the grievance files, one acknowledgement letter was sent later than required by the MCO's policies.

The SFY 2016 compliance review also included a review of five checklists: access standards, provider directory, member handbook, MCO website requirements, and member rights. **NHHF**'s checklist reviews included 150 elements, and **Well Sense**'s checklist reviews included 148 elements. The findings are listed below.

Table 4-3—Comparison of MCO Scores for the SFY 2016 Checklist Reviews

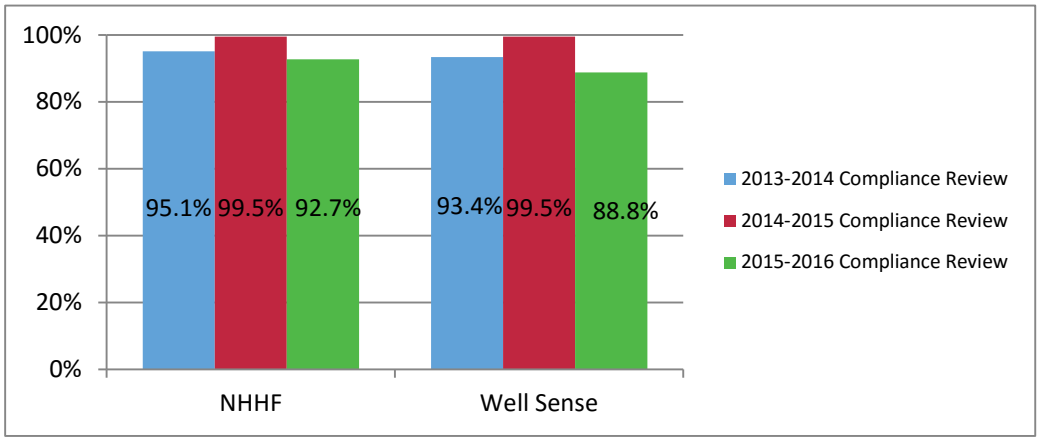
Checklist	NHHF	Well Sense
Access Standards	100%	100%
Provider Directory	100%	100%
Member Handbook	97.0%	100%
MCO Website	100%	100%
Member Rights	100%	100%
Checklist Review Totals	**99.3%**	**100%**

Well Sense achieved full compliance for all checklists. The one checklist that did not achieve full compliance for **NHHF** was the member handbook checklist. **NHHF** could not provide evidence of notifying all members annually of their disenrollment rights.

Trending

Figure 4-1 displays the compliance scores achieved by **NHHF** and **Well Sense** during the three years that HSAG conducted compliance reviews. In SFY 2014, the number of elements reviewed was 294 for **NHHF** (one element was found to be not applicable [NA]) and 295 for **Well Sense**. The SFY 2015 compliance review was the initial year for reviewing one-third of the elements in all the standards each year. In SFY 2015, the number of elements reviewed was 92 for **NHHF** and 91 for **Well Sense** (one element was found to be NA). In SFY 2016, HSAG reviewed 130 elements for **NHHF** and 129 elements for **Well Sense** (one element was found to be NA).

Figure 4-1—Trending of Compliance Review Scores for NHHF and Well Sense for the Three Years of Compliance Reviews



Both MCOs improved their compliance scores from the first compliance review (SFY 2014) to the second compliance review (SFY 2015). During the first compliance review (SFY 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. Both MCOs missed one element in the second compliance review (SFY 2015) and scored a *Partially Met* score for 1.1 percent of the elements with an overall score of 99.5 percent.

The scores for **NHHF** and **Well Sense** declined from the second compliance review to the third compliance review. In the SFY 2016 review, **NHHF** received a *Partially Met* score for 5.4 percent of the elements (n=7) and a *Not Met* score for 4.6 percent of the elements (n=6). **Well Sense** received a *Partially Met* score for 2.3 percent of the elements (n=3) and a *Not Met* score for 10.1 percent of the elements (n=13).

During the third compliance review, HSAG also evaluated the CAPs from the elements scored *Partially Met* or *Not Met* in the second compliance review. The number of CAP items reviewed included one for **NHHF** and one for **Well Sense**. Both MCOs corrected the deficiency identified during the prior review.

NHHF Conclusions and Recommendations

During the SFY 2016 compliance review, 10 percent of the elements (n=13) were found to be noncompliant with federal and State regulations. The file reviews for grievances, appeals, and denials were 96.1 percent compliant with the required elements, and the checklist reviews generated a score of 99.3 percent compliance with required elements. HSAG also validated through a review of meeting minutes that the MCO corrected the one deficiency found during the prior year's audit.

NHHF received a score *over 90 percent and lower than 100 percent* on three standards (Behavioral Health, Network Management, and Utilization Management), representing an opportunity for improvement. To improve the Behavioral Health Standard, **NHHF** needs to ensure that the MCO retains

documentation to substantiate approval by DHHS of the policies concerning the coordination of care with PCPs and community mental health programs that are required to be approved 90 calendar days prior to the beginning of each agreement year. **NHHF** could improve the Network Management Standard by ensuring that plan documents include the statement that the provider manual will be updated at least annually. **NHHF** also could improve the Network Management Standard by ensuring that the MCO retains documentation to substantiate approval by DHHS of the provider manual and provider training materials that are required to be submitted 60 days prior to any substantive revisions. The Utilization Management Standard could be improved by **NHHF** by updating the definition for "Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services" to include the appropriate age limits for the services.

NHHF received a score *over 80 percent and lower than 90 percent* on three standards (Plans Required by the Contract, Member Enrollment and Disenrollment, and Member Services), representing an opportunity for improvement. To improve the Plans Required by the Contract Standard, **NHHF** must update policies, procedures, and workflow documents to include the requirement that all members affected by a termination (by receiving ongoing care from a terminated provider) have a transition plan in place within three calendar days following the effective date of the termination. **NHHF** also needs to include in the EPSDT Plan the MCO's procedures for referral, tracking, and follow-up for annual dental examinations and visits upon receipt of dental claims information from DHHS. The Member Enrollment and Disenrollment Standard could be improved by **NHHF** ensuring that the MCO provides members and their representatives with written notice of disenrollment rights at least 60 calendar days before the start of each reenrollment period. The Member Services Standard could be improved by ensuring that **NHHF** arranges for video conferencing opportunities for the Member Advisory Board meetings, and that the minutes of the Member Advisory Board meetings are sent to DHHS within 30 days of the meeting.

NHHF received a score of *42.9 percent* on one standard: Substance Use Disorder. This standard, representing the opportunity for the most improvement for **NHHF**, was a new standard added to the MCO contract with DHHS and included in the SFY 2016 review. To improve the score for this standard, **NHHF** needs to implement the reporting requirements for substance use disorder services.

Well Sense Conclusions and Recommendations

During the SFY 2016 compliance review, 12.4 percent of the elements (n=16) were found to be noncompliant with federal and State regulations. The file reviews for grievances, appeals, and denials were 98 percent compliant with the required elements, and the checklist reviews generated a score of 100 percent compliance with required elements. HSAG also validated through a review of meeting minutes that the MCO corrected the one deficiency found during the prior year's audit.

Well Sense received a score *over 90 percent and lower than 100 percent* on three standards (Behavioral Health, Grievances and Appeals, and Network Management), representing an opportunity for improvement. To improve the Behavioral Health Standard, **Well Sense** needs to ensure that the MCO retains documentation to substantiate approval by DHHS of the policies concerning coordination of care with PCPs and community mental health programs that are required to be approved 90 calendar days prior to the beginning of each agreement year. **Well Sense** could improve the Grievances and Appeals

Standard by ensuring that expedited appeals can be extended as required by the agreement with DHHS, and ensuring that plan documents include the requirement that **Well Sense** is obligated to fully resolve all appeals and grievances until final resolution of any grievance or appeal upon termination of the agreement between **Well Sense** and DHHS. **Well Sense** could improve the Network Management Standard by ensuring that the MCO retains documentation to substantiate approval by DHHS of the provider manual and provider training materials that are required 60 days prior to any substantive revisions.

Well Sense received a score of *50 percent* on one standard, Member Services, representing an opportunity for improvement. To improve this standard, **Well Sense** must ensure that the MCO gives each member written notice of the change at least 30 days before the intended effective date of any change affecting member rights; filing requirements; time frames for grievances, appeals, and State fair hearings; availability of assistance in submitting grievances and appeals; and the toll-free numbers of the MCO grievance system resources. **Well Sense** also needs to hold in-person regional meetings for the Member Advisory Board at least twice each year, provide minutes of the Member Advisory Board meetings to DHHS within 30 days of the meeting, and arrange for video conferencing opportunities for the Member Advisory Board meetings.

Well Sense received a score of *14.3 percent* on one standard: Substance Use Disorder. This standard, representing the opportunity for the most improvement for **Well Sense**, was a new standard added to the MCO contract with DHHS and included in the SFY 2016 review. To improve the score for the Substance Use Disorder Standard, **Well Sense** needs to implement the reporting requirements for substance use disorder services.

Assessment of Prior Year Recommendations for Compliance

During the second compliance review in SFY 2015, **NHHF** and **Well Sense** achieved 100 percent compliance on 13 standards, and both MCOs failed to meet the same element in the Network Management Standard. Both MCOs failed to convene a Consumer Advisory Board a minimum of four times each agreement year as required in Section 20.4.1 of the New Hampshire Department of Health and Human Services Amendment #5 to the Medicaid Care Management Contract. A review of the minutes of the advisory board meetings during the SFY 2016 compliance reviews at **NHHF** and **Well Sense** confirmed that both MCOs corrected the item of noncompliance and held Consumer Advisory Board meetings as required by the MCM Contract.

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 2016, 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

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 Readmissions to New Hampshire Hospital (New Hampshire's Inpatient Psychiatric facility)*
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*

Validation 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—SFY 2015 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% (70/70)	100% (57/57)
Implementation	Activities VII–VIII	100% (32/32)	100% (30/30)
Outcomes	Activities IX–X	*Assessed in 2016; results included in 2017 technical report*	*Assessed in 2016; results included in 2017 technical report*
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**100%**	**100%**

Both MCOs progressed through Activity VIII, the Design and Implementation stages 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. The Implementation stage includes data analysis and interpretation and development and implementation of improvement strategies. In 2015, the MCOs reported the baseline measurement for each PIP and described improvement strategies that occurred during the baseline measurement period. Both MCOs met 100 percent of the requirements for all activities in the Design and Implementation stages 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 allowed successful progression to the next stage of the PIP process. The MCOs accurately reported the baseline study indicator results for each PIP and documented sound quality improvement strategies. The PIPs will be validated through the Outcomes stage in 2016, when the MCOs progress to reporting first re-measurement study indicator results and improvement strategies. Those results will be reported in the 2017 EQR Technical Report.

PIP-specific Outcomes

NHHF

The tables below display the baseline study indicator outcomes for each **NHHF** PIP.

Table 4-6 displays the baseline study indicator results for the *Comprehensive Diabetes Care—Vision Screening* PIP.

Table 4-6—Performance Improvement Project Outcomes for *Comprehensive Diabetes Care—Vision Screening*

Study Indicator	Baseline Period
1. The percentage of members aged 18 to 75 years with diabetes (type 1 or type 2) who had an eye exam (retinal) performed.	59.8%

For the *Comprehensive Diabetes Care—Vision Screening* PIP, **NHHF** reported a baseline study indicator rate of 59.8 percent.

Table 4-7 displays the baseline study indicator results for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP.

Table 4-7—Performance Improvement Project Outcomes for *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Study Indicator	Baseline Period
1. The percentage of members ages 18 to 64 years with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening in the measurement year.	81.3%

For the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PIP, **NHHF** reported a baseline study indicator rate of 81.3 percent.

Table 4-8 displays the baseline study indicator results for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* PIP.

Table 4-8—Performance Improvement Project Outcomes for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

Study Indicator	Baseline Period
1. The percentage of eligible members aged 3 to 17 years with evidence of body mass index (BMI) documentation.	68.6%
2. The percentage of eligible members aged 3 to 17 years with evidence of counseling for nutrition.	74.8%
3. The percentage of eligible members aged 3 to 17 years with evidence of counseling for physical activity.	69.5%

For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* PIP, **NHHF** reported the following baseline rates: 68.6 percent for Study Indicator 1 (evidence of BMI documentation), 74.8 percent for Study Indicator 2 (evidence of counseling for nutrition), and 69.5 percent for Study Indicator 3 (evidence of counseling for physical activity).

Table 4-9 displays the baseline study indicator results for the *Well-Child Visits for 3-to-6-Year-Olds* PIP.

Table 4-9—Performance Improvement Project Outcomes for *Well-Child Visits for 3-to-6-Year-Olds*

Study Indicator	Baseline Period
1. The percentage of members ages 3 to 6 years who had at least one well-child visit with a PCP in the measurement year.	79.3%

For the *Well-Child Visits for 3-to-6-Year-Olds* PIP, **NHHF** reported a baseline study indicator rate of 79.3 percent.

Well Sense

The tables below display the baseline study indicator outcomes for each **Well Sense** PIP.

Table 4-10 displays the baseline study indicator results for the *Chlamydia Screening* PIP.

Table 4-10—Performance Improvement Project Outcomes for *Chlamydia Screening*

Study Indicator	Baseline Period
1. The percentage of women 16 to 24 years of age who were identified as sexually active and had had at least one chlamydia test performed in the measurement year.	43.5%

For the *Chlamydia Screening* PIP, **Well Sense** reported a baseline study indicator rate of 43.5 percent.

Table 4-11 displays the baseline study indicator results for the *Diabetes Care—HbA1c Testing* PIP.

Table 4-11—Performance Improvement Project Outcomes for *Diabetes Care—HbA1c Testing*

Study Indicator	Baseline Period
1. The percentage of members 18 to 75 years of age with diabetes (type 1 or type 2) who had an HbA1c test performed in the measurement year.	92.5%

For the *Diabetes Care—HbA1c Testing* PIP, **Well Sense** reported a baseline study indicator rate of 92.5 percent. Because the baseline rate was so high, with little room for improvement, the rate did not support selection of the PIP topic as an area for improvement; therefore, HSAG recommended that the MCO select of a new topic for the PIP. After technical assistance discussions involving the MCO, DHHS, and HSAG, **Well Sense** identified a replacement PIP topic, supported by plan-specific historical data, to be initiated in the following year.[4-2]

Table 4-12 displays the baseline study indicator results for the *Reducing Hospital Readmissions* PIP.

Table 4-12—Performance Improvement Project Outcomes for *Reducing Hospital Readmissions*

Study Indicator*	Baseline Period
1. The percentage of eligible members readmitted to New Hampshire Hospital within 30 days of discharge.	13.3%
2. The percentage of eligible members readmitted to New Hampshire Hospital within 60 days of discharge.	18.1%
3. The percentage of eligible members readmitted to New Hampshire Hospital within 90 days of discharge.	18.8%

* The PIP's study indicators are inverse indicators, where a lower rate is better.

For the *Reducing Hospital Readmissions* PIP, **Well Sense** reported the following baseline rates: 13.3 percent for Study Indicator 1 (30-day readmission rate), 18.1 percent for 2 (60-day readmission rate), and 18.8 percent for Study Indicator 3 (90-day readmission rate).

Table 4-13 displays the baseline study indicator results for the *Well-Child Visits for 3-to-6-Year-Olds* PIP.

Table 4-13—Performance Improvement Project Outcomes Results for *Well-Child Visits for 3-to-6-Year-Olds*

Study Indicator	Baseline Period
1. The percentage of members 3 to 6 years of age who had at least one well-child visit with a PCP in the measurement year.	77.5%

[4-2] **Well Sense** selected *Comprehensive Diabetes Care—Medical Attention for Nephropathy* as the PIP topic to replace the *Diabetes Care-HbAlc Testing* PIP.

For the *Well-Child Visits for 3-to-6-Year-Olds* PIP, **Well Sense** reported a baseline study indicator rate of 77.5 percent.

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** used a methodologically sound approach to data analysis and quality improvement strategies in the Implementation stage. The MCO met 100 percent of the requirements across the four PIPs for all eight activities. **NHHF** will report results of the first re-measurement for each PIP in the next annual validation cycle.

HSAG offered the following recommendations, identified as *Points of Clarification* in the PIP validation tools, which may strengthen future submissions:

- **NHHF** should establish and document specific, measureable goals for the first re-measurement of the study indicators, based on the baseline results in each PIP.
- **NHHF** should ensure that next year's annual PIP submission identifies the priority level, or priority ranking, of identified barriers and clearly documents the process used to prioritize barriers. Additionally, high-priority barriers should have a direct impact on the PIP study indicators.
- **NHHF** should ensure that each intervention implemented during the first re-measurement period is accompanied by an intervention-specific evaluation of effectiveness. Next year's annual PIP submission will require documentation of the results of each intervention's evaluation. The MCO will need to document each intervention's effectiveness based on evaluation data that determine the specific impact of the intervention on the study indicators.

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** used a methodologically sound approach to data analysis and quality improvement strategies in the Implementation stage. The MCO met 100 percent of the requirements across the four PIPs for all eight activities. **Well Sense** will report results of the first re-measurement for each PIP in the next annual validation cycle.

HSAG offered the following recommendation for the **Well Sense** *Diabetes Care—HbA1c Testing* PIP:

- Because the high baseline study indicator rate does not support the selection of HbA1c testing as an area for performance improvement, **Well Sense** should work with DHHS and HSAG to pursue selection of a replacement PIP topic for the next validation cycle.

Assessment of Prior Year Recommendations for PIPs

Both **NHHF** and **Well Sense** met 100 percent of the requirements across the eight PIPs validated during 2014–2015; therefore, there were no recommendations requiring follow-up. HSAG provided **NHHF** two *Points of Clarification* in the final SFY 2015 tools, and both points were addressed in SFY 2016.

Validation of MCO Performance Measures

This section of the report describes the results of HSAG's SFY 2015 and SFY 2016 EQR activities specific to validation of performance measures. 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. During SFY 2015, each MCO submitted rates for 32 state-specific measures that were validated during PMV. Additionally, during SFY 2016, each MCO submitted rates for 11 state-specific measures that were validated during the PMV audit. Recommendations are offered to each MCO to facilitate continued quality improvement in the Medicaid program. A list of the measures reviewed in SFYs 2015 and SFY 2016, and a complete description of the audit methodology used to conduct the review of performance measures are included in Appendix B.

Results for SFY 2015

Table 4-14 provides an overview of the findings of the HSAG performance validation review for SFY 2015.

Table 4-14—SFY 2015 PMV 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
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	One Measure Not Acceptable	One Measure Not Acceptable

Conclusions and Recommendations for Improvement

NHHF

For SFY 2015, **NHHF** staff members were dedicated to quality reporting and proactively clarified measure-specific questions with the State and HSAG prior to reporting rates. **NHHF**'s information

technology staff members were experienced data miners and proficient in SQL and Informatica software packages. **NHHF** business staff members participated in each session of the audit and provided critical documentation and presentations necessary for the completion of the audit. HSAG prefers and recommends that **NHHF** provide source code for review prior to the on-site review. Historically, **NHHF** has indicated that the source code is proprietary and will not release the code for review. Although **NHHF** provides pre-on-site review sessions via WebEx, HSAG would prefer to have the source code for verification and follow-up.

NHHF was unable to report the DEMOGPROF.01 (i.e., *Community Demographic, Cultural, and Epidemiologic Profile: Preferred Spoken Language*) measure correctly. While data were captured in the health risk assessment as required for this measure, they were not uploaded to the Care Management system. Therefore, these data were not available for measure calculation and reporting. The health plan should revise its processes for data capture in order to report this rate in the future.

Well Sense

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

Similar to the previous PMV 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** continue to monitor each of its vendors monthly for encounter submissions. In addition, HSAG recommended that trending reports for encounter submissions be added to the MCO's monthly monitoring process. This will allow **Well Sense** to have an additional check and balance for each external vendor, identify gaps, and trend claims over time.

Well Sense was unable to report the HPP_ACCESSREQ.01 (i.e., Member Requests for Assistance Accessing MCO Designated PCPs per Average Members by Geographic Region for the NHHPP Members) measure correctly. After discussions with the HSAG auditor, **Well Sense** identified an issue with the configuration of this measure and confirmed that the MCO was not accurately reporting the measure. **Well Sense** informed DHHS of this finding.

Results for SFY 2016

Table 4-15 provides an overview of the findings of the HSAG performance validation review for SFY 2016.

Table 4-15—SFY 2016 PMV 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
Appeals Data System and Process Findings	Acceptable	Acceptable

Performance Measures	NHHF	Well Sense
Prior Authorization Data System and Process Findings	Acceptable	Acceptable
Call Center Data System and Process Findings	Acceptable	Acceptable
Performance Measure Production and Reporting Findings	One Measure Not Acceptable	One Measure Not Acceptable

Conclusions and Recommendations for Improvement

NHHF

NHHF used a variety of methods for producing the measures under review and had staff members who were dedicated to quality reporting. HSAG worked with **NHHF** to review source code through separate off-site sessions. **NHHF** and HSAG walked through some measures to confirm data elements that were either accounted for or excluded from the source code to understand the concerns regarding some rates reported by **NHHF**. In addition, HSAG conducted primary source verification and measure walkthroughs.

All measures except SERVICEAUTH.02 (i.e., *Percentage of Medical Service, Equipment and Supply Service Authorization Determinations for Request Involving Urgent Care and Relating to the Extension of an Ongoing Course of Treatment Made Within 24 Hours After Receipt of Request for Requests Made During the Measure Data Period*) were successfully approved for reporting. HSAG considered the calculation of the SERVICEAUTH.02 measure to be materially biased and *Not Reportable.* HSAG identified concerns with the authorization processes of **NHHF** and its behavioral health vendor during the authorization period which determined whether to extend services or days based on the patient's condition and progress. The behavioral health vendor generated a new authorization, rather than extend an existing authorization. This process did not capture information that met the intent of the SERVICEAUTH.02 measure. Although HSAG and DHHS granted an extension to **NHHF** to recalculate the measure according to the specifications, **NHHF** was not able to produce the rates in accordance with the intent of the measure.

NHHF should consult with DHHS when producing measures to eliminate any issues related to understanding the measures, especially those involving the inclusion or exclusion of behavioral health claims and authorizations. **NHHF** should continue to consult with DHHS to ensure timely reporting of the measures to DHHS throughout the year and to HSAG for final review.

Well Sense

Well Sense used a variety of methods for producing the measures under review. Each measure underwent source code review by HSAG to ensure eligible populations, numerators, and denominators were accounted for accurately.

One issue was discovered during the on-site visit with regard to how **Well Sense** created and extended existing authorizations. **Well Sense**'s concurrent review process eliminated the need for the provider to

submit an additional, urgent request when an original authorization was expected to expire. **Well Sense** had a robust concurrent review process for medical services (i.e., non-mental health services). **Well Sense** reviewed all authorizations during the authorization period to determine whether to extend services or days based on the concurrent review of the patient's condition. **Well Sense**'s proactive processing of the extension essentially eliminated any need for the provider to request an urgent extension for services. If services were exhausted under the original request and a provider was seeking additional services, the provider would be required to submit additional medical documentation.

According to **Well Sense**, this would result in a new authorization being created rather than an extension. This process therefore did not capture information that met the intent of the SERVICEAUTH.02 (i.e., *Percentage of Medical Service, Equipment and Supply Service Authorization Determinations for Request Involving Urgent Care and Relating to the Extension of an Ongoing Course of Treatment Made Within 24 Hours After Receipt of Request for Requests Made During the Measure Data Period*) measure. As a result, HSAG considers the calculation of the SERVICEAUTH.02 measure to be materially biased and *Not Reportable*. **Well Sense** was granted additional time to recalculate the measure and research scenarios that would have met the measure criterion. Despite its effort, **Well Sense** was still unable to capture the essence of the measure's intent.

Well Sense should continue to work with DHHS and HSAG to understand the details of each measure. Through continued dialogue, **Well Sense** can prevent additional measures from becoming *Not Reportable*. **Well Sense** still has several manual steps in the measure production process. This primarily affects measures that rely heavily on external vendor data. **Well Sense** should continue to automate data flow processes and integrate automation steps to systematically produce the measures.

Assessment of Prior Year Recommendations for PMV

In the prior audit, HSAG did not make any recommendations for **NHHF**. HSAG recommended that **Well Sense** monitor each of its vendors monthly for encounter submissions. **Well Sense** maintained its relationship with external vendors as was demonstrated in the pre-on-site vendor reviews. However, **Well Sense** still needed to improve its data validation processes for the measure-specific rates that were calculated by these vendors to ensure data accuracy.

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. Both **NHHF** and **Well Sense** used a mixed-mode methodology for data collection for the adult and child Medicaid populations.[4-3] Adult members and parents or caretakers of child members completed the surveys in 2016, following NCQA's data collection protocol.

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 positive 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 response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of positive responses is referred to as a global proportion for the composite scores. The positive 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.

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 2015 NCQA CAHPS Adult and General Child Medicaid national averages, where applicable.[4-5] 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.

[4-3] For the adult and child Medicaid populations, **NHHF** and **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] National data were obtained from the 2015 Quality Compass. Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Results

NHHF

In 2016, a total of 2,228 **NHHF** adult Medicaid members were surveyed, of which 485 completed surveys were returned. After ineligible members were excluded, the response rate was 23.3 percent. In 2015, the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey was 27.2 percent, which was higher than the **NHHF** adult Medicaid response rate. Figure 4-2 and Figure 4-3 on the following pages show the 2015 positive rates, and lower and upper confidence intervals for the CAHPS global ratings and composite measures, respectively, for **NHHF**'s adult Medicaid population. The black lines on the figures indicate the range of the confidence intervals for each rate.

Figure 4-2—NHHF Adult Medicaid CAHPS Results: Global Ratings

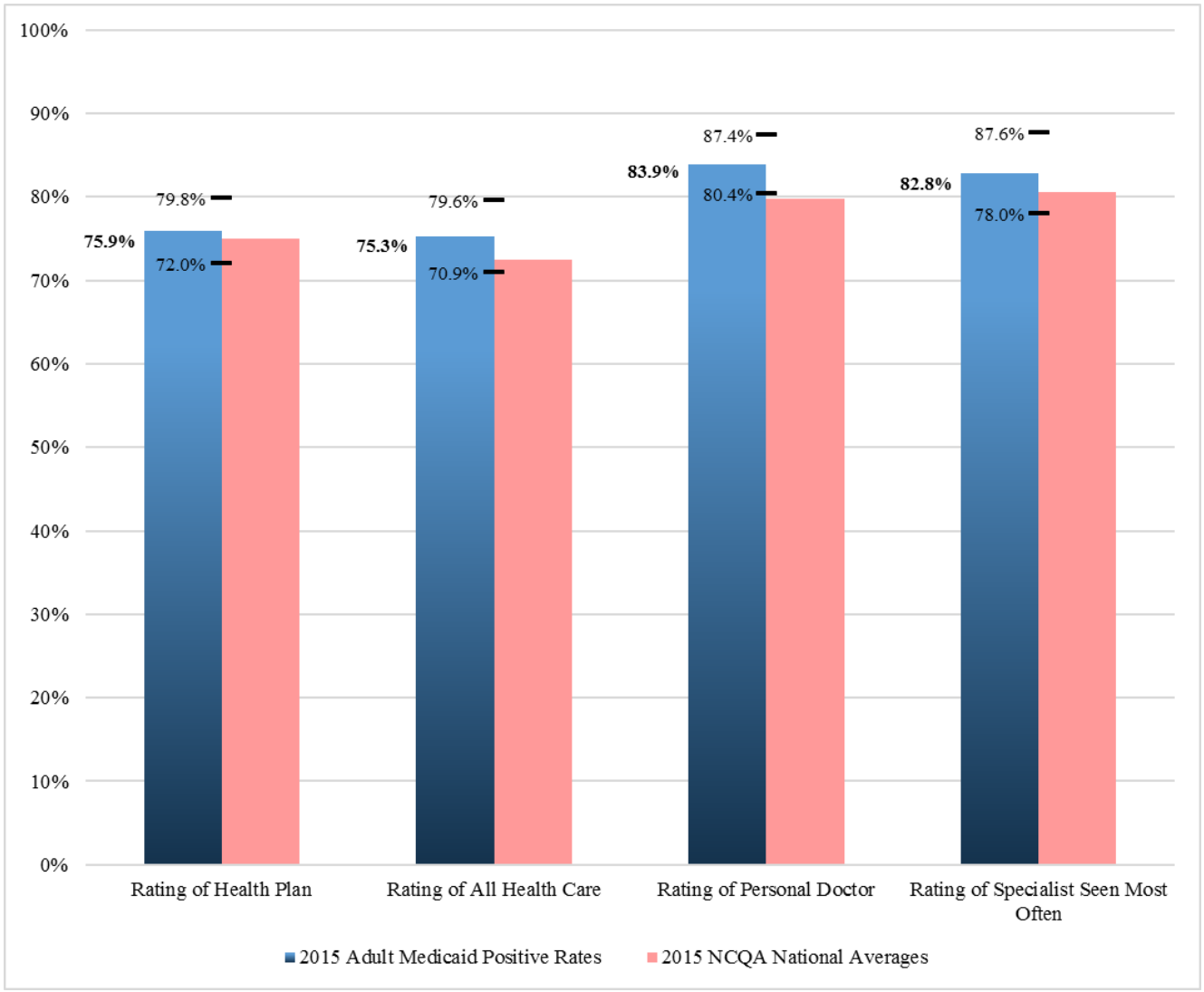
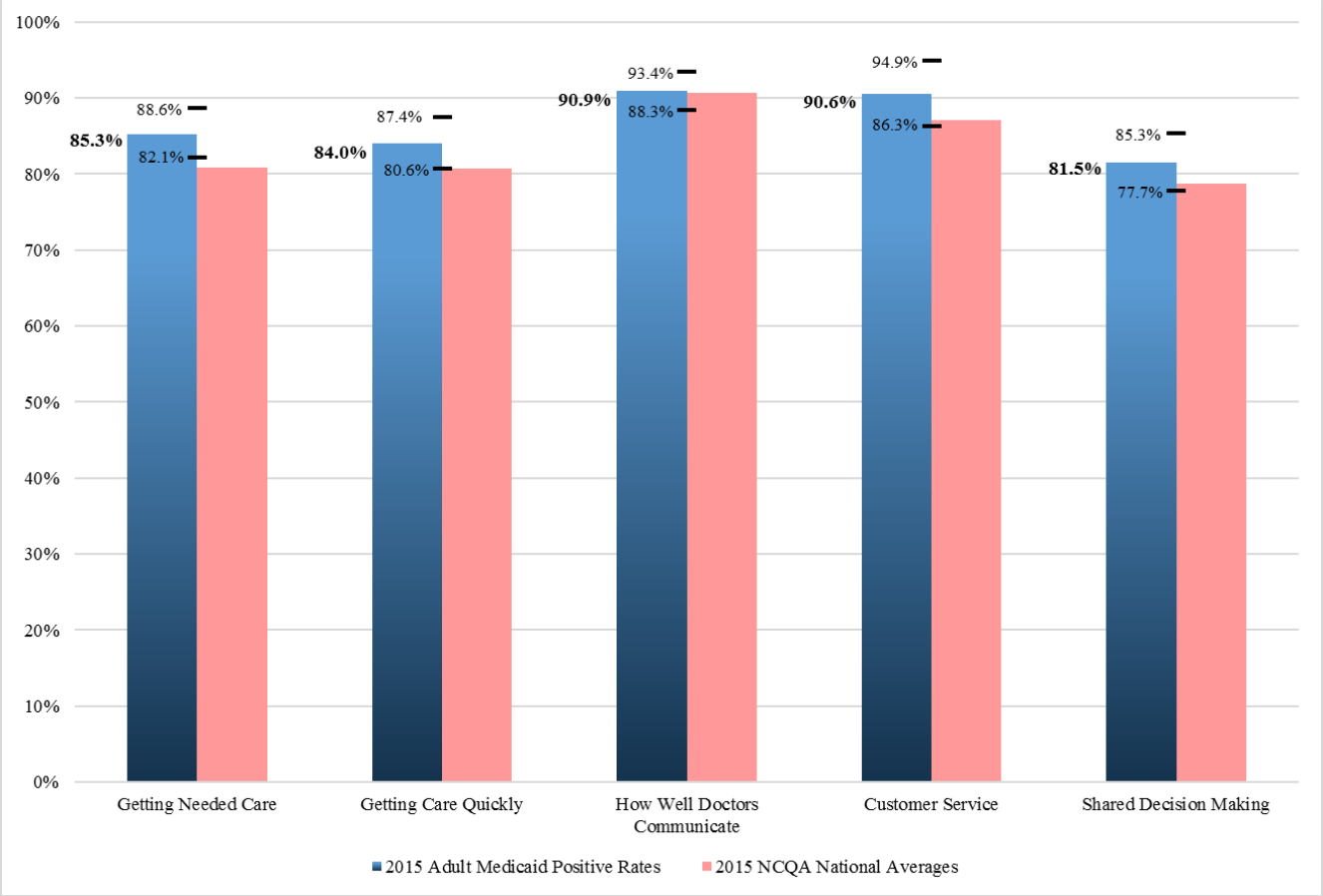


Figure 4-3—NHHF Adult Medicaid CAHPS Results: Composite Measures



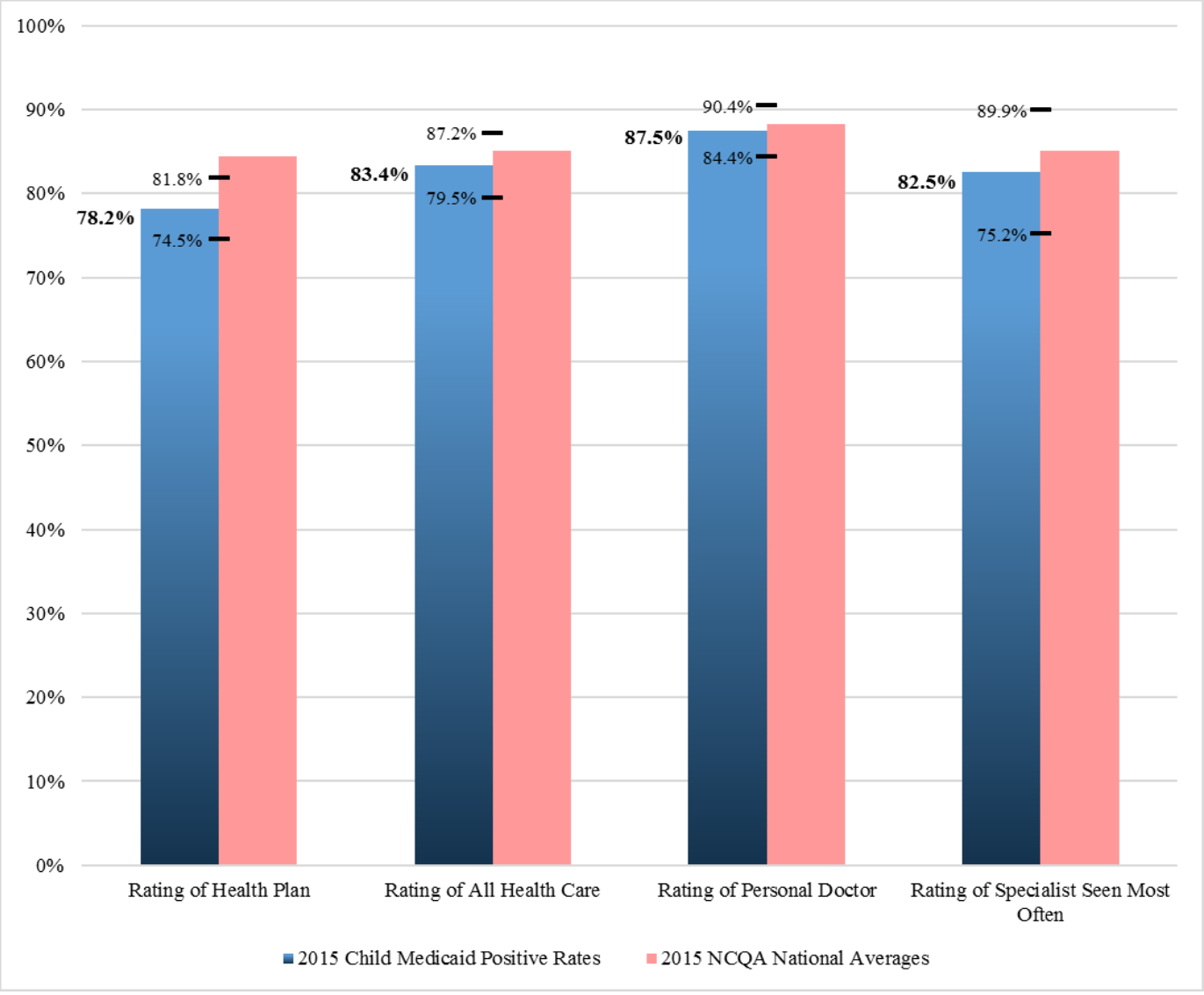
For **NHHF**'s adult Medicaid population, all 2015 positive rates exceeded the 2015 NCQA adult Medicaid national average.

In 2016, a total of 2,723 **NHHF** general child Medicaid members were surveyed, of which 513 completed surveys were returned on behalf of the child member. After ineligible members were excluded, the response rate for the general child population was 20.5 percent.[4-6] In 2015, the average NCQA response rate for the CAHPS 5.0H Child Medicaid Health Plan Survey without the CCC measurement set was 26.8 percent, which was higher than the **NHHF** general child Medicaid response rate. Figure 4-4 and Figure 4-5 on the following pages show the 2015 general child positive rates, and lower and upper confidence intervals for the CAHPS global ratings and composite measures,

[4-6] 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).

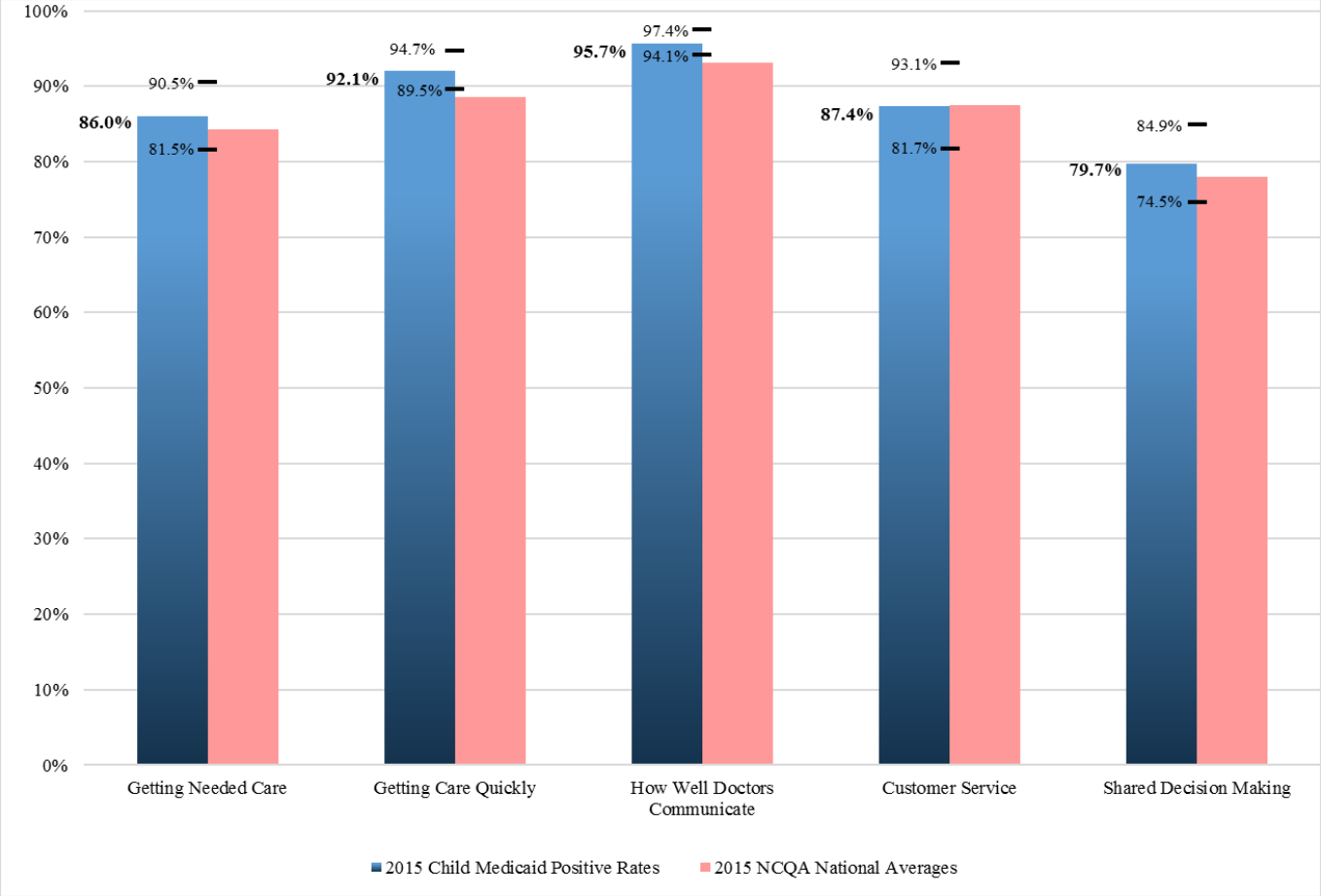
respectively, for **NHHF**'s child Medicaid population.[4-7] The black lines on the figures indicate the range of the confidence intervals for each rate.

Figure 4-4—NHHF Child Medicaid CAHPS Results: Global Ratings



[4-7] The 2015 child Medicaid CAHPS results presented in Figure 4-4 for **NHHF** are based on results of the general child population only.

Figure 4-5—NHHF Child Medicaid CAHPS Results: Composite Measures



For **NHHF**'s general child Medicaid population, the 2015 positive rates for five measures fell below the 2015 NCQA child Medicaid national averages: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Customer Service*. Of these, the rate for *Rating of Health Plan* was lower than the 2015 NCQA child Medicaid national average by at least 5 percentage points. However, for the remaining measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*), the 2015 positive rates for the general child population exceeded the 2015 NCQA child Medicaid national averages.

Well Sense

In 2016, a total of 1,418 **Well Sense** adult Medicaid members were surveyed, of which 316 completed surveys were returned. After ineligible members were excluded, the response rate was 23.1 percent. In 2015, the average NCQA response rate for the CAHPS 5.0H Adult Medicaid Health Plan Survey was 27.2 percent, which was higher than the adult Medicaid **Well Sense** response rate. Figure 4-6 and Figure 4-7 show the 2015 positive rates, and lower and upper confidence intervals for the CAHPS global ratings and composite measures, respectively, for **Well Sense**'s adult Medicaid population. The black lines on the figures indicate the range of the confidence intervals for each rate.

Figure 4-6—Well Sense Adult Medicaid CAHPS Results: Global Ratings

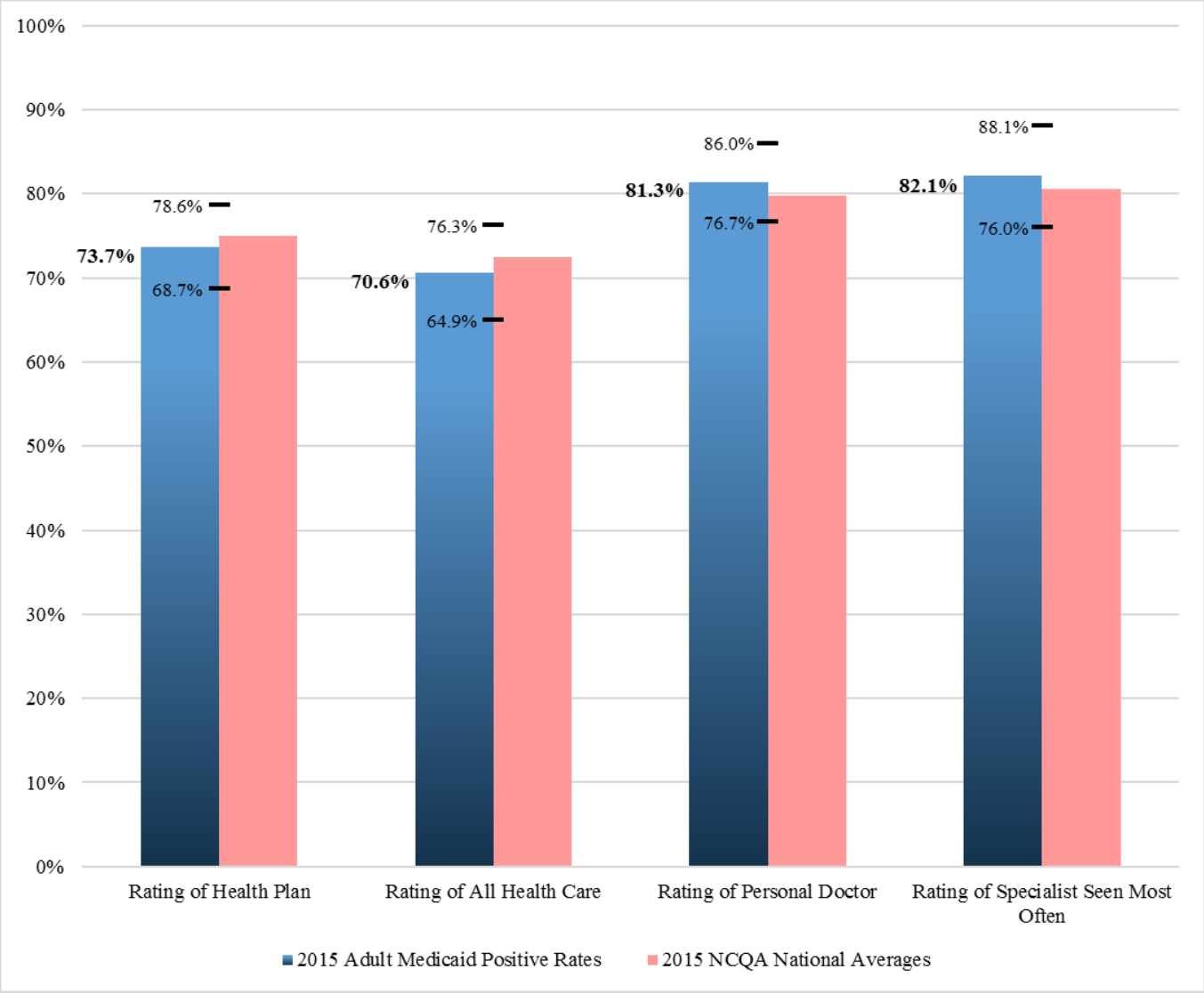
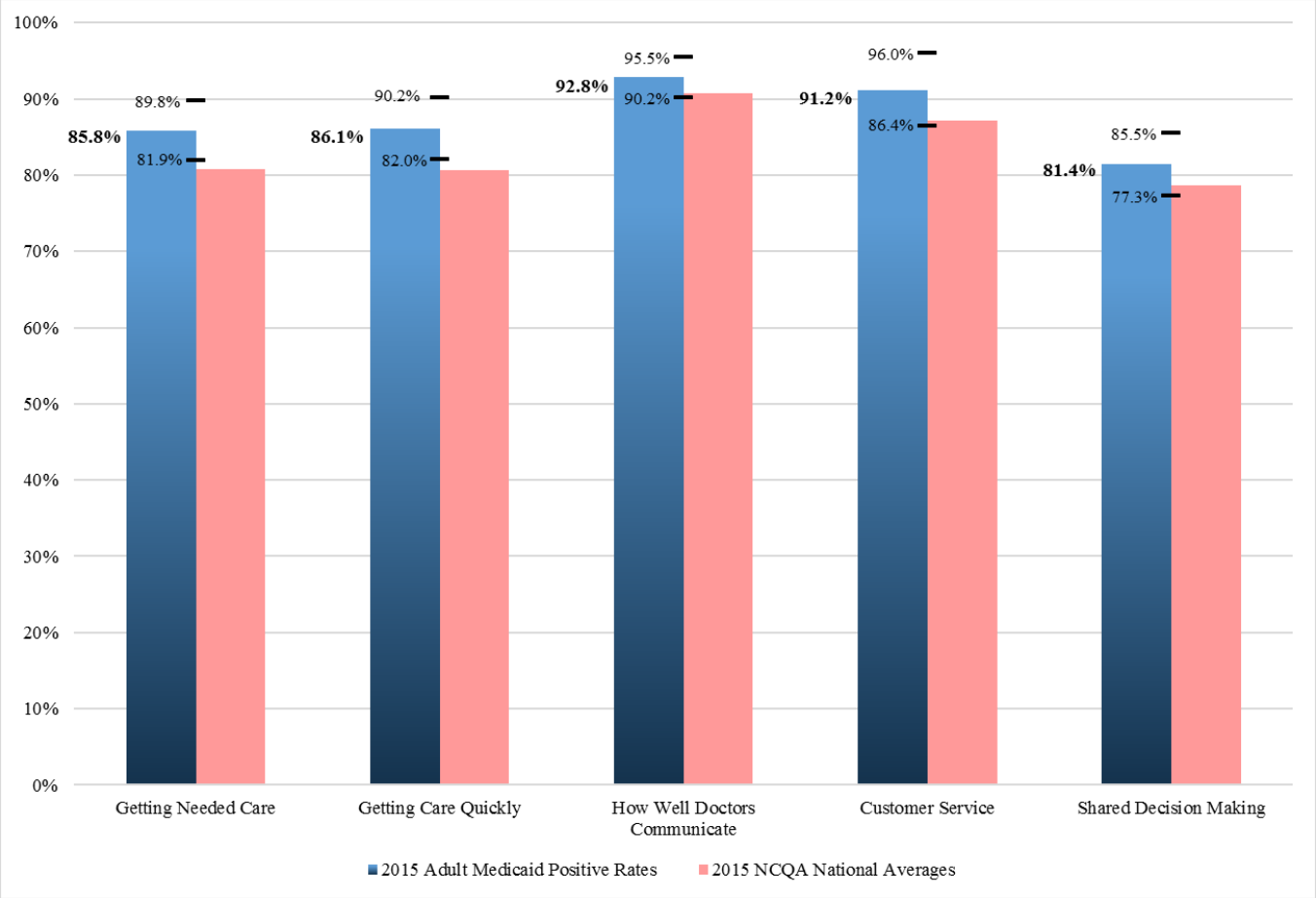


Figure 4-7—Well Sense Adult Medicaid CAHPS Results: Composite Measures



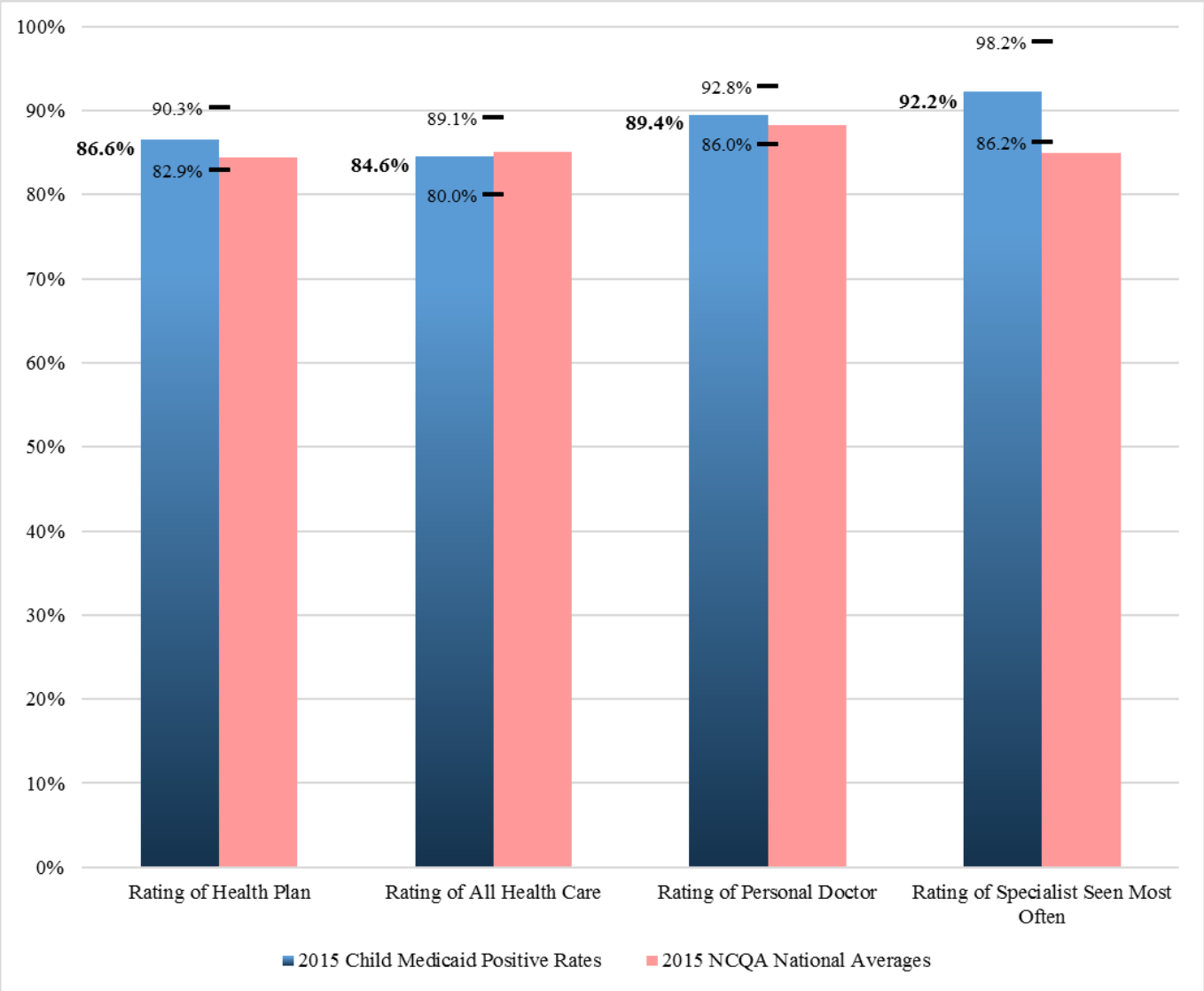
For **Well Sense**'s adult Medicaid population, the 2015 positive rates for two of the measures fell below the 2015 NCQA adult Medicaid national averages: *Rating of Health Plan* and *Rating of All Health Care*. However, for the remaining measures, the 2015 positive rates for the adult Medicaid population exceeded the 2015 NCQA national averages. Moreover, the 2015 positive rates for *Getting Needed Care* and *Getting Care Quickly* exceeded the 2015 NCQA adult Medicaid national averages by at least 5 percentage points.

In 2016, a total of 1,650 **Well Sense** general child Medicaid members were surveyed, of which 338 completed surveys were returned on behalf of the child member. After ineligible members were excluded, the response rate for the general child population was 20.9 percent.[4-8] In 2015, the average NCQA response rate for the CAHPS 5.0 Child Medicaid Health Plan Survey without the CCC measurement set was 26.8 percent, which was higher than the **Well Sense** child Medicaid response rate. Figure 4-8 and Figure 4-9 show the 2015 general child positive rates, and lower and upper confidence

[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).

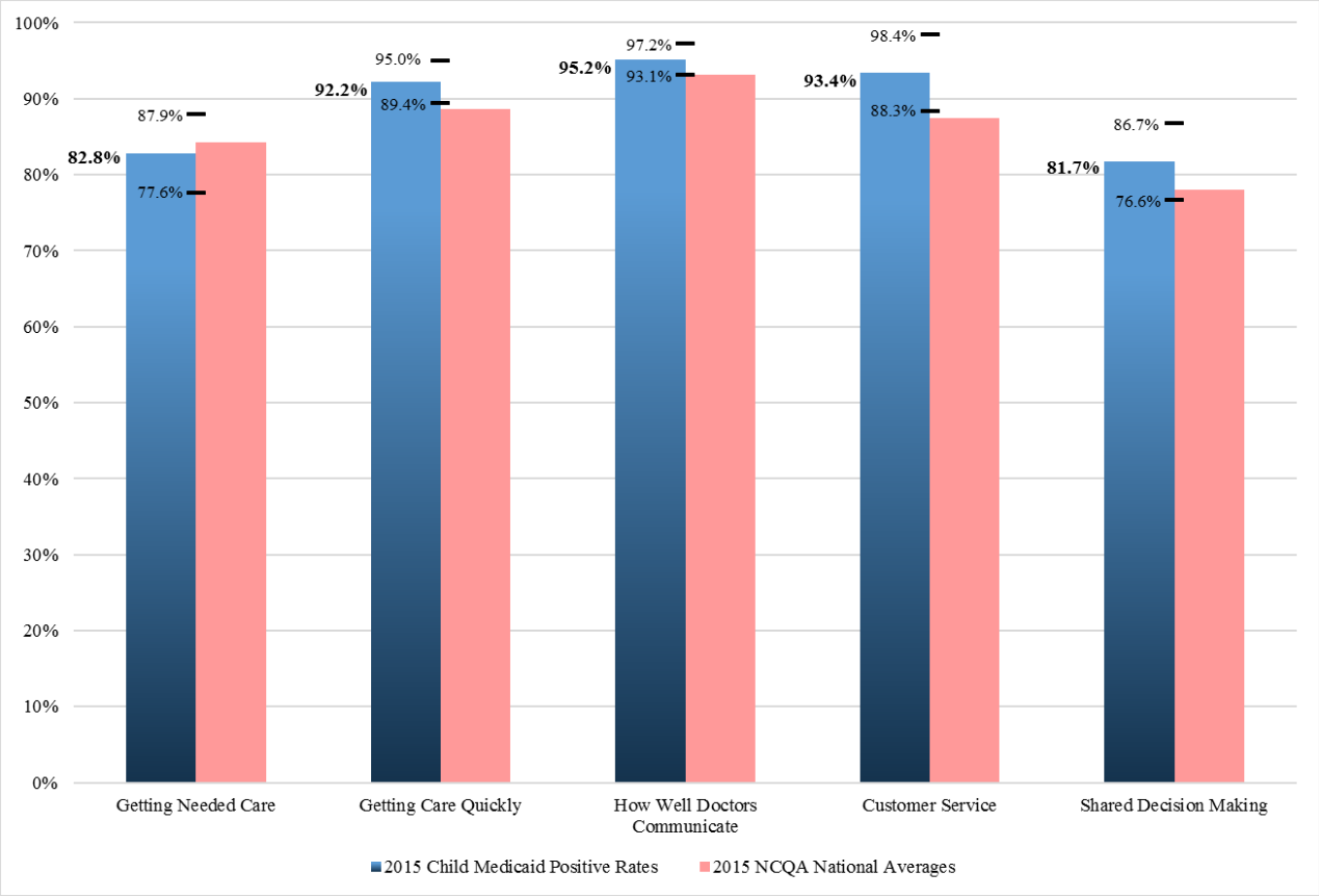
intervals for the CAHPS global ratings and composite measures, respectively, for **Well Sense**'s general child Medicaid population.[4-9] The black lines on the figures indicate the range of the confidence intervals for each rate.

Figure 4-8—Well Sense Child Medicaid CAHPS Results: Global Ratings



[4-9] The 2015 child Medicaid CAHPS results presented in Figure 4-8 and Figure 4-9 for **Well Sense** are based on results of the general child population only.

Figure 4-9—Well Sense Child Medicaid CAHPS Results: Composite Measures



For **Well Sense**'s general child Medicaid population, the 2015 positive rate for two measures, *Rating of All Health Care* and *Getting Needed Care*, fell below the 2015 NCQA child Medicaid national averages. For the remaining measures, the 2015 positive rates for the general child population exceeded the 2015 NCQA child Medicaid national average; of these, the rate for *Customer Service* was higher than the 2015 NCQA child Medicaid national average by at least 5 percentage points.

NHHF

Conclusions and Recommendations for Improvement

For **NHHF,** HSAG performed a comparison of the adult and child Medicaid populations' 2015 CAHPS survey results to the 2015 NCQA CAHPS Adult and Child Medicaid national averages to determine potential areas for improvement. Since all 2015 positive rates for the adult Medicaid population exceeded the 2015 NCQA adult Medicaid national averages, HSAG recommends that **NHHF** focus quality improvement efforts on the child Medicaid rates. HSAG recommends that **NHHF** focus quality improvement efforts on *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Customer Service*.

Well Sense

Conclusions and Recommendations for Improvement

For **Well Sense,** HSAG performed a comparison of the adult and child Medicaid populations' 2015 CAHPS survey results to the 2015 NCQA CAHPS Adult and Child Medicaid national averages to determine potential areas for improvement. For **Well Sense**'s adult Medicaid population, HSAG recommends that the MCO focus quality improvement efforts on *Rating of Health Plan* and *Rating of All Health Care*, since the measures' rates were below NCQA's 2015 CAHPS adult Medicaid national averages. For **Well Sense**'s general child Medicaid population, HSAG recommends that efforts focus on improving *Rating of All Health Care* and *Getting Needed Care*, since the measures' rates were below NCQA's 2015 CAHPS child Medicaid national averages. Of these comparisons, the rate for *Rating of All Health Care* for both the adult and child Medicaid populations was below NCQA's 2015 CAHPS 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 All Health Care*, and *Getting Needed Care.*

The following are recommendations of best practices and other proven strategies that can be used or adapted by the MCOs to target improvement.

Rating of Health Plan

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

Rating of All Health Care

Access to Care—The MCOs should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. The MCOs should attempt to reduce any hindrances a patient might encounter while seeking care. Standard practices and established protocols can assist in this process by ensuring access to care issues are handled consistently across all practices.

Involving Families in Care Coordination—The MCOs should ensure that care plans for children with chronic conditions include the desired outcomes for both the child and family. The family's role in the coordination of care process should be taken into account when developing a child member's care plan. According to the American Academy of Pediatrics' policy statement regarding "Family-Centered Care and the Pediatrician's Role," improved health outcomes of children with chronic conditions are linked to the concept of the family as a primary partner in care coordination. The MCOs should encourage family member participation in coordination of care as the family is most knowledgeable about the child's healthcare needs. Collaboration between family members and medical team professionals can lead to improved health for child members. To assist in family involvement, the MCOs should ensure that parents and caretakers of child members are informed about their child's health condition(s), available healthcare services, and how to access those services.

Rating of Personal Doctor

Direct Patient Feedback—The MCOs 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. The MCOs 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.

Improving Shared Decision Making—The MCOs 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 healthcare. 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.

Rating of Specialist Seen Most Often

Planned Visit Management—The MCOs should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used by staff to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons. For example, after a planned visit, follow-up contact with patients could be scheduled within the reminder system to ensure patients understood all information provided to them and/or to address any questions they may have.

Telemedicine—The MCOs may want to explore the option of telemedicine with their provider networks to address issues with provider access in certain geographic areas. Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine such as live, interactive videoconferencing allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there is a shortage of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Furthermore, the local provider is more involved in the consultation process and more informed about the care the patient is receiving.

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 MCOs 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.

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.

Getting Needed Care

Interactive Workshops—The MCOs should engage in promoting health education, health literacy, and preventive healthcare among their membership. Increasing patients' health literacy and general understanding of their healthcare needs can result in improved health. The MCOs should continue to bolster their community-based interactive workshops and educational materials to provide information on general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations. Access to free health

assessments also can assist health plans in promoting patient health awareness and preventive healthcare efforts.

"Max-Packing"—The MCOs can assist providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit when feasible—a process called "max- packing." "Max-packing" is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during the scheduled visit, whenever possible. Processes could also be implemented wherein staff review the current day's appointment schedule and assess if any patients have future appointments that could be addressed during the current day's appointment. For example, if a patient is scheduled for their annual physical in the fall and a subsequent appointment for a flu vaccination, the current office visit could be used to accomplish both, eliminating the need for the future appointment. Health plans should encourage the care of a patient's future needs during a visit and determine if, and when, future follow-up is necessary.

Assessment of Prior Year Recommendations for CAHPS

NHHF needed to 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. The Adult **NHHF** rate is now above the national average; however, the Child rate is still below the national average.

From the results from the 2014 CAHPS survey, HSAG recommended 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. The results from the current survey indicated that the adult **Well Sense** rate for *Rating of Health Plan* is still below the national average. The Adult **Well Sense** rate for *Rating of Personal Doctor* is now above the national average. For **Well Sense**'s general child Medicaid population, HSAG recommended that efforts focus on improving *Customer Service*, since the measure's rate was below NCQA's 2014 CAHPS child Medicaid national average. The Child **Well Sense** rate for *Customer Service* is now above the national average.

HEDIS

This section reports results of the 2016 NCQA HEDIS Compliance Audits™ for the health plans. 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.[4-10,4-11] Compliance with the guidelines also helps an auditor to understand a health plan's HEDIS reporting capabilities. For HEDIS 2016, health plans were assessed on seven IS standards. To assess an MCO's adherence to the IS standards,

[4-10] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).
[4-11] National Committee for Quality Assurance. HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5. Washington D.C.

HSAG reviewed several documents for the New Hampshire MCOs. These included the MCOs' FARs, 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' FARs and ensured that these software vendors participated and passed NCQA's Measure Certification process. MCOs either purchased the software with certified measures and generated HEDIS measure results internally or provide all data to the software vendor who generated 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 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 HEDIS 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, version control, and testing.
- The organization regularly monitors vendor performance against expected performance standards.

IS Review Results

NHHF was found to be fully compliant with most applicable IS assessment standards except IS standard 4.2, which was partly met. The final medical record review validation (MRRV) resulted in required administrative-only reporting for two measures/plans employing in-house medical record review. (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 two supplemental data sources, one standard and one nonstandard, for its performance measure reporting. The lead auditor detected many mapping errors throughout the audit process. The lead auditor recommended that **Well Sense** develop a robust approach to reviewing the data integrity reports of its software vendor, Inovalon, to resolve issues discovered during the audit.

HEDIS Measures Results

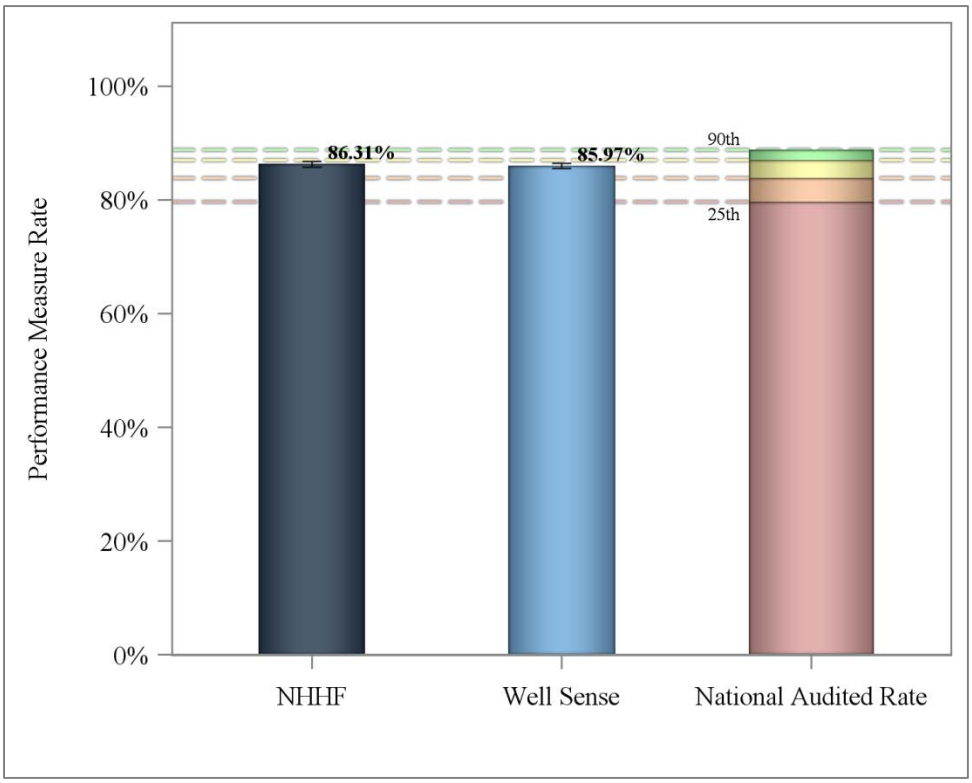
HSAG organized, aggregated, and analyzed the validated performance measure data to draw conclusions about **NHHF**'s and **Well Sense**'s performance in providing quality, accessible, and timely care and services to its members. The following performance measure results reflect all three domains of care—quality, access, and timeliness. Each figure contains CY 2015 performance measure rates for **NHHF** (i.e., the bar shaded dark blue) and **Well Sense** (i.e., the bar shaded light blue), along with confidence intervals and national benchmarks (i.e., the bar shaded light red, orange, yellow, and green), when applicable. The National Audited Rate stacked bar is shaded to indicate national Medicaid percentiles (i.e., light red represents the national Medicaid 25th percentile, orange represents the national Medicaid 50th percentile, yellow represents the national Medicaid 75th percentile, and green represents the national Medicaid 90th percentile). National benchmarks are based on NCQA's HEDIS Audit Means and Percentiles (national Medicaid HMO percentiles) for HEDIS 2015. 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 2015. **NHHF**'s and **Well Sense**'s *AAP—Total* measure results are shown in Figure 4-10.

Figure 4-10—CY 2015 *AAP—Total* Measure Results

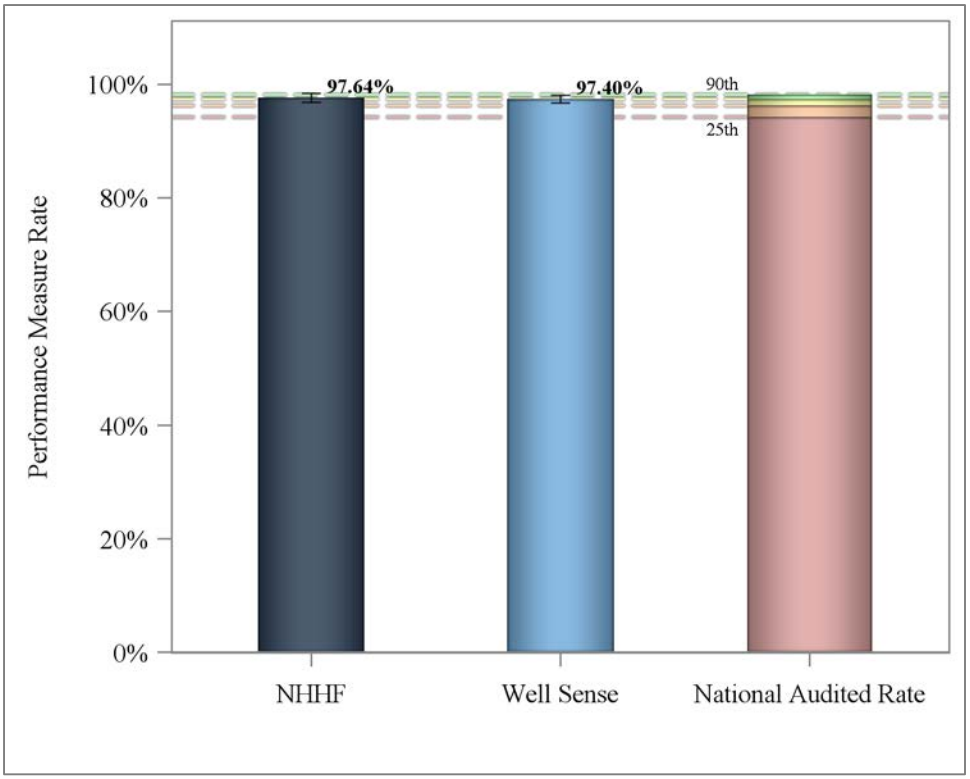


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 PCP during 2015. **NHHF**'s and **Well Sense**'s *CAP—12–24 Months* measure results are shown in Figure 4-11.

Figure 4-11—CY 2015 *CAP—12–24 Months* Measure Results

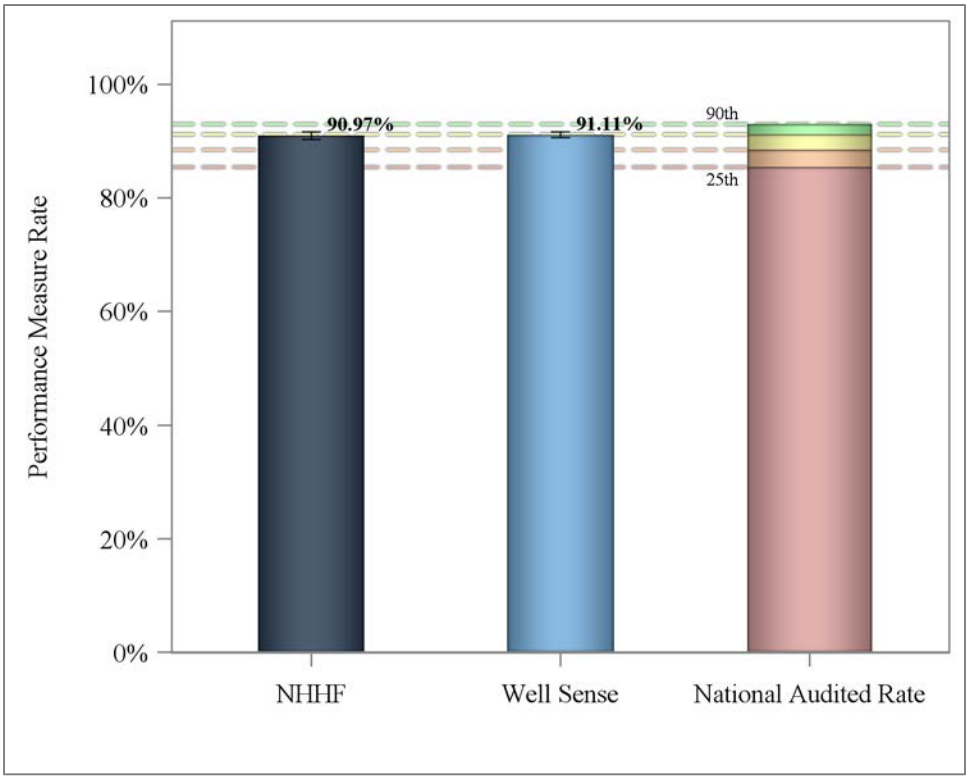


NHHF's reported rate was at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *CAP—25 Months–6 Years* measure results are shown in Figure 4-12.

Figure 4-12—CY 2015 *CAP—25 Months–6 Years* Measure Results

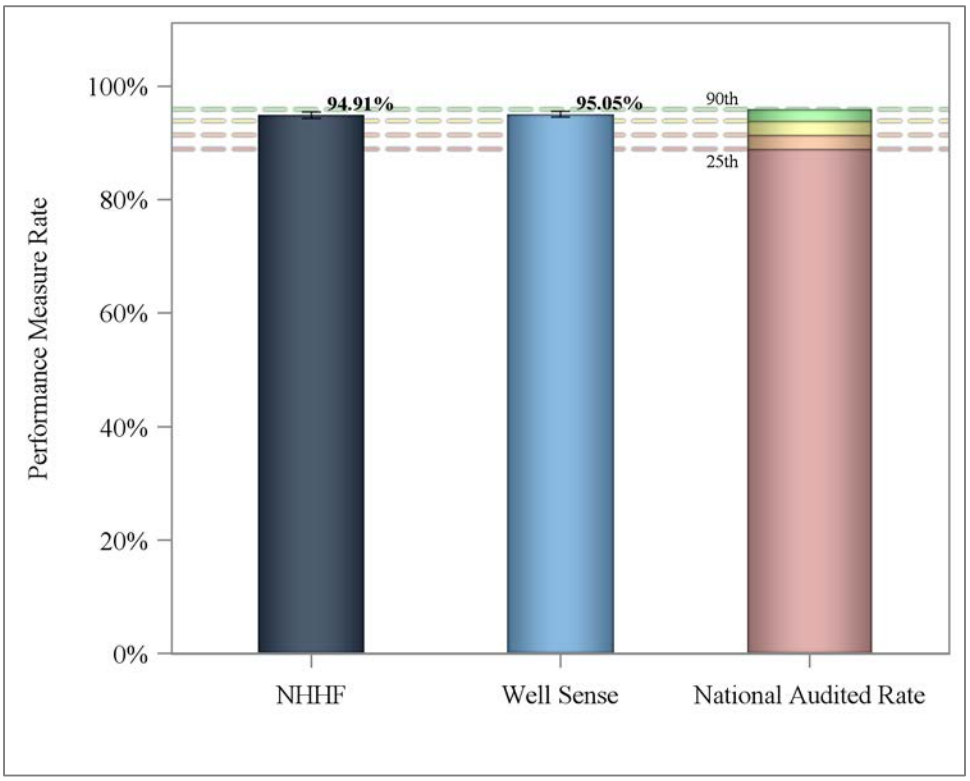


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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

CAP—7–11 Years measures the percentage of members ages 7 to 11 years who had a visit with a PCP during 2015. **NHHF**'s and **Well Sense**'s *CAP—7–11 Years* measure results are shown in Figure 4-13.

Figure 4-13—CY 2015 *CAP—7–11 Years* Measure Results

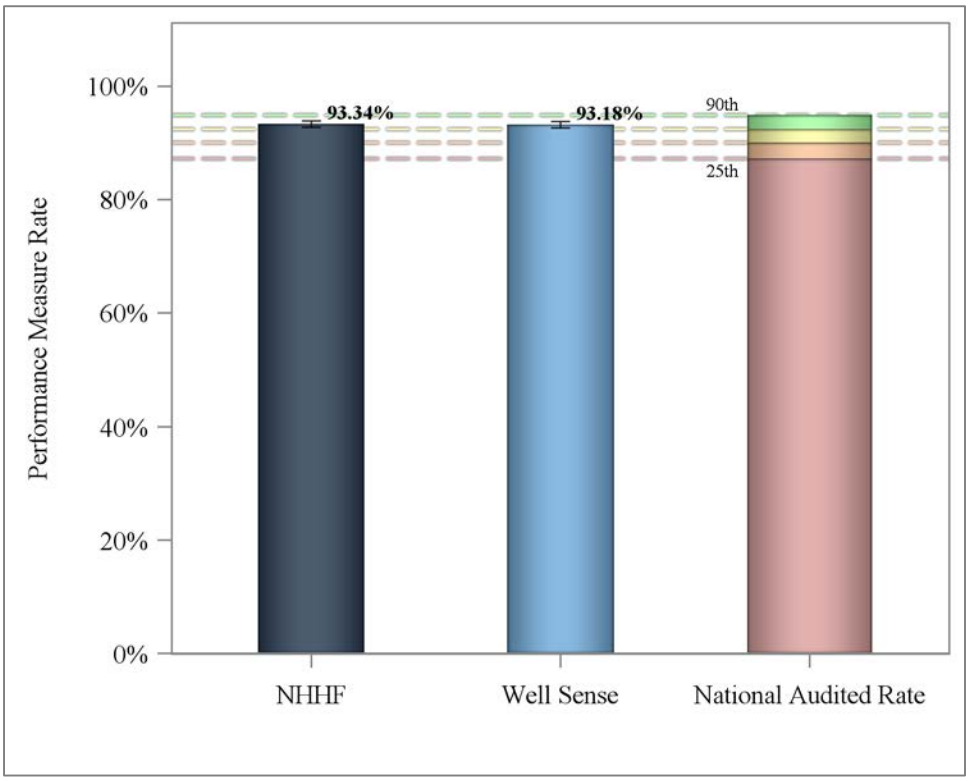


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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

CAP—12–19 Years measures the percentage of members ages 12 to 19 years who had a visit with a PCP during 2015. **NHHF**'s and **Well Sense**'s *CAP—12–19 Years* measure results are shown in Figure 4-14.

Figure 4-14—CY 2015 *CAP—12–19 Years* Measure Results

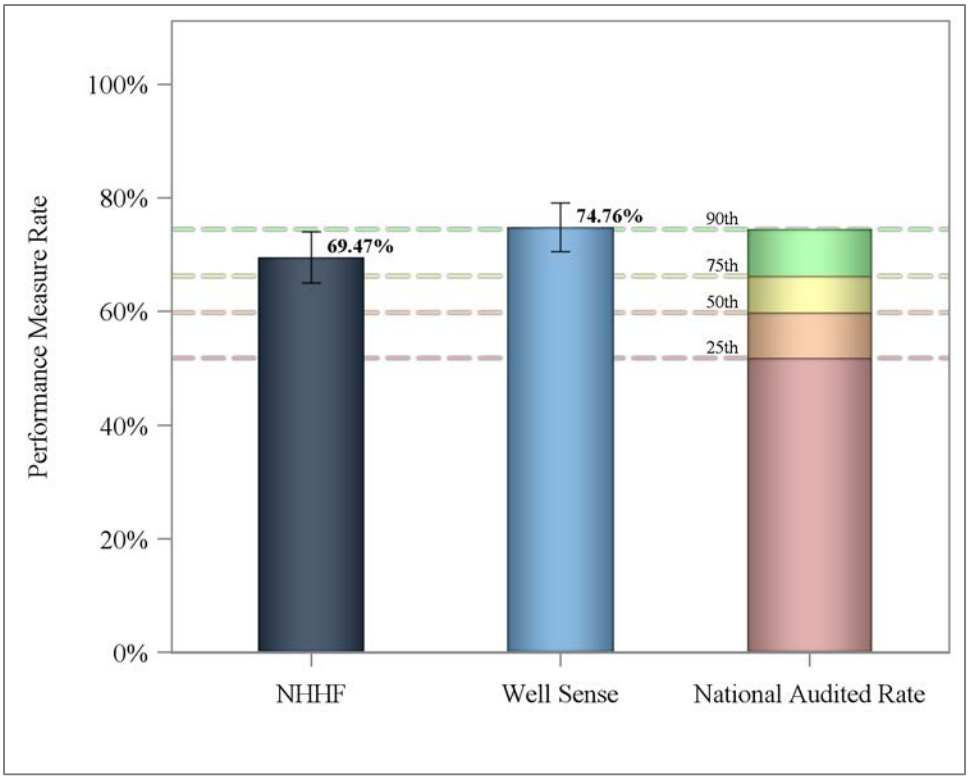


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

Well-Child Visits in the First 15 Months of Life (W15)—Six or More Visits

W15—Six or More Visits measures the percentage of members who turned 15 months old during 2015 and who received six or more well-child visits with a PCP during their first 15 months of life. **NHHF**'s and **Well Sense**'s *W15—Six or More Visits* measure results are shown in Figure 4-15.

Figure 4-15—CY 2015 *W15—Six or More Visits* Measure Results

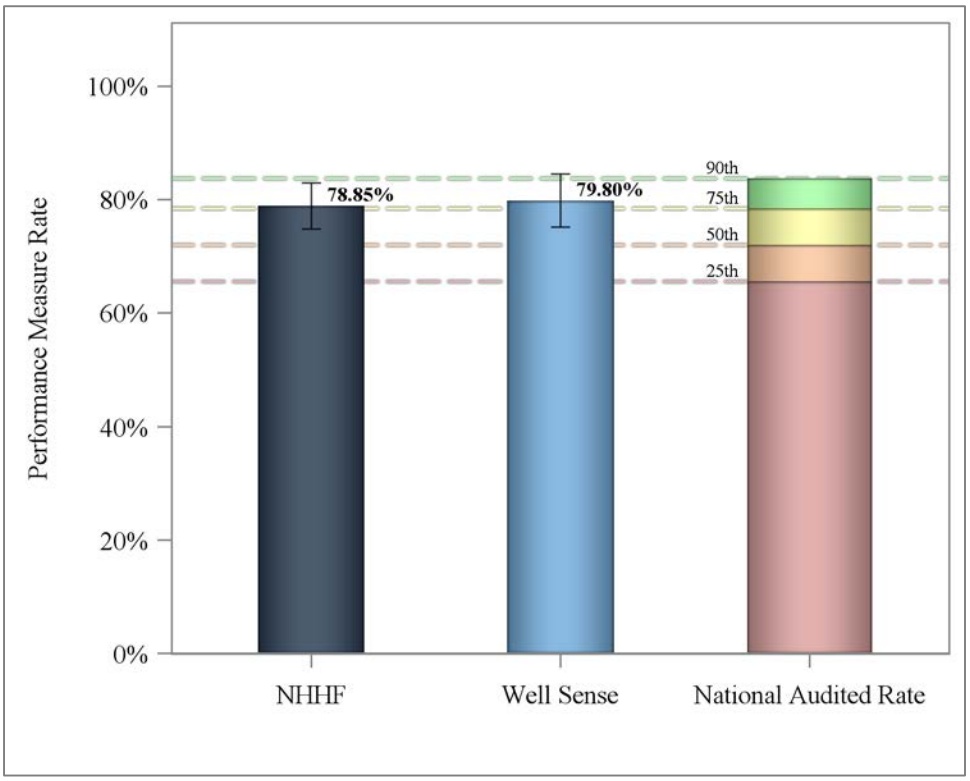


NHHF's reported rate was at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 90th percentile.

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

W34 measures the percentage of members 3 to 6 years of age who had one or more well-child visits with a PCP during 2015. **NHHF**'s and **Well Sense**'s *W34* measure results are shown in Figure 4-16.

Figure 4-16—CY 2015 *W34* Measure Results

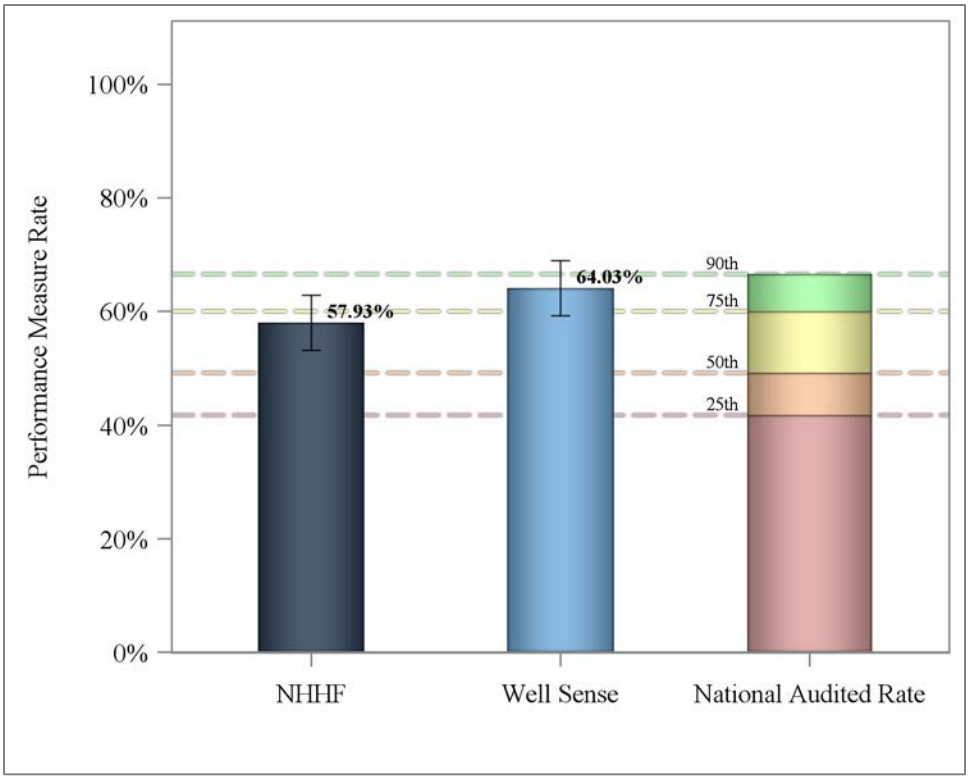


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

Adolescent Well-Care Visits (AWC)

AWC measures the percentage of members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrician/gynecologist (OB/GYN) practitioner during 2015. **NHHF**'s and **Well Sense**'s AWC measure results are shown in Figure 4-17.

Figure 4-17—CY 2015 *AWC* Measure Results

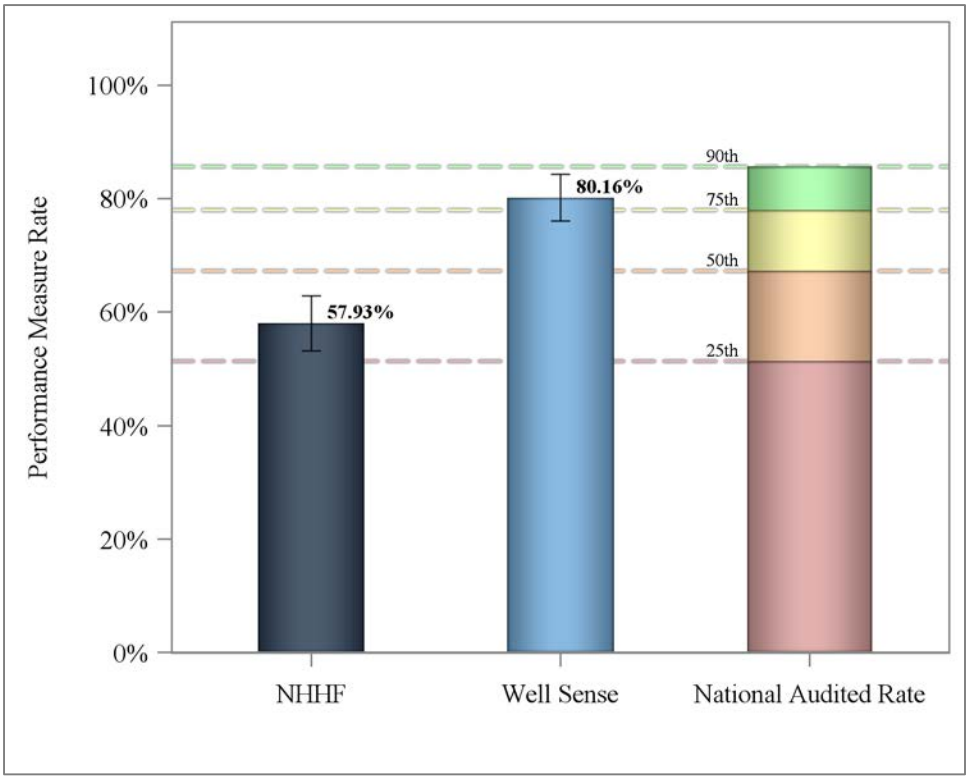


NHHF's reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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

WCC—BMI Percentile measures the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had documentation of BMI percentile during 2015. **NHHF**'s and **Well Sense**'s *WCC—BMI Percentile* measure results are shown in Figure 4-18.

Figure 4-18—CY 2015 *WCC—BMI Percentile* Measure Results

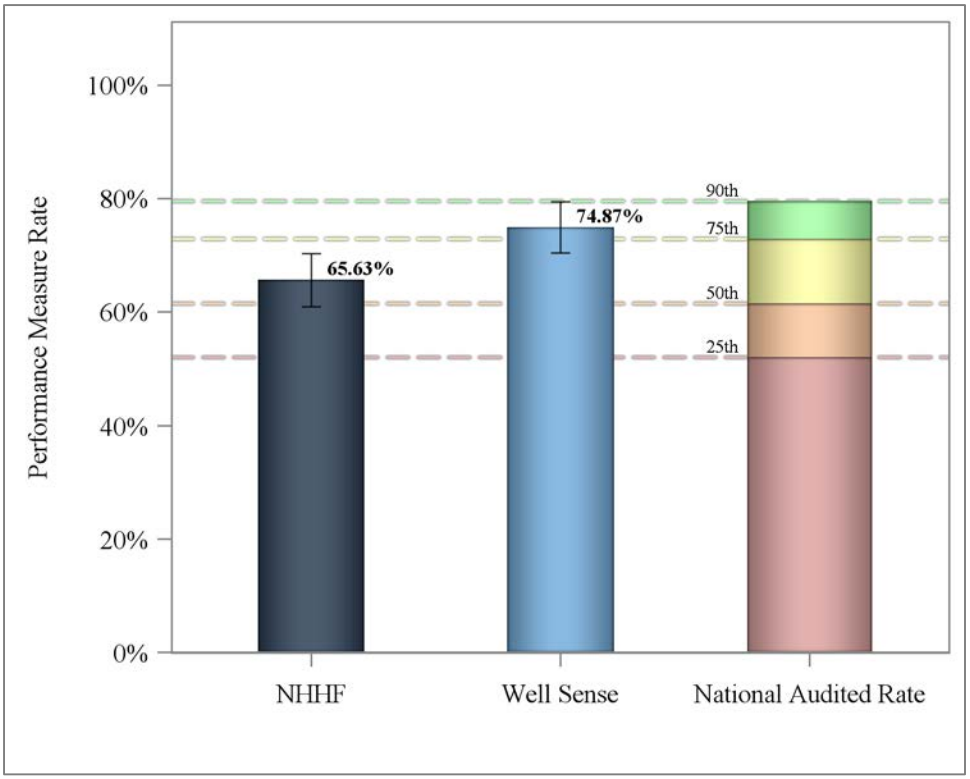


NHHF's reported rate was at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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

WCC—Counseling for Nutrition measures the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during 2015. **NHHF**'s and **Well Sense**'s *WCC—Counseling for Nutrition* measure results are shown in Figure 4-19.

Figure 4-19—CY 2015 *WCC—Counseling for Nutrition* Measure Results

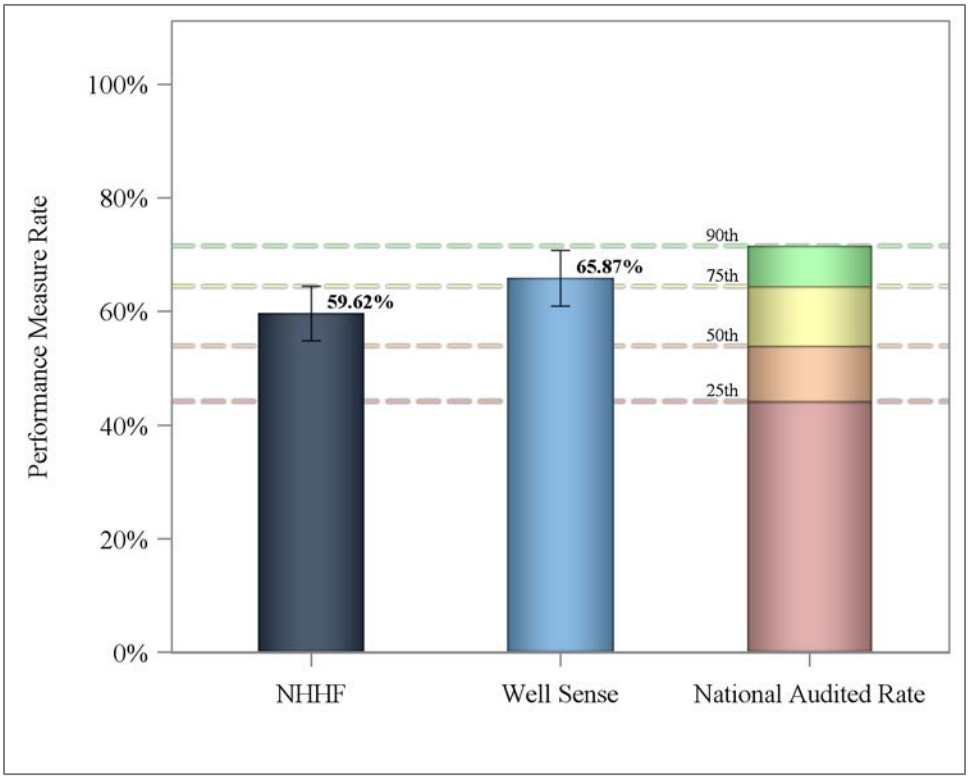


NHHF's reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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

WCC—Counseling for Physical Activity measures the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during 2015. **NHHF**'s and **Well Sense**'s *WCC—Counseling for Physical Activity* measure results are shown in Figure 4-20.

Figure 4-20—CY 2015 *WCC—Counseling for Physical Activity* Measure Results

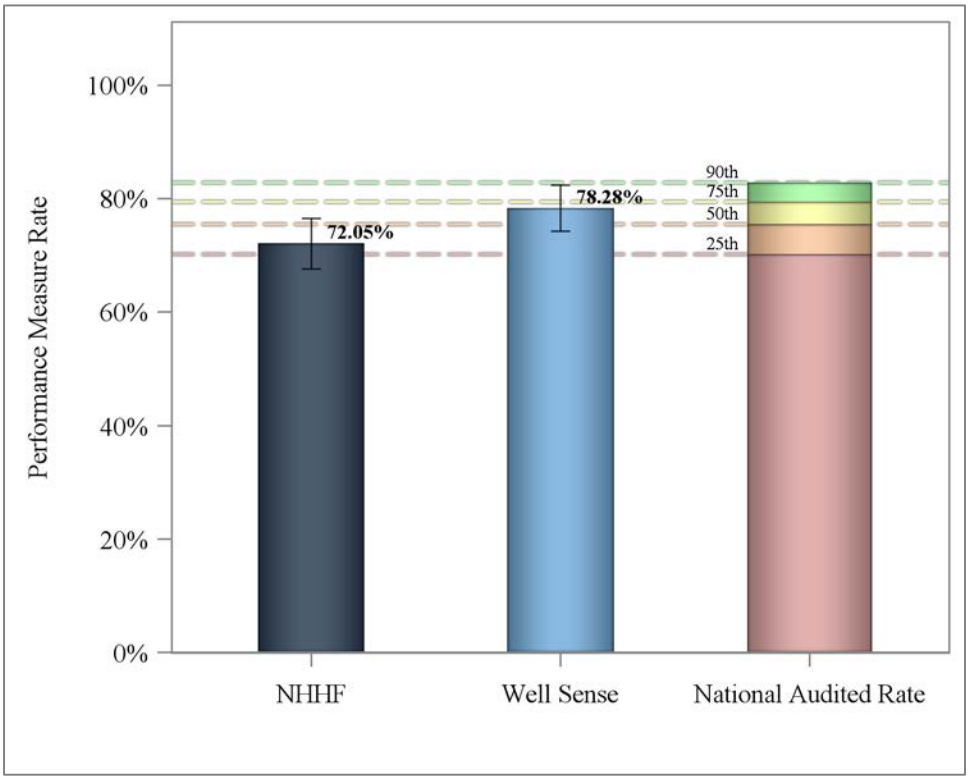


NHHF's reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

Childhood Immunization Status (CIS)—Combination 2

CIS—Combination 2 measures the percentage of children 2 years of age during 2015 who were given the required immunizations listed in Combination 2 by their second birthday. This measure calculates the rate of appropriate vaccinations for diphtheria, tetanus and acellular 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 4-21.

Figure 4-21—CY 2015 *CIS—Combination 2* Measure Results

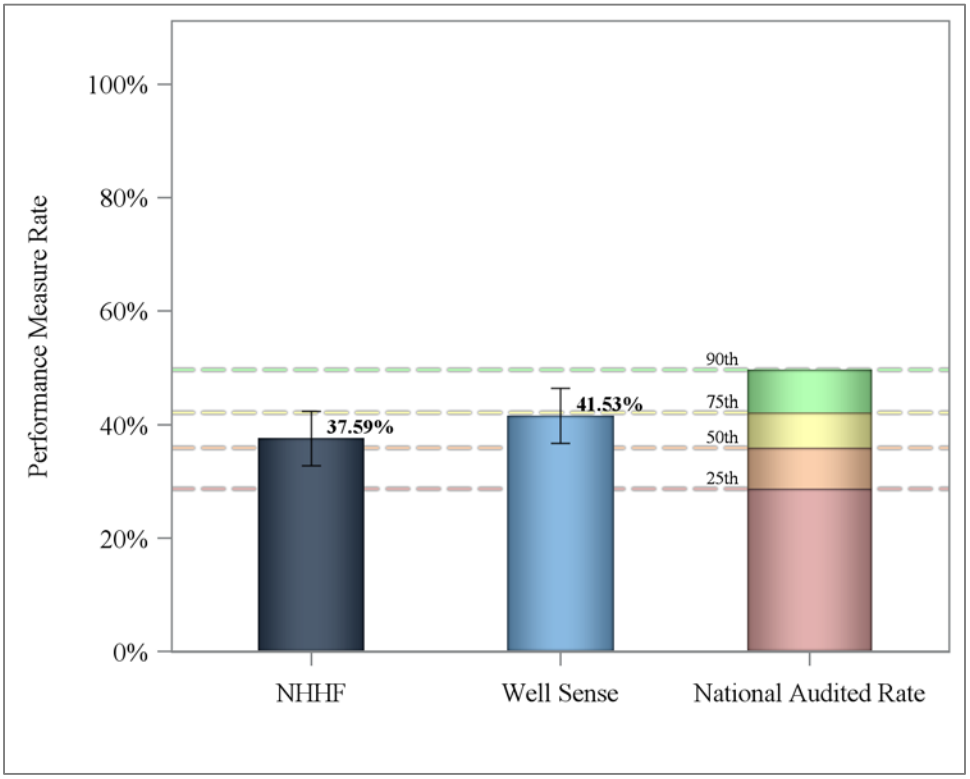


NHHF's reported rate was at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

Childhood Immunization Status (CIS)—Combination 10

CIS—Combination 10 measures the percentage of children 2 years of age during 2015 who were given the immunizations listed in Combination 10 by their second birthday. This measure calculates the rate of all 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 4-22.

Figure 4-22—CY 2015 *CIS—Combination 10* Measure Results

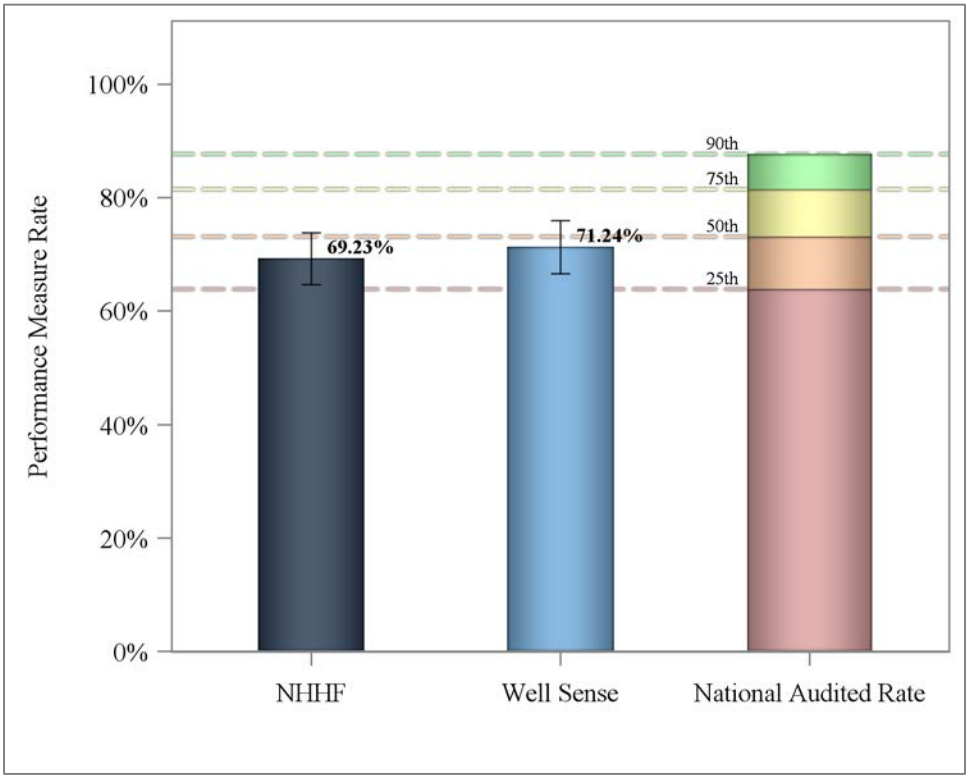


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 2015 who had appropriate vaccinations by their 13th birthday. Combination 1 prescribes one dose of meningococcal vaccine, and one tetanus, diphtheria and acellular 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 4-23.

Figure 4-23—CY 2015 *IMA—Combination 1 (Meningococcal, Tdap/Td)* Measure Results

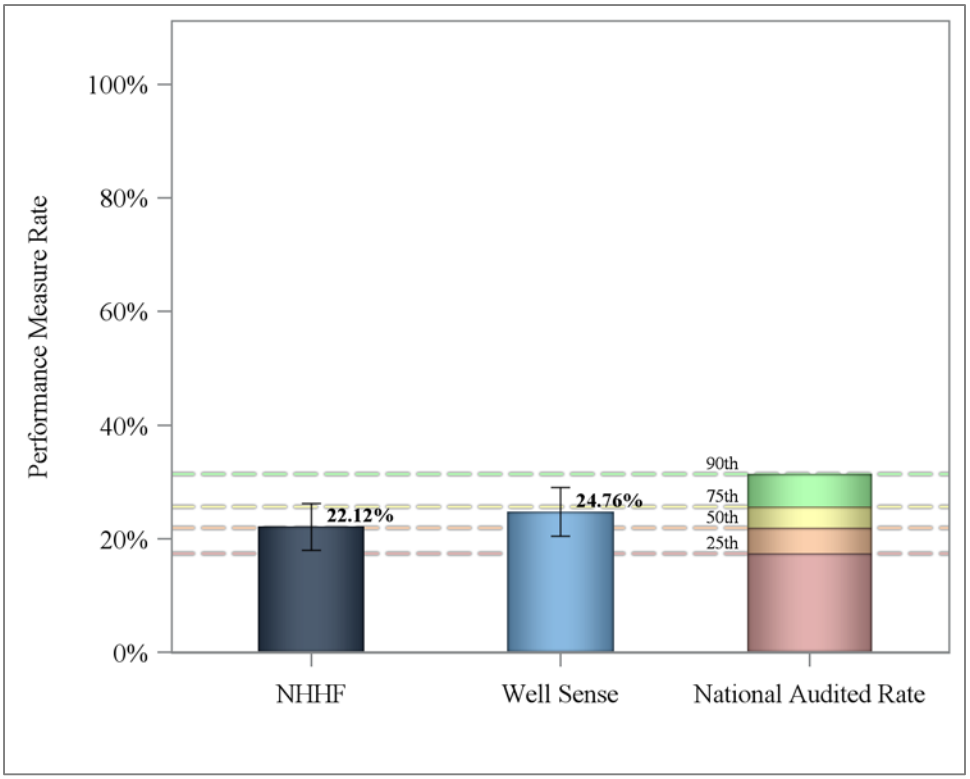


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *HPV* measure results are shown in Figure 4-24.

Figure 4-24—CY 2015 *HPV* Measure Results

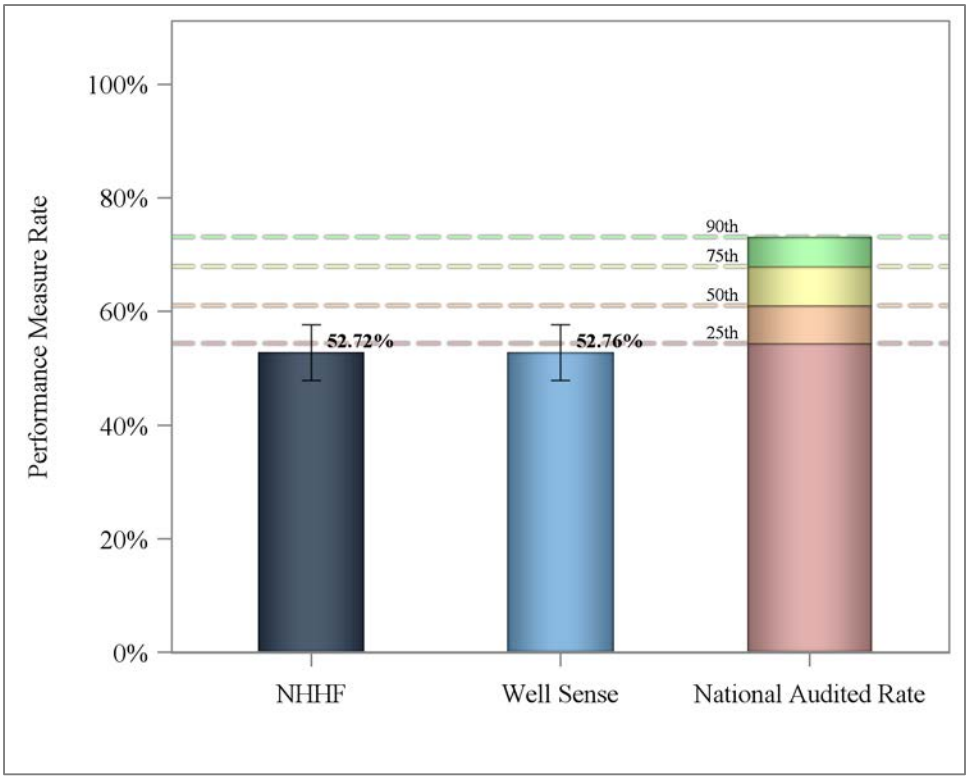


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

Cervical Cancer Screening (CCS)

CCS measures the percentage of women 21 to 64 years of age who met the criteria for appropriate screening for cervical cancer during 2015. **NHHF**'s and **Well Sense**'s *CCS* measure results are shown in Figure 4-25.

Figure 4-25—CY 2015 *CCS* Measure Results

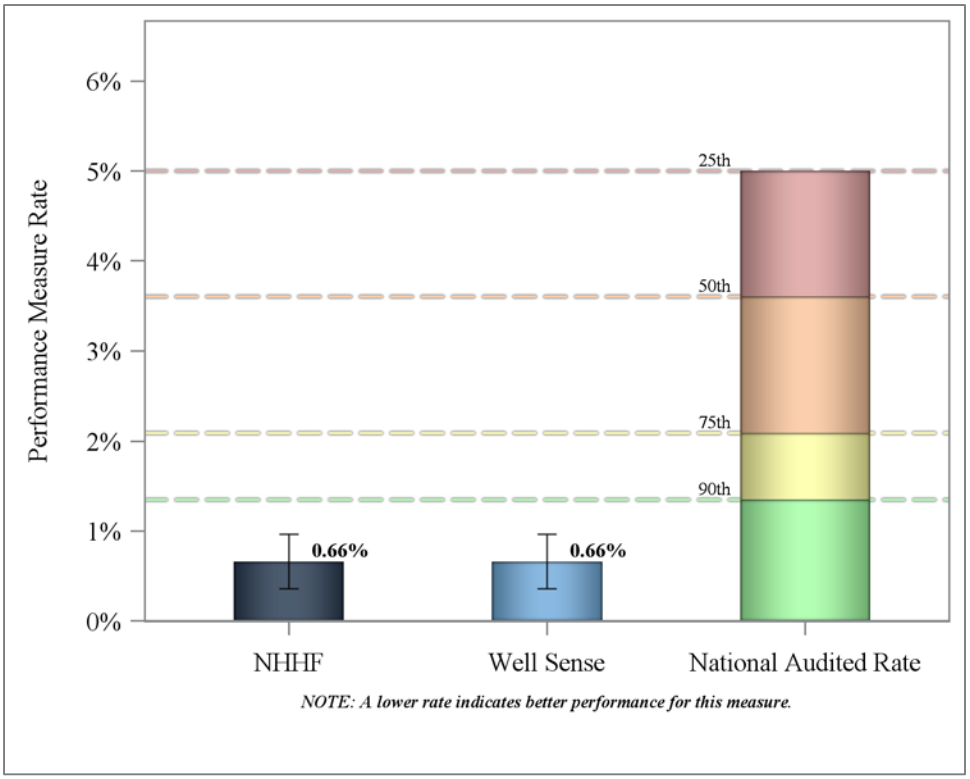


NHHF's and **Well Sense**'s reported rates were below the national Medicaid 25th percentile.

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

NCS measures the percentage of adolescent females 16 to 20 years of age who were screened unnecessarily for cervical cancer during 2015. **NHHF**'s and **Well Sense**'s *NCS* measure results are shown in Figure 4-26. Note, lower rates for this measure indicate better performance.

Figure 4-26—CY 2015 *NCS* Measure Results

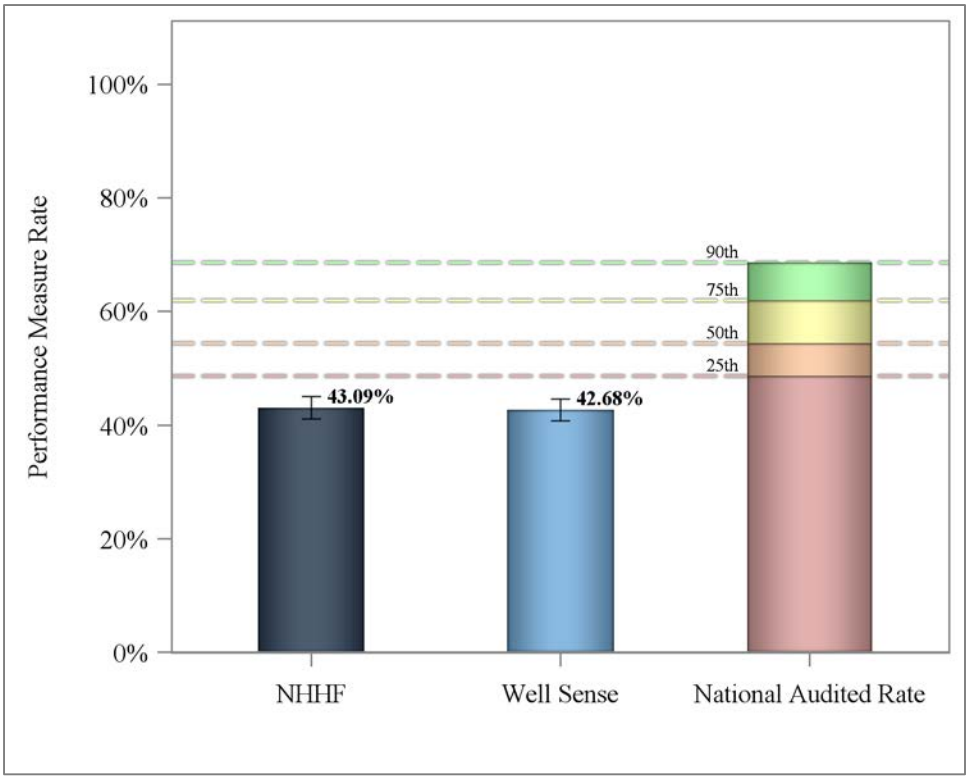


NHHF's and **Well Sense**'s reported rates were at or better than the national Medicaid 90th percentile.

Chlamydia Screening in Women (CHL)—Total

CHL—Total measures the percentage of women 16 to 24 years of age identified as sexually active who had at least one test for chlamydia during 2015. **NHHF**'s and **Well Sense**'s *CHL—Total* measure results are shown in Figure 4-27.

Figure 4-27—CY 2015 *CHL—Total* Measure Results

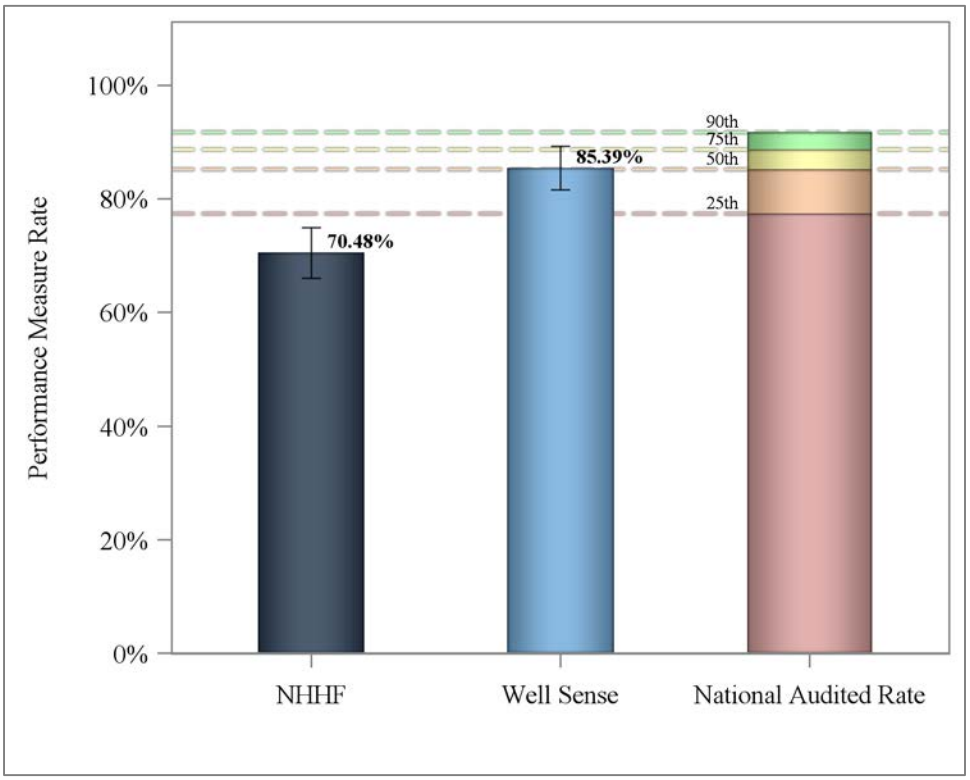


NHHF's and **Well Sense**'s reported rates were below the national Medicaid 25th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *PPC—Timeliness of Prenatal Care* measure results are shown in Figure 4-28.

Figure 4-28—CY 2015 *PPC—Timeliness of Prenatal Care* Measure Results

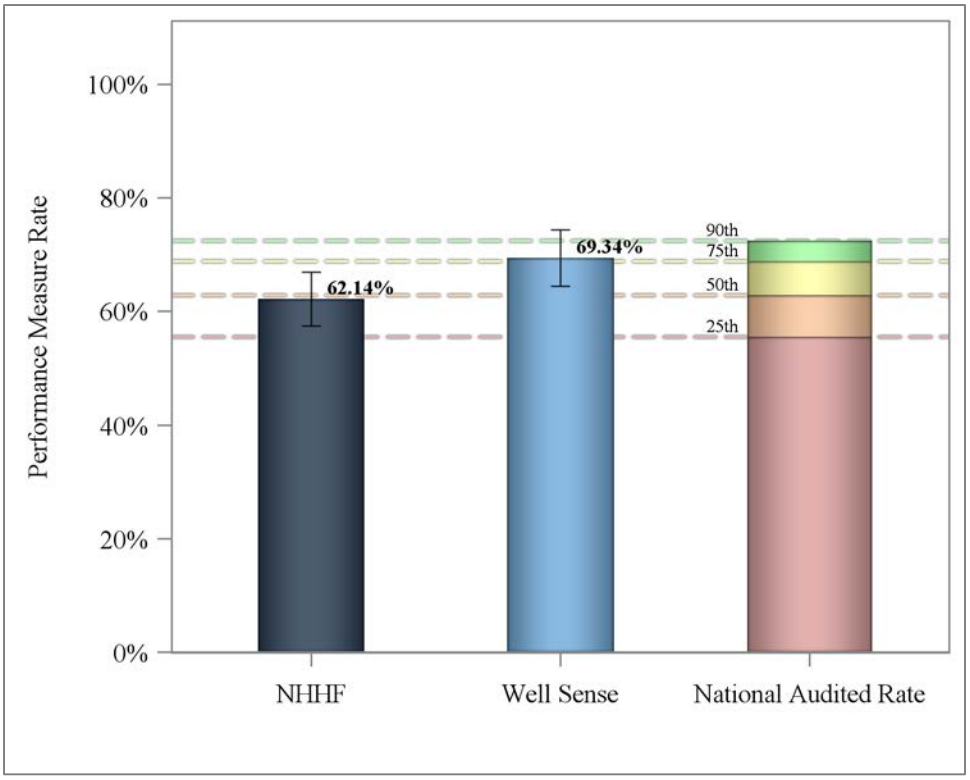


NHHF's reported rate was below the national Medicaid 25th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *PPC—Postpartum Care* measure results are shown in Figure 4-29.

Figure 4-29—CY 2015 *PPC—Postpartum Care* Measure Results

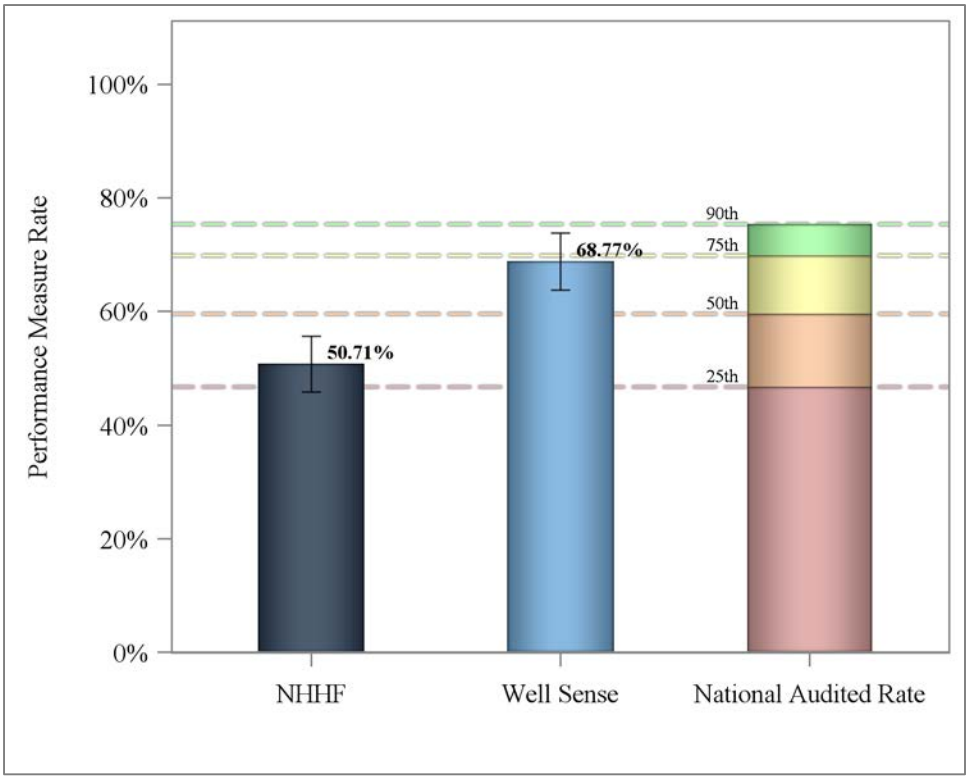


NHHF's reported rate was at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *FPC—≥ 81 Percent of Expected Visits* measure results are shown in Figure 4-30.

Figure 4-30—CY 2015 *FPC—≥ 81 Percent of Expected Visits* Measure Results



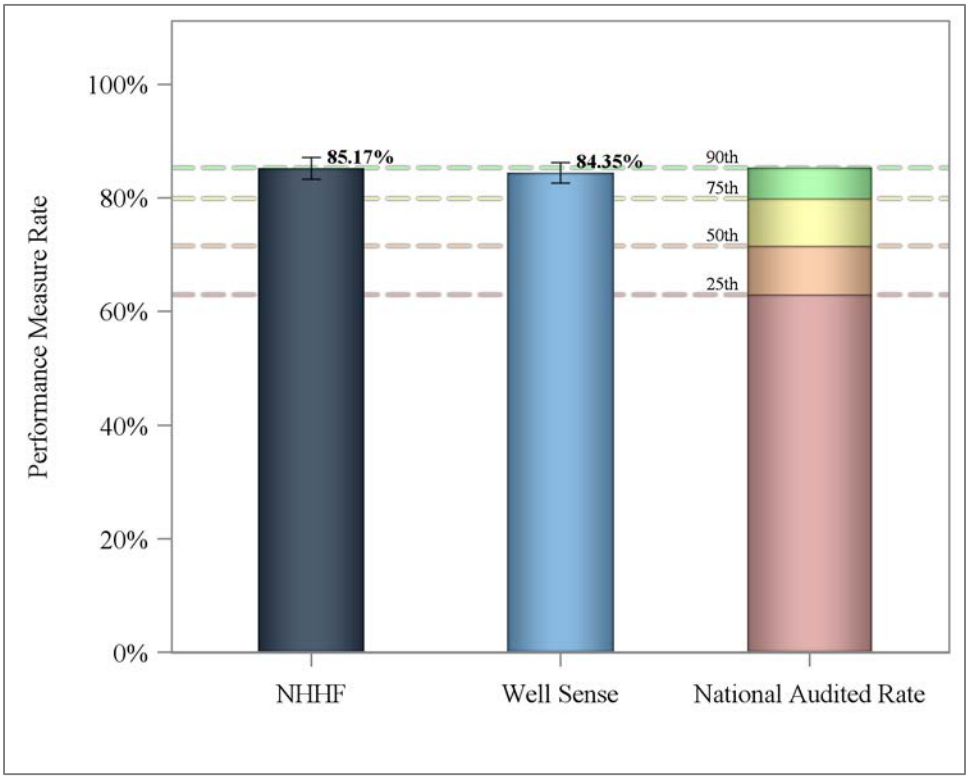
NHHF's reported rate was at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

Acute and Chronic Care

Appropriate Testing for Children with Pharyngitis (CWP)

CWP measures the percentage of children 2 to 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode during 2015. (A higher rate represents better performance; i.e. appropriate testing.) **NHHF**'s and **Well Sense**'s *CWP* measure results are shown in Figure 4-31.

Figure 4-31—CY 2015 *CWP* Measure Results

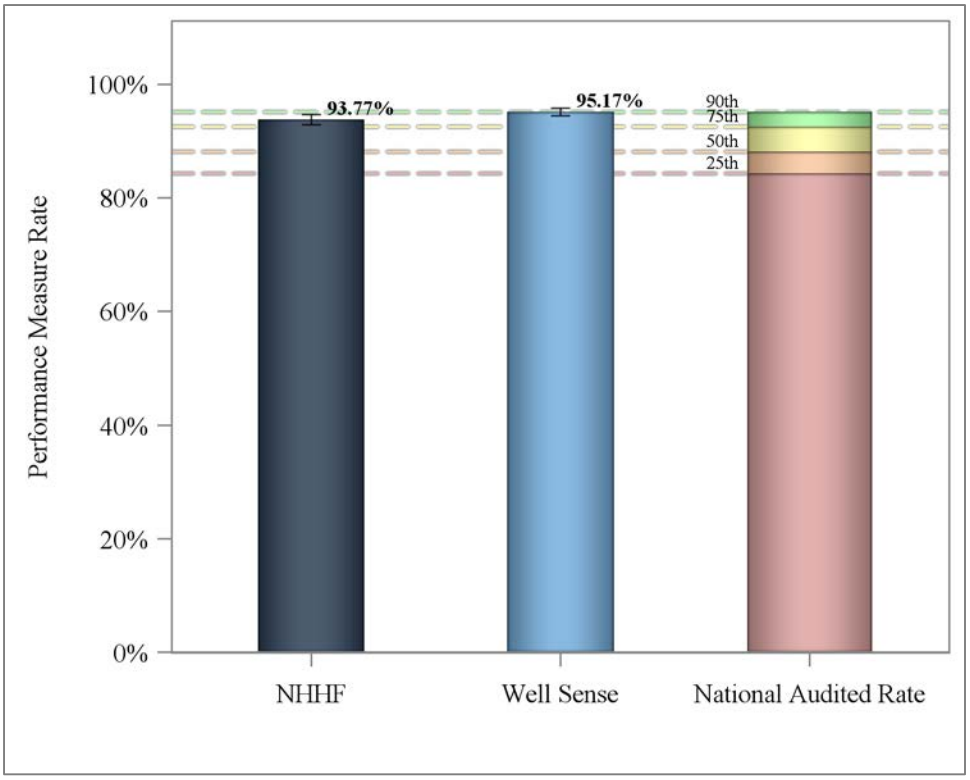


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *URI* measure results are shown in Figure 4-32.

Figure 4-32—CY 2015 *URI* Measure Results

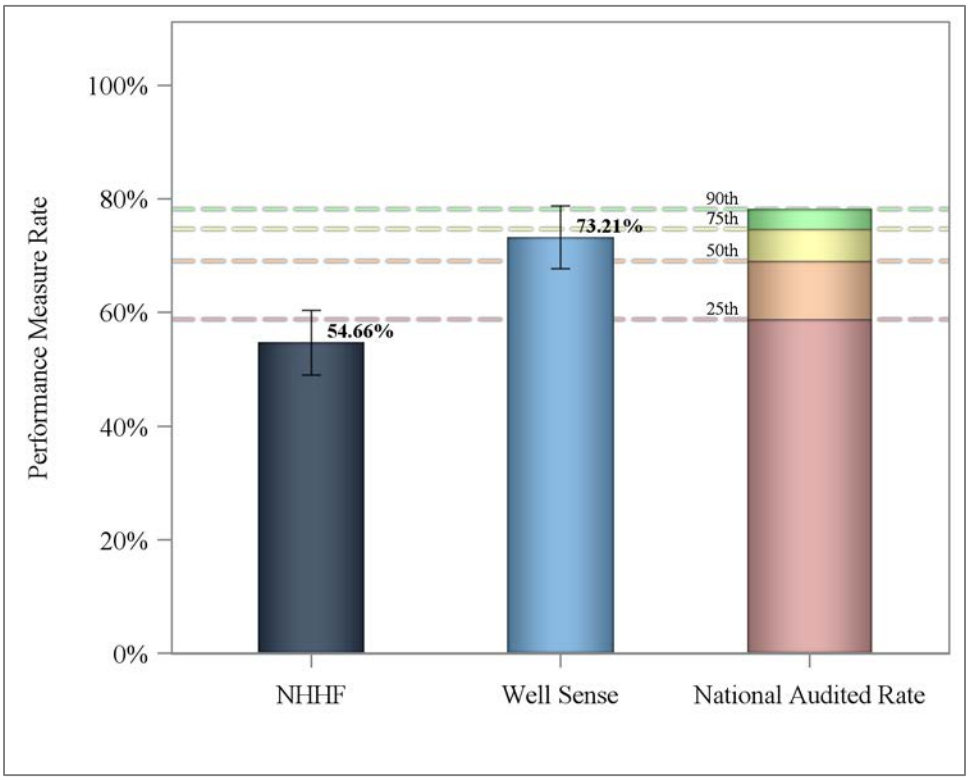


NHHF's reported rate was at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 90th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *PCE—Systemic Corticosteroid* measure results are shown in Figure 4-33.

Figure 4-33—CY 2015 *PCE—Systemic Corticosteroid* Measure Results

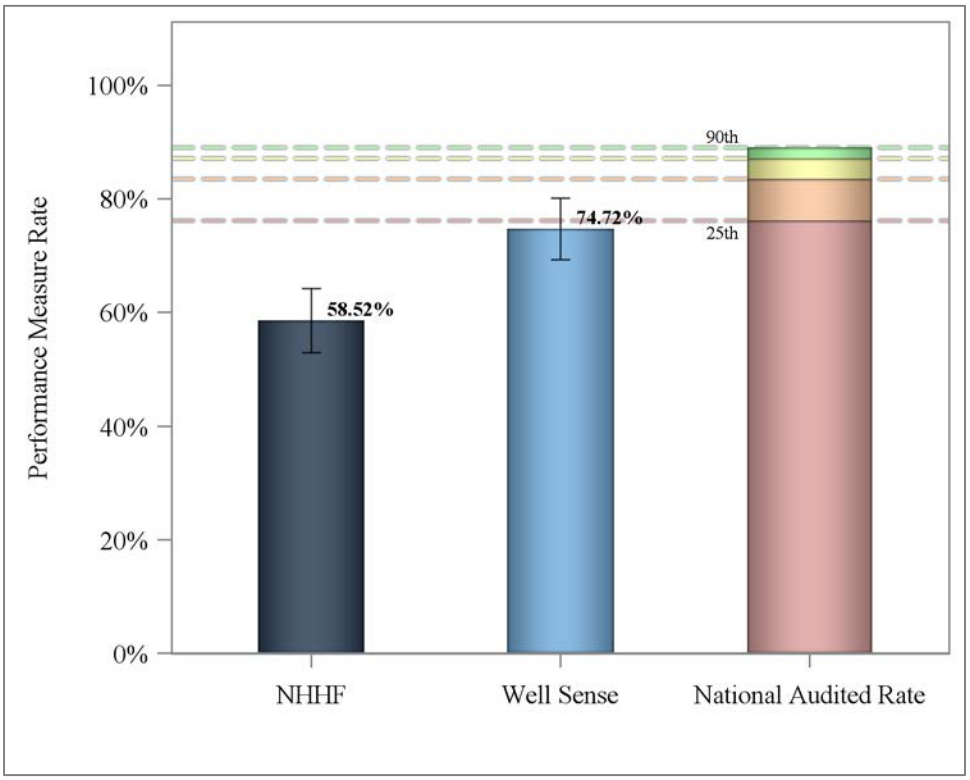


NHHF's reported rate was below the national Medicaid 25th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *PCE—Bronchodilator* measure results are shown in Figure 4-34.

Figure 4-34—CY 2015 *PCE—Bronchodilator* Measure Results

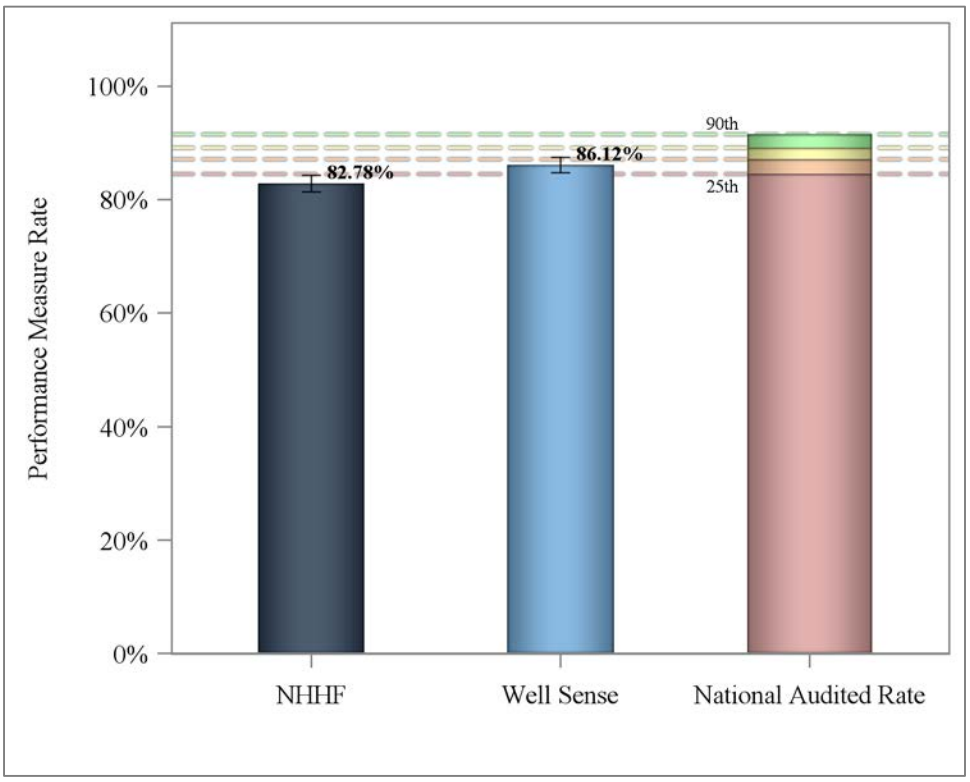


NHHF's and **Well Sense**'s reported rates were below the national Medicaid 25th percentile.

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 at least 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 2015. **NHHF**'s and **Well Sense**'s *MPM—Total* measure results are shown in Figure 4-35.

Figure 4-35—CY 2015 *MPM—Total* Measure Results

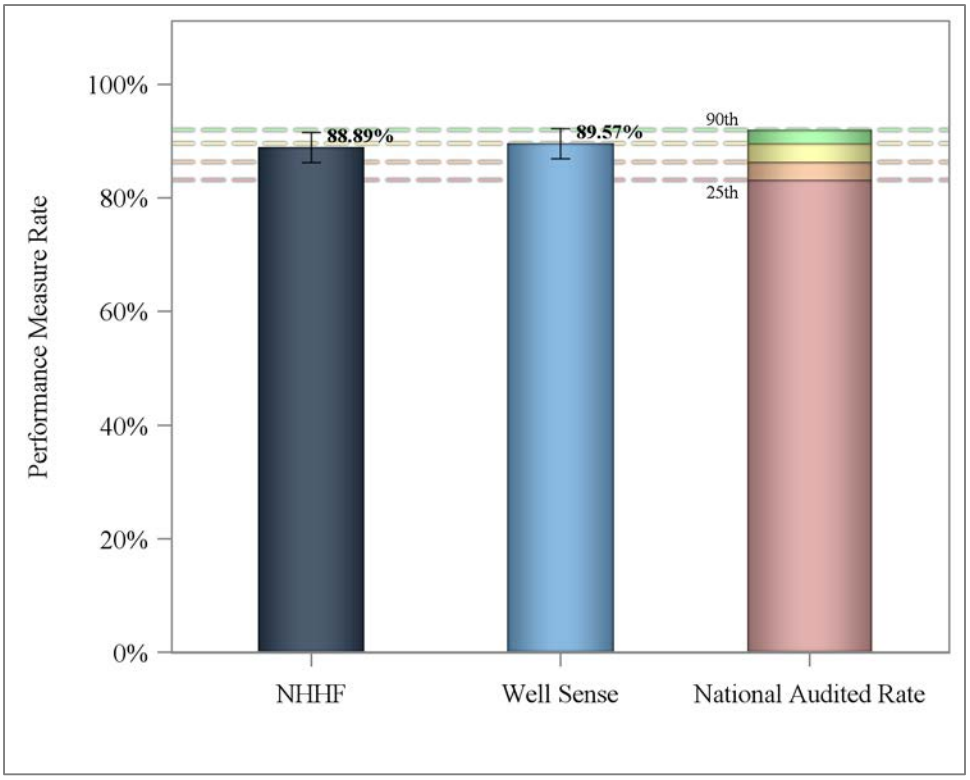


NHHF's reported rate was below the national Medicaid 25th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile.

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

CDC—HbA1c Testing measures the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c testing during 2015. **NHHF**'s and **Well Sense**'s *CDC—HbA1c Testing* measure results are shown in Figure 4-36.

Figure 4-36—CY 2015 *CDC—HbA1c Testing* Measure Results

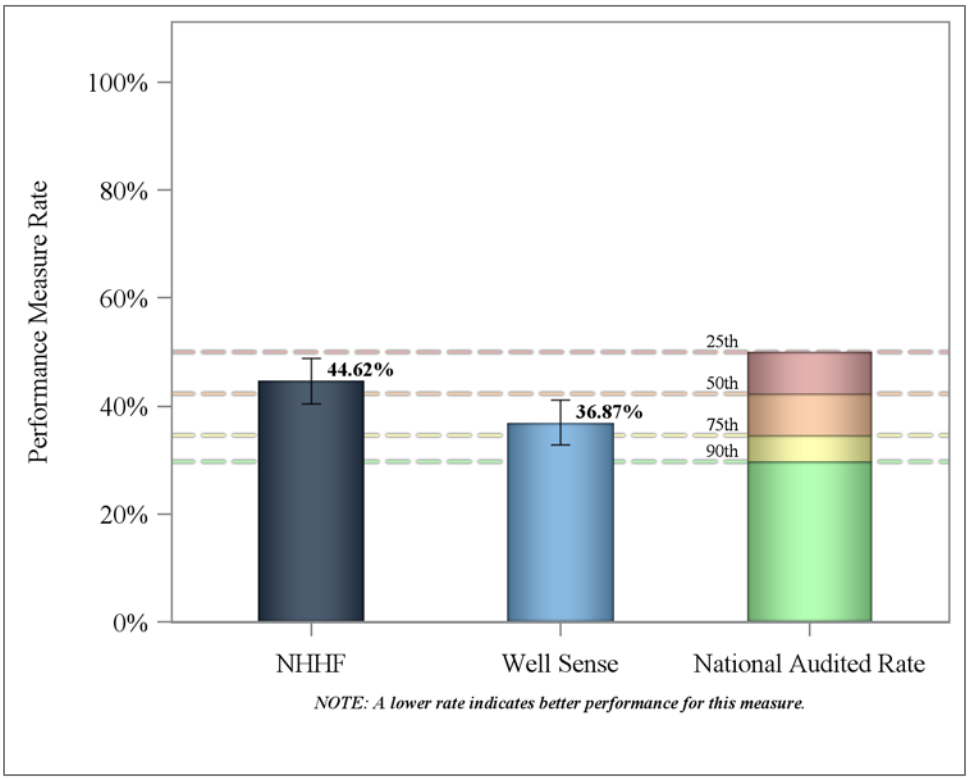


NHHF's reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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

CDC—HbA1c Poor Control (>9.0%) measures the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose HbA1c testing showed poor control, with levels greater than 9.0 percent during 2015. **NHHF**'s and **Well Sense**'s *CDC—HbA1c Poor Control (>9.0%)* measure results are shown in Figure 4-37. Note, lower rates for this measure indicate better performance.

Figure 4-37—CY 2015 *CDC—HbA1c Poor Control (>9.0%)* Measure Results

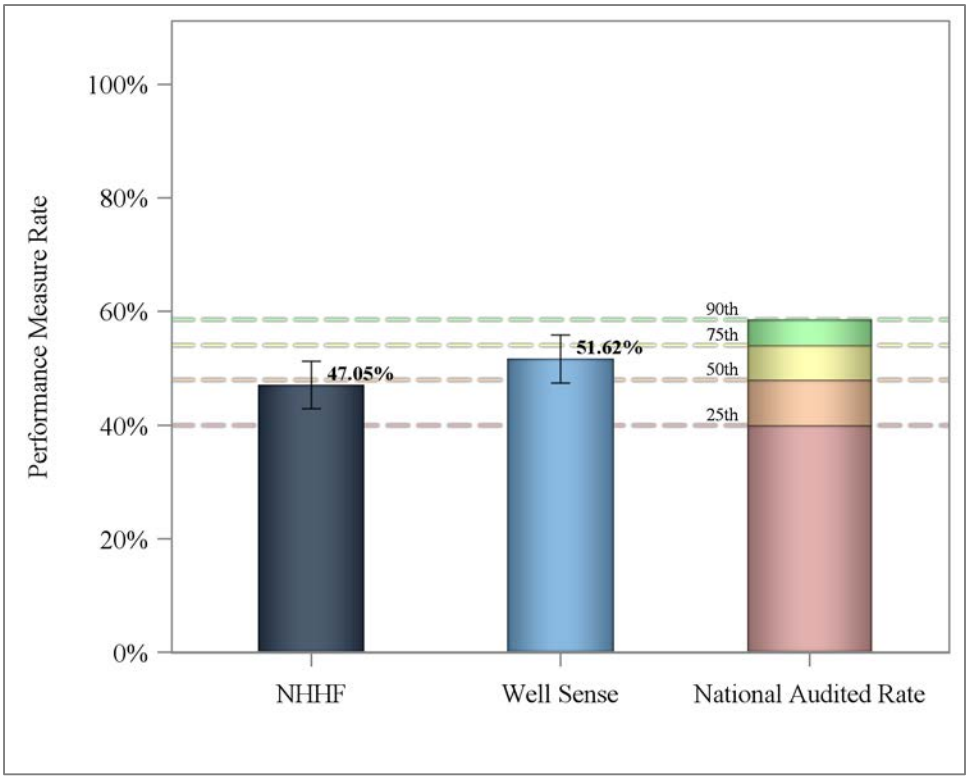


NHHF's reported rate was at or better than the national Medicaid 25th percentile but worse than the national Medicaid 50th percentile, and **Well Sense**'s reported rate was at or better than the national Medicaid 50th percentile but worse than the national Medicaid 75th percentile.

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

CDC—HbA1c Control (<8.0%) measures the percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) whose HbA1c testing revealed levels less than 8.0 percent during 2015. **NHHF**'s and **Well Sense**'s *CDC—HbA1c Control (<8.0%)* measure results are shown in Figure 4-38.

Figure 4-38—CY 2015 *CDC—HbA1c Control (<8.0%)* Measure Results

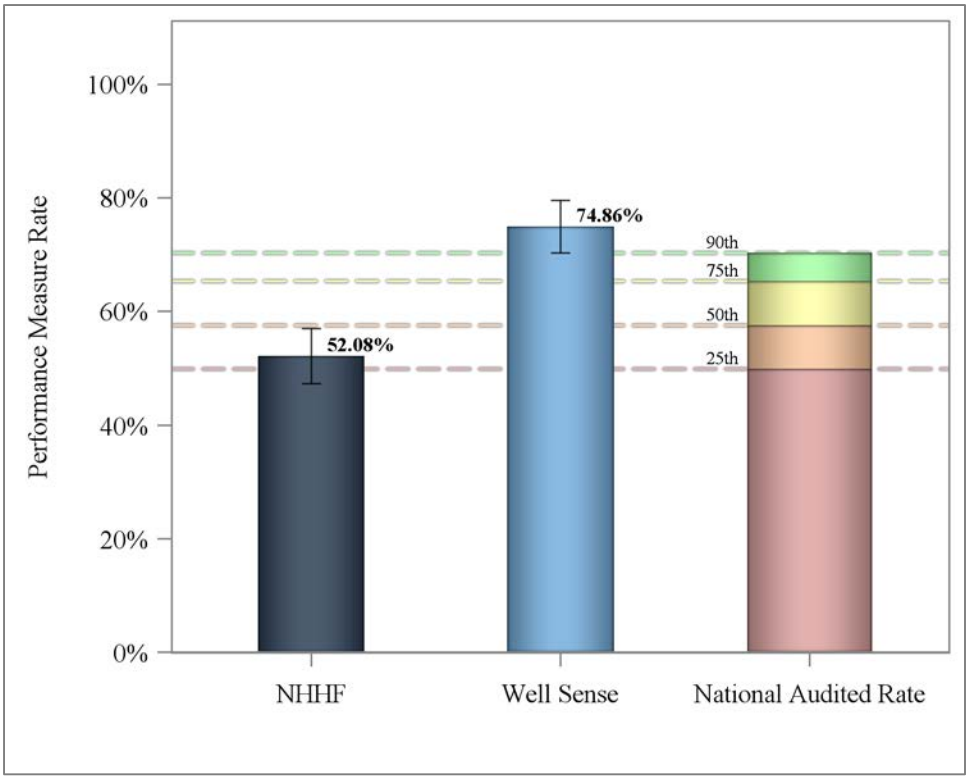


NHHF's reported rate was at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

Controlling High Blood Pressure (CBP)

CBP measures the percentage of members 18 to 85 years of age and diagnosed with hypertension whose blood pressure was adequately controlled during 2015. **NHHF**'s and **Well Sense**'s *CBP* measure results are shown in Figure 4-39.

Figure 4-39—CY 2015 *CBP* Measure Results

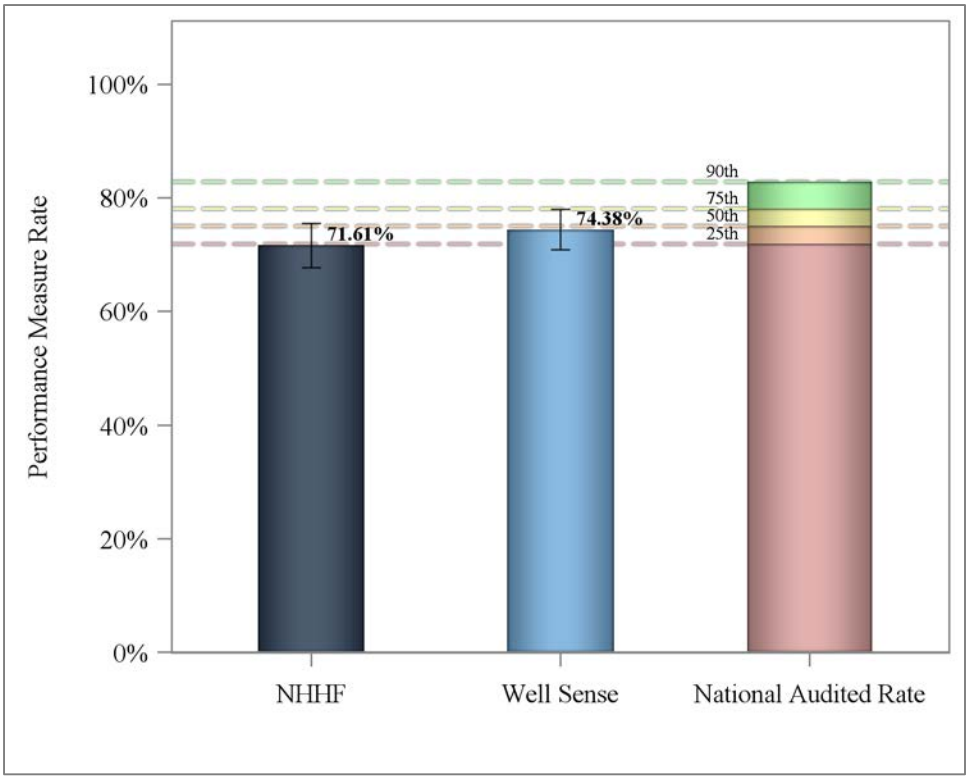


NHHF's reported rate was at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and **Well Sense**'s reported rate was above the national Medicaid 90th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *LBP* measure results are shown in Figure 4-40.

Figure 4-40—CY 2015 *LBP* Measure Results

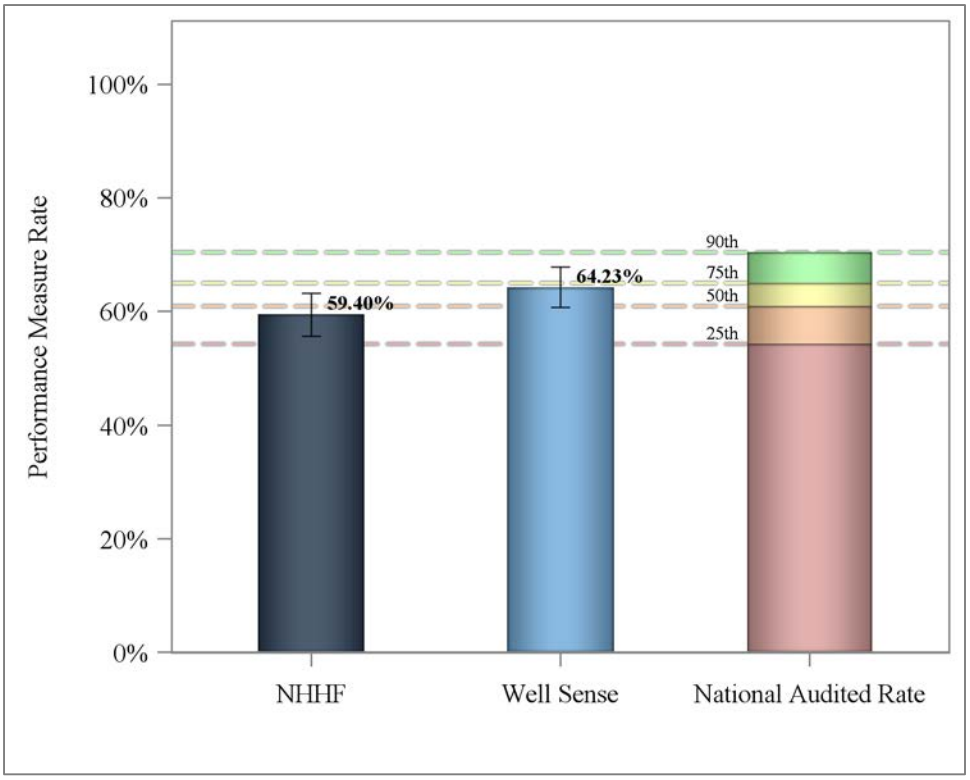


NHHF's reported rate was below the national Medicaid 25th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile.

Asthma Medication Ratio (AMR)—Total

AMR—Total measures the percentage of members 5 to 64 years of age identified as having persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater during 2015. **NHHF**'s and **Well Sense**'s *AMR—Total* measure results are shown in Figure 4-41.

Figure 4-41—CY 2015 *AMR—Total* Measure Results

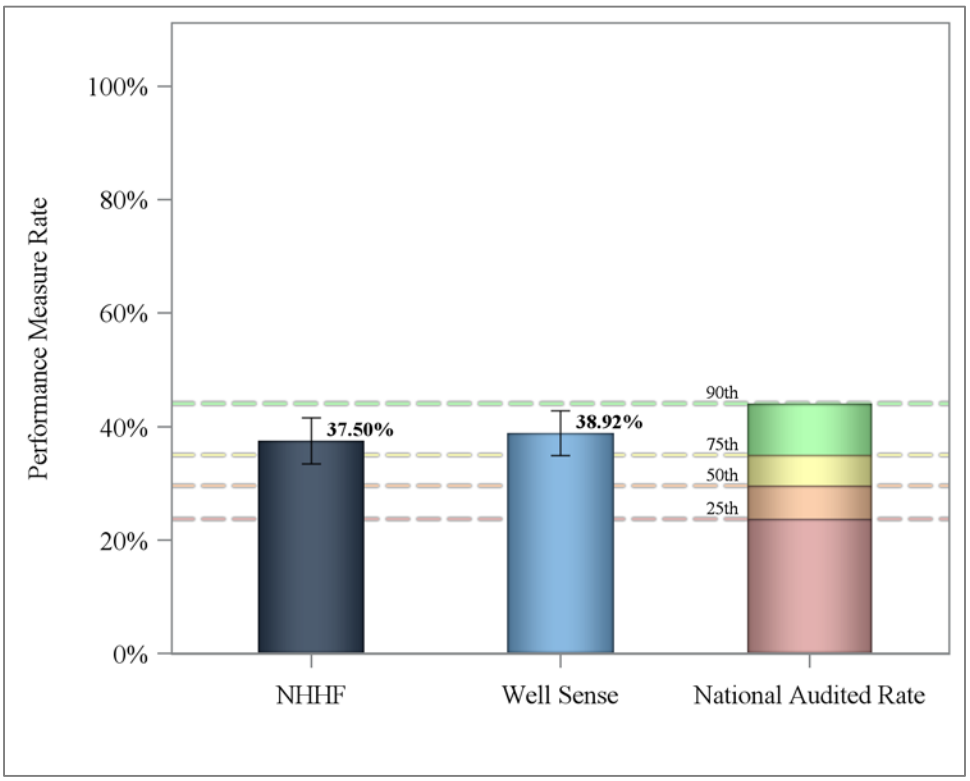


NHHF's reported rate was at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

Medication Management for People With Asthma (MMA)—Medication Compliance 75%—Total

MMA—Medication Compliance 75%—Total measures the percentage of members 5 to 64 years of age identified as having persistent asthma and dispensed appropriate medications who remained on an asthma controller medication for at least 75 percent of the time during the treatment period. **NHHF**'s and **Well Sense**'s *MMA—Medication Compliance 75%—Total* measure results are shown in Figure 4-42.

Figure 4-42—CY 2015 *MMA—Medication Compliance 75%—Total* Measure Results

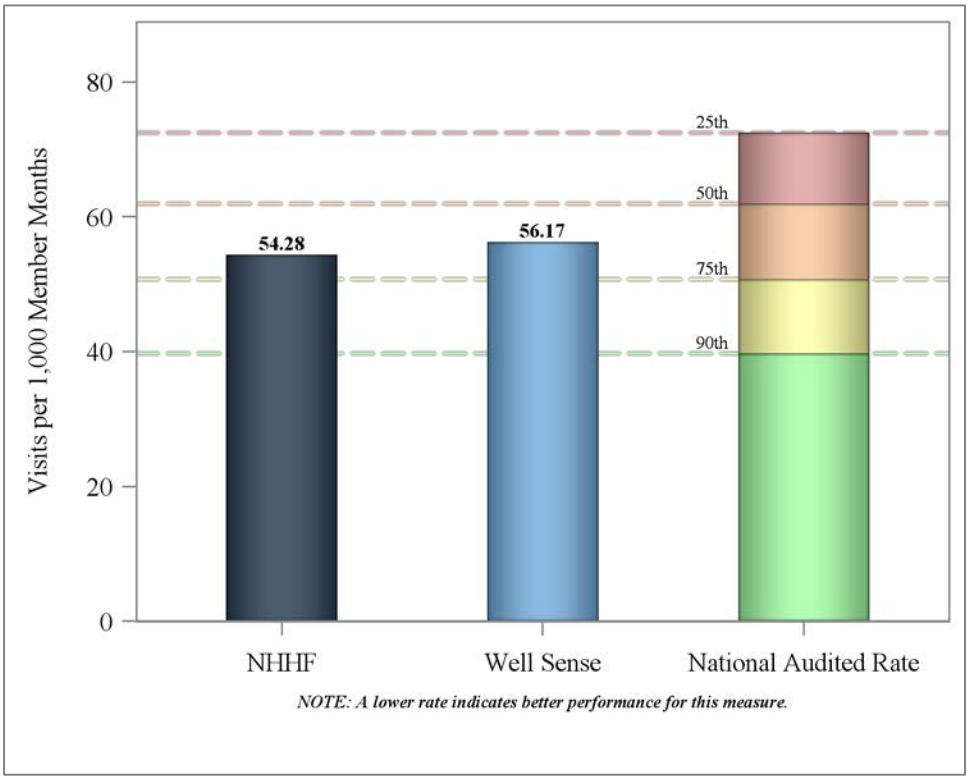


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

Ambulatory Care (Per 1,000 Member Months) (AMBA)—ED Visits

AMBA—ED Visits measures the utilization of ED visits among the member population during 2015. **NHHF**'s and **Well Sense**'s *AMBA—ED Visits* measure results are shown in Figure 4-43.[4-12] A lower rate indicates better performance for this measure, and HSAG reversed the order of the national Medicaid percentiles to be applied to this measure consistently with the other measures. For example, the national Medicaid 10th percentile (a lower rate) was reversed to become the national Medicaid 90th percentile, indicating better performance.

Figure 4-43—CY 2015 *AMBA—ED Visits* Measure Results



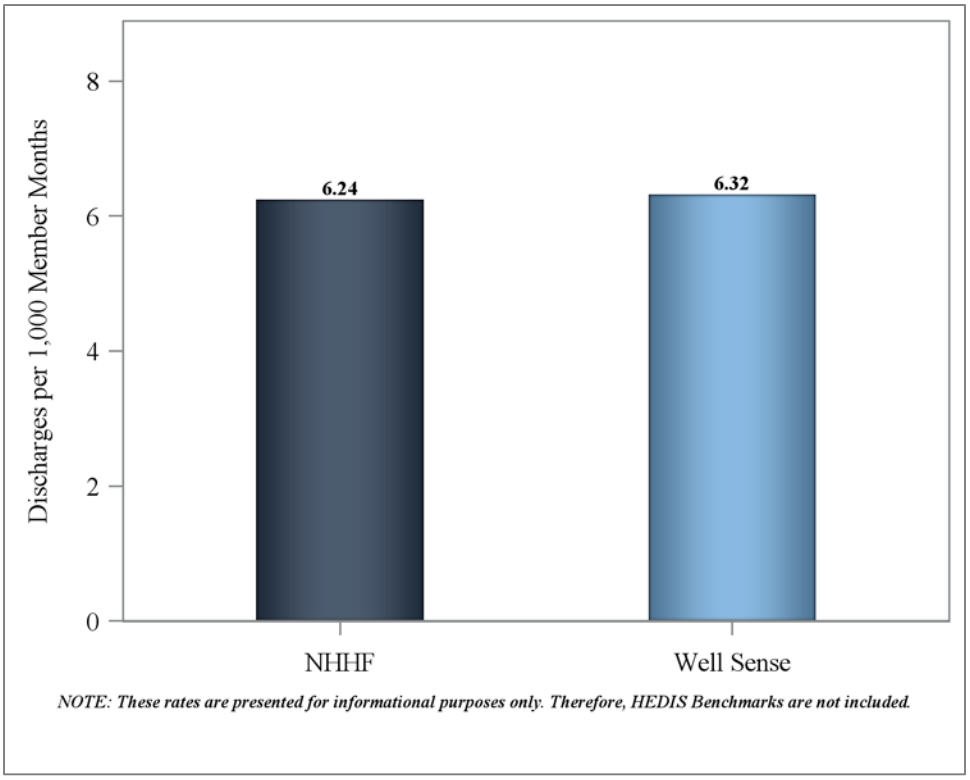
NHHF's and **Well Sense**'s reported rates were better than the national Medicaid 50th percentile but worse the national Medicaid 75th percentile.

[4-12] 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 2015, per 1,000 member months. **NHHF**'s and **Well Sense**'s *IPUA—General Hospital/Acute Care—Total* Inpatient Discharges measure results are shown in Figure 4-44.[4-13]

Figure 4-44—CY 2015 *IPUA—General Hospital/Acute Care—Total Inpatient Discharges* Measure Results



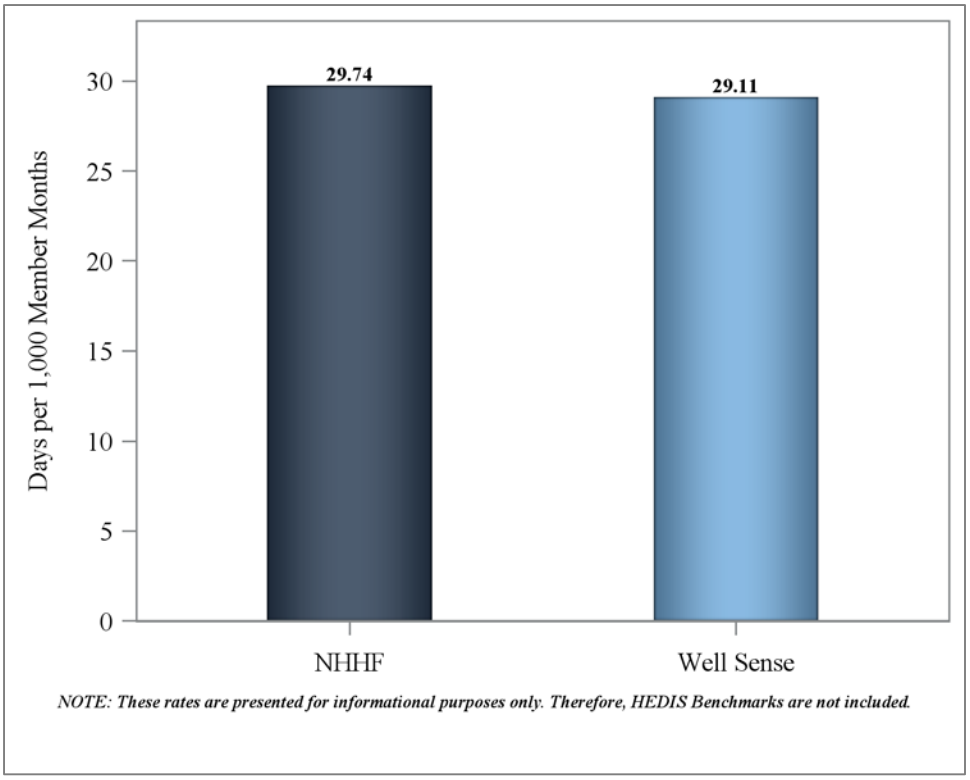
Rates for this measure were similar between **NHHF** and **Well Sense**.

[4-13] 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 inpatient discharges during 2015, reported as a rate per 1,000 member months. **NHHF**'s and **Well Sense**'s *IPUA—General Hospital/Acute Care—Total Inpatient Days* measure results are shown in Figure 4-45.[4-14]

Figure 4-45—CY 2015 *IPUA—General Hospital/Acute Care—Total Inpatient Days* Measure Results



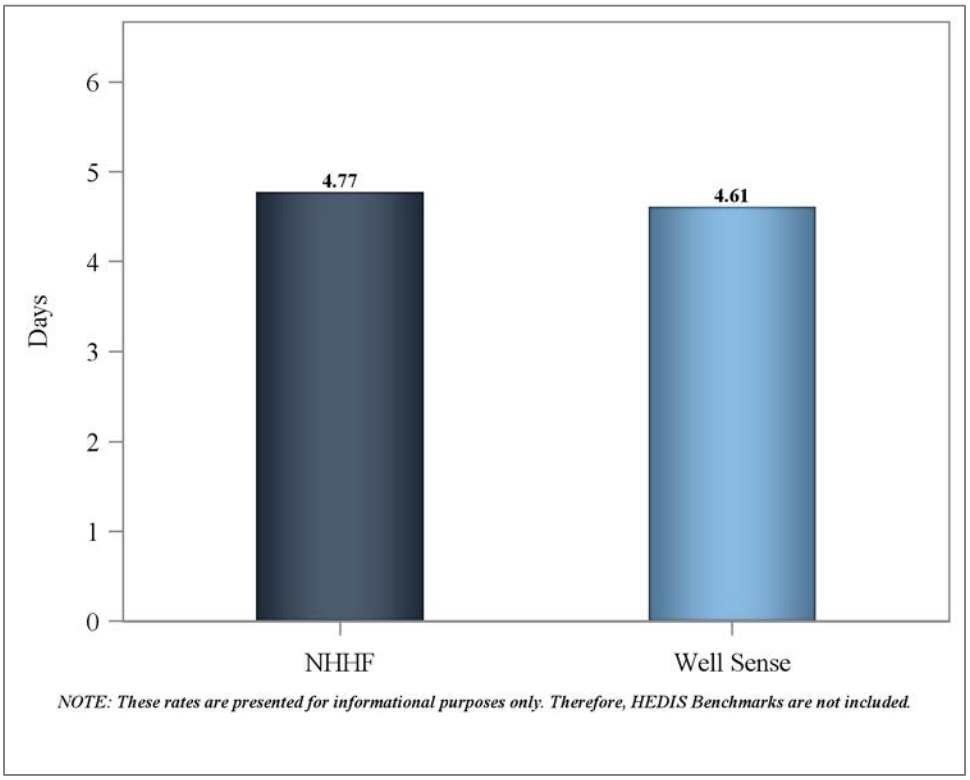
Rates for this measure were similar between **NHHF** and **Well Sense**.

[4-14] 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 2015. **NHHF**'s and **Well Sense**'s *IPUA—General Hospital/Acute Care—Total Inpatient—Average Length of Stay* measure results are shown in Figure 4-46.[4-15]

Figure 4-46—CY 2015 *IPUA—General Hospital/Acute Care—Total Inpatient—Average Length of Stay* Measure Results



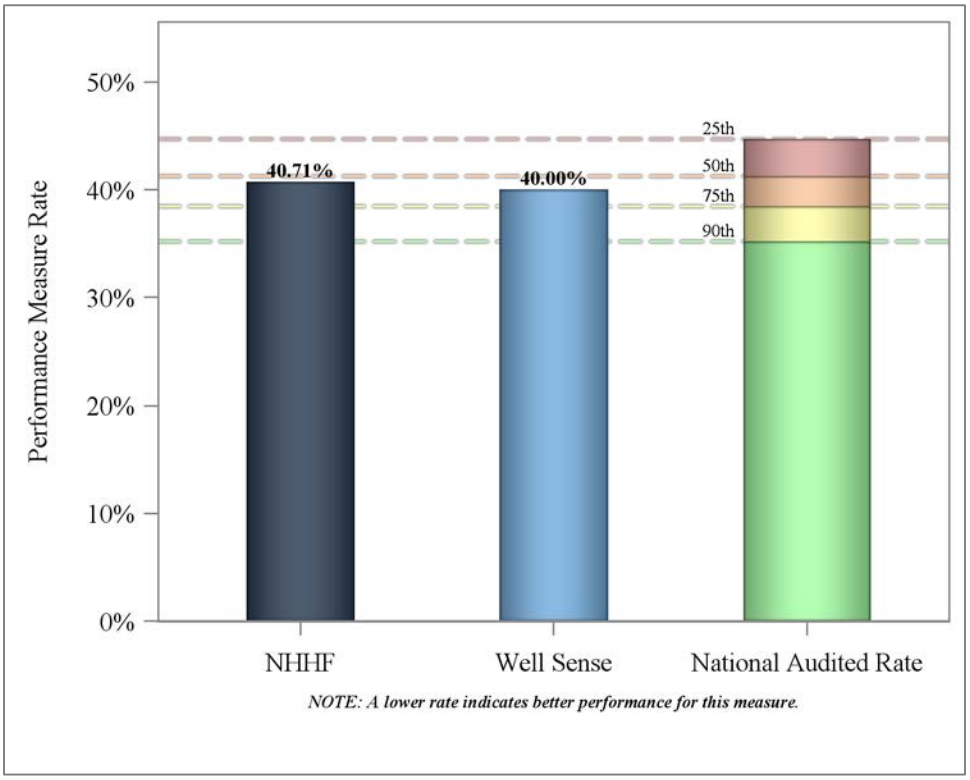
The total inpatient average length of stay was similar between **NHHF** and **Well Sense**.

[4-15] 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 2015. **NHHF**'s and **Well Sense**'s *ABXA—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions* measure results are shown in Figure 4-47.[4-16] Note, a lower rate indicates better performance for this measure, and HSAG reversed the order of the national Medicaid percentiles to be applied to this measure consistently with the other measures.

Figure 4-47—CY 2015 *ABXA—Percentage of Antibiotics of Concern for all Antibiotics Prescriptions* Measure Results



NHHF's and **Well Sense**'s reported rates were at or better than the national Medicaid 50th percentile but worse the national Medicaid 75th percentile.

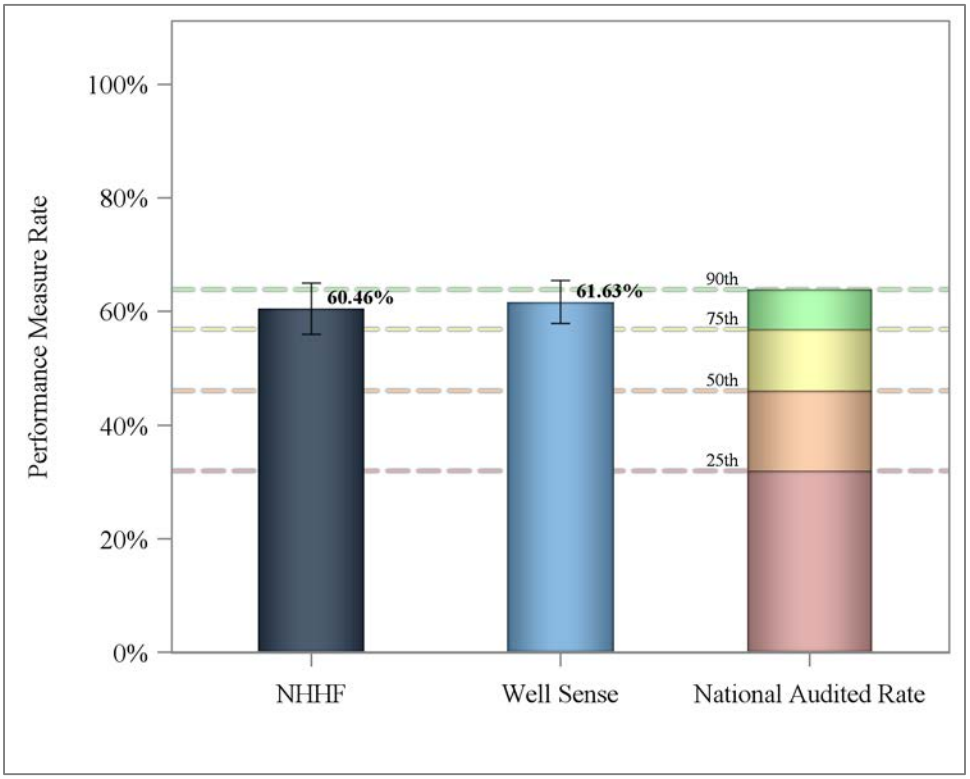
[4-16] Confidence intervals are not included for this measure in accordance with HEDIS guidelines.

Behavioral Health

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

FUH—7-Day Follow-Up measures the percentage of discharges for 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 2015. **NHHF**'s and **Well Sense**'s *FUH—7-Day Follow-Up* measure results are shown in Figure 4-48.

Figure 4-48—CY 2015 *FUH—7-Day Follow-Up* Measure Results

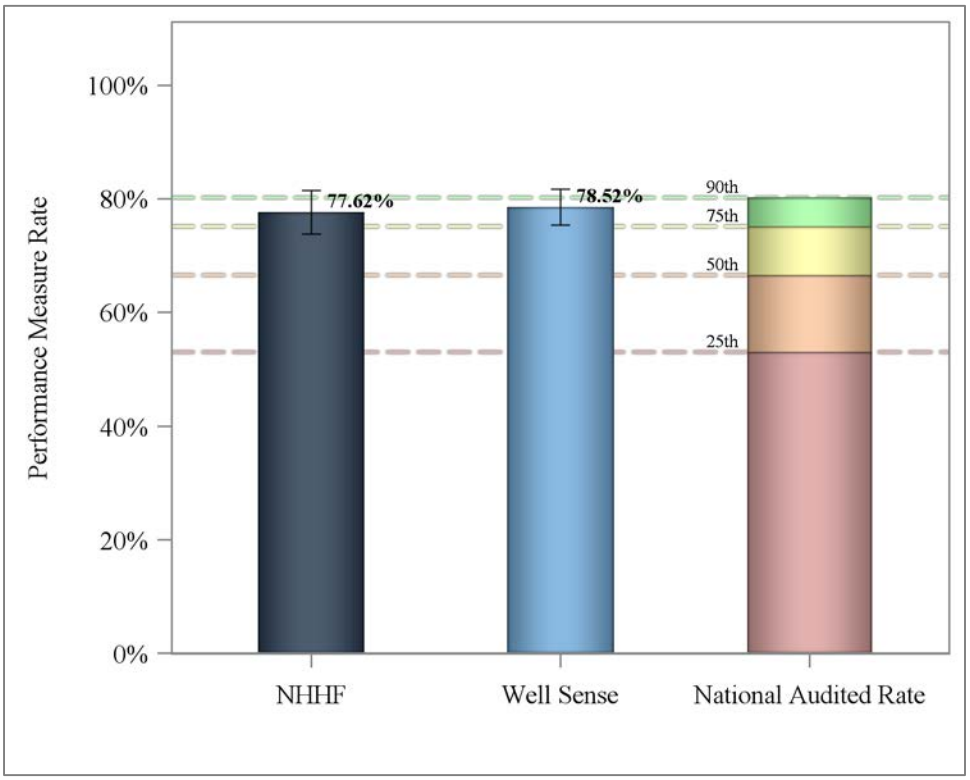


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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

FUH—30-Day Follow-Up measures the percentage of discharges for 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 2015. **NHHF**'s and **Well Sense**'s *FUH—30-Day Follow-Up* measure results are shown in Figure 4-49.

Figure 4-49—CY 2015 *FUH—30-Day Follow-Up* Measure Results

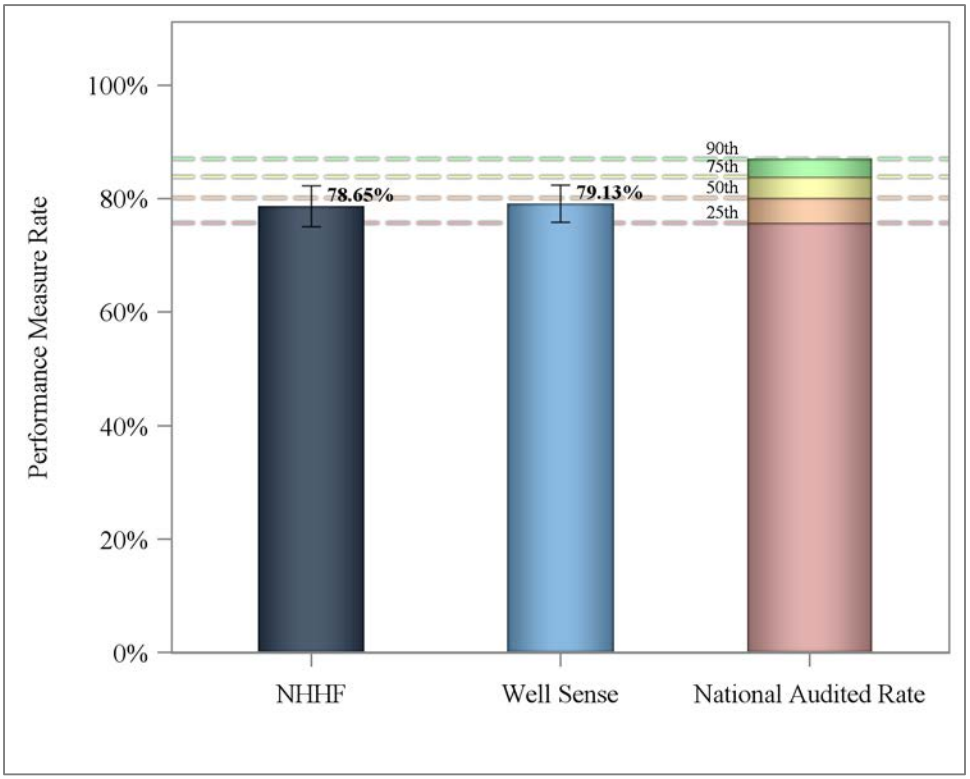


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *SSD* measure results are shown in Figure 4-50.

Figure 4-50—CY 2015 *SSD* Measure Results

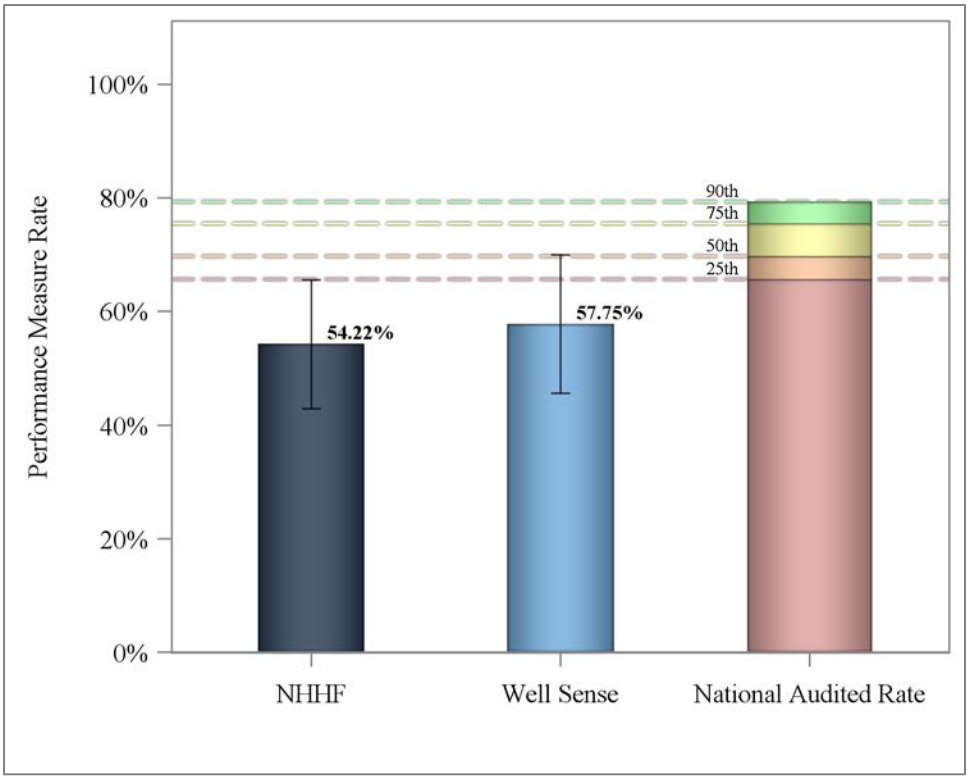


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *SMD* measure results are shown in Figure 4-51.

Figure 4-51—CY 2015 *SMD* Measure Results

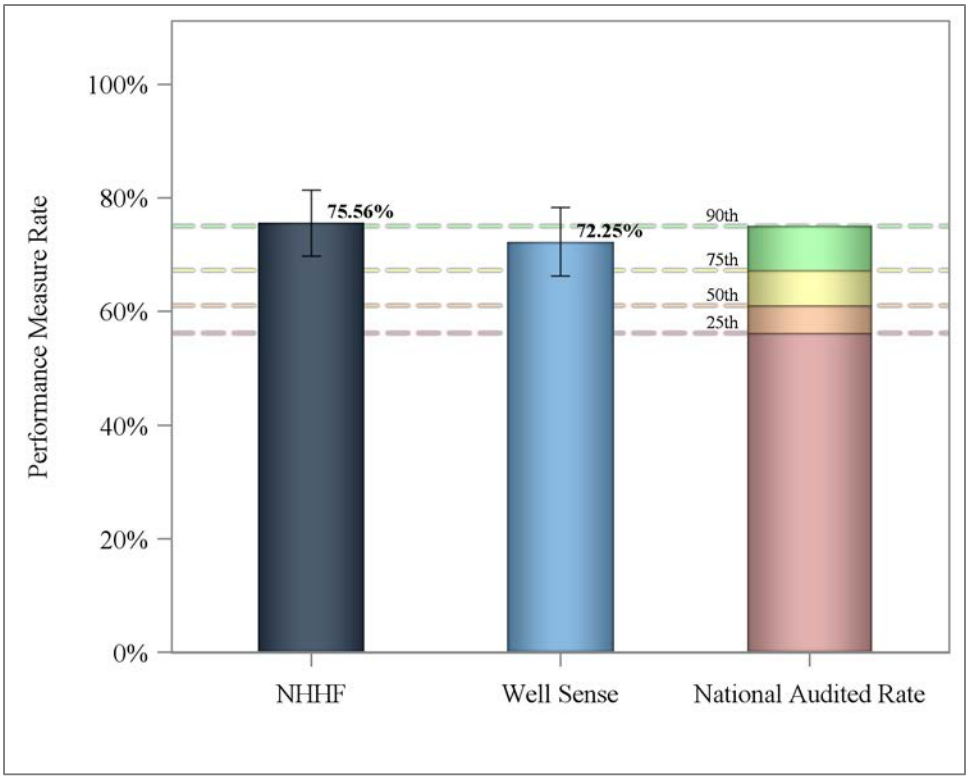


NHHF's and **Well Sense**'s reported rates were below the national Medicaid 25th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *SAA* measure results are shown in Figure 4-52.

Figure 4-52—CY 2015 *SAA* Measure Results

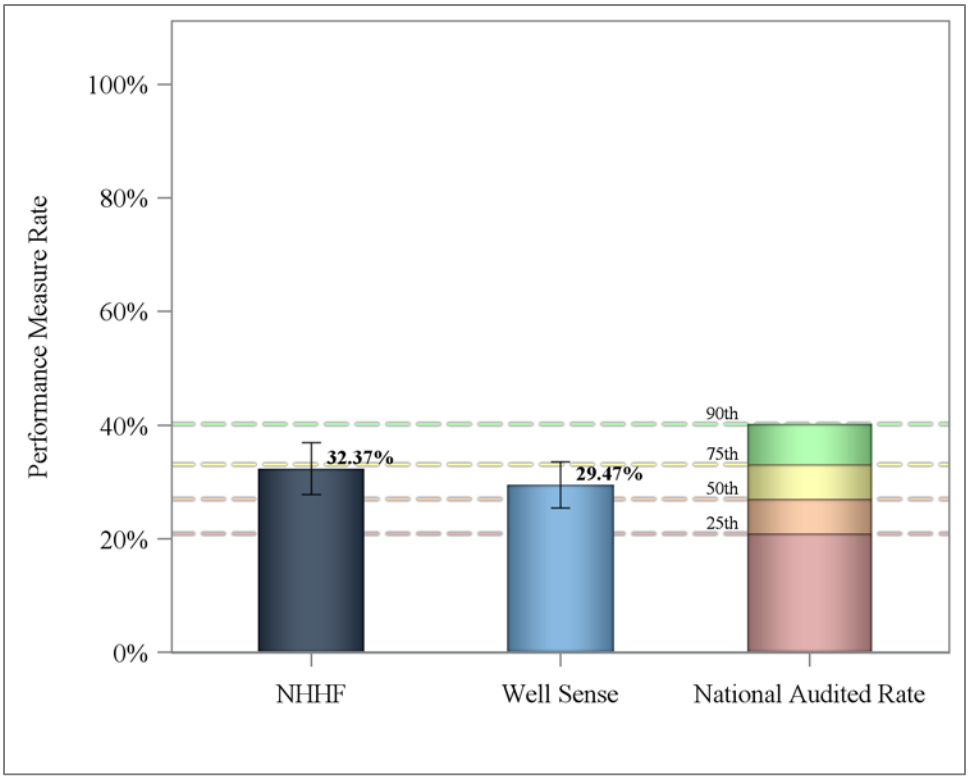


NHHF's reported rate was at or above the national Medicaid 90th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *APM—Total* measure results are shown in Figure 4-53.

Figure 4-53—CY 2015 *APM—Total* Measure Results

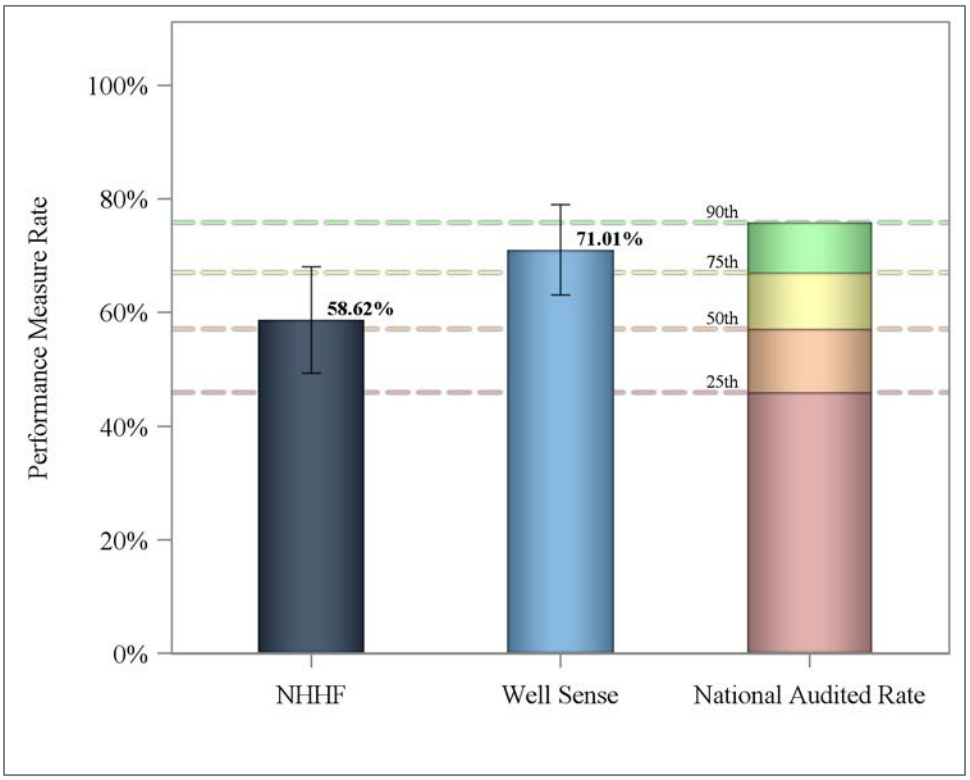


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *APP—Total* measure results are shown in Figure 4-54.

Figure 4-54—CY 2015 *APP—Total* Measure Results

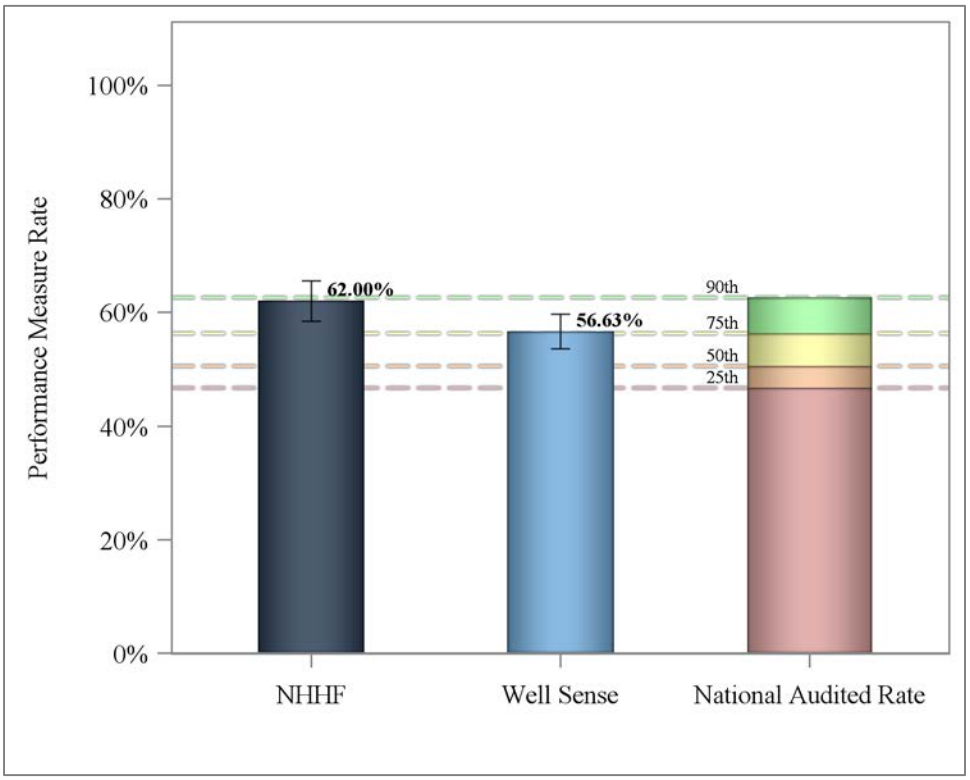


NHHF's reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment

AMM—Effective Acute Phase Treatment measures the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days (12 weeks). **NHHF**'s and **Well Sense**'s *AMM—Effective Acute Phase Treatment* measure results are shown in Figure 4-55.

Figure 4-55—CY 2015 *AMM—Effective Acute Phase Treatment* Measure Results

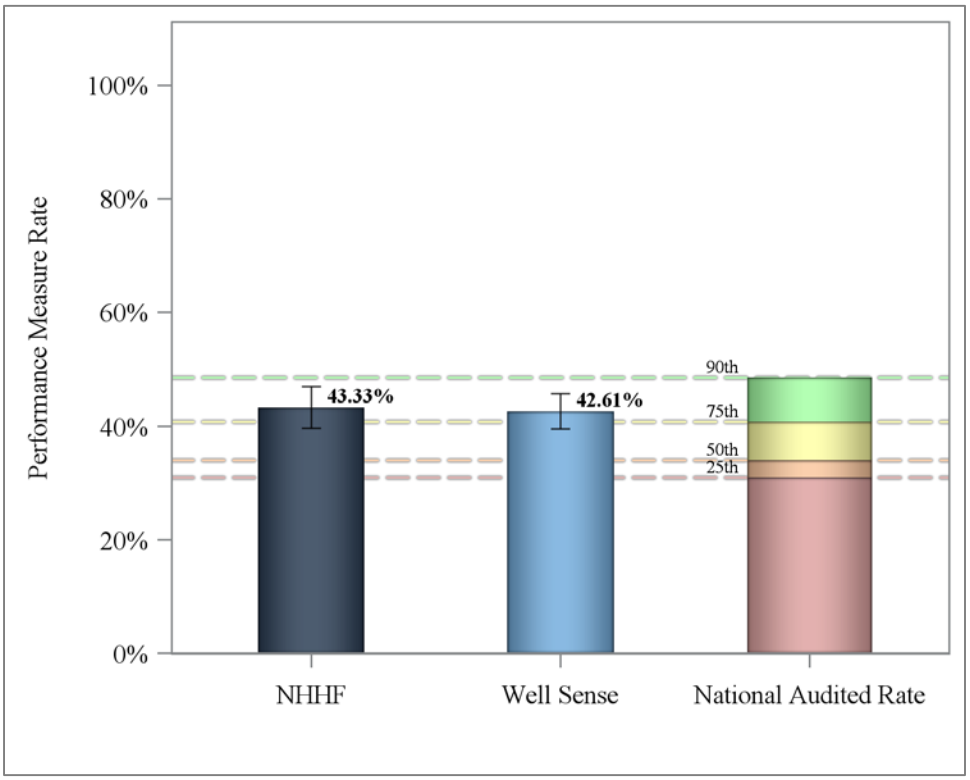


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

Antidepressant Medication Management (AMM)—Effective Continuation Phase Treatment

AMM—Effective Continuation Phase Treatment measures is the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 180 days (6 months). **NHHF**'s and **Well Sense**'s *AMM—Effective Continuation Phase Treatment* measure results are shown in Figure 4-56.

Figure 4-56—CY 2015 *AMM—Effective Continuation Phase Treatment* Measure Results

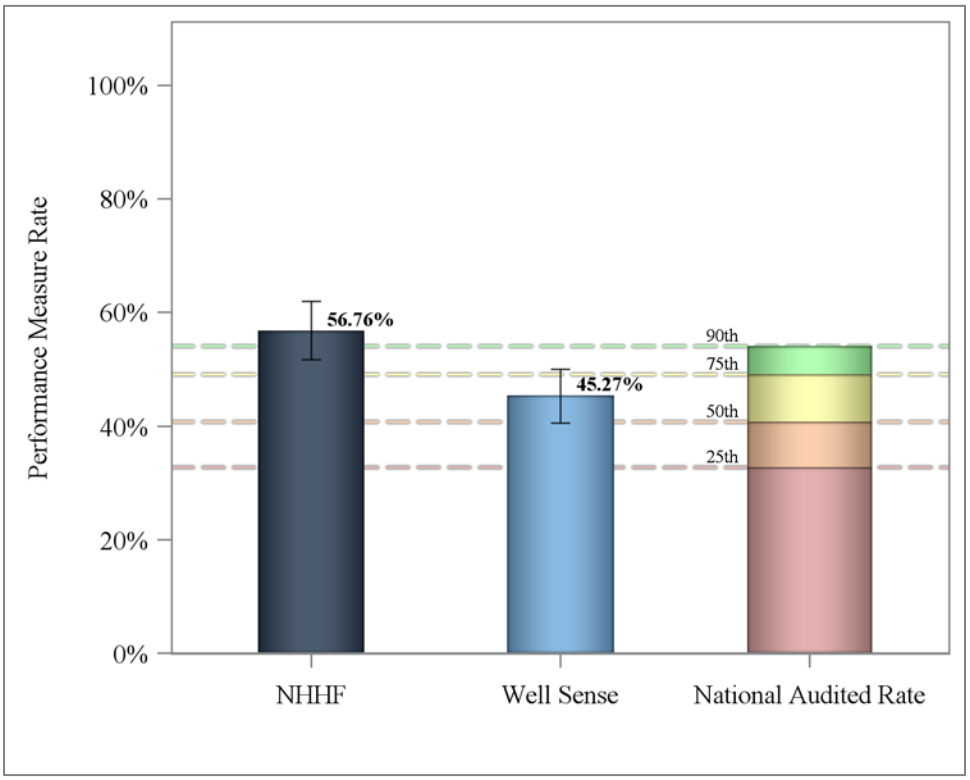


NHHF's and **Well Sense**'s reported rates were at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase

ADD—Initiation Phase measures the percentage of members 6 to 12 years of age who were newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had a follow-up care visit within 30 days of the first ADHD medication being dispensed. **NHHF**'s and **Well Sense**'s *ADD—Initiation Phase* measure results are shown in Figure 4-57.

Figure 4-57—CY 2015 *ADD—Initiation Phase* Measure Results

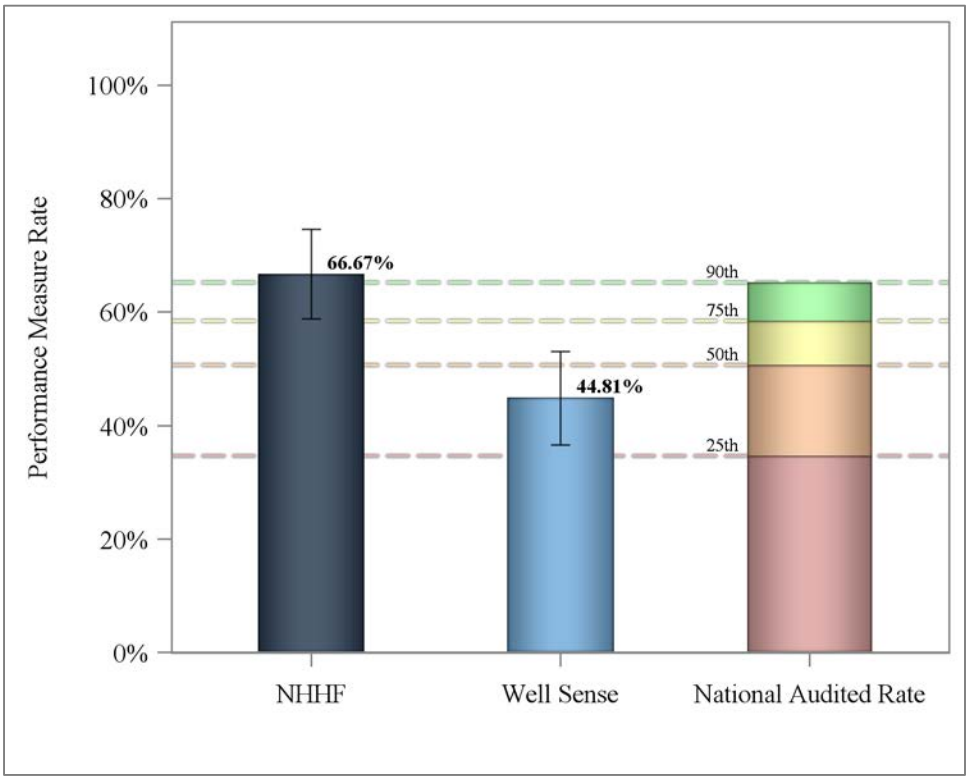


NHHF's reported rate was at or above the national Medicaid 90th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Continuation and Maintenance Phase

ADD—Continuation and Maintenance Phase measures the percentage of members 6 to 12 years of age who were newly prescribed ADHD medication, remained on the medication for at least 210 days, and had at least two follow-up care visits within a 9-month period, after the first 30 days of the first ADHD medication being dispensed. **NHHF**'s and **Well Sense**'s *ADD—Continuation and Maintenance Phase* measure results are shown in Figure 4-58.

Figure 4-58—CY 2015 *ADD—Continuation and Maintenance Phase* Measure Results

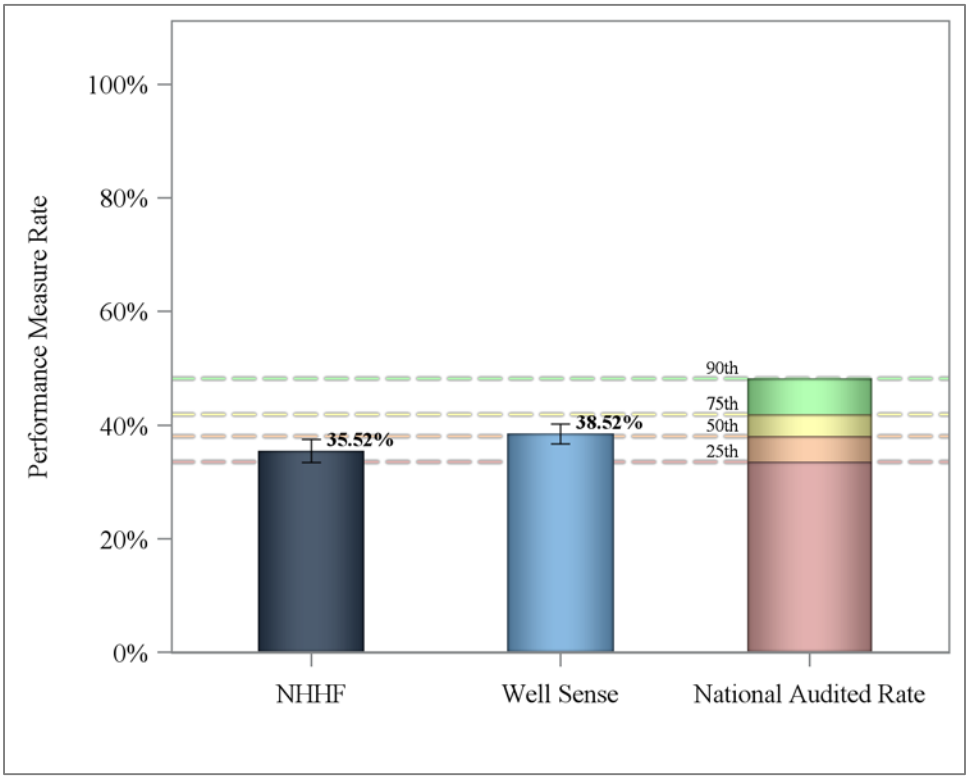


NHHF's reported rate was at or above the national Medicaid 90th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile.

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 initiated appropriate AOD treatment within 14 days of the diagnosis during 2015. **NHHF**'s and **Well Sense**'s *IET—Initiation of AOD Treatment* measure results are shown in Figure 4-59.

Figure 4-59—CY 2015 *IET—Initiation of AOD Treatment* Measure Results

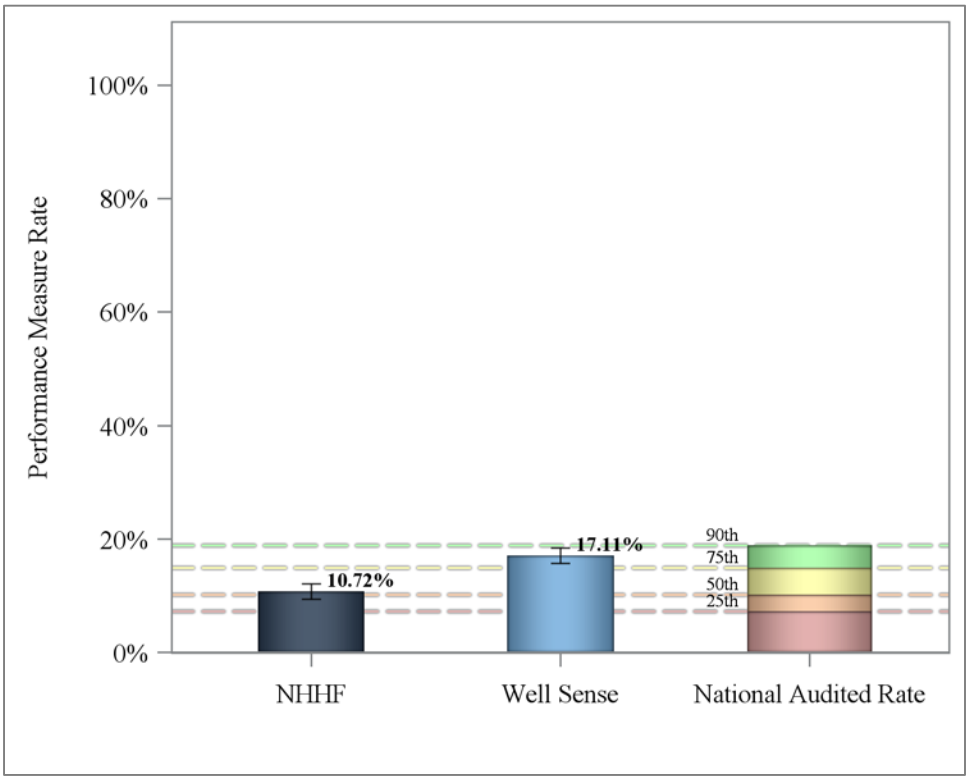


NHHF's reported rate was at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile.

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 of AOD within 30 days of the initiation visit during 2015. **NHHF**'s and **Well Sense**'s *IET—Engagement of AOD Treatment* measure results are shown in Figure 4-60.

Figure 4-60—CY 2015 *IET—Engagement of AOD Treatment* Measure Results

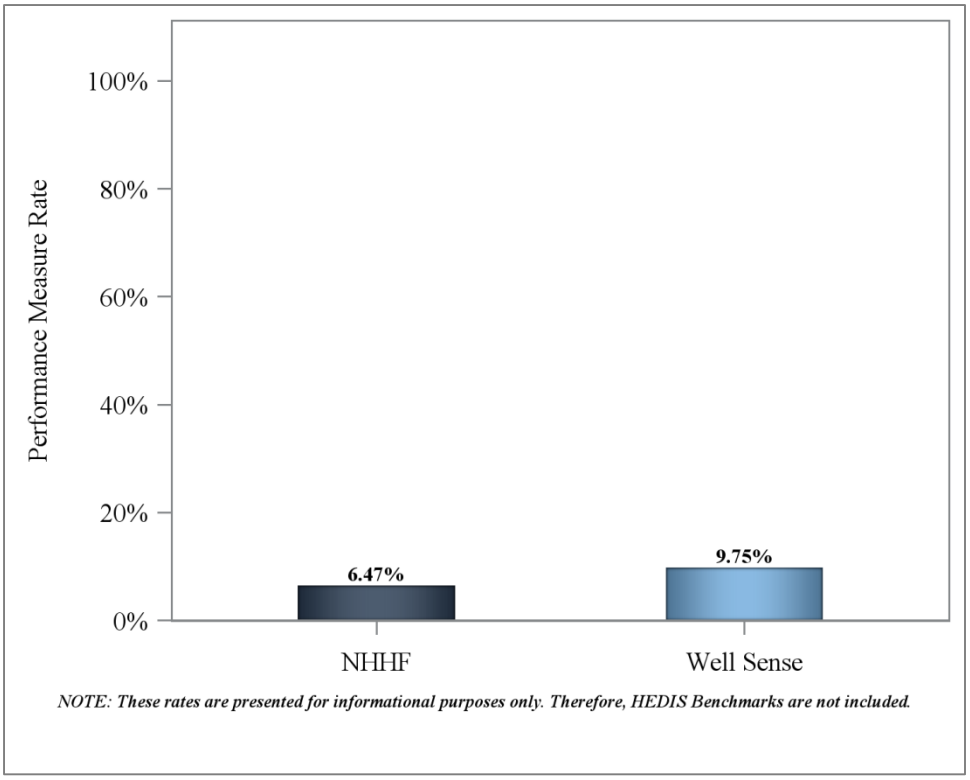


NHHF's reported rate was at or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile, and **Well Sense**'s reported rate was at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

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 2015. **NHHF**'s and **Well Sense**'s *IADA—Any Service* measure results are shown in Figure 4-61.[4-17]

Figure 4-61—CY 2015 *IADA—Any Service* Measure Results



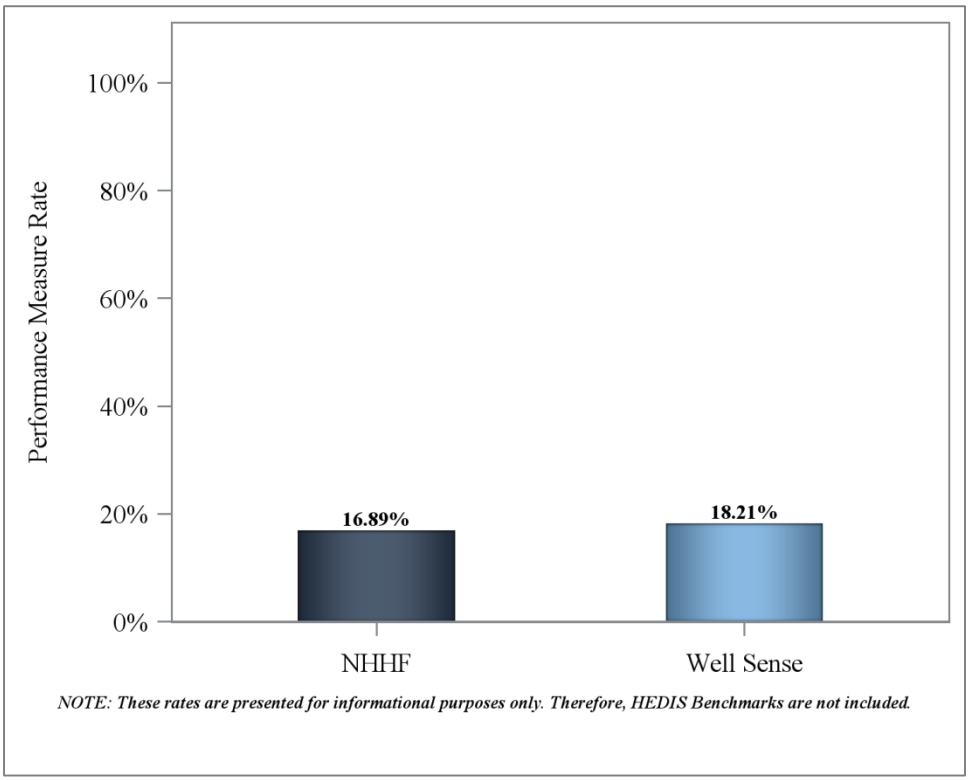
Rates for this measure were similar between **NHHF** and **Well Sense**.

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

Mental Health Utilization (MPTA)—Any Service

MPTA—Any Service measures the percentage of members receiving any mental health services during 2015. **NHHF**'s and **Well Sense**'s *MPTA—Any Service* measure results are shown in Figure 4-62.[4-18]

Figure 4-62—CY 2015 *MPTA—Any Service* Measure Results



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

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

Conclusions and Recommendations

NHHF

Based on the review of the FARs, 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, HSAG recommends that **NHHF** adopt a review process to ensure that all manually entered rates are correct and use the most recent and updated versions of code.
- The *Comprehensive Diabetes Care (CDC)* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* measures failed the first round of the MRRV, and a second sample was required. HSAG recommends that **NHHF** improve its vendor oversight and over-read processes for HEDIS 2017.

Based on the MCO's performance measure results, **NHHF** scored at or above the NCQA national Medicaid HEDIS 2015 75th percentile for the following measures. An asterisk (*) indicates measures that met or exceeded the 90th percentile of performance.

Prevention

- *CAP—Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*
- *CAP—Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- *CAP—Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- *W15—Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *W34—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *NCS—Non-Recommended Cervical Cancer Screening in Adolescent Females**

Acute and Chronic Care

- *CWP—Appropriate Testing for Children with Pharyngitis*
- *URI—Appropriate Treatment for Children with Upper Respiratory Infection*
- *MMA—Medication Management for People with Asthma—Medication Compliance 75%—Total*

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**
- *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment*
- *AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment*
- *ADD—Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase**

- *ADD—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase**

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

Prevention

- *CCS—Cervical Cancer Screening*
- *CHL—Chlamydia Screening in Women—Total*
- *PPC—Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Acute and Chronic Care

- *PCE—Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid*
- *PCE—Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*
- *MPM—Annual Monitoring for Patients on Persistent Medications—Total*
- *LBP—Use of Imaging Studies for Low Back Pain*

Behavioral Health

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

Well Sense

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

- Data mapping issues were discovered during the audit when benchmarking against the previous year's data; however, during the April refresh, all identified issues were corrected to ensure accurate reporting. HSAG recommends that **Well Sense** develop an improved process when reviewing data integrity reports provided by the software vendor.

Based on the MCO's performance measure results, **Well Sense** scored at or above the NCQA national Medicaid HEDIS 2015 75th percentile for the following measures. An asterisk (*) indicates measures that met or exceeded the 90th percentile of performance.

Prevention

- *CAP—Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- *CAP—Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- *W15—Well-Child Visits in the First 15 Months of Life—Six or More Visits**
- *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*
- *NCS—Non-Recommended Cervical Cancer Screening in Adolescent Females**
- *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**
- *MMA—Medication Management for People with Asthma—Medication Compliance 75%—Total*

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*
- *APP—Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *AMM—Antidepressant Medication Management—Effective Acute Phase Treatment*
- *AMM—Antidepressant Medication Management—Effective Continuation Phase Treatment*
- *IET—Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment—Engagement of AOD Treatment*

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

Prevention

- *CCS—Cervical Cancer Screening*
- *CHL—Chlamydia Screening in Women—Total*

Acute and Chronic Care

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

Behavioral Health

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

Assessment of Prior Year Recommendations for HEDIS

For **NHHF**, the HEDIS recommendations included in the 2015 technical report included improving four measures that scored below the national Medicaid 25th percentile: *Chlamydia Screening in Women (CHL)—Total*, *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*, *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*, and *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD).* The current HEDIS rates indicate that those four measures remain below the national Medicaid 25th percentile.

For **Well Sense**, the HEDIS recommendations included in the 2015 technical report included improving eight measures: *Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months*, *Children and Adolescents' Access to Primary Care Practitioners (CAP)—25 Months–6 Years*, *Cervical Cancer Screening (CCS)*, *Chlamydia Screening in Women (CHL)—Total*, *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*, *Pharmacotherapy Management of COPD Exacerbation (PCE)—Bronchodilator*, *Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication (SSD)*, and *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD).* The rates generated in 2016 showed improvement in four of the eight measures: *Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months*, *Children and Adolescents' Access to Primary Care Practitioners (CAP)—25 Months–6 Years*, *Pharmacotherapy Management of COPD Exacerbation (PCE)—Systemic Corticosteroid*, and *Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medication (SSD).* The remaining four measures continue to score below the national Medicaid 25th percentile.

Other EQR Activities

Focus Groups

During SFY 2016, Horn Research conducted two focus groups covering the same topic in fall 2015 and two focus groups covering the same topic in spring 2016. DHHS chose the topics for the focus groups and assisted Horn Research in developing the questions for the sessions with the MCO members. The information generated by the focus groups can be used to identify salient issues relevant to the population, provide contextual information for the larger assessment process, and identify avenues for further research, but it should not be assumed to be *statistically* representative of the whole population because of the sample size.

Fall Focus Groups

The fall focus group activities included two focus groups and telephone interviews with targeted Medicaid beneficiaries during January 2016. Four Key Points of Inquiry were identified to explore during this period's data collection efforts: *Access to Case Management*, *Experience with Health Care Management*, *Barriers to Receiving Care*, and *Suggested Improvements.* The targeted population included individuals currently enrolled in case management from the MCOs for at least 30 days and members discharged from case management within the last three months and currently enrolled with the

MCO. Due to the concentration of population needed to sample for the study, Horn Research conducted both focus groups in Manchester, New Hampshire.

Results

The results of the spring focus groups are shown below:

Access to Case Management

Participants were asked to describe the extent of their contact with case management including the types, quality, and consistency of support and interactions with a case manager from their MCO as well as the availability and quality of educational materials they receive. In general, participants reported that contact was initiated by their case manager once a month. The majority of participants reported positive experiences with case management including support in managing medications, coordinating providers, and organizing ancillary needs such as transportation and housing. Key challenges connected with case management for participants included difficulties with continuity between case managers, a lack of consistency in quality between case managers, and communication on behalf of family members. Overall, participants were pleased with the quantity and quality of the educational materials they received.

Experience with Health Care Management

Participants were asked to describe their plan of care, experiences with their doctors, the level to which their doctors and health plan coordinated with each other, and their perception of any changes in their health management since enrolling with the MCO. Most participants had selected their PCP and were happy with the care received from their doctor. The main complaint with regard to physicians was the lack of availability of specialists locally requiring travel to receive care. The majority of participants believed that their health had been better managed since enrolling with the health plan.

Barriers to Receiving Care

Participants were asked to identify any challenges and barriers they have experienced in attempting to receive needed care. The most commonly identified barrier to care was a lack of coverage for needed care, specifically with medications. Participants also identified the preauthorization process as causing delays in receiving care. Communication within their health plan was found to be a barrier for participants as were cultural issues and reduced time with physicians.

Suggested Improvements

Participants were asked to offer suggestions to improve the care management they receive from their health plan. While several participants said they were pleased with their MCO and said there was no need to change anything, other participants had specific suggestions for improvement. The most commonly mentioned suggestion was to improve and enhance communication from their MCO and between their MCO and healthcare providers. Several participants suggested increasing coverage, better communication from providers, and offering more opportunities for member feedback.

Recommendations

The challenges participants most frequently mentioned concerning communication were centered around communication. Specifically, participants would like:

- Clearer communication about starting and ending case management including simple written materials summarizing whom to contact.
- Improved communication within the MCO to give case managers access to more information from physicians so they can more effectively help manage other aspects of healthcare.
- Proactive communication from case managers including recommendations for care and ancillary supports.
- Proactive communication and coordination with family caregivers of participants with high medical needs.

Additional recommendations are shown below:

- *Improve understanding and addressing of cultural needs*—Caregivers expressed challenges managing the care for their non-English-speaking family members.
- *Improve consistency*—Participants noted significant differences in the quality of communication and support received from various case managers, indicating a potential need for consistent training and skill development.
- *Simplified information*—Participants said they would appreciate receiving simplified information about Medicaid in general.
- *Improved coverage*—Participants suggested improving the coverage they receive from their health plan for medications and dental care.
- *Better communication from providers*—Members may not understand the reason for changes in medication(s) or dose(s), or why procedures and tests are ordered; better communication from the provider may help diminish these concerns.
- *Provide opportunities for member feedback*—Participants were excited to share their experiences at the focus group and expressed a desire for further opportunities in the future.

Spring Focus Groups

For the spring focus groups, the targeted population included individuals who previously opted out of the MCM program and who were now part of the mandatory population receiving benefits through an MCO as of February 1, 2016. Four Key Points of Inquiry were identified to explore during this period's data collection efforts: *Experience with MCM*, *Access to Care*, *Quality of Care and Care Management*, and *Suggested Improvements.* The targeted populations, who had been receiving their benefits from an MCO for just over 90 days at the time of the study, included three categories: (1) individuals dually eligible for Medicaid and Medicare, (2) parents or caregivers of children with disabilities, and (3) parents or caregivers of children in foster care. The geographic regions of the State targeted for this round of data collection were the Concord and Derry areas. The dually eligible population group was

large enough to require random sampling, whereas the entire population groups for parents/caregivers of children with disabilities and parents/caregivers of children in foster care were included in the recruitment sample because of the relatively small number of members. A total of 21 individuals participated in the project.

Results

The results of the spring focus groups are shown below:

Experience with MCM

To understand their first 90 days of experience with MCM, participants were asked to describe whether they understood their plan and if they knew whom to contact for help, what they liked best and least about their MCO, and whether they experienced any problems. The majority of participants said they either understood their plan or could find the answers they needed. A few participants commented that they appreciated being able to keep their PCP. Parents of children with severe disabilities were most likely to report negative experiences with their MCO including disruption in the continuity of care for their children, requirements to change long-standing relationships with providers, and increased stress and time related to managing their children's care.

Access to Care

A key to understanding how well the MCM Program is performing is to identify whether participants experienced improved or diminished access to doctors, specialists, medications, and ancillary services in the initial 90 days of enrollment with an MCO as compared to their fee-for-service (FFS) experience. Overall, participants said their access to preventive care had remained the same since enrolling with an MCO. About half of participants indicated that accessing medications had become more difficult due to changed dosages, medications no longer being covered, and the requirement to switch medications. While the majority of participants said their access to specialists had remained the same, parents of children with disabilities said their access to specialists had dramatically decreased since enrolling with an MCO.

Quality of Care and Care Management

Participants were asked to assess the quality of their providers and care coordination, describe their role in their healthcare, and share whether they felt they are or could be active participants in coordinating their care. Participants nearly universally had positive experiences with their PCP, most of which were the same physicians they had prior to enrolling with an MCO. The majority of participants said that their providers worked well together, but parents of children with disabilities were more likely to say they coordinated their children's care rather than relying on providers to do so. In general, participants said they had an active role in the decision making of their or their family member's healthcare; however, some parents of children with disabilities felt their role was not being respected by the MCO.

Suggested Improvements

Participants were asked what types of support and information they would like to receive from their MCO and also to propose improvements regarding their MCO and Medicaid overall. Participants suggested they would like to receive details on their benefits and coverage, healthcare options, nutrition and healthy eating advice, and cost and quality information. Participants noted that they would like this information to be simple, easy to read, and available online. The majority of participants, and nearly all parents of children with disabilities, suggested discontinuing managed care and returning to FFS Medicaid. Participants from other eligibility groups suggested enhancing benefits to include dental and vision care, and applied behavior analysis (ABA) therapy for autism.

Recommendations

Recommendations from the spring focus groups are listed below:

- *Further review for children with severe disabilities*—The focus groups and interviews showed a clear divide in experiences for families with children with severe disabilities and other eligibility groups. Parents of children with severe disabilities shared their deep distress over being required to leave their long-standing relationships with their health providers. They also expressed worrying about future care coordination for their children's complex needs. However, because this report only evaluates members' first 90 days of enrollment, this population's experience should be re-reviewed in the future to determine whether these impressions have diminished after a transition period or if they continue to be ongoing concerns.
- *Improve communication*—Participants said they would appreciate receiving additional information from their MCO in a number of areas including details on their benefits and coverage, health information on topics such as healthy eating and nutrition, transportation support, and provider cost and quality data.
- *Improve coverage*—Participants suggested improving the coverage they receive from their health plan for dental and vision care, and specific therapies such as ABA therapy.

Encounter Data Validation 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 contract year 2015–2016, DHHS contracted HSAG to develop and implement an EDQRS for evaluating the quality encounter data files submitted by the MCOs. The EDQRS was designed to import, store, and review incoming encounter data and generate automated, weekly validation reports for DHHS.

Methodology

HSAG used the same general process and files as DHHS's fiscal agent, Xerox, when collecting and processing encounter data. The EDV activity focused on providing the State with an assessment of the overall quality of encounter data submitted by its contracted MCOs. Participating MCOs, on a daily or

weekly basis, prepare and translate claims and encounter data into the 837 P/I and NCPDP pharmacy files. The files are simultaneously transmitted via secure file transfer protocol (FTP) to DHHS (and Xerox) and HSAG, where the files are downloaded and processed. The MCOs' 837 P/I files are processed through an EDI translator by both vendors (Xerox and HSAG). It is important to note that the application and function of compliance edits implemented by Xerox and HSAG are slightly different due to the overall intent of processing. HSAG's process includes 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 is used for reporting purposes only.

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

Measures in the EDQRS

The weekly EDV report includes measures assessing the following four areas:

- Submission accuracy and completeness measures assess the MCOs' overall adherence to DHHS' encounter submission standards through a direct assessment of encounters processed by HSAG, as well as submission documentation provided by the MCOs. The measures in this group examine whether or not the submitted records pass X12 EDI compliance edits, and if they meet DHHS's pre-established naming conventions that facilitate record identification and organization. Additionally, these measures assess the level to which the MCOs' reconciliation reports align with the submitted encounter files regarding the names of files submitted, and overall counts for specific data elements from the files. Results from these metrics facilitate addressing submission quality from MCOs.
- Encounter data completeness measures demonstrate MCOs' trends in encounter submission volume over time. Metrics in this category analyze several aspects of submission, including encounter submission volume by submission month (i.e., months during which encounters were submitted to HSAG), monthly visit volume in relation to 1,000 enrolled members per service month (i.e., the month during which services associated with encounters were provided), monthly proportions of distinct P visits by place of service category, and monthly proportions of distinct I visits by type of

bill category. Monthly trends in MCO paid amounts are assessed in terms of submission month, as well as the service month. Finally, submitted encounters are assessed for total duplicates, in which values for all data fields are equivalent, as well as line-level duplication (i.e., using selected data elements in relation to each encounter type).

- Encounter data accuracy measures demonstrate the overall quality of submitted encounter records, specifically, examining the proportion of submitted records with non-null and accurate values for key data elements. The data elements selected for this evaluation provide critical information in terms of service provision and costs.
- Encounter data timeliness measures assess MCOs' compliance with time-based submission standards for encounter data. These metrics focus on the overall regularity with which encounter records are submitted to DHHS and HSAG, time-to-submission after provider payment by MCOs, and time-to-submission regarding the date for which services are rendered. In additional to overall compliance with DHHS standards, this metric area facilitates real-time detection of lags in encounter submission.

In addition, HSAG generates a monthly supplemental report. The supplemental measures provide additional insight into encounter accuracy issues through providing the top five most frequently reported incorrect values for key data elements. Additionally, the 20 most frequently reported values and the 20 costliest values for key data elements are presented.

Overall, results for all measures are displayed at the MCO and statewide levels for the appropriate encounter type.

EDQRS Development and Implementation

At the end of SFY 2015, HSAG had begun testing implementation of an EDI translator to calibrate the translation of MCOs' encounter data. Once testing and implementation of the EDI translator were completed, HSAG initiated programming of EDV-specific submission and quality edits and developed the EDQRS reports. To successfully complete this project, HSAG collaborated with key DHHS staff for feedback on the evaluation metrics and reporting template during the development stage. After the initial report was produced, HSAG presented and reviewed the report with DHHS for additional feedback and enhancements. At the end of SFY 2016, the EDQRS was ready to be moved into production mode[4-19] to generate weekly reports and monthly supplemental reports.

Findings from the First Two Reports

By the end of SFY 2016, HSAG had generated two EDV reports. The first report included encounters submitted by MCOs between December 1, 2013, and December 31, 2015. The second report included encounters submitted by MCOs between January 1, 2016, and May 2, 2016. From the two reports, this

[4-19] HSAG began producing weekly reports in August 2016. In addition, after DHHS provides specifications for denied and void encounters, HSAG will incorporate appropriate changes into the EDQRS so that the system can process denied/void encounters and identify final adjudication records for reporting purposes in the future.

section presents the aggregate rates for three standards within Exhibit A-Amendment #7 of the MCM Contract.

Standard 25.2.24.2.1 specifies that "Ninety-eight percent (98%) of the records in an MCO's encounter batch submission shall pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits." While an evaluation of the "MMIS threshold and repairable compliance edits" is out of scope for the EDV report, Table 4-16 shows that all 837 P and 837 I records received before May 3, 2016, passed X12 EDI compliance edits for both **NHHF** and **Well Sense**.

Table 4-16—Percentage of Records Passing X12 EDI Compliance Edits

Encounter Type	NHHF	Well Sense
837 P Encounters	100.0%	100.0%
837 I Encounters	100.0%	100.0%

Standard 25.2.24.2.3 requires that "One-hundred percent (100%) of member identification numbers shall be accurate and valid." For all encounter types from both MCOs, Table 4-17 shows that the member identification numbers were present on 100 percent of records. In addition, more than 99 percent of member identification numbers were valid, which was slightly lower than the standard (i.e., 100 percent).

Table 4-17—Percentage Present and Percentage Valid for Member Identification Numbers

Encounter Type	NHHF		Well Sense	
	% Present	% Valid*	% Present	% Valid*
837 P Encounters	100.0%	99.9%	100.0%	99.7%
837 I Encounters	100.0%	99.9%	100.0%	99.7%
NCPDP Encounters	100.0%	99.1%	100.0%	99.4%

* To be considered valid, the member identification number should meet the following three criteria: (1) included in member file, (2) eligible for Medicaid on the date of service, and (3) enrolled in a specific MCO on the date of service.

Standard 25.2.24.2.4 states that "Ninety-eight percent (98%) of servicing provider information will be accurate and valid." Table 4-18 shows that the servicing provider numbers were present for 100 percent of records for both **NHHF** and **Well Sense**. While the validity rates for 837 P and NCPDP encounters met or were slightly below the standard (i.e., 98 percent), the validity rates for 837 I records were 2.0 and 2.9 percentage points below the standard for **NHHF** and **Well Sense**, respectively.

Table 4-18—Percentage Present and Percentage Valid for Servicing Provider Information†

Encounter Type	NHHF		Well Sense	
	% Present	% Valid*	% Present	% Valid*
837 P Encounters	100.0%	98.0%	100.0%	97.1%
837 I Encounters	100.0%	96.0%	100.0%	95.1%
NCPDP Encounters	100.0%	97.9%	100.0%	97.8%

† For professional encounters, "servicing provider information" refers to rendering provider numbers (i.e., National Provider Identifier [NPI]) or billing provider NPIs if rendering provider NPIs are missing. For institutional and NCPDP encounters, "servicing provider information" refers to the billing provider NPIs.

* To be considered valid, the servicing provider number should have been included in the daily provider file received from DHHS for the reporting period.

Standards within the MCM Contract also specify the timeliness with which the encounter data should be submitted to DHHS. Since the first two EDV reports included historical/backlog encounters (i.e., timeliness results were not applicable), any results related to timeliness will be included in the SFY 2017 technical report.

Provider Secret Shopper Survey

Overview

In March 2014, New Hampshire's Governor Hassan signed into law a bill that created the NHHPP. The NHHPP provides eligible residents with health insurance coverage through the Affordable Care Act's provision to expand State Medicaid programs.[4-20] Coverage for the eligible residents began in the State's FFS Medicaid system, and enrollees were transitioned to MCOs between September and December, 2014. Since the NHHPP fee schedule included higher payment rates than the MCM Program, DHHS was interested in determining whether appointment accessibility differed based on the member's enrolled program. 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 or MCM Program. The secret shopper telephone survey allows for objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor.

Methodology

The eligible population included PCPs who were actively enrolled in both of the New Hampshire Medicaid programs as of May 28, 2015. "PCPs" were defined as physicians whose primary specialty included family practice, general practice, internal medicine, or an advanced registered nurse

[4-20] 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: Dec 13, 2016.

practitioner. Using provider data received from DHHS, HSAG selected an eligible population of active, office-based PCPs with telephone numbers. HSAG then used Quest Analytics software to standardize the physicians' addresses and remove duplicated addresses for the same provider.

HSAG used a two-stage random sampling approach to generate the list of sampled provider locations. The sampled providers were surveyed by telephone, and the information collected was used to evaluate the availability of appointments. HSAG then determined whether appointment availability varied based on Medicaid program and type of appointments—i.e., preventive (e.g., annual check-up) and routine/episodic (e.g., sore throat with congested nose).

Based on the eligible population, HSAG generated a random sample of PCPs. HSAG selected 412 unique provider locations and randomly assigned 50 percent of them to each appointment type (i.e., 206 cases for preventive appointments and 206 cases for routine/episodic appointments) to ensure a minimum margin of error of +/- 7.1 percent and 95 percent confidence level separately for preventive and for routine/episodic appointments. An additional 25 percent oversample (i.e., 104 PCPs) was included to accommodate invalid provider contact information for a final sample provider pool of 516 PCPs.

HSAG staff called each selected provider's office twice to determine the number of days required to obtain an appointment with the selected provider.[4-21] The only variables differing between the two calls were the programs (i.e., NHHPP or MCM), with the MCO being defined as one of two MCOs (i.e., **New Hampshire Healthy Families** and **Well Sense Health Plan**).

Findings

Overall, the results of the study suggested no presence of any bias in the scheduling of appointments due to program enrollment (i.e., MCM versus NHHPP). Regardless of the appointment type (i.e., preventive or routine/episodic), differences in the ability to schedule appointments was negligible and not statistically significant.

In general, very few calls resulted in an appointment. Overall, only 669 of 1,032 total attempted calls were valid cases (i.e., eligible for the study population). Out of those 669 calls, only 12.0 percent (i.e., 80 calls) resulted in an appointment. Moreover, of the 80 appointments that could have been scheduled, less than half of the appointments were within the required time frame (i.e., 45 percent) regardless of appointment type or program (i.e., 42.6 percent for MCM and 48.0 percent for NHHPP). As such, there is no evidence that appointment time varies based on program, and subsequently, differential payment structures. The primary reason callers were unable to make an appointment was because the provider was not accepting new patients. To investigate this finding further, HSAG conducted 64 supplemental secret shopper calls as a member of a "commercial" health plan to confirm the finding regardless of the source of coverage. Results indicated no difference in the ability to schedule appointments between

[4-21] If an appointment was offered by the appointment scheduling staff for the sampled provider but at a different location, HSAG collected the appointment time and included this information in its analysis. However, an appointment time offered for an alternate provider was not accepted.

commercial enrollees and Medicaid enrollees. This finding suggests that the inability to make an appointment is a larger New Hampshire issue, not an issue limited to New Hampshire Medicaid.

Similarly, there was little difference in the availability of *preventive appointments* between MCM and NHHPP members. Of the 328 valid cases, only 63 calls ended with an appointment. In more than three-quarters of the calls (i.e., 80.8 percent), callers were unable to secure an appointment despite reaching the scheduling department. Of the 63 appointments, only 34.9 percent (i.e., 22 appointments) were within the 30-day standard established for preventive visits. Regarding the availability of *routine/episodic appointments*, again, there was little difference between MCM and NHHPP members. Of the 341 valid cases, only 17 calls ended with an appointment. In 95.0 percent of the calls, callers were unable to secure an appointment despite reaching the scheduling department. However, unlike preventive visits, of the 17 routine/episodic appointments, only 82.4 percent (i.e., 14 appointments) were within the 10-day standard established for this appointment type. The primary reasons callers were unable to schedule an appointment were because (1) the provider was not accepting new patients; or (2) the physician office required patients to complete additional steps before an appointment could be scheduled, or to submit clinical information.

Focused Study

In March 2016, at the request of DHHS, HSAG conducted a focused review of the two MCOs, **NHHF** and **Well Sense**, to examine the processes and methods employed by each health plan to identify and assess members for care management and care coordination. If a member's assessment indicated that the person could benefit from care management, DHHS also wanted to review the process for completing and updating the care plan.

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

Findings

Below is a summary of the findings from the review of case management files during the on-site review.

- Both MCOs used nationally recognized care management information systems. **NHHF** used the TruCare Enterprise Care Management System, and **Well Sense** used the CareEnhance Care Management System (CCMS). The systems were designed using clinical protocols to guide the care managers as they completed comprehensive assessments and care plans.
- The MCOs used 15 data sources to identify members for care management, and the two MCOs completed 13 comprehensive assessments within 30 days of member identification.

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

Recommendations

- The MCOs need to ensure that the care management systems used by the MCOs (i.e., TruCare and CCMS) are continuously enhanced to include protocols and algorithms to evaluate and accommodate the needs of new populations served or additional services provided by the MCOs.
- In the future, new members will be added to the MCM population and additional services will be administered by the MCOs. Both MCOs need to begin planning staffing scenarios to meet the future care management needs of the MCM population.
- While no State standards for care management caseloads exist in New Hampshire, the caseload ratios maintained by **NHHF** and **Well Sense** appear consistent with industry research. Both MCOs need to ensure that the caseloads do not change significantly as they continue to provide care management services for the MCM population.
- Both MCOs assessed members upon enrollment and also employed methods to trigger an assessment for case management if there was a change in a member's health status after enrollment (e.g., hospitalizations, frequent emergency room visits, and predictive modeling).
- Every file contained the name of the PCPs; however, identification of the specialists involved in the member's care was not consistent. Because the members included in the study had multiple comorbidities complicating their primary diagnosis, HSAG recommends that a specific field be created to list the names and specialty of the specialists involved in caring for the member.
- Both MCOs need to consider sending a copy of the care plan goals and objectives to members and to the PCPs.

Appendix A. Abbreviations and Acronyms

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
- **ABA—**Applied behavior analysis
- **ABXA—**Antibiotic Utilization
- **ACE—**Angiotensin converting enzyme
- **ADD—**Follow-up Care for Children Prescribed ADHD Medication
- **ADHD—**Attention deficit/hyperactivity disorder
- **AMBA—**Ambulatory Care Utilization
- **AMM—**Antidepressant Medication Management
- **AMR—**Asthma Medication Ratio
- **AOD—**Alcohol and Other Drug Dependence
- **APM—**Metabolic Monitoring for Children and Adolescents on Antipsychotics
- **APP—**Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics
- **APRN—**advanced practice registered nurse
- **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
- **CAP—**Corrective Action Plan
- **CBP—**Controlling High Blood Pressure
- **CCC—**Children with Chronic Conditions
- **CCMS—**CareEnhance Care Management System
- **CCS—**Cervical Cancer Screening
- **CDC—**Comprehensive Diabetes Care
- **CFR—**Code of Federal Regulations
- **CHCA—**Certified HEDIS compliance auditor

- **CHL—**Chlamydia Screening in Women
- **CIS—**Childhood Immunization Status
- **CMS—**Centers for Medicare & Medicaid Services
- **COPD—**Chronic Obstructive Pulmonary Disease
- **CWP—**Appropriate Testing for Children with Pharyngitis
- **CY—**calendar year
- **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
- **EPSDT—**Early and Periodic Screening, Diagnostic, and Treatment
- **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 A1c; a measure of longer-term glucose management
- **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
- **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 services and supports
- **MCM—**Medicaid Care Management
- **MCO—**managed care organization
- **MMA—**Medication Management for People with Asthma
- **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
- **MRRV—**medical record review validation
- **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
- **P—**professional
- **PCE—**Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation
- **PCP—**primary care provider
- **PCV—**pneumococcal conjugate vaccine
- **PIHP—**prepaid inpatient health plan
- **PIP—**performance improvement project
- **PMV—**performance measure validation
- **PPC—**Prenatal and Postpartum Care
- **R—**report

- **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
- **SUD—**substance use disorder
- **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
- **W15—**Well-Child Visits in the First 15 Months of Life
- **W34—**Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- **WCC—**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Appendix B. Methodologies for Conducting External Quality Review (EQR) Activities

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: Dec 13, 2016.

[B-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. (n.d.). State Quality Strategies. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/state-quality-strategy/index.html. Accessed on: Dec 13, 2016.

- 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. 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.

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.**
	The HSAG team reviews 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.

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 CAPs 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 *Met* 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 PMV 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 2014–2015 and 2015–2016 validation activities. HSAG completed the reports for this activity in October 2015 and October 2016.

Table B-2—Performance Measures Audited by HSAG for SFY 2014–2015

Performance Measures
Ambulatory Care: Emergency Department Visits • *By Age Group* • *Excluding NHHPP Members*
Resolution of Appeals by Disposition Type
Appeals by Type of Resolution and Category of Service
Timely Pharmacy Claim Processing
Claims Quality Assurance: Claims Processing Accuracy
Claims Quality Assurance: Claims Payment Accuracy
Claims Quality Assurance: Claims Financial Accuracy
Timely Professional and Facility Medical Claim Processing: Sixty Days of Receipt
Community Demographic, Cultural, and Epidemiologic Profile: Preferred Spoken Language
EPSDT performance via Form-CMS 416 procedures: Total individuals eligible for EPSDT for 90 Continuous Days (Line 1b) including NHHPP members covered by EPSDT.
EPSDT performance via Form-CMS 416 procedures: Total individuals eligible for EPSDT who received at least one initial or periodic Screening (Line 9) including NHHPP members covered by EPSDT.
EPSDT performance via Form-CMS 416 procedures: Total individuals eligible for EPSDT who were referred to corrective treatment with the screening provider or referred to another provider for further needed diagnostic or treatment services. (Line 11) including NHHPP members covered by EPSDT.

[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: Dec 13, 2016.

Performance Measures
Grievance Log
Member Requests for Assistance Accessing MCO Designated Primary Care Providers [per Average Members] • *By Geographic Region—NHHPP Members*
Member Requests for Assistance Accessing Physician/Advanced Practice Registered Nurse (APRN) Specialists (non-MCO Designated Primary Care) Providers per Average Members • *By Geographic Region—NHHPP Members*
Ambulatory Care: Emergency Department Visits [per Member per Month] • *By Age Group—NHHPP Members*
Health Risk Assessment Completion Percentage—NHHPP Members
NEMT Request Authorization Approval Rate • *By Mode of Transportation—NHHPP Members*
NEMT Contracted Transportation & Wheelchair Van Provider Schedule Trip Results • *By Outcome—NHHPP Members*
Health Risk Assessment Completion Percentage—Excluding NHHPP Members
Quarterly Inpatient Hospital Utilization Summary—Excluding NHHPP Members
Maintenance Medication Gaps—Excluding NHHPP Members
Member Communications: Speed to Answer Within 30 Seconds
NEMT Request Authorization Approval Rate • *By Mode of Transportation—Excluding NHHPP Members*
NEMT Schedule Trip Results • *By Outcome for Contracted Providers—Excluding NHHPP Members*
New Hampshire Hospital Discharges Where Patient Had a Visit With a Mental Health Practitioner Within 7 Calendar Days of Discharge—Excluding NHHPP Members
New Hampshire Hospital Discharges Where Patient Had a Follow up Appointment Scheduled for Within 7 Calendar Days of Discharge—Excluding NHHPP Members
Readmission to New Hampshire Hospital at 30 days—Excluding NHHPP Members
Provider Communications: Speed to Answer Within 30 Seconds
Medical Service, Equipment and Supply Service Authorization Timely (14 Day) Determination Rate: New Routine Requests
Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members per Member per Month—Quarterly Rate—NHHPP Members
Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members—Quarterly Rate—Excluding NHHPP Members

Table B-3—Performance Measures Audited by HSAG for SFY 2015–2016

Performance Measures
Appeals by Type of Resolution and Category of Service by State Plan, 1915B Waiver, and Total Population
Congestive Heart Failure (CHF) Admission Rate per 100,000 Member Months (CMS Adult Core Set)
Substance Use Disorder (SUD) Services: Percent of NHHPP Population Using Buprenorphine • *By Age Group*
Professional and Facility Medical Claim Processing Results—Paid, Suspended, Denied
SUD Services: Percent of NHHPP Population Using Any SUD Specific Service • *By Age Group*
SUD Services: Average Number of Outpatient Non-Facility Individual, Family or Group SUD Counseling Services Used Per Service User in the NHHPP Population • *By Age Group*
SUD Services: Percent of NHHPP Population Using One or More Opioid Treatment Center Services • *By Age Group*
SUD Services: Average Number of Opioid Treatment Center Services Used Per Service User in the NHHPP Population • *By Age Group*
Average Number of Day's Supply of Buprenorphine Through a Point of Service Pharmacy Per Buprenorphine User in the NHHPP Population • *By Age Group*
SUD ED Use: Rate of ED Visits for SUD Diagnoses for the NHHPP Population Using Any SUD Service Per 1,000 Member Months • *By Age Group*
Percentage of Medical Service, Equipment and Supply Service Authorization Determinations for Requests Involving Urgent Care and Relating to the Extension of an Ongoing Course of Treatment Made Within 24 Hours After Receipt of Request for Requests Made During the Measure Data Period

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 PMV 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.

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

Table B-4—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 Reportable (NR)	This designation is assigned to measures for which the MCO rate was materially biased.
Not Required (NQ)	The MCO was not required to report this measure.
No Benefit (NB)	Measure was not reported because the MCO did not offer the benefit required by the measure.

[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: Dec 13, 2016.

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.

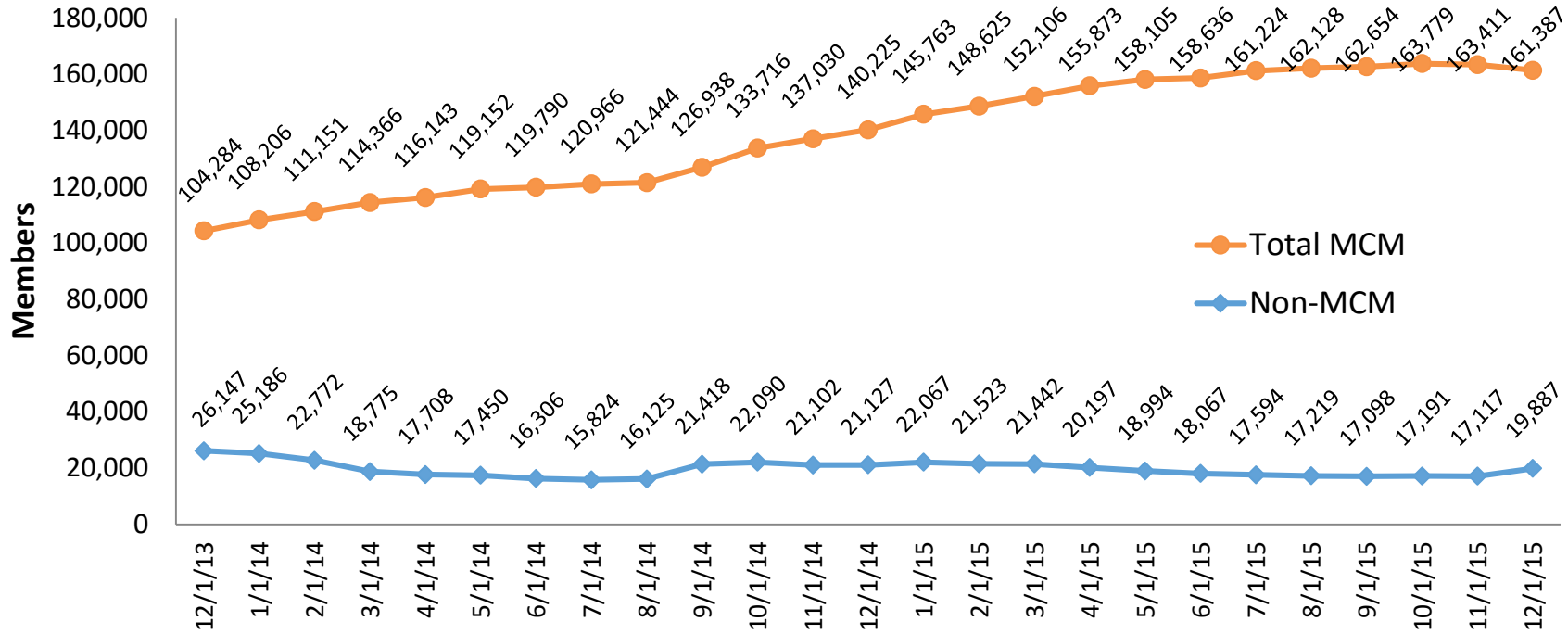
After completing the validation process, HSAG prepared a final report detailing the PMV findings and any associated recommendations for each MCO. These reports were provided to DHHS and to each MCO.

Appendix C. Demographics of the New Hampshire MCM Program

The demographic information displayed in this section of the report was provided by DHHS.

The following figures provide information concerning enrollment in the NH Medicaid Care Management program from its inception on December 1, 2013, to the end of 2015. Two charts also indicate the eligibility categories for the **NHHF** and **Well Sense** membership on December 1, 2015.

Figure C-1—NH MCM Enrollment and Non-MCM Enrollment From December 1, 2013, to December 1, 2015



Notes:

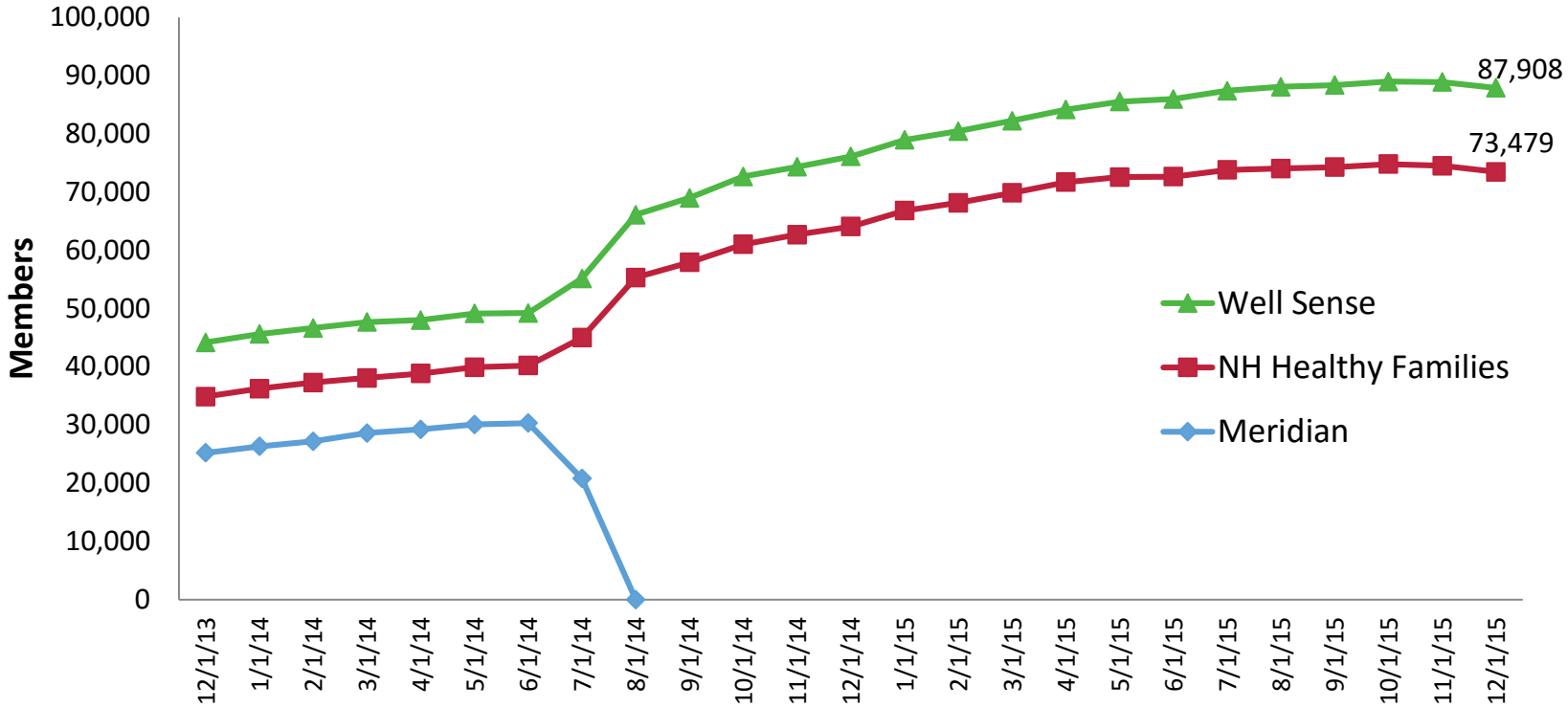
Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans).

New NHHPP members who enrolled after 10/1/2016 were temporarily assigned to a Non-MCM benefit plan in anticipation of the Premium Assistance Program beginning on 1/1/2016, when they will be placed in a Qualified Health Plan. This caused a net decrease in MCM enrollment and a net increase in Non-MCM enrollment as of 12/1/2015.

Source: NH MMIS as of 12/2/15 for most current period; Data subject to revision.

Figure C-2 displays the enrollment in the NH MCM program by MCO.

Figure C-2—Enrollment in the NH MCM by MCO as of December 1, 2015



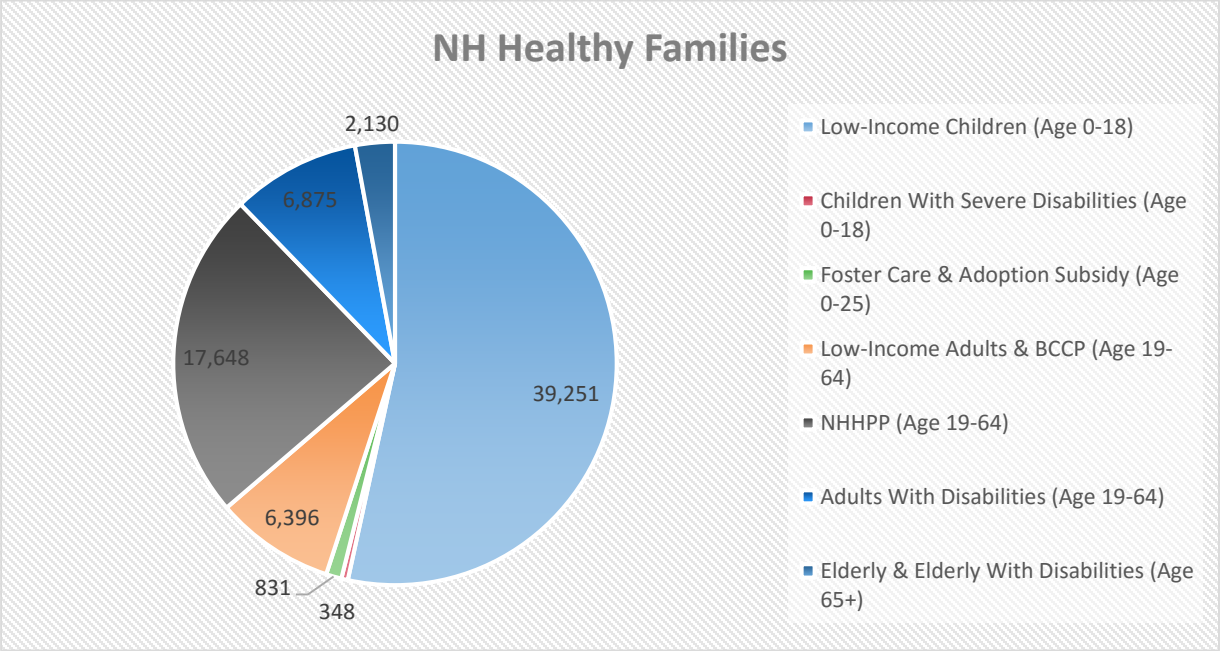
Note:

New NHHPP members who enrolled after 10/1/2016 were temporarily assigned to a Non-MCM benefit plan in anticipation of the Premium Assistance Program beginning on 1/1/2016, when they will be placed in a Qualified Health Plan. This caused a net decrease in MCM enrollment and a net increase in Non-MCM enrollment as of 12/1/2015.

Source: NH MMIS as of 12/2/15 for most current period. Data subject to revision.

Figure C-3 displays the **NHHF** eligibility categories of MCO members as of December 1, 2015.

Figure C-3—Point-in-Time Eligibility Category by MCO as of December 1, 2015



Note:

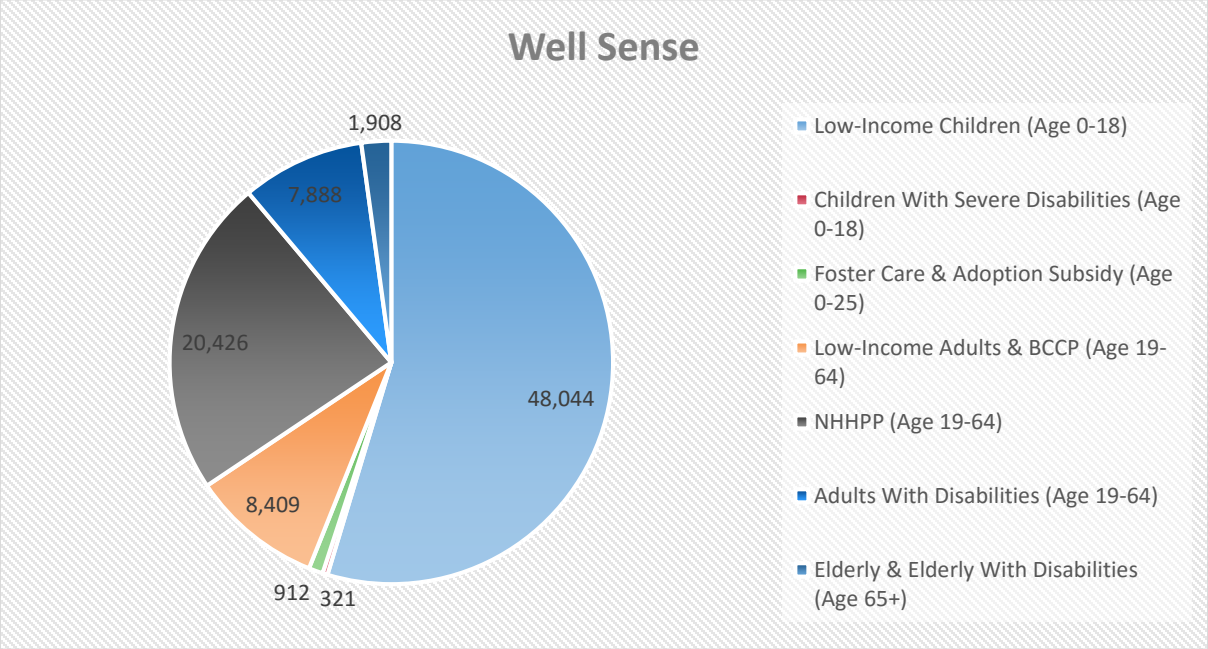
Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans) and non-MCM includes members transitioning into MCM.

Source: NH MMIS as of 12/2/15. Data subject to revision.

The low-income children category represented 53.4 percent of **NHHF** members. The NHHPP represented 24.0 percent of **NHHF** members. Total **NHHF** membership on December 1, 2015, in the seven eligibility categories was 73,479.

Figure C-4 displays the **Well Sense** eligibility categories of MCO members as of December 1, 2015.

Figure C-4—Point-in-Time Eligibility Category by MCO as of December 1, 2015



Note:

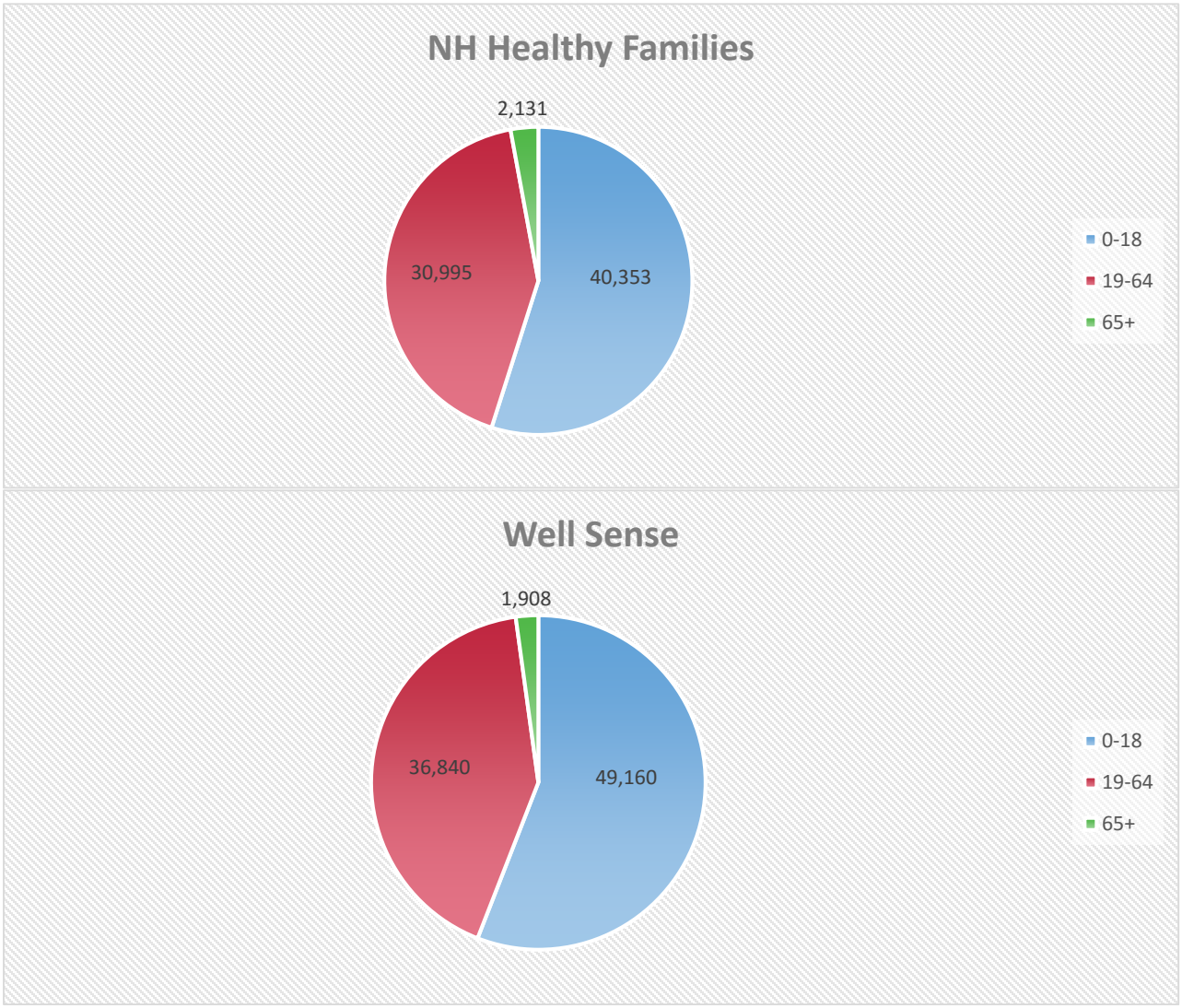
Excludes members without full Medicaid benefits (Family Planning Only & Medicare Savings Plans) and non-MCM includes members transitioning into MCM.

Source: NH MMIS as of 12/2/15. Data subject to revision.

The low-income children category represented 54.7 percent of **Well Sense** members. The NHHPP represented 23.2 percent of **Well Sense** members. Total **Well Sense** membership on December 1, 2015, in the seven eligibility categories was 87,908.

Figure C-5 displays information concerning the age groups of the Medicaid members in **NHHF** and **Well Sense** as of December 1, 2015.

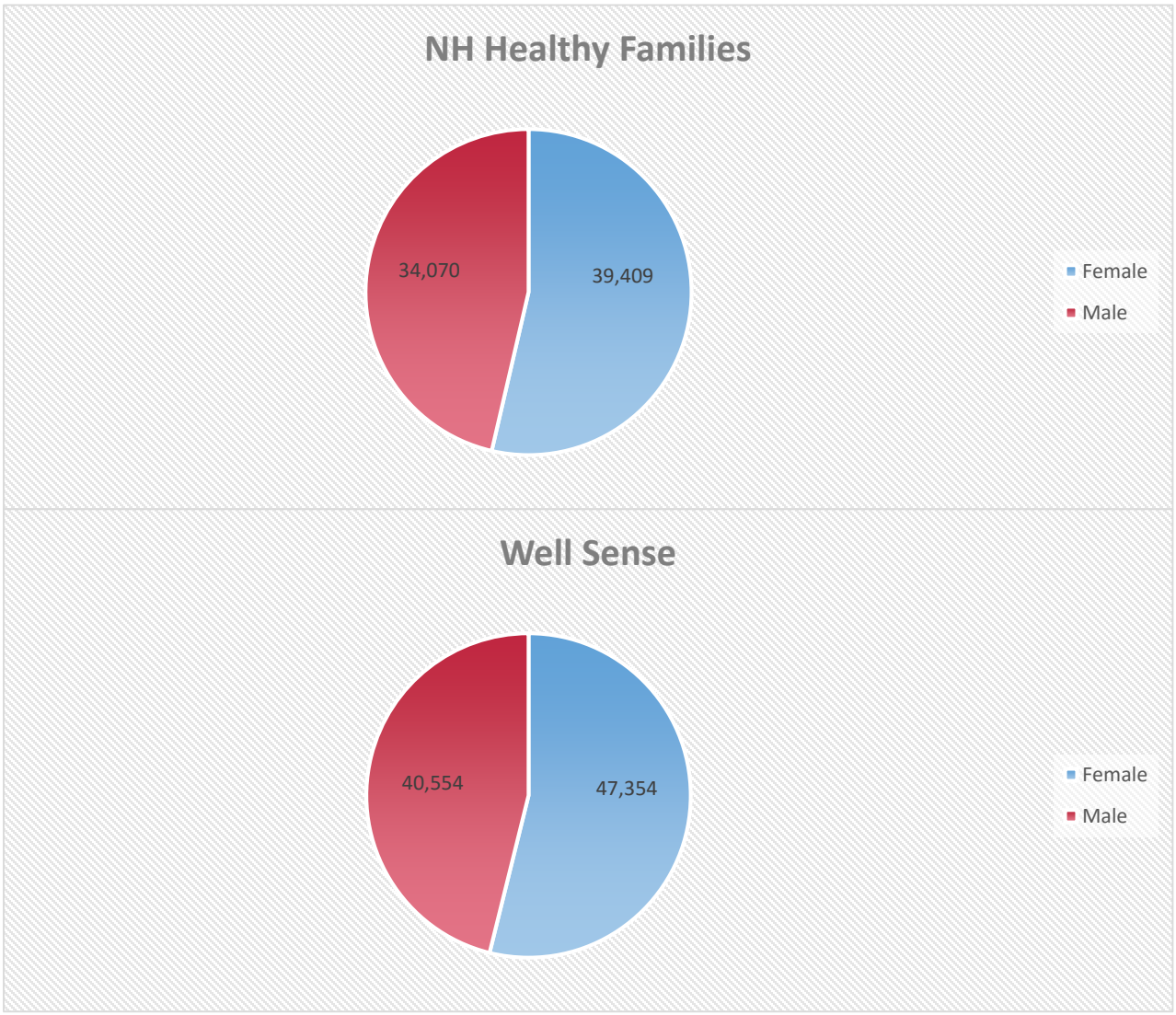
Figure C-5—Point-in-Time Age Groups by MCO as of December 1, 2015



The age distribution in the two MCOs was very similar. A total of 54.9 percent of the **NHHF** population was 0–18 years old as was 55.9 percent of the **Well Sense** population. A total of 42.2 percent of the **NHHF** population was 19–64 years old as was 41.9 percent of the **Well Sense** population. The **NHHF** population 65 years of age and older totaled 2.9 percent, and the **Well Sense** population 65 years of age and older totaled 2.2 percent.

Figure C-6 presents the gender distribution of the MCO members as of December 1, 2015.

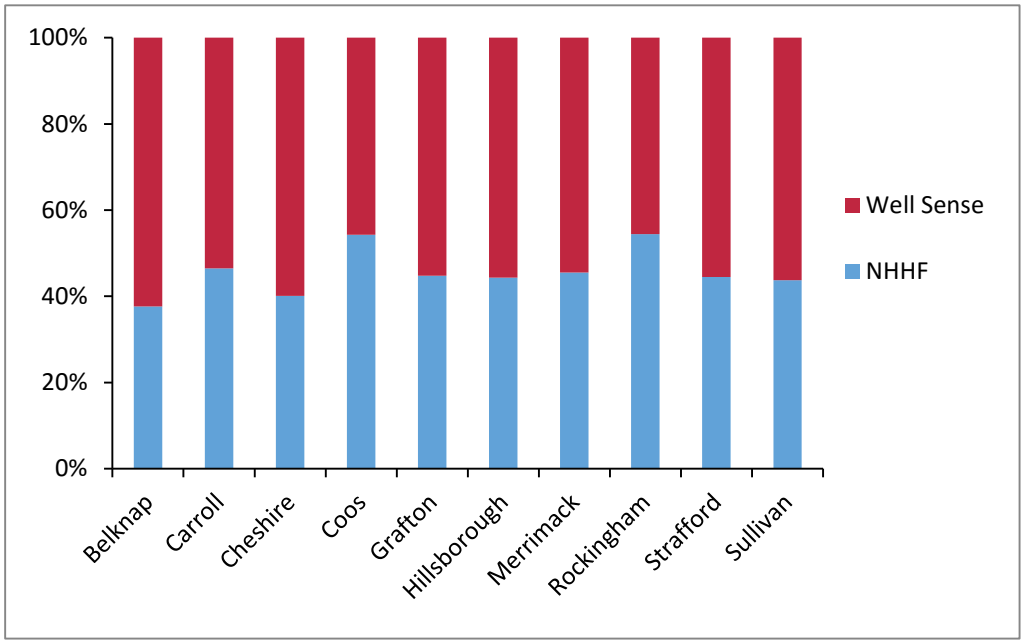
Figure C-6—Point-in-Time Gender by MCO as of December 1, 2015



The gender distribution in both plans was almost identical. Female members comprised 53.6 percent of the membership in **NHHF** and 53.9 percent of the membership in **Well Sense**. Male members comprised 46.4 percent of the membership in **NHHF** and 46.1 percent of the membership in **Well Sense**.

Figure C-7 shows the distribution of membership in the two MCOs for the 10 counties in New Hampshire as of December 1, 2015.

Figure C-7—Point-in-Time County Breakout by MCO as of December 1, 2015



The percentage of membership in the counties varied for **NHHF** between 37.3 percent in Belknap County to 53.0 percent in Rockingham County. The **Well Sense** membership in the counties varied between 47.0 percent in Rockingham County to 62.7 percent in Belknap County.

Table C-1 through Table C-7 provide information concerning the average quarterly MCO enrollment in seven eligibility categories during the four quarters of 2015. The seven eligibility categories include low-income children, children with severe disabilities, beneficiaries in foster care and with adoption subsidies, low-income adults and adults in the breast and cervical cancer program (BCCP), adults with disabilities, the elderly/elderly with disabilities, and NHHPP.

Table C-1 shows the average quarterly enrollment for low-income children by MCO during 2015.

Table C-1—Average Quarterly Enrollment for Low-Income Children (Age 0–18) by MCO During 2015

MCO	Quarter 1	Quarter 2	Quarter 3	Quarter 4
NHHF	39,487	39,395	39,320	39,342
Well Sense	47,816	47,668	47,845	48,006
Total	**87,303**	**87,063**	**87,165**	**87,348**

The average quarterly enrollment of low-income children in the MCOs during 2015 remained relatively constant in each quarter of 2015, with the highest enrollment in Quarter 4 (87,348) and the lowest enrollment in Quarter 2 (87,063).

Table C-2 displays the average quarterly enrollment for children with severe disabilities by MCO during 2015.

Table C-2—Average Quarterly Enrollment for Children With Severe Disabilities (Age 0–18) by MCO During 2015

MCO	Quarter 1	Quarter 2	Quarter 3	Quarter 4
NHHF	326	344	349	353
Well Sense	307	304	307	319
Total	**633**	**648**	**656**	**672**

There was a slight increase in the overall number of children with severe disabilities in the MCOs during 2015, with an average of 633 children in the MCOs during first quarter 2015, and an average of 672 children in the MCOs during fourth quarter 2015.

Table C-3 shows the average quarterly enrollment for foster care children and children with adoption subsidies by MCO during 2015.

Table C-3—Average Quarterly Enrollment for Foster Care and Adoption Subsidy Children (Age 0–25) by MCO During 2015

MCO	Quarter 1	Quarter 2	Quarter 3	Quarter 4
NHHF	784	828	826	830
Well Sense	841	903	896	903
Total	**1,625**	**1,731**	**1,722**	**1,733**

Overall participation in the MCM program by beneficiaries in foster care and with adoption subsidies included 1,625 children in first quarter 2015 and 1,733 children in fourth quarter 2015, which represented an increase of 108 members from the first quarter to the fourth quarter.

Table C-4 displays the average quarterly enrollment for low-income adults and members in the breast and cervical cancer program (BCCP) by MCO during 2015.

Table C-4—Average Quarterly Enrollment for Low Income Adults (Age 19–64) and BCCP by MCO During 2015

MCO	Quarter 1	Quarter 2	Quarter 3	Quarter 4
NHHF	6,483	6,542	6,473	6,542
Well Sense	8,214	8,371	8,447	8,580
Total	**14,697**	**14,913**	**14,920**	**15,122**

During 2015, the average quarterly number of low-income adults and adults in the BCCP enrolled in the MCOs increased from 14,697 in first quarter 2015 to 15,122 in fourth quarter 2015, which represented an increase of 425 members from the first quarter to the fourth quarter.

Table C-5 shows the average quarterly enrollment for adults with disabilities by MCO during 2015.

Table C-5—Average Quarterly Enrollment for Adults With Disabilities (Age 19–64) by MCO During 2015

MCO	Quarter 1	Quarter 2	Quarter 3	Quarter 4
NHHF	6,820	6,881	6,923	6,918
Well Sense	7,622	7,786	7,914	7,905
Total	**14,442**	**14,667**	**14,837**	**14,823**

The average quarterly enrollment of adults with disabilities in the New Hampshire MCM program increased slightly during 2015, with an average quarterly enrollment of 14,442 in first quarter 2015 and an average quarterly enrollment of 14,823 in fourth quarter 2015.

Table C-6 shows the average quarterly enrollment for the elderly/elderly with disabilities by MCO during 2015.

Table C-6—Average Quarterly Enrollment for Elderly and Elderly With Disabilities (Age 65+) by MCO During 2015

MCO	Quarter 1	Quarter 2	Quarter 3	Quarter 4
NHHF	1,695	1,753	1,884	2,070
Well Sense	1,528	1,565	1,731	1,866
Total	**3,223**	**3,318**	**3,615**	**3,936**

The average quarterly enrollment for the elderly/elderly with disabilities increased from an average quarterly enrollment of 3,223 in first quarter 2015 to an average quarterly enrollment of 3,936 in fourth quarter 2015.

In 2014, Senate Bill 413 created the NHHPP, which included the Medicaid expansion population resulting from New Hampshire's implementation of the Affordable Care Act.[C-1] Enrollment began in fall 2014. Table C-7 shows the average enrollment by MCO for the four quarters of 2015.

Table C-7—Average Enrollment for NHHPP (Age 19–64) by MCO During 2015

MCO	Quarter 1	Quarter 2	Quarter 3	Quarter 4
NHHF	12,681	16,572	18,273	18,213
Well Sense	14,229	18,626	20,814	21,013
Total	**26,910**	**35,198**	**39,087**	**39,226**

The most significant increase in members of all the eligibility categories occurred in the NHHPP. The total program enrollment increased from 26,910 in first quarter 2015 to 39,226 in fourth quarter 2015, an increase of 12,316 members.

[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: Dec 13, 2016.